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Chief Nurse Executive Role and Purpose:

Perceptions of Senior Leaders and Nurse Managers

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To my daughters Nisa and Nicole for their support
and constant encouragement and to my mother, the first nurse I knew

Abstract

Chief Nurse Executive Role and Purpose: Perceptions of Senior Leaders and Nurse Managers

This study explores and examines how senior leaders and nurse managers perceive the role and purpose of the chief nurse executive (CNE). Multiple changes in the healthcare environment, including restructuring, have affected the role of the CNE. Few studies document the effects of healthcare restructuring on the role of the CNE, although nurse executives across the country report multiple changes in authority and responsibility of the CNE. The perceptions of senior leaders and nurse managers are important in developing a greater understanding and appreciation of the CNE role. Case study and feminist methodology guided this study in an organization undergoing changes in organizational structure and experiencing financial pressures.

Findings from semi-structured interviews demonstrated perceptions of the CNE role are strongly influenced by contextual factors which include a limited understanding of the role, a lack of identity of the role with nursing, organizational uncertainty, and gender. In addition, organizational priorities on fiscal management, finance as a key determinant of CNE success, and the absence of disciplinary goals created tensions between perceived clinical care needs and financial goals. Nurse manager informants, more than senior leader informants, perceived an uneasy tension between the clinical and the financial goals of the organization. The themes that emerged from the data were *organizational culture, gender,* and *clinical-financial tension. Organizational culture, gender,* and *clinical-financial tension* formed the basis for the context within which the CNE functioned and nursing care was delivered.

Lack of understanding of the CNE role contributes to decisions to reduce or eliminate discipline specific leadership positions which ultimately affects the practice environment. Organizational uncertainty affects the power base and decision making authority of nurse leaders. Organizational context including gender, financial pressures, sex role stereotypes, expectations for physician satisfaction, and changes in administrative structure strongly influenced how senior leaders and nurse managers described the CNE role. While the consolidation of all clinical disciplines into a single reporting relationship facilitates integration of care, the question of how nursing maintains a disciplinary focus and a nursing identity remains unanswered.

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1 Introduction

The purpose of this study is to explore and examine perceptions of the role and purpose of the Chief Nurse Executive (CNE) held by senior leaders and nurse managers. Multiple changes in the healthcare environment, including restructuring, have affected the role of the CNE. In spite of few studies that document the effects of healthcare restructuring on the role of the CNE, nurse executives across the country report increases in eliminations of CNE positions along with reductions in authority and responsibility. While there are no statistics, attending a professional meeting with nurse executives seldom ends without a story of another CNE position which has been eliminated, demoted, or experienced reduced authority. It is not uncommon for highly respected CNEs with long tenures, educational credentials, and impeccable reputations to loose their positions. An example from an excerpt of a letter written to a 23 year veteran nurse administrator by her boss;

Effective March 1, the clinical and administrative services which report to you will be permanently reassigned...there is also a need to redefine nursing administration, its role, responsibilities, services, and structure...I would expect the process you use to develop recommendations be inclusive of key customers and stakeholders...(anonymous)
These communications come with no warning, no advance notice, and worst of all very little recourse for most CNEs.

Cost reductions, restructuring, mergers, and decentralization are the common rationale for changes in the CNE role. While high turnover in executive positions is not unheard of, there is no evidence that chief executive officer (CEO), chief operating officer (COO), or medical director positions are regularly eliminated during restructuring.

Since CNEs usually report to and are supported by CEOs and COOs, the perception of the CNE role by these and other senior leaders is important to the continued presence of the role. Nurse manager perceptions of the role also contribute to the support CNEs receive from nursing staff and nurse managers. In the absence of a CNE, nursing is at risk for the maintenance of nursing practice standards, the control of nursing work, and the maintenance of a professional practice environment for nurses. The CNE position is vital to both the clinical and financial goals of an organization.

A loss of clear and visible nursing leadership within an organization may significantly alter the practice environment of nurses by;

- eliminating nursing from organizational decision making processes
- reducing resources for nursing care
- substituting lesser qualified caregivers for professional nurses
- minimizing nursing autonomy
- reducing nurses job satisfaction

The effect of managerial structures on clinical and financial organizational outcomes is not well studied in nursing. However, the impact of strong leadership on achieving improved organizational outcomes is significant. Executive level nursing leadership positions are critical to the maintenance and development of professional nursing practice and to the creation of practice environments that promote nurse autonomy.

In addition to an organizational structure which supports the CNE role, organizational context is an important variable when examining how well the CNE role is supported. Organizational context influences not only individual perceptions of the CNE

role, but determines the extent to which the organization supports a CNE position. Male-female and doctor-nurse relationships, financial constraints, and leadership styles all contribute to the organizational culture which becomes the context in which care is organized and delivered. Organizational decision making structures demonstrate how power is distributed and the level of importance placed on leadership positions.

Healthcare is a highly gendered field with women occupying positions of less status and pay while men occupy positions of higher status and pay. Very few women occupy executive positions in healthcare. Furthermore, women continue to face barriers in achieving leadership roles as a result of sex role stereotypes that pervade many healthcare organizations. Healthcare settings are complex, bureaucratic organizations. Most healthcare administrators are male and usually dominate executive and senior level positions. Nursing and nursing care take place within this bureaucratic context in which dominance and power operate through administrative structures. Dominance and power are also present in the relationships between nurses and administrators as well as among doctors, nurses and administrators. Gender issues in healthcare have been likened to those in the larger society. Interestingly, very few studies in healthcare administration have explored why a glass ceiling exists for women in healthcare administration. Examining the organizational context within healthcare settings is important in understanding perceptions of the CNE role and purpose.

Background of the Study

The healthcare field has been profoundly affected by declining hospital admissions, rising costs, and reduced reimbursement from the federal government and third party payors. These changes affect the profit margins of both profit and not-for-

profit healthcare organizations. With the defeat of healthcare reform in 1993-4, most organizations faced the challenge of containing costs in order to restore profitability. Nursing, particularly in hospital settings, is significantly affected by cost reduction strategies. Due to the size of nursing budgets and the number of nursing employees, reductions in personnel and nursing labor costs have occurred at a rate greater than other disciplines (Leicht, Fennell, & Witkowski, 1995; Brannon, 1996). Hospital restructuring is characterized by the reduction of registered nurse (RN) staff and replacement with unlicensed personnel (Aiken & Fagin, 1997). There is little evidence that decreasing the percent of RN staff while increasing the percent of unlicensed caregivers either improves efficiency or reduces cost (Aiken & Fagin, 1997). In addition to reductions of RN staff, management restructuring has been a key feature of healthcare redesign (Gelinas & Manthey, 1997).

In many newly restructured healthcare organizations, traditional, hierarchical structures in which each discipline has its own leader are replaced by interdisciplinary teams or decentralized work units (Aroian, Meservey, & Crockett, 1996). Nursing departments are consolidated with other clinical disciplines (Gelinas & Manthey, 1997). For example, multiple clinical services such as pharmacy, nursing, respiratory therapy, and social service may report to one administrator. While consolidation may improve interdisciplinary coordination of care, it also has the effect of reducing disciplinary identity and leadership. There is limited research to show the effect of nursing administrative structures on clinical care; however, studies of magnet hospitals demonstrate that nurse executive participation in decision-making is a factor in creating

satisfying and effective practice environments for nurses (Green & Nordhaus-Bike, 1998).

> Organizational context has become an increasingly powerful factor affecting the implementation of clinical interventions and, through them, the outcomes of health care. Yet the domain of organizational outcomes research remains relatively underdeveloped. This situation is striking in view of the magnitude of investment in implementing untested models of organizational restructuring and re-engineering, particularly in the hospital industry (Aiken, Sochalski, & Lake, 1997, p. NS7)

Nursing is the largest professional group in most healthcare settings, yet nurses contribution to patient outcomes is not well explored (Aiken et al., 1997). The conditions under which these outcomes are best achieved are not well researched from an organizational perspective. The institutional roles of nursing leadership along with the organization of nursing are key factors in the creation of practice environments that promote nurse autonomy, enhanced physician-nurse communication, and nursing control over practice. Thus, the CNE role should be very influential in the development and maintenance of an environment conducive to professional practice.

The caregiving role of nurses is not usually identified as a factor in the organizational context of healthcare settings, but it is an important one. Since caring is a core tenet of professional nursing, the value society places on caregiving work becomes directly linked to the value of nursing (Rafael, 1996). Work performed by female caregivers has been less valued than work performed by men in healthcare. For many feminists, traditional caregiving work, such as nursing, is perceived to impede progress for women in the professional labor markets. When women engage in caregiving work in the labor market they reinforce the societal lack of value on caregiving work. If caregiving is less valued within society and healthcare, leaders of professions such as

nursing may also be less valued than their male counterparts in medicine. This decreased value results in lower status for nurse leaders, less power, and less access to resources. The debate surrounding the worth and value of caregiving has resulted in a tension among nursing, feminism, and the larger society.

My interest in this study has been motivated by the rapidly changing healthcare industry, restructuring that has reduced both RN staff and nursing leadership, and the need to better understand how the gendered nature of healthcare influences changes in the industry, especially changes in nursing. Cost constraints resulting in decreases in registered nurse staff and nurse leaders are incomplete explanations for the elimination of CNEs. Further examination of gender and healthcare as well as women in leadership roles is needed to more fully understand changes in the CNE role. This study examines perceptions of the CNE role and purpose held by senior leaders and nurse managers within the current healthcare environment and also uses a feminist framework as a lens of analysis.

Problem statement

While the formal role of the CNE is important in establishing authority and power for nursing, how others perceive the role and purpose are equally important. Much of the informal influence of the CNE comes from her participation and presence within leadership groups. A lack of understanding of her role and purpose or how it influences organizational outcomes and contributes to professional nursing practice adversely affects an organization's decision to retain, eliminate, or modify the CNE position. Restructured systems require extensive evaluation to determine the effectiveness of multiple strategies intended to reduce cost and improve efficiency. Evaluation of administrative structures

and their effects on the delivery of care are as important as evaluation of financial indicators.

This study explores and examines perceptions of the role and purpose of the CNE held by senior leaders and nurse managers. The research question was;

How do senior leaders and nurse managers describe the role and purpose of the CNE?

Professional Significance

Perceptions of the CNE role by senior leaders and nurse managers are important because they influence the development of new organizational structures as well as changes in existing structures. An executive nursing position impacts nursing autonomy and control over practice in addition to clinical and financial organizational outcomes. The effects of changes in nursing administrative structures needs to be better understood and evaluated. If nursing is significantly affected from organizational restructuring as suggested, the need for a CNE can not be underestimated. Changes in practice environments which reduce nurse autonomy and control of practice adversely affect the quality of care.

Overview of Methodology

The methodology is a single site case study. Case study is a research method often associated with qualitative research approaches. Qualitative approaches are used when little is known about a situation or phenomenon. The qualitative approach is used when one wants to describe, explain, and then understand situations. Instead of hypotheses or theories that emerge from the data while data collection is in progress, case studies are guided by study propositions. (Field & Morse, 1985; Yin, 1984).

Yin (1984) describes case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (p. 23). Case study is a useful strategy in nursing administration research as it allows for in-depth exploration of organizational issues. Case study method may be useful when extensive analysis is needed to better understand organizational issues (Smyth, 1989). While multiple data sources will be used, interviews with senior leaders and nurse managers will constitute a major source of information.

Study propositions are a significant component of case study methodology. They guide the collection of data and help to organize the case. Study propositions are:

1. Lack of understanding of the role and purpose of the CNE may contribute to decisions to eliminate or reduce discipline specific leadership positions
2. The absence, elimination, or reduction of discipline specific leadership adversely affects the practice environment
3. The absence, elimination, or reduction of discipline specific leadership adversely affects the ability of the discipline to control the content of its work
4. A lack of stability in healthcare organizations affects the power base and decision making authority of various leaders

While there is no single feminist method or methodology, my goal is to conduct a study that is consistent with feminist values. Specifically, I hope my research will have the potential to help women in executive practice and to influence change in the roles if warranted. Research using feminist methodology refers primarily to research that is pertinent to women, of interest to women, and developed out of the political struggles of

women (King, 1994). Feminist methodology views women through a female prism instead of traditional androcentric models. In other words, it supports the exploration of the female experience and gender. Feminist research seeks to create social change.

Limitations

The study was conducted in an organization undergoing extensive change. The leadership team and the organizational structure was relatively new. The administrator for patient care, also the CNE, had been in her position only eight months. Two other members of the senior leadership team had been there 3 months and 8 years respectively. Nurse managers, on the other hand, had very long tenure with the organization but limited exposure to the new CNE. In addition, the study was conducted shortly after the annual budget process which resulted in several cost reductions affecting nursing. The sample size was small with nine informants.

Definition of terms

The following is a definition of commonly used terms in this study.

Chief Nurse Executive	The nurse holding the most senior leadership position within an organization. The CNE is responsible for designing, facilitating, and managing patient care within complex health organizations and systems.
Disciplinary leadership	Leadership provided within and on behalf of a professional discipline such as nursing, pharmacy, social work.
Division of labor	Societal structures which support assigning some work to women and other work to men irrespective of technical or educational differences. Tasks and roles assigned to men are given greater significance and importance.
Feminism	A consciousness which opposes the oppression of women.

Gender behaviors and	Social constructions of sex which include attributes and assigned to females or males. Also referred to as a historically socially constructed pattern of power relations between men and women.
Sex stereotyping the	The assumption that certain traits are typical of one sex versus other. For example, all men are aggressive and all women are passive.
Restructuring	Changes in organization, structure, and care processes within a healthcare setting. In nursing restructuring is often characterized by the reduction of professional nursing staff and the increase of less skilled and unlicensed staff.

Summary

The purpose of this qualitative study is to explore perceptions of the role and purpose of the CNE held by senior leaders and nurse managers. A single site case study approach will be used in addition to feminist methodology. Interviews will be a major source of data. Current changes in the healthcare system which include changes in administrative structures within organizations increase the need for more evaluative research on the effects of these changes. Nurse manager and senior leader perceptions of the CNE influence organizational support for the position. Studies are needed to determine the effects of changes in leadership structures on the clinical practice environment. The next chapter identifies and critiques the major literature on women in healthcare administration, the CNE role, and feminist theory.

2 Review of the Literature

The purpose of this chapter is to examine nursing and feminism, gender and healthcare, women and leadership, and executive practice in nursing. While each of these content areas is present in the healthcare administration literature to varying degrees, they are not often linked. This chapter will explore the influence of gender in healthcare as well as women in leadership positions. While there is clear evidence of sex segregation in healthcare, very little research has studied the effect of gender on executive positions. The forces shaping CNE practice, evolution of the role, and current role responsibilities provide an opportunity to examine executive practice within the context of the gendered healthcare institution. Studies examining CNE turnover and CNE characteristics will also be reviewed. Understanding the relationships among gender, leadership, and executive nursing practice is important in order to facilitate a dialogue about the value and relevance of executive nursing practice in the changing healthcare environment.

Feminism and Nursing

Nursing has been affected in multiple ways by the women's movement. Professional nursing organizations and individual nurses distanced themselves from the early women's movement, fearing lack of professionalism and negative influence on the nursing image (Roberts & Group, 1995). In spite of this early position, individual nurses, using a feminist framework, rethought the gendered nature of the nursing profession (McBride, 1997). Reverby (1987) writes about the dilemma of nurses as they are literally ordered to care in the absence of autonomous professional status. Ashley (1980) has written about nursing's lack of power in terms of structured misogyny. Ehrenreich &

English (1972) describe the history of women healers along with the opposition by the Church and organized medicine to their work. This resulted in the eventual demise of women healers. At the core of many feminist discussions in nursing is the concept of caregiving as women's work. For many feminists, "Women's caregiving work has become a negative standard against which we measure our progress. Our progress, that is, charted in the distance women have traveled away from caregiving work, and toward traditional male activities and preoccupations" (Gordon, 1991, p. 46). Nursing and feminism have maintained a tension over the importance of caregiving work. Even though caring is a core tenet of professional nursing (Rafael, 1996), the association of caregiving with traditional women's work led nursing to be viewed as an oppressed profession by some feminist groups (Freidman, 1990). Typically female dominated professions, such as nursing and education, are held in lower esteem than male dominated professions (Crawford, 1993; Cummings, 1995). Greater use of feminist theory is needed in nursing to better examine issues such as nursing leadership and the gendered nature of the profession.

Feminist Theory

Jaggar (1988) describes four forms of contemporary feminist theory; (a) liberal, (b) traditional Marxism, (c) radical, and (d) socialist. While feminist theory in general is concerned with women's oppression and liberation, different theories explain oppression and male domination differently. Capitalism, class, patriarchy, and sexism are key concepts in most feminist theories (Jaggar, 1988). For purposes of this discussion, patriarchy is a significant issue for nursing. Hartman (as cited in Tong, 1989) defined patriarchy as;

> a set of social relations between men which have a material base, and which, though hierarchical, establish or create interdependence and solidarity among men that enable them to dominate women. This material base rests in men's control over women's labor power; this control is constituted by restricting women's access to important economic resources and by disallowing women any control over female sexuality and especially female reproductive capacities (p. 180).

There are many authors who would argue the male dominated professions of medicine and healthcare administration have perpetuated control of nursing by others (Ashley, 1980; Ehrenreich & English, 1972). Patriarchy is linked to the division of labor which is very evident in healthcare.

Division of Labor

One of the theoretical tasks of feminism is to better understand the construction of gender, which is most often defined as a social versus a biological construction. Within different forms of feminism, gender or the social construction of sex and gender are used to examine differences between men and women. In addition to the physical differences attributed to males and females, feminists focus on the social construction of female and male character types (Jaggar, 1988). Most feminist theory includes not only claims about human psychology and physiology but also claims about social institutions and ways of organizing social life. Social institutions and the way social life is organized have contributed significantly to the social differences between females and males.

> The differences between men and women are both physical and psychological. ...feminism claims all of the following: that our "inner" lives, as well as our bodies and behavior, are structured by gender; that this gender-structuring is not innate but is socially imposed; that the specific characteristics that are imposed are related systematically to the historically prevailing system of organizing social production; that the gender-structuring of our "inner" lives occurs when we are very young and is reinforced throughout our lives in a variety of different spheres; and that these relatively rigid masculine and feminine character structures are a very important element in maintaining male dominance (Jaggar, 1988, p. 127).

In order to fully understand the social construction of gender, socialist feminists use the construct of division of labor to further explore differences (Jaggar, 1988). Division of labor focuses not only on the individual but on social relations and institutions (Tong, 1989). Young (1990) describes the importance of institutional context with non-distributive issues of justice such as decision making structure and procedures, division of labor, and culture. Thus division of labor at both the institutional and individual levels is critical to the discussion of gendered work or who does the stimulating work and who does the repetitive or drudge work. This division of labor is very apparent in hospital systems with lower paid female employees performing housekeeping, bathing, and feeding duties while male employees are more often engaged in high technology and diagnostic work. The way work is organized in hospitals also reflects class status of many employees including nurses (Allen, 1987). The production process in hospitals is similar to that in manufacturing industries (Allen, 1987) and is male dominated (Jaggar, 1988).

> ...the division of labor reflects the same principles that capitalists in other industries have used to control labor and maximize profit. Despite the non-profit status of some hospitals and their claims to employ "professionals: rather than just "workers," hospitals "do not differ greatly from professionally managed-for-profit firms, both seeking growth as the primary source of managerial gratification (Alford as cited in Allen, 1987, p. 22).

Historically, women have been defined by their roles in childbearing and childrearing or what Jaggar calls procreative labor. The significance of sex and gender identity stems from this perspective. Just as the role of women in the private domain arises from procreation, so are the roles assigned to women in the public domain or markets outside the home. As a result, women are disproportionately assigned to nurturing and service occupations such as nursing, secretarial and social work, and teaching (Jaggar, 1988).

> ...feminism recognizes the extent of women's productive work, it recognizes that this work has rarely, if ever been the same as men's. Even in contemporary market society, socialist feminism recognizes that the paid labor force is almost completely segregated by sex; at every level, there are "women's specialties." Within the contemporary labor force, moreover, women's work is invariably less prestigious, lower paid, and defined as being less skilled than men's, even when it involves such socially valuable and complex skills as dealing with children or sick people (Jaggar, 1988, p. 129).

Like the description of division of labor used by Young to move beyond class analysis, alienation is a unifying concept for Jaggar (1988). Jaggar (1988) claimed women experience alienation with their bodies, motherhood, the process of reproductive labor, childrearing, and intellectual capacities (Jaggar, 1988; Tong, 1989). This alienation is caused by a separation from the product and the process much like workers are separated from the products of production. Capitalism, patriarchy, division of labor, and alienation provide frameworks for understanding women' oppression in healthcare as well as society in general. The bureaucratic nature of most healthcare organizations reinforces both patriarchy and an unequal division of labor.

Feminism and Bureaucracy

In the Feminist Case Against Bureaucracy, Ferguson (1984) describes the problematic relationship between feminism and bureaucracy. As a movement for social change, feminists have been interested in either gaining access to established institutions or transforming them based on the assumption they are fundamentally flawed. Healthcare systems are bureaucratic organizations with patterns of dominance and subordination. Bureaucracies are both a structure and a process in which there exists a context of social relations between classes, races, and sexes that are unequal (Ferguson, 1984). The commitment of bureaucratic organizations is to rule-following and control. Specific

language is developed in order to allow personnel to maintain control over their objects and procedures. One must learn the language and the rules in order to play on the turf of the organization. Bureaucratic language often obscures who is responsible for actions, making it difficult to resist (Ferguson, 1984). "In fact bureaucracies are political arenas in which struggles for power, status, personal values, and/or survival are endemic (Ferguson, 1984, p. 7). Women, who may already be under-represented in executive positions, may have difficulty gaining the access and acceptance they need to learn organizational rules and language.

Ferguson (1984) believes women's experience institutionally is different from men's, and results in a submerged voice rendering a distorted experience for women because of oppression. There is a relationship between capitalism and bureaucracy in that capitalism needs bureaucratic administrative structures to "impose predictability and stability on the economic realm" (Ferguson, 1984, p. 38). Nursing and nursing care take place within the context of bureaucratic organizations in which dominance and power are constantly operating through administrative structures as well as relationships between nurses and administrators, males and females, doctors, nurses and administrators. The consequences of hierarchical domination characteristic of bureaucracies is that the roles available in the organization parallel a class system. Tasks, as well as people, are divided and subdivided across and within occupations resulting in an organizational class structure consisting of the elite (physicians and administrators), working class (nurses and technicians), and marginal workers (janitors, aides, and dietary workers) (Ferguson, 1984). This division of labor in healthcare mirrors the division of labor described by Tong and Jaggar. The division and subdivision of tasks results in deskilling which has

invaded technical, managerial, and professional activities within bureaucracies. Deskilling has been very evident in nursing with the introduction of lesser skilled and trained employees hired to perform tasks usually performed by licensed personnel. Deskilling minimizes autonomy as well as individual control over work processes, subjecting workers to greater supervision and control by others (Ferguson, 1984). Power relations are tied to the activities they organize.

> Bureaucratic power is certainly repressive in clear and definable ways: it does cognitive and affective damage to its victims, rendering them "less restricted to themselves and their environment, more restricted in the scope of their actions, more cautious in their aspirations and rigidly narrow in their cognitive structures." (Polsky as cited in Ferguson, 1984). The incumbents in the higher levels of organizations lose greatest sensitivity to and flexibility in the arenas of concrete action, while the incumbents in the lower levels are made more insensitive and rigid with regard to abstract thought, but in both cases genuine cognitive damage has been done, rendering people less than they could otherwise have been (Ferguson, 1984, p. 90).

Thus bureaucracies reinforce the oppression and domination characterized by patriarchal systems. Women within these institutions function as subordinates and learn skills necessary to cope with subordinate status (Ferguson, 1984). "Women entering organizations are usually required to put aside the person-oriented values of women's traditional role in order to embrace the organization and prove themselves "one of the boys" (Ferguson, 1984, p. 94). Understanding how patriarchal systems continue to influence nursing, especially executive practice, is equally important to understanding how gender influences healthcare. Increasing awareness and knowledge about both patriarchal systems and gender are necessary in advancing the dialogue about the CNE role.

Gender in Healthcare

Gender is a historically and socially constructed pattern of power relations between men and women (Cummings, 1995; Harding, 1998; Klenke, 1996; Witz, 1992). Despite the prevalence of sex segregation in healthcare, there is minimal evidence of how it affects the structure or delivery of healthcare services (Butter, Carpenter, Kay, Simmons, 1987). There are no known studies of women in leadership positions in the healthcare industry (Muller & Cocotas, 1988). The majority of participants in the 1997 Gender and Leadership in Healthcare Study indicate gender plays a major role in healthcare leadership (Robinson-Walker, 1999). The marriage of the male dominated medical culture with the male dominated hierarchical corporate culture results in "dominance squared" (Robinson-Walker, 1999). Nursing, as a female dominated profession, in a physician oriented healthcare system, often mirrors the role of women in the general society (Ashley, 1980; Butter et al., 1987; Carter, 1994; Crawford, 1993; Cummings, 1995; Ehrenreich & English, 1972; Passau-Buck, 1994; Vance, 1979). Historically, women do not hold large numbers of senior positions in healthcare (Butter et al., 1987; Crawford, 1993; Muller & Cocotas, 1988; Weil & Kimball, 1996). Less than 5% of all hospital chief executive officers (CEOs) are women (Prothro, 1981). Between 1981 and 1991 women healthcare managers increased by 14%, but the proportion of women senior executives only increased from 1% to 2% (Crawford, 1993). Stereotypic sex role attitudes toward women's qualifications and potential for management roles continues to present barriers for women in healthcare administration. The strength of the glass ceiling for nursing is a reflection of the power structure of a male dominated system (Crawford, 1993). The glass ceiling "effectively cuts the pool of potential corporate

leaders by eliminating over one-half of the population" (US Department of Labor, 1995). Borman (1993) found few publications in nursing have studied why a glass ceiling exists for nurses in hospital administration. While women continue to have difficulty achieving executive positions in healthcare, physicians are entering the ranks of executive leadership in growing numbers.

Physicians in the Executive Ranks

Increasingly, executive teams are made up of politically powerful physicians who are trained in skills of leadership and management (Davidson, 1996). Their participation in the executive arena is changing the composition and character of executive teams (Tjosvold & MacPherson, 1996). While there is little evidence that greater physician involvement in organizational management results in better profitability, physicians are doing more than serving as committee members (Tjosvold & MacPherson, 1996). Physicians generate revenue within hospital settings and consequently retain status and power in resource decisions (McMahan, Hoffman, & McGee, 1994). Physicians are valued and rewarded above others in the healthcare system (Roberts, 1983). In the current environment, physicians are critical to the financial success of hospitals. They are necessary for attracting patients to hospitals and for increasing hospital admissions, therefore many hospitals work hard to attract physicians. On the other hand, nursing services are rarely billed separately from the room and board charge. Nursing wages are considered high costs in most hospitals which has prompted much of the recent replacement of licensed professional nurses with unlicensed caregivers.

Nursing, with its historic ties to medicine, is one of the strongest examples of oppressive behavior of physicians (men) toward nurses (women) (Passau-Buck, 1994).

Historically, relationships between nurses and physicians have been strained due to issues of control of practice, wages, and decision making roles. Organized medicine and hospital administrators directly influence nursing education, economics, and professional status (Friss, 1994; Passau-Buck, 1994; Roberts, 1983). More than 25 years ago, Cleland (1971) asserted "leaders in nursing have often been an elite and marginal group that have maintained the status quo in return for rewards from physicians in power" (p. 1544). While nurse leaders may be perceived as elite within the ranks of nursing, maintaining the status quo is no longer possible. However, the effects of having mostly male physicians in executive positions is unknown, but it is bound to influence the leadership dynamics in most organizations. Unlike physician leaders who are valued for their clinical expertise, nurse leaders have faced an ironic dilemma of a lack of value of their clinical background.

Nurse Leaders and Nursing Identity

The nursing identity within organizations is a very real issue for many nurse executives. Many titles no longer reflect the nursing role (Beyers, 1997; Fagin, 1996). Nurses in administrative practice find the nurse identity disadvantageous. It is not uncommon for nurses to say they would not be hired for jobs outside the nursing department if they promoted their nursing identity. Deliberately omitting nursing credentials makes nursing roles, power, and the future of nursing invisible (Fagin, 1996). The elimination of nursing credentials in titles or position descriptions suggests the knowledge base of nurses is not needed for the complex work in healthcare administration.

Within an organizational context of cost constraints, male dominance, tension between professional groups, declining reimbursement for services, and projected RN workforce shortages, CNEs must attempt to translate the nursing agenda, caring practice and the creation of environments that foster caring and the delivery of complex care, into a meaningful dialogue. The new paradigm of leadership requires flexible networks or integrated systems to replace hierarchies and for caring to become a legitimate workplace motivator (Klakovich, 1994) The critical work of the CNE is to facilitate integration of clinical systems and retain caring environments in which highly complex care can be delivered. Increasingly, nurse executives are members of senior management teams and face the ever-present challenge of balancing patient care needs against organizational constraints and forces (Buerhaus et al., 1997). They must confront staff nurse perceptions that they are further away from patient care and have "joined the elite administrative" ranks (Klakovich, 1994).

In addition to identity with the profession and perceptions of distance from clinical staff, CNEs may need to assume a different set of values, those of their male business and medical executive counterparts, in order to get ahead (Roberts, 1997). Nurse executives may also believe their association with nursing weakens their power (Roberts, 1997). Women who move up in the hierarchy must decide whether to emulate the normative behaviors defined by males and break sex role stereotypes or emulate 'female leadership characteristics' (Muller & Cocotas, 1988). The most recent era of downsizing and cost containment places nurse executives in the difficult position of making reductions in professional staff with minimal data to support these changes. These decisions represent significant personal and professional conflicts for many CNEs. It is

difficult to defend nursing positions and the work of nurses when they are associated with the less valued caretaking roles of women.

Women's Work

There is evidence that healthcare work performed by women is less valued than work performed by men. This may also suggest leaders of healthcare workers who are predominately women may be less valued than their male counterparts. Butter et al., (1985) noted that men are over-represented in somatic-diagnostic and technical occupations such as medicine, dentistry, and podiatry, while women are over-represented in psychosocial and supportive occupations such as nursing, social work, and counseling.

> The traditional division of labor between men and women in the family has penetrated into the health labor force. Functions performed by women in the family-cooking, cleaning, and educating, as well as caring, consoling, counseling, nursing and nurturing-become institutionalized in the health care system in the form of "female type jobs." ...The health labor force is notorious for its hierarchical status and power structure (Butter et al., 1985, p. 10).

Gendered social structures are produced by assigning some work to men and others to women (Harding, 1998). The historical context of healthcare is one in which women have the lower paid, lower status work and men usually have higher status, higher pay work. Harding (1998), like Tong and Jaggar, describes gender difference as constituted through structural divisions of labor. Caring for bodies and the places they reside is part of women's paid and unpaid work. Smith (as cited in Harding, 1998) suggests that men in administration and management have difficulty seeing these activities, as the caring for bodies has become invisible in our culture. This lack of visibility of a major component of women's work contributes to the lower pay and lower value associated with the work. Caring, a core tenet of nursing, is women's work; it is thought not to require knowledge,

thus creating gender and power inequities between medicine and nursing (Rafael, 1996). Nursing uses caring as a concept to differentiate itself from other disciplines. It has developed theories of caring and identified nursing interventions that support the concept. While much of this effort is positive, it may adversely affect the discipline by reinforcing work that is undervalued. Hare-Mustin and Marecek (1994) describe how caring is extolled as a superior virtue of women and at the same time is a virtue arising from women's subordination. Weil & Kimball (1996) found activities which promote and maintain health are less valued than the curative functions of medical care. Masculinity is associated with curing while femininity is associated with caring (Passau-Buck, 1994). Thus, even though nurses and physicians bring very different but necessary skills and knowledge to the care of patients, they are not viewed equally by the system or administrators.

In spite of the fact that both men and women work in healthcare organizations, often side by side, they live differently and have different experiences within the same 'culture'. Nurse leaders continue to work in a patriarchal system in which men dominate top level positions and make decisions about who is mentored, promoted, and hired (Borman, 1993). Within the healthcare culture, gender provides another lens for understanding the division of labor and how historical contexts for women's work contributes to meaning systems (Code, 1995). Gender is also co-constituted with other hierarchically organized social relations such as class, race, and ethnicity. Class differences, primarily differences in education and earnings, exist between nurses and physicians as well as nurse executives and other healthcare administrators.

Women in Healthcare Administration

In a survey by the American College of Healthcare Executives, men in healthcare earned more than women in healthcare on average of $16,000 annually; women were more likely to have degrees in fields other than healthcare administration and business; women were more likely than men to have practiced in a clinical discipline such as nursing prior to entering administration; and women with clinical experience earned significantly less than men (Weil & Kimball, 1996). The same study concluded that women were less likely to be promoted to CEO, stereotypes of male and female leadership still operate, women reported more home responsibilities than men, and women reported less satisfaction with male colleagues (Robinson-Walker, 1999). Larger wage differentials occur when women work in male dominated areas such as executive positions (Butter et al., 1987).

In spite of the fact that enrollment of women in healthcare administration programs has increased from 14% to 52%, the overall percent of women in executive positions remains low (Weil & Kimball, 1996). Currently, only 2-5% of executive positions are filled by women (Martell, Parker, Emrich, Crawford, 1998). Women in healthcare administration are more likely to have staff positions than line positions, and be responsible for housekeeping, dietetics or nursing than their male counterparts (Butter et al., 1985). Sex role stereotyping continues to operate in healthcare. Factors which affect sex role stereotyping in health occupations include;

- social and economic role of family in society
- relegation of women to secondary labor markets

- role socialization and sex role stereotyping that devalue the feminine
- hierarchical organization and rigid barriers between levels of health occupations

Healthcare continues to be a gendered field with few women rising to executive level positions. Far too little information is available about why this happens and what the effects are within healthcare organizations. In addition to the influence of gender in healthcare, sex role stereotyping of women in leadership positions continues to challenge women's ability to effectively enter the executive ranks.

Women and Leadership

Medical culture remains male dominated as does the corporate culture of most healthcare organizations. Leadership for women in this male dominated culture has been difficult. There continues to be skepticism about women's ability to lead in spite of numerous studies that demonstrate minimal or no sex differences in leader effectiveness (Dobbins & Platz, 1986; Eagly, Makhijani, & Klonsky, 1992; Eagly, Steven, & Makhijani, 1995; Kolb, 1997). While there is no single definition of leadership, it is often described by individual traits, leader behavior, interaction patterns, role relationships, follower perceptions, influence over followers, influence over task goals, and influence on organizational culture (Klenke, 1996; Yukl & Van Fleet, 1992). Situational approaches to leadership, which consider how the situation influences leadership and how the situation moderates the relationship between leader attributes and measures of effectiveness, include contextual factors such as leader authority and discretion (Yukl & Van Fleet, 1992). Klenke (1996) describes leadership as shaped by culture which is influenced by gender, context, and leadership/followership relations. Healthcare and

medicine are cultures influenced by male values. Stivers (1991) traces the low profile of nursing, the lack of recognition of its contribution, the blurred image of its executives, and its strained relationships with other key professions to the fact that the majority of the profession are women, "striving to be effective in an organizational and political world that is still, despite some gains, overwhelmingly dominated by masculine perspectives and largely controlled by men" (p. 49). Leadership styles, in addition to culture, inform perceptions of women in executive positions.

Male versus Female Leadership

The scientific literature fails to support the distinctions between feminine and masculine leadership styles (Eagly et al., 1992; Eagly et al., 1995; Klenke, 1996). Results from many studies on sex linked leadership differences are conflicting and inconsistent (Dobbins & Platz, 1986). Prior to the 1980s, most leadership research was conducted by men on male leaders (Klenke, 1996). In spite of an absence of sex differences in managerial ability (Klenke, 1996) or motivation, women do less well in earnings, performance ratings, and organizational mobility (Martell et al., 1998). The process of male initiated and maintained sex role stereotyping has attributed personality traits of aggression, dominance, and objectivity as masculine and nurturance, passivity, and subjectivity as feminine (Klenke, 1996; Kolb, 1997; & Passau-Buck, 1994). Research on sex stereotyping show people still have perceptions that women lack the characteristics seen as those needed to succeed in managerial ranks (Martell et al., 1998). Sex stereotyping reinforces skepticism about the ability of women to lead (Eagly et al., 1995). The common understanding of what it means to be a leader is shaped by men, as well as the characteristics associated with men, men's values, and performance (Stivers, 1991).

Dobbins and Platz (1986) found leader behavior, initiating structure, and subordinate satisfaction did not differ by sex. Eagly et al., (1992) found female leaders were evaluated only slightly less positively than men in an analysis of evaluation of men and women in leadership roles. When women use stereotypically masculine styles, such as aggressive behavior and less relationship focused communication, they are devalued more than males using the same styles (Eagly et al., 1992). When women occupy male dominated roles and the evaluators are men, they are also valued less highly (Eagly et al., 1992). Leadership is more often associated with the masculine and women may violate societal expectations of women's roles when they assume leadership positions resulting in prejudiced reactions, biased performance evaluations, and negative preconceptions about future performance (Eagly et al., 1995).

Leadership and Power

While gender plays a critical role in leader perceptions and behavior, structural variables such as formal role structure are powerful guides to leader behavior (Eagly et al., 1995). Formal roles confer authority and power (Kantor, 1993). Leadership requires the development and exercise of power, which is needed to sustain action within organizations (Pfeffer, 1992). Dominance plays a significant role in the acquisition and exercise of power (House, 1991). Control over resources, control over access to information, formal authority, ties to powerful others, and importance of the department or unit to the organization are all sources of power (Pfeffer, 1992). The role of the CNE, her location within the organizational structure, her ability to obtain resources, and access to information are key indicators of power of the position. Ragins and Sundstrom (1989) argue that power develops over time and grows from an accumulation of resources during

an individual's career. The high turnover and chaos in healthcare may negatively affect the ability of the CNE to obtain needed resources. As uncertainty increases in large, complex organizations, power bases shift (Kantor, 1993). Reorganizations, which have been frequent in healthcare systems, can be seen as power moves or ways to enhance leader power by creating new uncertainties, removing opposition, or rendering others less effective (Kantor, 1993).

Many authors (Ashley, 1973; Doering, 1992; Rafael, 1996; Roberts and Group, 1995) describe the historical forces that have lead to the lack of power in and subsequent oppression of nursing. Roberts and Group (1995) describe the need to link the relationship between gender and professional roles in order to fully understand the struggles of professional nursing. Rafael (1996) cites the increased use of unlicensed personnel and medical lobbying to restrict the scope of advanced practice nurses as examples of others exerting control over nursing. The wages and working conditions of nurses are usually subject to the decision making authority of administrators and physicians (Allen, 1987; Rafael, 1996). The power relationship that has evolved between nursing and medicine limits the scope, recognition and potential of nursing. The replacement of nurses by unlicensed personnel not only indicates a lack of acknowledgment of the economic worth of nursing but a lack of recognition that caring requires specialized knowledge possessed by professional nurses (Hernandex, Spivack & Zwingman-Bagley, 1997; Rafael, 1996). Nursing provides specialized care based in the behavioral, physiological, and sociological sciences.

Young (1990) describes power as being unequally distributed in some domains and suggests those with more power in one domain are likely to have it in several

domains. She further asserts that the connection between the distribution of power and income, status, privilege and wealth is not random. Historically, physicians have earned significantly higher wages, been afforded higher status and privilege in society and been more influential in the decisions affecting the delivery of healthcare. Hospital revenues are highly dependent upon physicians. The American public has come to believe that medical care and health care are one in the same. Healthcare, historically, and to a large degree currently, continues to be defined by physicians. When one dominant group such as physicians define healthcare, the perspectives of the non-dominant group, nurses, are unrecognized (Young, 1990). This failure to acknowledge the perspective of the non-dominant group renders nursing invisible in the political arena. As a result, the knowledge base and research of nursing is accorded minimal attention from medical and healthcare institutions. Just as non-dominant groups become invisible within healthcare systems, the elimination or reduction of nurses in executive positions renders leadership for professional nursing ineffective.

Nurses and nursing executives become marginalized when their positions are eliminated or minimized. Marginalization, a form of oppression, occurs when the labor system chooses not to use a particular group (Young, 1990). The increased use of unlicensed personnel marginalizes professional nurses as a group. The elimination or reduction of the scope of a CNE marginalizes the administrative practice of nursing. As healthcare systems reduce the use of registered nurses in favor of unlicensed staff, new rules of employment are created with which nurses must comply in order to work. These rules promote marginalization and include greater responsibility for supervision of others, fewer full time positions, and higher patient to nurse ratios. Marginalization within

nursing administration reduces the control of nursing practice by nurses and shifts control to other groups. Without strong and visionary leaders the profession remains powerless and divided (Girvin, 1996).

Feminist theory, gender, and leadership are critically important in providing a context for understanding changes in the CNE role. While cost reductions and market forces may help to explain changes in healthcare, they are inadequate explanations for why women have not increased their numbers in executive positions in healthcare. Healthcare occupations remain highly gendered. Nursing has not escaped the effects of being a female dominated profession. Nursing executive practice is clearly influenced by gender. A more in-depth explanation of the evolution, responsibilities, and education of the CNE will follow.

Forces Shaping the CNE Role

The last 10 years have seen remarkable and unprecedented change in the health care field. A transformation of the healthcare system with massive reform was expected in 1993 and 1994. This reform would have maintained nursing's goals of universal access, equity, primary care, prevention and wellness, and a recognition of the fuller use of nurses (Keepnews & Marullo, 1996). In 1995 and 1996, with the defeat of comprehensive health reform, the healthcare environment was radically different. The focus on patients and quality of care shifted to cost, utilization control, and profit (Keepnews & Marullo, 1996). Healthcare, in the later part of the decade, was characterized by the pursuit of market share, the development of referral networks, the search for profitable admissions and subscribers, relentless cost cutting, and other practices (Keepnews & Marullo, 1996; Kuttner, 1999). Characteristics of the current

healthcare environment include downsizing of the workforce, increased use of unlicensed personnel, shorter lengths of stay, declining hospital admissions, increased acuity in both acute and ambulatory care, and a change in locus of care from acute to ambulatory settings. Declining hospital admissions, increasing costs of labor and technology, reduced reimbursement from the federal government and insurance plans all contribute to the need to change the healthcare system. As profit margins have narrowed, there is greater pressure to contain costs and restore profitability especially in the not for profit sector.

The role of chief nurse executive (CNEs) is also undergoing unprecedented change. The CNE role has a long history in the hospital setting and its evolution and subsequent changes are often linked with the acute care setting. Organizational changes resulting in downsizing and reengineering of hospitals and healthcare systems have many effects on the numbers, influence, and future capabilities of nurses and nursing. The future of nurse executive practice is not only changing but uncertain. CNE roles and status in newly integrated delivery systems are inconsistent and unclear.

Evolution of the Nurse Executive Role

The nursing administrative role originated in the early hospitals organized by Nightingale. While most often associated with the establishment of modern nursing, Nightingale was also instrumental in developing the organization of nursing services (Henry, Woods, & Nagelkerk, 1992). Nightingale established two groups of nurses, head nurses and superintendents. Head nurses and superintendents were selected from those of a higher class and with better finances (Klakovich, 1994). Called specials, superintendents and head nurses were generally better educated, and assigned less ward duty (Klakovich, 1994). The administrative structures of the late 19th and early 20th

century hospitals were centralized and hierarchical (Clifford, 1998). Nightingale's administrative plan for the hospital included a lay administrator, the senior nursing leader, and a physician leader (Clifford, 1998). This plan remained central to the administrative structures of many of the nations' hospitals until the last 15 years.

In 1927, an American Medical Association survey found nurses managed 20% of all hospitals (N=1506) (Alexander, 1997). By 1941, 41% of all hospitals were managed by nurses (Alexander, 1997). Following World War II, when most hospital expansions took place, boards and trustees began to worry more about the financial status of hospitals. They believed the women, mostly nuns and nurses, did not have the financial skills needed to manage the increasing revenues from reimbursement (Alexander, 1997). It was during this time that many heads of hospitals, who were nurses, were replaced by mostly male administrators and physicians. Healthcare administration has remained dominated by men since then (Butter et al., 1985; Butter et al., 1987; Caplan, LeRoy, Rosenthal, & Shyavitz, 1988; Crawford, 1993; Cummings, 1995; Martell et al., 1998). In spite of the presence of a nursing director, physicians and administrators politically dominated hospital systems through control of nurse training, numbers of students, and nursing practice (Lewenson, 1996). Physicians worried nurses would become too educated or too independent to serve in the "nonthreatening" assistant role (Lewenson, 1996).

Over time, hospitals became increasingly complex with sicker patients and more complex technology. The number of registered nurses also grew to provide more complex hospital care. Nursing units became specialized, demanding a management structure to oversee and supervise clinical care. Historically, the top nursing administrative position

was referred to as the Director of Nursing. While early on most leaders agreed the leadership position in nursing should be confined to nursing, by the mid 1980s many supported responsibility for non-nursing departments such as nutrition, social service, and respiratory therapy in addition to nursing (Klakovich, 1994). From the mid 1980s to the early 1990s, the title and scope of responsibility changed, reflecting not only increasingly complex environments and the need for educationally prepared nurses but also the desire to establish parity with other executive level positions. Nurse executive titles began to change from Director of Nursing to Vice President of Nursing or Patient Care Services or Chief Nurse Executive (CNE) (Klakovich, 1994; Singleton & Nail, 1988). Along with changes in title came changes in responsibilities. CNEs became members of executive leadership teams.

CNE Role and Responsibilities

The chief nurse executive refers to the person holding the most senior nursing position within an organization. With increasing complexity of hospital care, CNEs are viewed as key players along with other senior leaders. They are relied upon for management of the nursing organization, to establish productive relationships with medical staff, to assess the clinical environment, initiate programs, develop and implement policy, and forecast trends (Klakovich, 1994). High cost, multi-million dollar nursing departments require sophisticated, and educated leaders. CNE practice is most often defined as designing, facilitating, and managing patient care within complex health organizations and systems (AONE, 1996). The CNE is responsible for the environment of care and practice (AONE, 1996). This responsibility includes;

- managing relationships within nursing and other disciplines
- developing a management system to ensure organized and efficient care practices
- facilitating resources for patient care
- assuring knowledge and skill needed for effective and efficient care for patients, families, and communities (AONE, 1996)

The American Organization of Nurse Executives has been instrumental in defining and expanding the definition of CNEs. In addition to role responsibilities, the key processes recognized by the AONE for executive practice include;

1. facilitating patient care delivery design
2. advancing the discipline
3. building relationships and connections
4. facilitating transitions
5. positioning and representing nursing
6. researching, developing and supporting clinical care
7. negotiating
8. fostering stewardship
9. system integration (AONE, 1996).

The CNE requires skills of cost accounting, predictive modeling, budgeting, variance analysis, personnel management, and system design (Fralic, 1987). .

CNEs play a pivotal role in establishing a practice environment for nurses and are instrumental in building a cadre of professional caregivers who can manage the complexities of the healthcare system. The CNE does this through the development of

practice standards, policies, compliance with regulations, hiring processes, continuing education, and effective managerial structures for monitoring work processes. The Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHO) requires standards for the organization of nursing services. They include clinical practice, staffing, education, and training standards. In 1991, JCAHO mandated nurse executive participation in the development of the hospital mission, strategic plans, budgets, resource allocation, operation plans, medical staff meetings, governing board meetings, and policies (Banaszak-Holl et al., 1999; Smith et al., 1994). While studies of magnet hospitals demonstrate that the participation of the nurse executive in organizational decision making is a key factor in the increased autonomy of nurses, nursing control over practice, improved clinical outcomes, and lower mortality rates (Aiken, 1995), there are few studies that link organization of nursing services with patient care outcomes. In the current environment of predicted shortages of RNs, the CNE plays a critical role in the projection of workforce needs, the development of organizational strategies to meet those needs, and the continued monitoring of the quality of nursing care. A trained and appropriately managed nursing workforce is essential to patient safety (Keepnews & Marullo, 1996). The successful management of scare resources, while assuring quality, is critical to managing costs in constrained environments. Balancing patient care needs against organization constraints is a significant challenge for the CNE. While organizational and disciplinary goals should be compatible, they may be in conflict.

Disciplinary Leadership

Fagin (1996) describes the dilemma for nursing in the current environment as one in which discipline building is challenged. Historically, discipline leaders are responsible

for building their disciplines in addition to promoting organizational goals. In nursing this means the continued development of nursing practice standards, the conduct of nursing research, the integration of nursing research into clinical practice, and the development of professional practice systems which promote autonomy and foster the clinical judgment of nurses as independent caregivers. Cost constraints in the current climate tend to place organizational goals over discipline building goals (Fagin, 1996). When nurse leaders seek to build disciplinary goals they are subject to the criticism of turf protection. Organizational goals of interdisciplinary practice are often interpreted as either-or: either support interdisciplinary practice to the exclusion of the discipline or support disciplinary practice at the expense of interdisciplinary care processes. Both discipline building and interdisciplinary processes are needed in complex care environments. Members of professional groups must learn to interact outside of the rigid departmental hierarchies in many hospitals and at the same time establish, maintain, and monitor their own standards of practice. Discipline building is important in order to control nursing work processes, wages, and working conditions, as well as to the provision of a competent workforce. The education of the nursing workforce, as well as the preparation of its leaders, is critical to the ability of nursing to maintain professional standards and to patient safety.

CNE Preparation

While medical education moved quickly into the university setting in the early 20th century, nursing was slow to do so (Doering, 1992). The first program for nursing administration was opened at Teachers College at Columbia University in 1899. The program was eight months long and prepared nurses for supervisory and superintendent positions (Alexander, 1997). A rise in graduate programs for nursing administration was

not seen until the 1950s and early 60s. This increase was in response to the need to have better prepared and qualified nurse administrators. During the same time, the standard education for healthcare administrators was a masters degree in business administration (Alexander, 1997).

By providing direction to the largest group of healthcare professionals, Sovie (1987) states the leadership activities of the nurse executive shapes both the present and the future. Historically, nursing is the largest cost center in a hospital with the largest number of employees (Aiken, Sochalski, & Anderson, 1996; Clifford, 1998; Fralic, 1987). The CNE must be well prepared to assume executive role responsibilities and to influence organizational outcomes. Debate about the preparation of the CNE is ongoing. Most agree graduate education is a minimum for the CNE, yet opinion is divided on whether graduate education should be in nursing or in business. Dual degrees in nursing and business are advocated by some nursing administrators and educators (Alexander, 1997). The focus of nursing administration graduate education is on theories of leadership, economics, and politics; decision making; management; organizational theory and behavior; change and change strategies; and research methods (McCloskey, Gardner, Johnson, & Maas, 1988; Simms, 1991). The purpose of graduate preparation in nursing administration is to integrate concepts from nursing, business, and management (McCloskey et al., 1988). Nursing administration programs integrate clinical knowledge with organizational processes. McCloskey et al., (1988) suggests the focus of health care administration or business graduate programs is on goods rather than service. Nursing administration programs focus on knowledge needed to coordinate human and material resources for care in addition to knowledge needed to function within different

organizational structures (Simms, 1991). While only 9% of the nation's 2.5 million registered nurses are master's prepared (Moses, 1994), by 1991 approximately 41% of directors of nursing held advanced degrees (Fagin, 1994). Less than 1% of all nurses are doctorally prepared (Moses, 1994). By 2000, the need for master's and doctorally prepared nurses is expected to double (Aiken, 1995). As care shifts from hospitals to community settings and is increasingly complex, the need for more broadly prepared clinicians and effective nursing leaders also increases.

The development of a theory base for administrative practice has been slow (Alexander, 1997). This absence of a strong theoretical basis for practice often disadvantages nurse executives in their ability to integrate research into their administrative practice. Very few studies explore how nursing administrative structures affect clinical, financial, and satisfaction outcomes. While programs to prepare advanced practice nurses rose in the 1970s and 1980s, programs for nursing administration declined (Alexander, 1997). Federal Nurse Education Act funds have been targeted toward the preparation of advance practice nurse such as nurse practitioners, midwives, and nurse anesthetists (Rapson & Rice, 1999). The number of graduate prepared nurses in administration and education has declined as a result of a shift in resources to advanced practice education (Rapson & Rice, 1999). In 1993 the Public Health Service Act eliminated traineeship funds for graduate education in nursing administration (Alexander, 1997). The federal government continues to subsidize medical education, including diploma nursing education, at the rate of 6.5 billion dollars annually (Aiken, 1995; Pew Health Professions Commissions (PHPC), 1995).

It is difficult to separate the education and preparation of nurse executives from nursing in general. The education of members of a profession is directly linked with its status, economics, and influence. The multiplicity of entry levels in nursing is a key factor in nursing economics, supply, and parity with other professions. Entry levels for pharmacy, public health, medicine, and dentistry are all higher than nursing (PHPC, 1995). Wage and educational differences between nurses and other healthcare providers have reinforced power imbalances. The educational preparation of the CNE at the graduate level is important in achieving parity with other executive positions. In addition to changes in educational preparation, roles and responsibilities, cost constraints have affected the role of the CNE.

Restructuring, Redesign, and CNEs

Restructuring and redesign in acute care settings significantly affect the role of the CNE. Efforts to redesign systems in order to reduce cost began in the late 80s and continues (Aiken et al., 1996; Aiken & Fagin, 1997; Alexander, 1997; Anderson, 1993; Brannon, 1996; Byers, 1994; Davidson, 1996; Gelinas & Manthey, 1997; Greene & Nordhaus-Bike, 1998; Hinderer, 1997; Jobes & Steinbinder, 1996; Leicht, Fennell, & Witkowski, 1995; Lumsdon, 1995; Patterson, 1994; and Ryan, 1990). In spite of declining hospital admissions and increasing outpatient visits, hospital employment grew 11.3% between 1981 and 1993 (Aiken et al., 1996). Hospitals experienced a 46% increase in non-nurse administrators and a 50% increase in other professional staff while nursing employment declined 7.3% (Aiken et al., 1996). The majority of the nation's 2.5 million registered nurses continue to be employed in hospitals (Moses, 1994). The Bureau of Labor Statistics (as cited in Shindul-Rothschild, Berry, Long-Middleton, 1996) predicts

the percent of RNs employed in hospitals will decrease from 63.8% in 1995 to 57.4% in 2005. Until recently, the largest employee group and highest cost in the hospital was the nursing department. While nursing employees as a total percent of the hospital workforce have dropped from 45% in 1981 to 37% in 1993 (Aiken et al., 1996), the size of nursing budgets and the number of employees make nursing departments vulnerable to cost reductions. Nurses are significantly affected by changes in the healthcare environment (Aiken, 1995; Brannon, 1996; Leicht et al., 1995).

While hospital restructuring efforts are labeled patient focused care, they generally reduce nursing staff and substitute them with less educated caregivers (Aiken & Fagin, 1997). There is little known about the effects of redesign on reduced expenditures or quality, however, Woodward et al., (1999) found an increase in emotional distress among staff and a decline in their relationship with their employer over a two year period following rapid organizational change. There is also data which indicates nurse satisfaction is affected by restructuring. Nurse satisfaction is a correlate of nurse performance, quality of patient care, and cost savings (Hinshaw, Smeltzer, & Atwood, 1987). In addition there is strong evidence that nurse to patient ratios and nursing skill mix are significant correlates of inpatient mortality (Sochalski, Aiken, Fagin, 1997). Further, there is no evidence new team models, a cornerstone of restructuring, have solved old problems such as better coordination of care (Aiken & Fagin, 1997). In spite of recent shifts in redesign goals which include a focus on patient satisfaction and quality outcomes (VHA, 1998) there continues to be minimal evidence to show patient care redesign positively affects cost reduction and patient satisfaction (Aiken & Fagin, 1997). According to the American Management Association, only 34% of companies who pared

their workforce report increases in productivity and only 45% report improvements in operating profits (Beckham, 1995). Sixty percent of US hospitals and other healthcare institutions reduced their workforce in the last two years (Hawkins, 1997). Most organizations cite restructuring as a way to maintain market position. Regardless of the reasons for restructuring, there is clear evidence that the effects on nursing, nurses, and ultimately patients is significant, while its effects on profits remains unproven.

Many of the changes from reengineering affect organizational structure, access to care for consumers, and the relative power of occupational groups (Leicht et al., 1995).

> The larger institutional environment supporting physicians seems to buffer them from bearing the consequences of many organizational changes. ... In fact, there appears to be a clear pecking order when it comes to bearing the consequences of organizational change in hospitals. Physicians are at the top, almost never bearing the consequences of organizational change. Administrators are just below physicians, and nurses bear the brunt of most of the changes we have studied. The first two groups enjoy considerable institutional protection. Administrators are protected because they are the occupational group that manages the increasingly complex environment of the hospital. Further, administrators and managers generally play a large role in defining institutional environments in the first place.... Physicians are protected by traditional institutional norms that are violated only in rare instances, as a last resort. Nurses in spite of their changing roles, have none of these protections...(Leicht et al., 1995, p. 164).

There is a growing but limited literature suggesting nursing, as the core labor process in hospitals, is more affected by restructuring and downsizing than other groups (Brannon, 1996; Sochalski, Aiken, & Fagin, 1997). "However, changes in the healthcare environment and delivery systems have seriously eroded the profession's sense of meaning, and thus morale" (VHA, 1998). Changes affecting nurses include increasing turnover, layoffs or reassignment to other clinical areas, declining job satisfaction, and less commitment among younger nurses (Cameron, Horsburgh, Armstrong-Strassen, 1994). If nursing is significantly affected from organizational changes, as suggested, the

presence of a nurse leader to provide discipline specific as well as organizational leadership is critical. Practice environments can be altered in ways that do not support care delivery or achievement of clinical outcomes when changes are made by administrators who lack clinical knowledge and understanding of the care delivery process. While the intended or stated goal of restructuring is to improve efficiency and productivity in order to compete in an increasingly competitive market, cost reductions often take center stage over quality of care (Brannon, 1996; Leicht et al., 1995).

The higher salaries of nurses may also contribute to greater cost reductions among their ranks (Fagin, 1996; Brannon, 1996). While nursing wages rose substantially in the late 1980's as a result of the nursing shortage, they have leveled off due to cost containment efforts in many acute care settings. The average 1996 full time salary for an RN was $38,567 (Moses, 1994). There are wide variations in nursing salaries across geographic areas. While labor expenses account for a significant portion of hospital costs, it can be argued that nursing labor expenses represent a smaller percent of total hospital costs than physician fees, technology, and administrative costs (Rafael, 1996). Since nursing services in hospitals are viewed as cost centers rather than revenue centers, the size of the RN workforce in combination with higher wages makes nursing an easy target for cost cutting (Wunderlich, Sloan, & Davis, 1996).

Restructuring and Magnet Hospitals

Restructuring is resulting in adverse effects on nurses and the organization of nursing care. Prior research on magnet hospitals suggests further examination of the effects of restructuring by administrators prior to cost reductions. During the nursing shortage of the 1980s, when many hospitals were having trouble recruiting and retaining

qualified nursing staff, a group of hospitals emerged as having no difficulty. They were designated as 'magnets' due to their success in recruitment and retention. A significant body of knowledge is available on these magnet hospitals which define professional nursing practice of nurse administrators and staff (Scott, Sochalski, & Aiken, 1999). The initial research on these hospitals presented findings in three categories which included; leadership attributes of nurse administrators, professional attributes of staff, and the environment supporting professional practice (Scott, 1999). Studies on magnet hospitals show professional nurse practice models characterized by nurse autonomy and close relationships between nurses and physicians result in higher patient and staff satisfaction and superior clinical outcomes with costs no greater than other hospitals (Aiken & Fagin, 1997; Scott, et al. 1999). Magnet hospitals have lower mortality rates, slightly better RN to patient ratios, and a richer nursing skill mix in addition to nurse executive participation in organizational decision making (Greene & Nordhaus-Bike, 1998). The strategies that facilitated higher nursing performance in magnet hospitals are those being eliminated through restructuring with fewer professional staff, less identity with the discipline, and less autonomy of the nurse (Greene & Nordhaus-Bike, 1998). Aiken et al., (1997) cautions that focusing on staff mix or percent of RN staff obscures issues of the organization of nursing care which is critical to creating conditions which promote autonomy, professional decision making, satisfaction, and enhanced nurse-physician communication. In addition, Brannon (1996) suggests the interest of managers and staff are inconsistent in current redesign efforts resulting in a highly visible battle over staffing and changes in work processes. In spite of the fact unions represent only 17% of the nation's nurses, they have mounted an ongoing public campaign to challenge the

reduction of professional nurses in hospitals (Lumsdon, 1995; Shindul-Rothschild et al., 1996). While magnet hospital research clearly identifies the relationship of effective leadership to a cohesive and efficient work team, nurse leaders, collectively, have been less vocal about the effects of restructuring on their roles.

Changes in the CNE Role

Many nurses in executive practice are transitioning from traditional roles in acute care settings to newer roles in integrated community based practice (Beyers, 1995). Smith et. al. (1994) call the new CNE a hybrid of clinical and business roles. Financing, physicians, integration, and contracting are the language of the healthcare organizations of the future (Davidson, 1996). The roles for CNEs in these changing systems vary and are less defined than previous hospital based CNE roles. The organization of nursing services in integrated systems as well as the use of professional nurses, varies significantly. In 1993, a study by the Voluntary Hospital Association (VHA) documented the typical chief nurse had no responsibility for non acute services; by 1998 many had broad responsibility for both nursing and non nursing departments across a continuum of care (VHA, 1998). Separate nursing departments managed by nurse leaders may not be a consistent feature of administrative structures in integrated systems.

Integrated systems are often the result of mergers and consolidations. Between 1980 and 1994 there were more than 250 mergers and consolidations of rural, community, and university affiliated hospitals (Alexander, 1997). Downsizing, mergers and hospital closures have created uncertainty and conflict for staff (Klakovich, 1994). As more and more hospitals change the way they are structured and provide services, the role of the CNE, along with other traditional roles, is subject to uncertainty. Elimination of the

CNE role has been one of the unanticipated changes (Alexander, 1997; Davidson, 1996; Gelinas, 1997; Jobes & Steinbinder, 1996; Singleton & Nail, 1988). Many new structures focus on financial integration rather than clinical integration (Donoho, 1999). Redesign efforts and mergers have resulted in changes in the way administrative structures are designed.

Several patterns of role changes emerged for CNEs as a result of organizational changes cited by Clifford (1998). In some cases the CNE role expands with the CNE assuming responsibility for both nursing and non-nursing departments. This expansion results in a change of the CNE position to that of chief operating officer or chief executive officer. In other cases the CNE role remains the same, overseeing the nursing department. In yet other cases the CNE role moves from the hospital structure into a corporate structure. Changes to a corporate position were more common in merged organizations. Elimination of the chief nurse as a result of mergers or acquisitions was reported by 19% of 444 VHA respondents (VHA, 1998). Another change involves the elimination or limitations on the role of CNE which can also occur in restructured systems. Non-nurse leaders then assume responsibility for nurses, or 'mini' decentralized nursing departments are created according to product lines (Clifford, 1998). With any of these changes, the impact on staff and the organization can be significant.

A primary purpose of the CNE role is to establish a practice environment for caregivers conducive to high quality care. This includes organizing nursing services to promote nurse autonomy, control over practice, and enhanced communication with physicians and the organization as well as nursing representation in decision making. The quality of the care given by nurses and other caregivers is related to the effectiveness of

nursing management (Aiken, Sochalski, & Lake, 1997). Nursing management, under the leadership of the CNE, indirectly influences patient care outcomes by empowering nurses in their practice (Clifford, 1998). Changes in organizational structures in which the CNE position is eliminated or authority is reduced may adversely affect the practice environment. More data is needed to determine how changes in organizational structure affect the practice environment. Clifford's work is among the first to document how restructuring affects changes in the CNE role.

CNE Research

Past research on the CNE role has been limited. Beyond studies of magnet hospitals, there is limited research to demonstrate how the presence of the CNE makes a difference in achieving clinical and organizational outcomes. There is a lack of adequate research to demonstrate the impact of administrative structures on the organization and delivery of care. Most research on the role of nursing leaders focuses on education, competencies, characteristics, and decision making as well as CNE turnover.

Restructuring and CNEs

In a multi-site case study by Clifford (1998) on how restructuring affected the CNO role in three organizations, numerous contextual variables were noted to influence the Chief Nurse Officer (CNO) role [Clifford uses the term CNO instead of CNE]. These contextual variables included organizational structure, role expectations of the CNO, job and person related variables, CNO tenure, title as status symbol, and concerns about patient care (Clifford, 1998). Five major themes emerged from Clifford's study and included: boundary expansion, transitions, loss, cohesiveness, power shifts. Though expansion of the CNO responsibilities varied across the sites studied, no general pattern

emerged. That is, in one organization CNO boundaries expanded to include other departments yet, in another site the CNO role was diminished. Transitions reflected the changes in leadership roles and subsequent ambiguity that accompanied such changes. Clifford (1998) describes the theme of loss as the most emotionally intense as evidenced in nurse manager descriptions. The loss of a centralized nursing department, a centralized nursing leadership position, and nursing titles reflected a lack of organizational recognition of nursing. Cohesiveness suggested a change in how nurse managers perceived problem solving would occur in a newly restructured system of product lines and in the absence of a centralized nursing leadership position. Lastly, power shifts reflected organizational changes in which physicians increased their numbers in administrative roles and nurse managers were less unified due to changes in structure. CNE turnover, as well as restructuring, is a major influence on CNE roles.

CNE Turnover

Weaver (1988) noted minimal turnover in CNE positions in the early 1980s. However, beginning in 1985 the situation changed and CNE turnover began to rise (Weaver, 1988). Of 14 former CNEs who left their positions involuntarily, disagreement with the administrator was the chief reason for departure (Weaver, 1988). Additional reasons included; (a) administrator not backing the CNE when MDs perceived staff nurses becoming too independent in their practice, (b) philosophical differences between administrators and the CNE who was trying to initiate innovative programs, and (c) insecurity of administrator after the CNE was invited to attend Board of Directors meetings, (d) staff nurse dissatisfaction with "administration" regarding the nursing shortage and inadequate support services, and (e) administrator supporting MD demands

for more beds when the CNE felt a lack of staff would compromise care (Weaver, 1988). Several studies demonstrate continued high CNE turnover since the mid 1980s (Freund, 1985; Weaver, 1988; delBueno, 1993). In university owned or affiliated hospitals, Freund (1985) found settings averaged 2.5 chief nurse officers (CNOs) in a ten year period. In addition, 19% of hospitals had four or more CNOs in the same period (Freund, 1985). Reasons for leaving included termination or requested resignation (40%), retirement/personal (27%), promotion/better job (17%), and job satisfaction (12%) (Freund, 1985).

Kippenbrock and May (1994) found 110 CNE turnovers among 102 hospitals studied from 1988-1992. The turnover rates from 1988 to 1990 range from 21.6% to 27.5% (Kippenbrock & May, 1994). In a subsequent study to determine departure, performance, relationships, and demographic variables for CEOs and CNEs, Kippenbrock (1995) found the average tenure of CNEs was 5.5 years. Among the CNEs, 93% were female and 26% had master's degrees, while 72% of CEOs were male and 45% had master's degrees (Kippenbrock, 1995). CNE reasons for departure as reported by the CNE, included lack of power to make changes, conflicts with the CEO, inadequate nursing personnel, changing environments, difficulty developing and managing a team, financial instability, and conflicts with medical staff (Kippenbrock, 1995). When CEOs reported reasons for the same CNE departures, the reported insufficient management and leadership skill, changing health care environment, difficulty developing a team, perceived lack of power, conflict with the CEO, inadequate nursing staff, and conflict with the medical staff (Kippenbrock, 1995). While CNEs cite lack of power to make changes as the main reason for departure, CEOs indicate insufficient management and

leadership skill, suggesting a gap in perceptions (Kippenbrock, 1995). In the same study, CNEs reported lower salaries than other administrators while CEOs reported equivalent salaries; CNEs reported higher performance ratings of their own performance than CEOs did (Kippenbrock, 1995). CEOs did not think CNE departure would have much of an effect on the organization (Kippenbrock, 1995). In reality, the effects of CNE departure on the organization, especially effects on the nursing department and staff, have not been extensively studied.

The influence of both physicians and chief executive officers (CEOs) in the tenure of CNEs may be even more significant than these studies demonstrate. The relationship between CNEs and chief executive officers (CEO) is not often studied. Freund (1985) found that 12.2% of newly appointed CEOs terminated the CNE within one year. Smith et al., (1994) noted in a review of 19 articles on CNE qualities and qualifications, CEO and board role expectations of the CNE are often not mentioned. How the board and CEO understand the role and purpose of the CNE as a member of the executive team is important.

CNE Characteristics

In addition to studies on turnover, profiles or characteristics of nurse executives have also been studied (Rozier, 1996). Dunham and Fisher (1990) studied 85 hospital nurse executives who indicated, through self reporting, excellent leadership attributes, including administrative competence with commensurate educational preparation, business skills, clinical expertise, ability to influence the clinical practice environment, ability to integrate nursing leadership into the organizational effort, and marketing nursing. Brandi (1998) conducted a study on 17 female nurse executives from both profit

and non-profit organizations to determine if a typology of nurse executives could be identified. A typology of four categories of battlefield positions or professional identities is described; (a) unsung heroines who have a high identity with nursing but little organizational influence, (b) engineers who have high nursing identity and are more influential beyond nursing, (c) team leaders who have a lesser identity with nursing, are more influential, less competitive, and recognize gender inequities, and (d) champions who think like businessmen, develop a thick skin and are the least tolerant of gender inequality (Brandi, 1998). One dilemma for female CNEs is they must assume political and organizational leadership responsibilities traditionally assumed by men (Brandi, 1998). Brandi's (1998) work also suggested nursing in managed care environments may be moving away from a nursing identity in order to gain influence in the organization. In spite of the recognition of nursing as a sex segregated profession with 96% of its workforce female (Butter et al., 1987), very little research in administrative practice studies issues of gender.

Historically, nursing research has focused on CNE turnover and CNE characteristics. Factors in CNE turnover such as disagreements with administrators or physicians as well as staff nurse dissatisfaction need to be re-examined in light of the current healthcare environment. The work of Clifford in exploring the effects of restructuring on CNOs is a needed addition to the nursing administration literature on changes in the CNE role.

Summary

This chapter has reviewed feminist theory, its relationship to nursing and the gendered nature of healthcare. A review of the literature on women in leadership reveals no significant differences between male and female leaders. Gender is a strong influence on executive positions for women in healthcare, affecting wages, access to senior positions, and level of authority. Changes in healthcare environments such as restructuring due to the need to reduce costs has also affected the CNE role. Women's institutional experience is different than men's and requires different approaches. The use of feminist theory and methodology provides an opportunity to examine issues of nursing leadership and gender in different ways than previously. The next chapter describes the methodology used for this study.

3 Methodology

The purpose of this study is to explore perceptions of the role and purpose of the CNE held by senior leaders and nurse managers. This chapter explains the methods used in carrying out the study. The general study design and theoretical frameworks for analysis will be discussed, including a description of case study and feminist methodology. The research context, selection of informants, informed consent process, scientific rigor, and organizational access is also described. A description of the procedures used for data analysis of the interviews is also included. Other sources of data are identified as well. The study question was;

> How do senior leaders and nurse managers describe the role and purpose of the chief nurse executive?

Study Design

The study design and analysis is guided by the theoretical frameworks of feminist and case study methodology. A single site, qualitative case study was conducted using Yin's (1984) case study design and methods. Qualitative approaches are used when little is known about a situation or phenomenon or when one wants to describe, explain, and then understand situations. While hypotheses and theories emerge from the data while the data collection is in progress in many qualitative studies, study propositions guide the development of the case study (Yin, 1984; Field & Morse, 1985).

Case Study Methodology

Case study is a research method often associated with a qualitative approach. Yin (1984) describes case study as "an empirical inquiry that investigates a contemporary

phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (p. 23). Stake (1998) defines a case as "having working parts, it probably is purposive, even having a self. It is an integrated system. The parts do not have to be working well, the purposes may be irrational, but it is a system" (p. 87). Healthcare settings are good examples of systems with many parts, many not working well, and in which the environment is critically important. Case study methods are designed to promote better understanding of real life events and complex social phenomena (Stake, 1998 & Yin, 1984). According to Yin, "the case study contributes uniquely to our knowledge of individual, organizational, social, and political phenomena" (p. 14).

The case method strategy can be used for descriptive, exploratory, or explanatory purposes (Yin, 1884). The type of the research question, degree of control the researcher has over events, and the degree of focus on contemporary versus historical events guides the decision to use case study as opposed to other methods of study (Yin, 1984). The use of 'how' in the research question of this study, along with the minimal control the researcher had over the events of the case and the focus on contemporary events supported the use of case study. Additionally, single-case study design versus multiple-case design, is appropriate when the case is rare or unique or serves as a revelatory purpose (Yin, 1984). In this study, the organization provided a unique opportunity to study perceptions of the CNE in a healthcare facility undergoing significant change including cost constraints.

Yin describes five components for case study design: (a) study questions, (b) propositions, (c) unit of analysis, (d) logic linking the data to the propositions,

(e) criteria for interpreting the findings. Study questions are usually framed by who, what, where, how, and why questions. How and why questions, which are more explanatory, favor case study method (Yin, 1984). Study propositions direct the researcher in what to study. They provide direction for where to look for relevant evidence. The unit of analysis reflects the basic definition of the case. For example, the unit of analysis may be an individual, an organization, or an event. The unit of analysis relates to the initial research question and study propositions. Though the least well developed in case study, logic linking data to propositions and criteria for interpreting results represent data analysis (Yin, 1984). One of the steps during the data analysis is to review the study propositions to determine if the data collected and analyzed is linked well to the original propositions. In a process called iteration, Yin recommends revision of propositions that may not be well supported by the data, again comparing data and propositions and continuing the processes until a proposition results in explanation building, a goal of case study.

Case studies are useful in nursing administration research as they allow for the in-depth examination of a single organization particularly when the goal is to gain insight into organizational problems and phenomena (Smyth, 1989). Smyth cites several areas of administrative practice that could benefit from case study approaches:

- examination of organizational structures to ensure nurse administrators are part of policy-making in institutions
- nurse executive contributions to short and long term policy and operational changes in the workplace

- how administrative technologies affect leaders, administrators, managers, and nurses
- how the use of temporary staffing agencies affects the quality of care

Single site case studies followed by cross case analyses could yield important findings for the future of nursing administrative practice (Smyth, 1989). In addition to case study methods, the relevance of feminist methodology to this study is described.

Feminist Methodology

While there is no single feminist methodology, a basic principle of feminist research is that it is for women (Bunting & Campbell, 1994). The research must have some benefit for women. Gender is central to the conduct, design, and interpretation of feminist research. A number of characteristics are identified to describe a feminist perspective:

- a feminist consciousness rooted in an attitude of equality
- the aim to include women
- a conscious partiality in which the biases of the researcher are acknowledged (Duffy & Hedin cited in Bunting & Campbell, 1994).
- feminism is a theme, not a research method
- feminists use a multiplicity of methods
- feminist research aims to create social change
- feminist research strives to represent human diversity
- feminist research critiques prior scholarship, especially for androcentric and ethnocentric bias
- feminist research portrays women's strengths (Reinharz, 1992)

Characteristics of feminist research are derived from three basic principles of feminism: (a) valuing women's experience, ideas, and needs; (b) recognizing conditions that oppress women; and (c) attempting to change conditions through political action and criticisms (Hall & Stevens, 1991). These principles contribute to an epistemology or a theory of knowledge which guides methodology in feminist research. These epistemologic issues include beliefs that women's experience is a legitimate source of knowledge, subjective data are valid, informants are experts on their own lives, knowledge is relational and contextual and boundaries between personal and public spheres are artificial (Campbell & Bunting, 1991). Relational and contextual knowledge is highly important in the design, conduct, and interpretation of feminist research. Understanding the context of the healthcare environments and relationships between professional and occupational groups within the system are critical elements of information in the interpretation of data. Feminist research attempts to understand women's oppression and the many power imbalances present in social structures (Webb, 1993).

Standpoint theory is relevant in feminist research. Standpoint theory is a concept that arises from women's political struggles to see their concerns represented in public policy (Harding, 1998). Certainly there is significant literature that speaks to the need for women to see their concerns represented in healthcare policy, but more importantly the representation of nursing and nursing issues through leadership positions is a political issue institutionally and professionally. Standpoint epistemologies suggest the importance of starting off research projects from the lives of women rather than from the dominant androcentric conceptual frameworks of disciplines and the larger social order. The social history of standpoint theory is closely tied to Hegels' reflections of what can be known

about the master/slave relationship (Harding, 1998). Later, Marx and others used this framework to develop the standpoint of the proletariat. Feminist have used this analysis to explain "how structural and symbolic gender relations had consequences for the production of knowledge" (Harding, 1998, p. 149). This analysis is useful in thinking about how healthcare institutions create and support structures that devalue or ignore the lives of women within these institutions. A standpoint may be articulated through one or more theories or discourses. The discourses of leadership/management, power, professionalism, medicine, and bureaucracy are the major discourses whose assumptions influence the thinking of dominant groups. For example, many of the narratives of leadership are associated with masculinity or ideals of masculinity and shape the thinking of dominant groups about who can and should be a leader. These discourses influence how members of dominant groups think about the capabilities of women in leadership positions.

In standpoint theory, the researcher starts from the lives of women who have been disadvantaged by dominant conceptual frameworks, such as the theories surrounding leadership. While CNEs may be privileged within the discipline of nursing, they are disadvantaged in relation to medicine, healthcare administrators, and healthcare organizations. Epistemological standpoint theory suggests existing conceptual frameworks, methods, rules and procedures for inquiry are constituted from the perspective of the ruling groups interests (Harding, 1998). Therefore, asking women in leadership positions about their perceptions of other women in leadership positions may tell us something different than asking men. Smith (cited in Harding, 1998) also sees standpoint theory as a way to ask about men's lives and social institutions designed

primarily by men. Interviewing nursing managers, as well as hospital administrators and medical directors who are most often male, provide this opportunity. Thinking from the perspectives of these different groups may raise new questions not previously asked.

The use of feminist methodology in the study of organizations and female dominated professions supports the recognition of women's experience as different from men's and also the recognition of conditions which oppress women. As demonstrated in the leadership and healthcare literature reviewed in Chapter 2, prior scholarship on women in healthcare leadership positions represents androcentric bias. Feminist methodology creates a different analytic lens for examining gender and structural relations between professional groups within healthcare organizations.

Scientific Rigor

Case study methods which primarily use qualitative approaches have unique problems with validity and reliability (Smyth, 1989). Construct validity is increased by using multiple sources of data. The use of multiple sources of data support the researcher's ability to address a broader range of issues such as historical, attitudinal, and observational (Yin, 1984). Yin identifies six sources of evidence for data collection which include documentation, archival records, interviews, direct observations, participant-observation, and physical artifacts (Yin, 1984). In addition to using multiple sources of evidence to increase validity, reliability is increased by the use of a research protocol which guides the design, procedures, questions, and report. Though replication of qualitative case studies is challenging, clearly identified steps that operationalize the research design enhance reliability (Yin, 1984).

Research Context

The study took place in a large, urban non-profit medical center. The facility is part of a regional system which also owns a health plan and is part owner of a large medical group. Like many of the healthcare facilities in the region, the organization has experienced financial pressures due to rising healthcare costs and decreasing medical reimbursements.

Organizational Access and Study Approval

In order to obtain permission to interview in the organization I initially met with the CEO to explain the study. During this meeting I shared the intent of the study and general goals. The CEO voiced concern about my position with another healthcare organization and concerns about confidentiality. I explained the processes used to maintain confidentiality and made slight modifications in the study questions. Based upon these changes the CEO agreed to support the study. I scheduled a subsequent meeting with the Administrator for Patient Care Services, also the CNE, to explain the study and elicit her support. The meeting resulted in her support which included identification of informants from the nursing department. I conducted interviews in October of 1999.

The study was reviewed and approved by the internal review board of the organization and my doctoral committee for The Union Institute.

Participant Selection

I conducted eight interviews with nine informants. The interview with the two clinical managers was conducted with both managers at the same time. Four nursing directors and three clinical managers were selected for interviews by the CNE. All four of

the nursing directors participated in an interview of approximately one hour in length. Two of the three clinical managers participated in a group interview which lasted one hour. The third clinical manager canceled at the last minute due to a staffing problem. I requested interviews with six members of the senior leadership team which included the CEO, the COO, the Administrator for Patient Care/CNE, the Medical Director, the Chief Financial Officer and the Chief of Human Resources. I was able to schedule interviews with three members of this team. The fourth scheduled interview was canceled with a request by the informant to not reschedule. I provided a brief explanation of the purpose of the study to all informants prior to the interview (Appendix A). In addition, the CEO sent a letter to all informants indicating his awareness of the study and encouraging voluntary participation. Appointments for interviews were scheduled by administrative secretaries within the departments. There were a total of eight nursing directors in the organization and four were selected to be interviewed. Approximately two out of twelve clinical managers participated and three out of six senior leaders.

Nurse managers were selected for the study because they occupy leadership positions with a close working relationship with the CNE and also positions which should have a clear understanding of the CNE role. Most nurse managers are women and asking women in leadership positions about other women in leadership positions may reveal different responses than asking men. Including senior leaders who tend to be predominately men also provides an opportunity for asking men about their perceptions of the nurse leader. Women's experience in leadership is different than men's and the inclusion of both male and females in the study provide opportunities to explore perceptions of both.

Protection of Participant Rights

Prior to each interview, informants received an informed consent form which identified the purpose of the study, reiterated voluntary participation, right to withdraw, and the right to not answer questions (Appendix B). Permission was obtained to tape record each interview. Consents were signed by each participant. Each participant was offered the opportunity to request a summary of the study upon completion. Participants were assured that data would be described and discussed based upon the group such as senior leader or nurse manager versus the individual position. The few number of senior leader participants necessitated careful protection of anonymity and confidentiality.

Procedures

Sources of Evidence

Archival records, documents, interviews, direct observation, and physical artifacts were used as sources of evidence to guide data collection. Due to issues of confidentiality, I was unable to obtain permission to access internal quality assurance data or nursing systems data such as turnover rates, vacancy rates, or grievances. However, I did review available data reported by hospitals to the State Department of Health which included average length of stay, percent of bed occupancy, and total patient revenue. In addition, the 1997-1999 archives of local newspapers were searched for information on the facility. Other sources of health related information were searched on the Internet for the geographic region. I also took notes during and after each interview. Once the taped interviews had been transcribed and imported into the data management system, I wrote additional memos of impressions and observations.

Interviews

The interview questions were designed to explore how nurse managers and senior leaders describe the role and purpose of the CNE (Appendix C). Prior to conducting the interviews, I asked five employed CNEs to review the questions for clarity and relevance. Minimal modifications of interview questions were made as a result of their feedback.

Each interview was then conducted, tape recorded and transcribed. I took notes during each interview and reviewed them within 24 hours. Each tape was replayed and additional notes taken if needed. I reviewed transcripts for accuracy by comparing them to the recordings. Typed transcripts were then imported into Ethnograph v5.0 for coding. Ethnograph is a software program designed to facilitate the management of data from qualitative studies. When using Ethnograph, Seidel (1998) recommends a process of noticing, collecting, and thinking about interesting things from the data. The process is iterative and progressive and therefore occurs in a cycle in which the researcher is continuously noticing, collecting, and thinking about the data. Patterns emerge from the ongoing review of the data. Pattern matching is also a case study analytic strategy described by Yin (1984).

Data analysis

Data analysis was conducted on information collected from documents, direct observation, archival records, physical artifacts and interviews. In addition, study propositions were continuously reviewed in order to guide and organize the case study. Review of the study propositions also help to define alternative explanations and guide examination of them (Yin, 1984). Greater detail will be provided on the analysis of the interviews as they provided a major source of data for the study.

Eight interviews with nine participants were conducted, recorded and then transcribed. After accuracy was assured through review of the tapes and transcripts, a coding and categorizing process was initiated. Coding is a process in which observations, phrases, sentences, events, or paragraphs are labeled with a name that represents the phenomena (Strauss & Corbin, 1990). For example, informants were asked to describe the role of the CNE including key responsibilities, reporting relationships, and qualifications. This resulted in a number of phrases, words, and sentences that were coded with code words such as *CNE clinical responsibilities, CNE reporting relationships, and CNE qualifications* (Appendix D). Coding is the naming of concepts from the data. Each code word is defined in order to increase consistency when naming each concept (Appendix E). After coding the interviews, categories were then determined to reflect groupings of codes that pertained to the same concept (Appendix F). For example, while multiple code words were used to reflect informant descriptions of the CNE role, they were then grouped under the category named *CNE Role* because they all pertained to the concept of role. Categories were then analyzed for relationships to one another. Further analysis of categories resulted in another grouping called contextual factors (Appendix G). The contextual factors represented renaming groups of categories to better reflect the phenomena being described. Using *CNE role* as an example, a number of code words contributed to the category of *CNE role*. Based upon my interpretation of the coded transcripts, along with other data sources, a review of the *CNE role* category resulted in a renaming of the category to limited understanding. Contextual factors were then reviewed for themes. Based on analysis of the data including study propositions, three themes emerged: *organizational culture, gender,* and *clinical-financial tensions* (Appendix G).

Finally, data analysis also included the identification of differences between nurse manager and senior leader informant responses. The findings in Chapter 4 differentiate nurse manager from senior leader perceptions when there are differences. When no differences were noted the term informants is used alone.

Study Propositions

Since the study design, research questions, and literature review are based upon the study propositions, Yin (1984) recommends further analysis of them in order to determine their usefulness in explanation building. Explanation building is a way of "explaining" a phenomenon in order to determine relevant links among different variables. Iteration, described earlier, takes place during the review of the study propositions. All sources of data, including study propositions, were reviewed to identify themes.

The study propositions included;

1. Lack of understanding of the role and purpose of the CNE may contribute to decisions to modify (eliminate, change scope/span of control) discipline specific leadership positions.
2. The absence, elimination, or reduction of discipline specific leadership adversely affects the practice environment.
3. The absence, elimination, or reduction of a CNE position adversely affects the ability of the discipline to control the content of its work.
4. A lack of stability in healthcare organizations affects the power base and decision making authority of various leaders.

The themes and study propositions will be discussed in greater detail in the next chapter.

Summary

This chapter explains the methodology used in this qualitative study of how nurse managers and other senior leaders describe the role and purpose of the CNE. Case study method and feminist methodology are highly relevant in the study of organizations and female dominated professions such as nursing. They are effective strategies for nursing administration research. Case study methods promote the use of multiple sources of evidence as well as the ability to analyze both context and phenomena. The context within which executive nursing practice takes place is critically important in shaping the role and purpose of the CNE. The next chapter presents the findings from the interviews and other data sources.

4 Findings

In this study I explored perceptions of the CNE role and purpose held by senior leaders and nurse managers. This chapter presents findings from the analysis of the interviews and other data sources such as documents, archival records, direct observation, and physical artifacts. I also discuss the context of both the organization studied and the interviews. Scientific rigor is also discussed.

The Context of the Organization

The Patient Care Administrator/CNE (PCA/CNE) was new to the organization, having assumed her position eight months earlier. It is important to note the organizational title for this role was patient care administrator. The term CNE was not officially included in the title and nurse managers did not refer to her as the CNE even though they were aware she assumed CNE responsibilities. Since the research question was to explore the role and purpose of the CNE, PCA/CNE is used throughout this study to clearly designate when informants referred to the CNE. The PCA/CNE had extensive experience as a nurse executive in both the profit and not-for-profit sectors of healthcare, and a graduate degree in nursing. The scope and span of her control differed from the prior PCA/CNE due to less responsibility for daily operations and more organization-wide accountability for integration of clinical services and financial management. The PCA/CNE had responsibility for approximately 900 full time equivalents which included acute and ambulatory clinical services such as nursing, pharmacy, respiratory therapy, social service, radiology, rehabilitation services, etc.. Approximately 14 administrative staff reported to the PCA/CNE, who in turn reported to the COO.

The PCA/CNE described her key responsibilities as including:

- overseeing service and care for all areas
- meeting regulatory requirements
- establishing competencies for staff
- assuring development of policy and procedure
- strategic planning
- budget and financial management
- business and program development
- relationship building with key customers such as the Board of Trustees, vendors, and physicians.

These responsibilities are consistent with the CNE responsibilities described in the literature. Current PCA/CNE performance expectations were strongly focused on financial performance, customer satisfaction, and business development. The PCA/CNE was expected to meet clearly identified financial and customer satisfaction targets. Physicians are major customers and are surveyed regularly to ascertain their satisfaction with nursing care as well as their perceptions of their relationships with administrators. At the same time they are asked about their satisfaction with other issues such as parking, food, and operating room scheduling. The patient care administrator/CNE position had been vacant for approximately two years. During these two years and prior to the current PCA/CNE, a product line structure was in place. The product line structure, also called a team structure, included eight product lines (teams) organized according to clinical services. For example, rehabilitation services was a product line and included all

ambulatory, acute, and ancillary rehabilitation services. A director whose background may have been nursing or another clinical discipline managed each product line.

The organization is a non-profit 436 bed hospital and offers general and intensive medical/surgical services in over 30 specialties, sub-specialties, and outpatient programs. It presents its mission as a values-driven organization in which "respect for the individual, clinical excellence, technical innovation, and community outreach form the basis of a compassionate approach to health care." The chief executive officer was a physician. The organization also includes home health agencies, acute and ambulatory facilities, long term care, and a health plan. Additional data for 1997 includes:

- an average length of stay of 4.35 patient days (a slight decline from 4.37 in 1996)
- an occupancy rate of 72.81% of available beds
- total patient revenue per adjusted patient day down 2.71% from 1996

Decreased medical reimbursements and rising health care costs were cited by the CEO as factors in the planned 1999 closure of two clinics and possible transfer of five other clinics to other operators.

Most physicians in the region are organized in large groups and informally affiliated with most hospitals. However, the health system which owns the hospital is a majority owner of a large physician group. Though the physician group was one of the largest in the state, with more than 400 primary care physicians, they did not have an exclusive referral relationship with the hospital. As a result, on any given day, there may be more patients cared for by the physician group in other because they had no contractual obligation to refer their patients to their own hospital. In 1998 the same

physician group elected to form a collective bargaining unit with an affiliate of the Service Employees International Union (SEIU). This physician group cited growing physician frustration with their influence on policies affecting pay and their relationship to patients as major factors in their decision to unionize. The registered nurses in the organization belong to a union and are also represented by an affiliate of SEIU.

Interviews were conducted shortly after the annual budget process. Finance and budgetary issues were major concerns for most informants and will be discussed in greater detail. The short tenure of the PCA/CNE influenced the degree to which nurse managers had established a relationship with their new leader. Financial concerns and a lack of familiarity with new leaders may have influenced responses in the interviews.

Location and size of offices often reflect status and are indicators of influence and power in organizations. The offices of the two senior leaders interviewed were in a professional services building which also housed physician offices while the CNE office was located in the hospital building along with the COO. Nursing director offices were located throughout the hospital, usually adjacent to clinical areas. The two clinical managers had offices on the nursing units in which they worked.

Context of the Interviews

A semi-structured interview with five primary questions was used to obtain information on perceptions of the role and purpose of the CNE. Each interview took place in a private office or conference room with minimal interruptions. None of the informants appeared uncomfortable or unwilling to participate. The PCA/CNE identified possible nursing informants and directed her secretary to schedule interview appointments. Though the information I sent to the nurse informants prior to their interview stressed

voluntary participation, a request from the PCA/CNE for their participation may have influenced participation. The PCA/CNE identified four out of eight nursing directors to participate based upon a range of diversity in nursing that they represented. There was no indication that nurse managers were unwilling to be interviewed and they were cordial and openly discussed difficult issues during the interviews. While scheduling interviews with the nurse managers was relatively easy, I was only able to schedule three out of six interviews with senior leaders. One interview was scheduled but canceled with a request not to reschedule and no apparent explanation. After three attempts with the administrative assistant of another senior leader, no interview was scheduled due to her failure to return my calls. I was unable to determine if my request for an interview was really communicated by administrative assistants in at least two situations, as I sensed their need to protect calendars of their bosses. It is also possible interviewing senior leaders on the role and purpose of the CNE may have been perceived to be a difficult topic or one in which saying what they might like to say would be challenging.

Each interview began with informed consent procedures and each informant signed an informed consent form which included permission for audio-taping. Prior to the taped interviews, I asked if there were any questions about the study purpose or my role. One informant voiced concern about confidentiality but consented to the interview after a more detailed explanation of how individual identity would be protected.

Demographic Data

Length of employment for the four nursing directors, two clinical managers, and three senior leaders interviewed ranged from 2 months to 26 years. The nurse manager informants had longer employment histories which ranged from 6-26 ½ years. Senior

leader length of employment ranged from 2 months to 8 years. The four nursing directors are each responsible for one or more clinical areas such as medical-surgical units, rehabilitation, and intensive care. Nursing directors report directly to the PCA/CNE and have budgetary, quality management, and personnel accountability for their areas. Clinical managers are unit-based supervisory staff who report directly to the nursing directors. They do not have budget responsibility but assist nursing directors in hiring, performance management, and disciplining staff. They are administrative staff and not represented by the bargaining unit which represents the staff nurses. Seven informants were registered nurses and two were non-nurses. Six informants were female and three were male. Education of informants included baccalaureate education in nursing, graduate education in business and nursing, and one doctorally prepared administrator.

The senior leader group identified for possible participation included six persons: chiefs from finance and human resources, the PCA/CNE, the COO, CEO, and Medical Director. In order to protect the anonymity of the three senior leader participants, they are referred to collectively as senior leader informants. References to nurse manager informants include the four nursing directors and the two clinical managers. When the term informants is used without nurse manager or senior leader, it refers to all informants.

Code Words and Categories

Analysis of the interviews involved coding key words and phrases. Initially, twenty-three code words were used to define concepts (Appendix D). Three additional code words were added after the second transcript review for a total of twenty-six individual code words (Appendix D). These code words were then collapsed into seven categories including: *CNE role, qualifications, goals, past history, finance, success, and*

organizational context (Appendix G). Specific code words were identified for key concepts associated with each interview question. Code words emerged from the transcript analysis of responses to questions. For example, key CNE responsibilities were identified in the text with the code words CNE role which included *CNE role relationships, reporting relationships, professional practice, finance, image, leadership, clinical responsibilities, educational qualifications, and legislative and community activity*. Scope of responsibility and span of control were identified by the code word *reporting relationships*. Qualifications of the CNE were identified with the code *CNE clinical and educational qualifications*. Past history of the CNE role included four codes; *decision making, inconsistency in nursing standards, references to the prior chief nurse executive, and references to the team or product line structure*. Expected outcomes of the CNE role evolved from the questions on key responsibilities and measures of success and included the code word success.

Finance was used to code any comments pertaining to budget or finance. It appeared most often in reference to measures of success as well as key responsibilities of the CNE. Measures of success were identified with the code word *success*. *Organizational context* identified text which referenced the current organizational environment. While there was no specific question about goals, several respondents mentioned them. I asked participants to differentiate between organizational versus disciplinary goals. The code word *goals* as well as *nursing* and *organizational goals* were the code words used for this content. The code *CNE role relationships* identified text which described role relationships between the CNE and other members of the senior leadership team. While 26 initial code words were used during analysis of the interviews,

some became more important than others. For example, while I anticipated greater discussion about goals, in reality very few informants discussed goals; however, the absence of this discussion became relevant in the analysis. The 26 code words were collapsed into seven categories which will be described in greater detail in the next chapter (Appendix G).

Interview Findings

The first question asked of informants was, "Tell me about the role and purpose of the CNE in your organization" (Appendix C). This question included examples or prompts such as history of the position, key responsibilities, scope/span of control, reporting relationships, and qualifications in order to guide informant responses. Informants were then asked, how success is measured for the CNE. This was followed by two questions: how the CNE position has changed over time and how organizational changes affected the CNE position. Informants had difficulty differentiating between these two questions because they viewed organizational changes and CNE changes as the same. Finally, informants were asked to describe the relationship of the CNE to the senior leadership team. Additional questions were asked to clarify responses or further explore a response.

Role descriptions of the CNE

In response to the question, "Tell me about the role of the CNE in your organization", informants described the history of the position, key responsibilities, expected outcomes, span of control, and reporting relationships. They also identified qualifications for the position. Perceptions of key CNE responsibilities varied among all informants with senior leader informants providing a more comprehensive description of

the PCA/CNE role. Patient care, finance, and physician/employee/patient satisfaction were the key responsibilities identified by both nurse and senior leader informants. *"It's the CNEs responsibility to ensure the patient is the focus of decisions."* Most informants believed financial management was a key CNE responsibility in the current environment. They recognized the organization placed a high priority on financial management, and thus the CNE was expected to improve fiscal management within the organization. *"Right now the focus is heavily on finance."* Nurse manager informants rarely mentioned more than two to three key responsibilities. Few nurse manager informants identified organizational leadership and stewardship, advancing the profession, or improving professional practice as key responsibilities of the CNE. Examples of key responsibilities discussed by informants included:

- understanding the nature of patient care (the pragmatic realities of caring for patients)
- making decisions and understanding the consequences for patient care
- representing the patient's perspective at higher levels
- discerning what is best for the patient
- managing flow across departments
- analyzing efficiency of care and care processes
- improving quality of care
- management of nursing units
- maintaining and developing interdisciplinary relationships
- assuring patient, staff, and physician satisfaction

- developing and maintaining professional practice standard
- providing clinical leadership
- establishing goals for nursing
- collaborating with the community and educational partners.

Though mentioned infrequently by only one or two other informants, additional CNE responsibilities included developing a vision, selection of competent staff, setting direction, advancing professional practice, mentoring, managing managers, and effectively utilizing resources. While the combined list of CNE responsibilities discussed by informants is comprehensive, individual informants provided limited examples of key responsibilities of the CNE role and purpose.

While most informants identified the educational requirement of the PCA/CNE position as a graduate degree, several were unclear if the graduate degree could be in nursing or any health related field. Three informants were unclear about the educational requirement for the position which was a graduate degree in nursing, business, or a health related field. Most nurse manager informants prioritized clinical experience over education as a needed qualification and believed administrators who had clinical practice experience could better identify with patient care needs and issues confronting nurses. According to one informant, *"...we really wanted someone who had done patient care and then evolved into an administrative person."*

Nurse manager informants raised questions about the degree to which the position title, patient care administrator, reflected the nursing executive aspects of the role. Nurse manager informants did not consistently identify the PCA/CNE position as a nursing

position. In other words, they did not consistently refer to this position as the CNE since it was not titled CNE. In their daily work, nursing informants indicated they used and were encouraged to use the organizational title, patient care administrator. For example, according to one informant, *"I think having the role titled chief nursing executive leads to cynicism"* because she [PCA/CNE] is really an "administrator." Though not always well articulated, some nursing informants attached a different meaning to the title patient care administrator as opposed to CNE, suggesting the absence of the CNE title reflected a distance or lack of association of the PCA/CNE with nursing. There was a general perception the CNE portion of the PCA/CNE role was more "*administrative*" and less "*nursing*." Some nursing informants characterized the current role as "*corporate*" and farther away from direct care and caregivers. According to one informant, *"she's [CNE] carrying a larger burden of administrative and budgetary focus, more than anyone has before."* Some nurse manager informants identified "*administrative*" as more focused on "*numbers*" than clinical care.

Additionally, there were times during the interviews when nursing informants had difficulty separating the CNE position from the person in the position. Since the person in the position was relatively new to the organization, nurse informants were unclear about her direction and skeptical of her actions. Despite prodding and encouragement from me to focus on the position, some informants had difficulty discussing the CNE role versus their opinions of the person in the role. For example, nurse managers voiced concern about recent budget decisions, their lack of clarity of the direction for nursing, and confusion about how to meet new expectations set by the PCA/CNE. This lack of clarity and uncertainty led some informants to be more negative about both the person and the

position. In some cases descriptions of the position were totally contingent on how the informant characterized the person.

In spite of challenges in separating the person from the position, both senior leader and nurse manager informants believed the PCA/CNE position was important and the presence of the position reinforced the organization's acknowledgment of the role of nursing in patient care management. Senior leader informants, more than nurse managers, clearly described how the clinical nursing experience of the PCA/CNE added value to the executive leadership team. According to one senior leader, *"when executive teams make decisions the patient must be first and the CNE is closest to the realities of taking care of patients."* In addition, senior leader informants recognized the PCA/CNE perspective as complementary yet different from the physician perspective.

How success of the CNE is measured

In response to the question "How is success measured for the CNE?" all informants identified meeting financial targets as the key measure of CNE success. *"Right now the focus is heavily on finance."* While employee/physician/patient satisfaction and clinical quality were also identified as measures of success, the majority of informants believed organizational expectations to meet financial targets were more critical than other indicators of success. Physician satisfaction was identified by the majority of informants as a determinant of CNE success. Physician satisfaction with the system, especially the internal functions of the system such as operating room scheduling, was a high priority for the organization and frequently associated with perceived success of the CNE. As one informant explained, *"They [docs] go wherever it's easier for them to do their work."* In addition, another informant added, *"when decisions are made, I know*

who the important players are: docs." And yet another informant indicated, *"we can't be successful without physician support. If they [physicians] conclude the administrator is a problem, the administrator won't survive."* The economic impact of these statements is obvious. At least two informants identified a difference between what the organization expected as measures of CNE success and what nurses themselves might identify. For example, according to one informant, *"...corporate views her success as making budget and making physicians happy. I would identify success as better staff accessibility to the CNE."*

While most nursing informants recognized the need for a high priority on finance, at times they felt it conflicted with the PCA/CNE patient care responsibilities. All informants discussed concerns related to organizational finances and several nurse managers identified concerns about the effects of staff /service reductions on clinical care. The environment of financial pressure was of great concern, especially for nurse managers. Many nurse manager informants believed the organization placed a higher priority on fiscal management than clinical care and they struggled with the ramifications of this on day to day care.

How the CNE position has changed over time

While most informants recognized changes in the CNE role, nurse managers were conflicted about what this meant for nursing and nursing leadership. They voiced concern that the greater distance they thought the PCA/CNE had from nurses might interfere with her ability to understand and support clinical care issues. For example, the use of the term *'corporate'* was a reflection of greater distance between nursing staff and the PCA/CNE.

In addition, organizational history played a role in how informants interpreted their current environment and new leaders. The current organizational structure had been in place for less than one year and the majority of the informants had experienced the product line structure. The product line structure, leaders with fairly long tenure, fewer financial pressures, and less competition were aspects of the past that influenced how informants discussed organizational changes. The PCA/CNE position had been eliminated during the reorganization to product lines. Many informants did not clearly understand the purpose of either the product line structure or the elimination of the prior PCA/CNE position. It was also unclear to several informants how nursing issues were managed in the absence of a CNE. In reality, one of the nursing directors assumed many traditional CNE responsibilities including compliance with regulatory, practice, and organizational standards and assuring consistent nursing practice. This nursing director did so without membership on the administrative leadership team.

The major changes in the CNE position described by nurse manager informants were differences they perceived between the current PCA/CNE and the prior PCA/CNE. Nurse managers perceived the prior CNE to be more focused on day to day operational activities, more in touch with nursing staff, more visible, and a strong nursing advocate. Perceptions of the current CNE included greater focus on finance, greater distance from nursing staff, and less accessibility to staff and managers. In spite of perceived differences between the current and former CNE, the nurse manager informants believed nursing required a leadership position within the organization and were pleased with the reestablishment of a PCA/CNE. According to one informant, *"we really felt the lack of a single unifying leader."*

Relationship of the CNE to the senior leadership team

Informants characterized the relationship of the CNE to the senior leadership team as generally positive. They believed the CNE role was recognized by the organization as important and as a very powerful role. *"...the position is powerful."* *"People were glad to see the position reinstated, they have high expectations."* Informants generally recognized the importance of strong relationships between the CNE and other senior leaders, however, the relationship of the CNE to clinical nursing staff was less clear. *"I have a sense the CNE is more divorced from patient care."* *"...the position is more upwards focused, more concerned with what the boss thinks."*

Senior leader informants identified the CNE as a key member of the leadership team. The medical director was also identified as a critical partner of the CNE. In addition, most informants thought the medical staff was supportive of a single executive position for nursing, as it provided a single point of contact for them regarding nursing issues. In spite of generally positive perceptions of relationships with senior leaders, a few informants characterized the CNE relationship with senior leaders as less positive. There were no examples or evidence to support their perceptions but rather a 'gut feeling.' *"I think some peers are struggling with her [CNE] style."* As indicated above, it was difficult for some informants to separate the person from the position as this quote indicates.

Additional factors influencing the perceptions of CNE role and purpose

All informants recognized and discussed the lack of organizational stability and environmental uncertainty associated with internal and external financial pressures. Nurse managers had recently completed the annual budget process which resulted in a decision

to reduce staff and services in specific clinical areas. These decisions created frustration for some nurse managers, as they were unsure how to proceed with cost reduction strategies. While nurse managers clearly understood the financial pressures of the organization, they indicated a greater need for direction on how to implement expected changes. As managers became more concerned about the future of the organization they identified a greater need for direction in the day to day activities.

Organizational uncertainty and limited understanding of the PCA/CNE role were strong influences in informant perceptions of the CNE role. While informants identified some of the patient care responsibilities of the PCA/CNE, key responsibilities such as strategic planning, advancing the discipline, and representing nursing at decision-making tables were not consistently discussed by either nurse manager or senior leader informants. In spite of the fact that the financial pressures of the organization were clear to most informants, nurse managers, in particular, voiced concern about the effects of financial constraints on the direction of nursing. The strong organizational focus on finance also led some nurse manager informants to describe a dichotomy between the nursing role of the PCA/CNE and the administrative role. There was a sense from nurse managers that if you were a nurse in an administrative role, you were somehow more distant from nursing. It was almost as if the absence of CNE in the PCA title rendered the nursing part of her role invisible. Equally important is how gender, though hidden, influences organizational context. Even though informants believed the organization valued nursing, there are many indicators of negative gender influences on role relationships, status, and power within the organization.

While gender was not overtly or deliberately mentioned as a factor by any informant, the analysis of the transcripts and informant words indicate several areas where gender influences the results. Gender was most notable in the recurring discussions about physician satisfaction. Most informants identified physician satisfaction as a key goal for both the organization and the CNE. As stated by one informant, *"corporate views CNE success as keeping physicians happy."* Thus the effort to attract, retain, and keep physicians satisfied was strongly linked with the PCA/CNE and nursing in general. This suggests that nurses have the ability to make life easier (or more difficult) for physicians. For example, a nurse manager would be expected to find ways to make operating room scheduling easier for physicians. '*Keeping physicians happy*' was associated with higher admissions, satisfied patients, and subsequently more physician referrals to the hospital. Many hospitals pursue strong ties with physician groups in order to increase occupancy. Though most informants did not explicitly link physician satisfaction with hospital revenue, there is a clear financial relationship between physician satisfaction with the institution and their willingness to refer patients who are then billed for services.

Summary of Interviews

The primary role and purpose of the CNE as described by nurse managers and senior leaders was patient care. The description of patient care activities varied slightly among informants but in general all agreed that maintaining a focus on patient care was the primary purpose of the CNE. In addition, most informants recognized fiscal management as a key CNE function. Senior leaders expected the CNE to represent the patient care focus in budget or finance discussions in order to promote informed decision

making. As a result of changes in the PCA/CNE role, changes in organizational structure, and organizational priorities, informants described the role as more administrative. The role was viewed less as a nursing role and more as an administrative role than the prior PCA/CNE.

In spite of the consistency among informants in identifying patient care and finance as key responsibilities of the CNE, there was a limited understanding among informants of the more comprehensive CNE role responsibilities and purpose. Very few informants identified the creation of a practice environment conducive to the delivery of professional nursing care as a key CNE function. Fewer informants identified discipline building goals as a purpose of the CNE in conjunction with her representation of nursing at decision making tables. Thus, informants demonstrated a limited understanding of the comprehensive nature of the role and purpose of the CNE. Their perceptions of the role and purpose were strongly influenced by a lack of organizational stability primarily related to cost constraints.

The overwhelming concern voiced by nurse managers about financial constraints indicated a high level of distress about the effects of constrained resources on patient care. Nurse manager informants sought greater direction from the PCA/CNE especially in relation to implementation of cost reduction strategies. Nurse manager informants, more than senior leader informants, perceived an uneasy tension between the clinical and the financial goals of the organization. Conversely, while senior leaders identified financial pressures as a critical organizational issue, they did not perceive the same level of tension between financial and clinical goals as nurse manager informants.

Scientific Rigor

Construct validity was enhanced in this study through the use of multiple sources of data including: interviews, documents, archival records, and direct observation. I was able to address a broader range of issues, historical, attitudinal, and observational, as a result of multiple sources of data. A research plan to guide design, procedures, and questions was used to improve reliability. Though research plans in case study methods are necessary and useful for reliability, replication of this study would be difficult due to the rapid changes in the healthcare environment, rapid changes within an organization, and how the context of care influenced study findings. The intent of case study is to promote better understanding of "real life events" or to explain individual and organizational phenomena. The single site and small number of participants limit generalizability of study findings.

Summary

Eight interviews with nine nurse managers and senior leaders were conducted to describe CNE role and purpose. Perceptions of the role and purpose of the CNE were strongly influenced by organizational uncertainty, a limited understanding of the CNE role, and a belief the PCA/CNE position was more administrative in nature than clinical. While informants identified patient care as the key CNE role, financial constraints and cost reductions resulted in a perceived tension between the clinical and the financial goals of the organization. Organizational priorities on fiscal management were perceived to be higher than priorities for clinical care. Gender, though not overtly discussed in the interviews, influenced the findings. The next chapter describes the contextual factors and themes that emerged from the analysis of the interview findings.

5 Thematic Analysis

This chapter discusses the two themes and contextual factors that emerged from the analysis of the interviews. In addition, the chapter concludes with a review of the study propositions and their relationship to the data.

Themes and contextual factors

While the categories of code words reflected informant responses to the interview questions, they did not provide adequate explanation or description for the development of themes. Thus, additional analysis was conducted and resulted in grouping the code words into categories which included; *CNE role, CNE qualifications, organizational context, finance, goals, past history,* and *success* (Appendix G). The categories were then further analyzed and seven contextual factors identified (Appendix G). The three themes that emerged from the data were: *organizational culture, gender,* and *clinical-financial tensions* (Appendix G). The theme *organizational culture* was supported by contextual factors which included a limited understanding of the role, identification of the role as an administrator versus a nurse, an absence of disciplinary goals, and organizational uncertainty. The theme of *clinical-financial tensions* was characterized by the contextual factors of an organizational priority on fiscal management and finance as a key determinant of CNE success. Gender was identified as a theme due to the significance of the gender influence throughout the study in spite of the absence of overt discussion of gender.

Organizational Culture

"I see her [CNE] as an advocate for nursing practice...in the face of financial pressures...an advocate for managers...a manager for the organization...that's it probably"

The contextual factors related to the theme *organizational culture* describe conditions within the organization, as well as within disciplines and relationships, that influence informant perceptions of the CNE role. Culture is influence by gender and informs perceptions of leaders, especially women leaders. For example, while most nurse and senior leader informants identified several key indicators when describing the CNE role, they did not usually describe a comprehensive set of responsibilities as I might expect thus, limited understanding of the CNE role was identified as a contextual factor. *"That's it"* from the above quote is indicative of how most nurse informants described the PCA/CNE role with limited examples of responsibilities. The following explains how data supported the contextual factors that were used to identify the themes.

Limited Understanding

Senior leader and nurse manager descriptions of the CNE role and purpose were often limited to the identification of two to three key responsibilities. While most informants identified patient care and finance as primary CNE responsibilities, additional responsibilities of the PCA/CNE such as strategic planning, organizational stewardship, and advancing the discipline of nursing were rarely discussed. The perception of the PCA/CNE role was based upon this somewhat limited perception of the responsibilities. Descriptions of the CNE role by senior leaders were more comprehensive than those of nurse managers but may have been influenced by the different context of their

interactions with the PCA/CNE. In other words, it was more likely that senior leaders would interact and observe the PCA/CNE in a variety of situations in which she represented nursing as well as other disciplines and demonstrated organizational and financial stewardship. Senior leaders clearly had more opportunity for participation with the PCA/CNE in organizational decision-making. Their descriptions of the CNE role suggested their broader organizational understanding of the key work of the PCA/CNE.

Organizational Uncertainty

The contextual factor of organizational uncertainty was based upon financial pressures, a change in leaders and leadership structure, and as a result, changes in expectations of nurse managers. Nurse managers were faced with new challenges of not only increasing their awareness of the complexities of cost constraints but of implementing cost reduction strategies. Nurse managers, in particular, expressed concern about the effect of financial pressures on clinical care delivery. They identified a greater need for information and direction on implementation strategies to reduce costs. While cost constraints are not new to healthcare, the effects in this organization were only recently reaching the nurse manager level. Most of the nurse managers had not been faced with the realities of cost constraints that necessitated staff reductions. Reducing staff in times of uncertainty only reinforced the lack of stability in the internal environment. Rumors about whether the organization would survive were openly discussed.

Identification of the CNE Role with Administration

In addition to a limited understanding of the PCA/CNE role, nurse managers described a dichotomy between the administrator role and the nursing role. For example, the organizational title of the PCA did not include chief nurse executive, though this was

clearly one of her responsibilities. Nurse managers described the PCA/CNE position as more connected to administration and less to nursing. The perception by some nurse managers that once a nurse becomes an '*administrator*' they no longer retain their nursing identity was an important finding. In spite of the fact the PCA was also the CNE, very few nurse manager informants identified her position with nursing. The descriptions of the CNE role as *corporate*, *distanced from staff*, and focused on *numbers* demonstrates a perceived alignment with administration as opposed to nursing. The absence of CNE in the administrator title also resulted in perceptions the patient care administrator was more distant from both nurse managers and clinical nursing staff. Nurse managers voiced concern that greater distance between the PCA/CNE and nursing directors might interfere with CNE ability to support clinical care. These nurse manager perceptions also contributed to difficulty separating the person from the position when describing the CNE role. On the other hand, senior leaders described the PCA/CNE as a key member of the leadership team and found her clinical knowledge and expertise added value to decision making processes. All informants believed the PCA/CNE position was important.

Disciplinary versus Organizational Goals

The purpose of providing an opportunity for informants to discuss goals was to ascertain the degree to which nurse managers or senior leaders might describe disciplinary goals. I was interested in ascertaining the degree to which informants might differentiate nursing goals from organizational goals. However, there was minimal discussion of disciplinary goals by all informants including the nurse managers. Most nurse manager and senior leader informants identified organizational goals such as improving financial status, increasing physician referrals, and improving market position

but nurse manager informants were less clear about specific nursing goals or how nursing work contributed to the organizational goals. For example, nurse manager informants could have identified discipline building goals such as improving care delivery through innovative use of professional staff, enhancing nurse-physician communication, or creating professional practice models as appropriate nursing work consistent with organizational goals. In spite of minimal discussion about nursing goals by nurse manager informants, several did indicate a need for more dialogue with the PCA/CNE to understand the direction of nursing within the organization.

Gender

Gender was a contextual factor that influenced perceptions of CNE role and purpose and also emerged as a theme. Gender often operates as an unconscious filter or lens in many discourses about leadership and healthcare. Gender is a significant variable in bureaucratic organizations such as healthcare. The contextual factor of gender reflects the degree to which gender continues to operate, however hidden, in healthcare environments. Gender was not specifically mentioned by any informant but was identified as influencing results during data analysis. Gender was most notable in four areas; the expectation that the CNE would manage physician satisfaction, the lack of PCA/CNE membership on the Community Board, an interim reporting relationship of nursing to medicine during the product line structure, and the use of first names only on nurse manager and non-physician senior leader name tags.

The expectation by informants and the organization that nursing leaders and nurses have a primary responsibility for physician satisfaction raises a number of questions about physician-nurse role relationships, power of physicians in the system, and

responsibility of the CNE. Is physician satisfaction the responsibility of nursing staff or the nursing leader? In creating systems that are easy for physicians to use, do organizations create systems that also work for patients and nurses? Several nurse manager informants perceived the organizational expectation to manage physician satisfaction as important as financial management. While it is hard to refute the idea that attracting qualified and competent physicians is essential to the ability of an organization to deliver effective care, it is difficult to place responsibility for physician satisfaction with one person. Physician satisfaction is affected by many variables such as; adequate medical record and documentation systems, ability to obtain laboratory and diagnostic data, ability to schedule procedures, and competent staff. In most organizations no one person or department is accountable for all factors that contribute to physician satisfaction.

Gender may be an influence in the absence of CNE membership on the Community Board as well as the past reporting relationship of nursing during the product line structure. The medical director is a member of the Community Board and more recently the COO was appointed ex-officio member, but the CNE is not a member of the Board. The CNE attends Board meetings as an invited guest if she has information to present. There is no clear information in the literature about the number of CNEs who are members of their organization's Community Board. The PCA/CNE is a senior leader with responsibility for all clinical departments and in this case is accountable for over 50% of the hospital resources, and one would think her board membership would be needed for the smooth functioning of the organization.

In addition to board membership, during the period of time in which a product line structure was in place, no nursing leader was officially designated by the organization nor was one a member of the hospital leadership team. In spite of this, one nursing director was assigned responsibility for many of the CNE activities, such as compliance with regulatory, practice, and organizational standards and assuring consistency in nursing practice across the hospital. This nursing director reported to the medical director for nursing issues. If nursing managers are voluntarily willing to assume leadership responsibilities in place of a CNE, organizations are less motivated to maintain a CNE position. Though the product line structure and thus the reporting relationship of nursing to medicine was short-lived, I was surprised that no informants voiced concern over the ramifications of this situation.

Lastly, gender influenced how most informants referred to the physician members of the senior leadership team by their professional titles, such as Dr. Smith or Dr. Brown. On the other hand, non-physician members of the senior leadership team were referred to by their first names. In addition, name tags of the four nursing directors and two clinical managers (five females and one male) listed first names only, omitting last name. These examples, though seemingly small, reflect differences in status between physicians, nurses, and administrators which are influenced by gender.

Clinical-Financial Tensions

"sometime there appears to be a collision between the quality goal and the financial goal. They sometimes seem to be working against each other..."

The theme *clinical-financial tensions* reflect contextual factors within the organization, disciplines and relationships that influence tension between perceived

clinical care needs and financial goals. Though meeting financial goals is not necessarily exclusive of clinical goals, nurse manager informants perceived a precarious tension between the two. This theme was characterized by three contextual factors: an organizational priority on fiscal management, finance as a determinant of CNE success, and the absence of disciplinary goals. *Clinical-financial tensions* created ambiguity in how nurse managers described the CNE role.

Organizational Priority on Fiscal Management

Improving fiscal management and cost containment were key organizational priorities identified by all informants. The PCA/CNE had clear expectations to improve financial management in the clinical departments, including nursing. The PCA/CNE role in fiscal decision-making was perceived by nurse managers to be far greater than that of her predecessor, resulting in nurse managers voicing concern about the ramifications of cost reductions on clinical care. These financial pressures created a tension between clinical care and financial constraints. Nurse managers in particular identified a gap between their desired expectations of the role and their actual experience of the role. For example, nurse managers expected patient care to be the priority of the PCA/CNE, but perceived fiscal management to be a higher priority as reflected in communication from both the PCA/CNE and other leaders in the organization.

Finance as a Determinant of CNE Success

All informants identified meeting financial targets as a key indicator of CNE success. While employee, patient, and physician satisfaction, were also identified as determinants of success, the majority of informants believed organizational priorities to meet financial targets were greater than other indicators. The majority of informants

identified fiscal management not only as a key CNE function but the main focus of the organization. CNE success was strongly linked to fiscal management thus, CNE failure is also linked to inadequate fiscal management.

Review of Study Assumptions

A review of the study assumptions is necessary in order to demonstrate how data is linked to the propositions.

Assumption # 1. Lack of understanding of the role and purpose of the CNE may contribute to decisions to modify (eliminate, change scope/span of control) discipline specific leadership positions.

Restructuring is a common organizational process that results in changes in administrative structures including the CNE role. While nurse manager and senior leader informants did not identify restructuring as a widespread organizational phenomena at the time of the interviews, the change in the scope of responsibilities of the PCA/CNE position reflect the organization's attempt to enhance clinical integration. While it is difficult to verify, limited understanding of the CNE role may influence reorganizations. There is no separate nursing leadership position as a result of the consolidation of all clinical services into a single reporting relationship to the PCA/CNE. Though not always clearly articulated, nurse managers are concerned about the implications of this absence of a disciplinary-specific leadership position and what it may mean for professional nursing within the organization. In one way, it may be perceived positively that the PCA is a nurse, yet the absence of the CNE title and her perceived distance from nursing may adversely influence nursing support of the position over time. For example, if the nurse

managers continue to perceive greater distance between the PCA/CNE and staff as well as describe the role as administrative, their support for both the position and the person in the position may be eroded.

Assumption # 2. The absence, elimination, or reduction of discipline-specific leadership adversely affects the practice environment.

While it is too soon to know 'how' and 'if' the absence of a disciplinary leadership position adversely affects the practice environment, it is fair to say nurse informants are concerned about the possible implications. Though implementation of cost reduction strategies did not take place during data collection, nurse managers voiced concern about how the PCA/CNE will balance clinical issues and allocate resources across multiple disciplines. Implications of the absence of a disciplinary leadership position would include: lower morale of nursing managers and staff, increased turnover of staff, inadequate representation of nursing in organizational decision making, decreased resources allocated to nursing, and changes in the status of nursing within the organization.

Assumption # 3. The absence, elimination, or reduction of a CNE position adversely affects the ability of the discipline to control the content of its work.

There was no specific data to support or refute the assumption the absence of a disciplinary leadership position adversely affects the ability of nursing to control the content of its work. Due to the fact that cost reduction strategies had not been implemented at the time of the interviews, it was difficult to determine impact on work activities of nurses. For example, planned budget reductions which reduce or eliminate unit-based or hospital wide resources to clinical nursing staff may affect the workload of

clinical staff thus altering their ability to control their work but since these reductions had not been implemented, it was not possible to determine the relationship to a disciplinary leadership position.

Assumption # 4. A lack of stability in healthcare organizations affects the power base and decision making authority of nursing leaders.

Organizational uncertainty is a strong influence in how informants perceive the PCA/CNE role. Nurse managers were less sure of their roles in the organization and identified a more centralized or top down approach to decision making. Many were taking a wait and see attitude and were unsure how changes in organizational decision-making processes might affect their decision-making. The consolidation of all clinical services under the PCA/CNE can be perceived positively or negatively as altering the authority of the nurse leader. The PCA/CNE has clear authority and responsibility as well as clearly identified nursing service accountability and thus there is no specific data to determine if the lack of stability affects the power base and decision making of nurse leaders. It would be important to follow how nursing identifies and advances its goals over time in this structure.

The review of study assumptions does not suggest a need for modification of propositions as much as a need for additional data over time. Assumption number one and four, clinical integration and lack of stability, were clearly linked to data. While I was able to link data to each proposition, both assumption two and three are based on the longer term effects of the absence of a disciplinary leadership position on disciplinary control of work and effects on the practice environment and require further study.

Summary

The study findings demonstrate perceptions of CNE role and purpose are strongly associated with multiple contextual factors including: *limited understanding of the role* and *purpose, lack of identity of the role with nursing, organizational uncertainty, gender, priority on fiscal management, finance as a key determinant of CNE success,* and *an absence of disciplinary goals*. The themes that emerged from these contextual factors were *organizational culture, gender,* and *clinical-financial tensions*. The context of healthcare is critically important in influencing perceptions of nursing leadership roles and the persons who occupy nursing positions. In this case study contextual factors clearly affected how nurse managers and senior leaders described the role and purpose of the CNE. It was both challenging and difficult for nurse managers to adjust to organizational changes in personnel and leadership structures. I was continuously struck throughout the analysis by the level of concern voiced by nurse managers about the impact of financial pressures. The next chapter will include a discussion of the findings and further implications for study.

6 Discussion and Summary

This chapter includes a summary of the study results in addition to a discussion of the findings. A review of the research problem and methodology will also be provided. Finally, implications for education, research, and practice will also be discussed.

Problem Statement and Study Design

This case study explored and examined perceptions of the role and purpose of the Chief Nurse Executive held by senior leaders and nurse managers. An environment of rapid change in healthcare settings driven by healthcare financing has resulted in restructuring to achieve cost reductions. Restructuring in hospitals results in a lower number of registered nurses and a higher number of unlicensed or less skilled caregivers. Changes in nursing administrative structures which reduce or eliminate nurse manager positions, including the CNE, are also a feature of many restructuring efforts. There is growing evidence to demonstrate that organizational context, which includes structure, influences patient care outcomes and nurse satisfaction. Studies of magnet hospitals have shown that professional practice models characterized by nurse autonomy, effective communication between nurses and physicians, and nursing control over work processes, results in higher staff satisfaction and superior outcomes. Nurse satisfaction is a correlate of quality and cost as well as performance. Nurse executives are critical to the development and maintenance of professional practice models. They are accountable for the organization of nursing within healthcare settings and thus have the authority and responsibility to create practice environments which promote professional practice. Adequate nursing management structures in addition to senior leader support are

instrumental in designing and sustaining professional practice models. Thus, the degree to which senior leaders and nurse managers understand the CNE role has a strong relationship to the CNE's organizational effectiveness. Nursing, as well as organizational support for the CNE role is enhanced by a clear understanding of both role and purpose. This study explores senior leader and nurse manager perceptions of the CNE role and purpose and identifies contextual factors which influence perceptions.

Case study method and feminist methodology were used in this single site, qualitative case study. Multiple sources of data included: interviews, documents, archival records, direct observation, and physical artifacts. The study site was a large urban hospital. Eight semi-structured interviews with nine senior leader and nurse manager informants were conducted for an hour each. Of the nine informants, four were nursing directors, two were clinical managers, and three were senior leaders. Interview questions were designed to explore informant perceptions of the role and purpose of the CNE and included questions on key responsibilities, qualifications, determinants of success, changes in the CNE role, and relationships with senior leaders. Each interview was transcribed, coded, and analyzed. Codes were then reviewed to determine categories and contextual factors. Two themes emerged from the data.

Themes and Contextual Factors

Organizational culture, *gender*, and *clinical-financial tensions* were the themes that emerged from the data. The themes were identified based upon seven contextual factors that influence perceptions of the CNE role. Contextual factors which supported the theme *organizational culture* included: a limited understanding of the CNE role, identification of the CNE role as administrative versus nursing, absence of disciplinary

goals, and organizational uncertainty. The theme *clinical-financial tensions* was characterized by an organizational priority on finance and finance as a key determinant of CNE success. Gender was identified as a theme due to the significance of the gender influence throughout the study in spite of the absence of overt discussion of gender. The themes *organizational culture, gender,* and *clinical-financial tensions* clearly demonstrate the significance of context on informant perceptions of the CNE role. Context has multiple implications for nursing leadership in rapidly changing healthcare environments.

Multiple contextual factors influence senior leader and nurse manager perceptions of the CNE role and purpose. Overriding concerns about financial constraints and pressure to reduce costs created an environment of uncertainty. Context, or the setting in which the PCA/CNE exercises her role, is strongly influenced by factors such as rapid changes in healthcare and significant financial pressures. As a result of organizational uncertainty and changes in organizational priorities, which were also affected by new leaders, nurse manager relationships with the PCA/CNE had changed. As the CNE role changes in response to the healthcare environment the effect on nurse manager perceptions is significant.

Study Propositions

The following study propositions were developed prior to the study and analyzed throughout the study.

1. Lack of understanding of the role and purpose of the CNE may contribute to decisions to eliminate or reduce discipline specific leadership positions

2. The absence, elimination, or reduction of discipline specific leadership adversely affects the practice environment
3. The absence, elimination, or reduction of discipline specific leadership adversely affects the ability of the discipline to control the content of its work
4. A lack of stability in healthcare organizations affects the power base and decision making authority of various leaders

Data was linked to study propositions one and four but because implementation of cost reducing strategies did not take place during the study, it was difficult to confirm propositions two and three.

Discussion

This study raises a number of issues for discussion including;

- implications of the absence of a disciplinary nursing leadership position
- gender based expectations of women leaders and how they influence perceptions of nurse leaders
- the consequences of cost constraints and cost reduction efforts on nurse managers and their perceptions of the CNE

Each of these issues will be discussed in greater detail in the following section.

Disciplinary Leadership

CNEs are responsible for the management of the nursing organization, establishment of productive relationships with physicians, assessment of the clinical environment, initiation of programs, development and implementation of policy, and forecasting of trends. Their role and leadership activities at least in acute care settings

have been well developed though they have been less stable in the last 5 years due to changes in healthcare. What is less clear is to what degree these leadership activities can take place when there is no disciplinary leadership position for nursing. Restructured organizations are choosing various administrative structures many of which no longer include a centralized, disciplinary nursing leadership position. The absence of a disciplinary leadership position results in perceptions of distance between the CNE, nurse managers and clinical staff, skepticism about future directions for nursing, and concerns about how the CNE will balance patient care needs with financial constraints. Clifford (1998) identifies the theme of loss in relation to the absence of disciplinary leadership. Nurse managers in this study, as well as Clifford's, describe a lack of nursing identity, confusion about future direction, and substantial changes in their relationships with the absence of a disciplinary leadership position. The nurse executive responsibilities in this study are consolidated into an administrator position with responsibility for all clinical departments. Individual competencies withstanding, a question must be raised about the ability of an integrated position to advance the nursing discipline as well as position and represent nursing at decision-making tables when the position is accountable for representing multiple disciplines.

Studies of magnet hospitals are critically important to the understanding of disciplinary leadership positions in nursing. Magnet hospitals are characterized by professional practice models which focus on the creation of environments that foster nurse independence and autonomy and control of nursing work processes. The development and support of these models does not occur in isolation from leaders who know and understand professional nursing practice and are capable of organizing care to

foster professional practice. Restructuring, which has resulted in fewer RNs, increased numbers of unlicensed staff, declines in employee morale and nurse satisfaction, and little evidence of cost savings, has focused its efforts on the percent of RN staff instead of the organization of nursing care. It is the organization of nursing care far more than numbers of staff that affect the conditions under which nurses work. Changes in the staffing ratios of professional staff to unlicensed staff affect how nurses perform their work and increases their degree of supervision over others. However, prior research demonstrates that the appropriate organization of nursing care, which includes a nurse executive role in organizational decision-making, results in higher patient and staff satisfaction and superior outcomes with no additional costs (Aiken & Fagin, 1997).

Even though a patient care administrator position incorporates the CNE role, in this case a limited understanding of the role and perceived distance between staff and the PCA/CNE made it difficult for managers to be supportive of the role. The lack of role identity with nursing negatively affects nurse manager perceptions. While the consolidation of all clinical disciplines into a single reporting relationship facilitates integration of care, the larger question of how nursing maintains a disciplinary focus and a nursing identity remains unanswered. The way nursing work is organized, the nature of nursing tasks and activities, and the management structures which support nurses are significant variables which contribute to the development of professional practice environments. The goal of disciplinary leadership is to manage and control these variables. An integrated administrative position for all clinical disciplines is not a substitute for a disciplinary leadership position.

There is no question that the CNE must be an organizational steward but does this at times conflict with or complement promotion of disciplinary goals? Discipline leaders are responsible for building and advancing their disciplines in addition to promoting the organization's goals (Fagin, 1996). Pressures to reduce costs result in organizational goals taking priority over disciplinary goals; however, the complex nature of healthcare settings requires both discipline building and organizational goals. Disciplinary goals facilitate control of nursing work processes, establishment of standards of practice, the conduct of nursing research, and the development of professional practice systems. Patient safety and patient care outcomes depend on a system of care in which key caregivers, such as nurses, have the autonomy they need to make appropriate clinical decisions and the managerial support to maintain and monitor their standards of practice.

Additionally, clinical staff and nurse managers look to leaders during times of uncertainty to help them interpret their environment. They also look to CNEs to continue to represent the nursing voice in organizational decision-making. The absence of a disciplinary leadership position results in a loss of voice for nursing. Along with loss of voice, the absence of a nursing in job titles decreases the visibility of nursing within the organization. Titles convey meaning and professional identity, and the absence of nursing in organizational titles reflects a loss of disciplinary visibility and leadership. While formal roles such as the PCA/CNE convey legitimate power, the importance of the department of nursing to the organization is also a source of power. Absence of a disciplinary leader, lack of nursing in the title of the PCA, and organizational uncertainty contribute to perceptions that nursing is not highly valued. Rafael (1996) and others describe the societal lack of value on caregiving work which can also extend to the value

placed on leaders of professional groups of caregivers such as nurses. Eliminating nurse executive positions or significantly changing their focus results in marginalization of nurse leaders.

Marginalization within nursing administration reduces the control of nursing practice by nurses and shifts control to other groups such as physicians and administrators. Without strong and visionary leaders the profession remains powerless and divided

Nursing administrative structures are critically important to the development, maintenance, and enhancement of a professional practice environment. Professional practice models characterized by nurse autonomy, clinical decision making, appropriate physician-nurse communication, and adequately prepared staff are developed by nurse leaders to improve patient care and to advance the nursing discipline. The delivery of nursing care is complex and takes place in multiple settings. In hospital settings, in particular, the patients primary relationship is with a professional nurse, who is present 24 hours per day 7 days a week. The relationship between a patient and a nurse is a function of both the nurse's skills and competencies as well as the environment in which she works. Nursing organizational structures are key to creating effective practice environments. The highly complex nursing activities of clinical judgment, administering therapeutic interventions, coordination of care, and professional caring must be supported by the organization and the environment in which nurses work.

Gender and Women Leaders

Context is critically important to leadership. Various contextual factors establish boundaries within which both followers and leaders interact (Klenke, 1996). Leadership is shaped by culture, which is also influenced by gender, context and

leadership/followership relations (Klenke, 1996). Increases in healthcare expenditures result in a need for organizations to manage costs in different ways. Changes in administrative structures represent one organizational strategy for improving fiscal management. In this case study changes in organizational structure resulted in a single administrative position accountable for all clinical services. The role of the CNE was integrated into the patient care administrator position. Financial pressures in the organization led to a strong expectation of the PCA/CNE to improve fiscal management within the organization. While this expectation is appropriate in the current environment, from the perspective of nurse managers, it represents a change in focus. Nurse managers are accustomed to a nursing leadership position whose main priority is patient care and nursing staff. And while it may be true that nurse leaders have steadily been increasing their role in organizational financial management, nurse managers continue to expect an equally strong focus on patient care. Changes in organizational or CNE priorities result in changes in relationships between nurse managers and the PCA/CNE. These changes influence how nurse managers perceive the CNE.

Improving fiscal management results in a need to establish different relationships between the CNE and nurse managers as well as with other senior leaders. Changes in relationships affect how nurse managers perceive the CNE and these perceptions are often influenced by gender. Leadership discourses are associated with masculinity and influence how women's capabilities are viewed. For example, financial management is frequently associated with masculine leadership behaviors such as objectivity and dominance. In fact, very few chief financial officers in healthcare are women. Historically and socially, finance is not a strength associated with nurses (women) or nurse leaders.

As the emphasis on costs continues to grow in healthcare environments, nursing leaders will need to continue to demonstrate the necessary skills for managing in cost constrained settings. When CNEs make complex and difficult decisions associated with restructuring, such as reducing RN staff, they may also be demonstrating behavior inconsistent with stereotypically female behaviors such as nurturance, subjectivity, and passivity. This is especially true in nursing where caring is a core value. Decisions to reduce RNs are also interpreted as not supportive of the discipline by staff and managers. CNEs can be perceived by nurses as emulating typically defined male leadership behaviors such as aggression, objectivity, and dominance. Stereotypically masculine behaviors such as cost cutting are inconsistent with expectations of female leaders and may violate nurse manager expectations of the CNE role. At the same time, CNEs, already functioning in a highly gendered environment, must meet expectations of superiors, mostly male, as well as expectations of subordinates, mostly female.

As evidenced in the findings, some nurse manager informants had difficulty differentiating the CNE position from the person. It is almost impossible to separate individual style from the formal responsibilities of any position. However, it is also important to reflect on the impact of sex-linked behaviors on nurse manager perceptions of the CNE role and purpose. To what degree did behaviors that are inconsistent with nurse manager expectations influence their ability to focus on the CNE position versus the person? Senior leaders did not demonstrate the same degree of difficulty in differentiating the person from the position, suggesting the CNE behaviors may not have been perceived as inconsistent by them. Culture informs perceptions of women in executive positions and in this case the male dominated culture of healthcare and

medicine as well as sex linked behaviors informed nurse manager perceptions of the CNE.

The dichotomy of nurse versus administrator is an interesting finding and at the same time troubling. In spite of concerns about distance between the PCA/CNE, nurse managers, and clinical staff, the fact remains this position is held by a nurse. The organization consciously choose a nurse for the position. Even though the PCA/CNE position is not a substitute for a disciplinary leadership position, nursing support is critical to the success of the both the person and the position. If nurse managers do not identify with the PCA position, support for the position is eroded. A lack of support by nursing influences future administrative positions and how organizations think about qualifications for roles.

CNE expectations for managing physician satisfaction raise interesting questions about physician-nurse relationships, the power of physicians in the system, and organizational versus PCA/CNE accountability for physician satisfaction. Though physician satisfaction with clinical care and administrative systems is necessary in order to attract physicians to the organization, neither the CNE nor the nursing department is solely accountable for assuring physician satisfaction. Weaver (1988) found physician perceptions of increased nurse independence and physician demands for more hospital beds, in spite of CNE resistance due to inadequate staffing, were factors in involuntary turnover of CNEs. In another study by Kippenbrock (1995), conflicts with medical staff were cited by CNEs as a reason for their departure. The notion that physicians have perceived or real power to diminish the role of the CNE is disturbing. CNE performance is a function of numerous and complex variables one of which might include the level of

physician satisfaction with nursing care. Power imbalances between nursing and medicine are reinforced by organizational expectations of nurse executives and nursing to manage physician satisfaction. The CNE is constantly faced with balancing patient care needs against organizational constraints and forces. These activities take place within the context of bureaucratic organizations in which gender, though hidden, continues to influence. The use of a feminist framework provides a different lens for viewing executive nursing practice.

Cost Constraints and Nurse Managers

While many of the causes of rising costs in healthcare are well known, effectively reducing and managing costs is challenging. The long term effects of restructuring, one of the industry's most significant cost reduction strategies, is not well understood. There are clear indications nurse satisfaction is declining, employee emotional distress is rising, and employee-employer relationships are declining as a result of restructuring and rapid change. Nurse managers are the link between administration and the clinical staff. While they are expected to implement organizational strategies such as restructuring, they must also deal with the realities of the effects of these changes on patients and clinical staff. The pressure to reduce costs and consequent concerns that clinical care may be compromised are very real concerns for nurse managers that influence their perceptions of leaders and their work environment. Perceptions that administrators prioritize cost over care must be understood by senior leaders. Organizational support is eroded when managers question the intent and meaning of organizational priorities and actions. If nurse managers feel distanced from the CNE, have major concerns about cost versus care,

and perceive inadequate support, they are not likely to remain in their positions. Retention and support of nurse managers requires CNE attention.

Other Relevant Research

There are several interesting similarities between this study and the work of Clifford (1998). In a study of the impact of restructuring on the role of CNEs, Clifford found the contextual variables of organizational structure, title, person related variables, and patient care to significantly influence the CNE role. Title, organizational structure, person variables, and concerns about patient care were recurring issues in this study as well. As also indicated, CNE turnover is influenced by both staff and physician perceptions (Kippenbrock, 1995; Weaver, 1988) thus, perceptions of senior leaders and nurse managers are linked to the support and organizational success of the CNE.

Implications for Research, Education, and Practice

The implication of this study for future research in nursing administration includes a need for additional studies which link nursing administrative structures with clinical and financial outcomes. Nursing administrative structures are highly significant in the establishment of professional practice environments. Additional study is needed to better understand the effects of the presence or absence of disciplinary leadership on the clinical practice environment. Disciplinary leadership requires further definition both as a concept and an operational imperative. As healthcare organizations continue to restructure in response to cost constraints, there is also a need for further study to understand what organizational factors contribute to decisions to retain or eliminate disciplinary leadership positions. The changing role of CNEs in integrated systems requires additional study. Integration must also address issues of disciplinary leadership

and professional identity. In addition, the emerging role of physician leadership in healthcare organizations requires further study. Does the role of physician leader enhance the overall ability of the organization to function, sustain clinical goals, and manage costs?

The influence of gender in healthcare also requires further study. In spite of increases in the number of women in healthcare management, very few rise to executive positions. Gender continues to operate as a subtext in the healthcare culture and the continued study of the effects of gender are critically important to advancing the discussion of women in executive positions in healthcare. More nursing administrative research, using feminist methodology, is needed to increase awareness of how gender operates in healthcare. Gender as a relevant topic for nurse managers and executives needs to be included in graduate curriculums.

This study also suggests implications for the education of nurse managers. Nurse manager positions have been changing as rapidly as the healthcare environment. The span of control and scope of their responsibility includes both nursing and other clinical disciplines. Nurse managers are faced with the difficult task of actually implementing many of the cost reducing strategies in healthcare environments. They are the first to deliver the news of layoffs or downsizing. Their work is physically challenging and emotionally exhausting. How then are they prepared for the difficult role of middle manager? Different skills are needed to manage in uncertain and rapidly changing environments. Additional skills are needed to manage the consequences of downsizing, changes in professional staff, and increased use of unlicensed personnel. The legal, professional, and ethical ramifications of many of these changes cannot be

underestimated nor can the need to better prepare nurse managers to more effectively manage in rapidly changing environments.

Finally, there are serious consequences when changes in organizational leadership structures result in the elimination, reduction, or modification of senior nursing positions. If the primary purpose of executive nursing positions is to develop systems to ensure the organized and efficient delivery of nursing care, their absence from organizations will adversely affect this capability. One of the key roles of the nurse executive is to integrate clinical care processes with organizational processes. Physician leaders and healthcare administrators are not substitutes for nurse leaders. They bring a unique but different perspective to the delivery of healthcare. It is the combined expertise of multiple leaders that contributes to successful organizations.

Nurse leaders must find new ways to articulate the impact of their roles on the delivery of care. Clearly articulating the role of the CNE and facilitating understanding among nurse managers is key to nursing support of the role. Executive positions that integrate the role of the CNE with other administrative responsibilities must continue to address and acknowledge disciplinary issues. This articulation includes the need to facilitate understanding of the CNE role not only with senior leaders but with nurse managers as well. The use of the nursing title is critically important to nursing identity and the value of nursing care to the organization. While there is clearly a greater need for research in this area, nurse executives know from their own experience the absence of nursing expertise, nursing roles, and nurse leaders can have a negative impact on care. There is a need for the collective voice of nurse leaders to communicate the vital importance of the CNE to patient care.

Summary

Perceptions of the CNE role are clearly influenced by multiple contextual factors including limited understanding of the role, gender based role expectations, and organizational pressures to reduce costs. Changes in organizational structures affects not only nurse manager and senior leader perception of the CNE role but the presence of disciplinary leadership positions as well. The absence of a disciplinary leadership position for nursing results in a loss of clear and visible nursing leadership within an organization which also alters the practice environment of nurses. While the effect of managerial structures on clinical and financial outcomes requires additional study, the impact of strong leadership on achieving improved organizational outcomes is significant. The presence of executive level nursing leadership positions is critical to the maintenance and development of professional nursing practice and to the creation of professional practice environments that promote nurse autonomy.

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Appendix A

Letter of Introduction

Barbara Trehearne
1101 E Lynn St
Seattle, WA 98102
206-328-4349

Dear Ms,

I am a graduate student in the doctoral program at The Union Institute in Cincinnati, Ohio. My area of study is Health Care Administration. I am studying how senior leaders and nurse managers describe the role and purpose of the Chief Nurse Executive.

Your organization has given permission for interviews to be conducted for this study. Your participation is voluntary. Information from the interviews is confidential and all reported data will be anonymous. Each interview is anticipated to last 45-60 minutes and be tape recorded. An informed consent form will be provided prior to the interview.

I would also appreciate your assistance in identifying 4-6 nurse managers who might participate in this study as well. I look forward to meeting with you to discuss my study further on October 6, 1999 at 12 noon. In addition, I am also scheduled to interview you on October 12, 1999 from 3-4pm. Should you have any questions, please feel free to call me at 206-328-4349.

Sincerely,

Barbara Trehearne RN, MS

Appendix B

The Union Institute
Cincinnati, Ohio
Informed Consent Form

Project Title: Role and Purpose of Chief Nurse Executives
Investigator: Barbara Trehearne RN, MS Phone: 206-328-4349 (H)

The purpose of this project is to understand how senior leaders and nurse managers describe the purpose and role of the chief nurse executive. An interview of approximately 45 minutes to one hour will be conducted with a follow up phone call if needed to clarify information from the interview. Each interview will be tape recorded and transcribed. The tapes will be destroyed after the study is completed. The final report and any subsequent publications will protect the anonymity of individual participants. Participants will receive a summary of the study findings upon request.

THIS IS TO CERTIFY THAT I,

_____
(print name)

HEREBY, agree to participate as a volunteer in the above project.

I hereby give permission to be interviewed and for these interviews to be tape recorded. I understand that, at the end of the research, the tapes will be erased. I understand that the information may be published, but my name and organization will not be associated with the research.

I understand I am free to deny any answer to specific questions during the interview. I also understand I am free to withdraw my consent and participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

_____
(participant)

_____
(witness)

_____
(researcher) (date)

Appendix C

Interview Questions

"How do senior leaders and nurse managers describe the role and purpose of the CNE

1. Tell me about the role of the CNE in your organization

a) history of position

b) key responsibilities

c) accountabilities

d) expected outcomes for the position

e) scope/span of control

f) reporting relationships

g) qualifications (how does this compare with other senior leaders)

2. How is success measured for the CNE?

3. How has the CNE position changed over time within your organization?

4. How have organizational changes affected the CNE position?

5. Describe the relationship of the CNE to the senior leadership team.

Appendix D

Independent Code Words

CNE Role
CNE Clinical
CNE Image
CNE & Education
CNE & Community
CNE & Legislation
CNE Professional Practice
CNE Reporting Relationships
CNE Role Relationships
CNE Qualifications
CNE Qualifications-Education
CNE Qualifications-Experience
Finance
Goals
Goals Nursing
Organizational Goals
Leadership
Negative Talk*
Organizational Context*
Gender*
Past History
Decision Making
Nursing Practice Inconsistency
Past History Team Negative
Prior CNE
Success

*Code words added after initial analysis and coding

Appendix E

Code Word Definitions

CNE Role CNE role refers to any aspect of the CNE role identified by the informant. It may include key responsibilities such as finance, clinical oversight, quality, or generic reference to any aspect of the CNE role.

CNE Clinical Clinical oversight is a key responsibility of the CNE. This code addresses anywhere in the text the informant refers to CNE responsibility for overseeing clinical care or patient care. It may also refer to the CNE when she represents clinical care concerns as a member of the senior leadership team.

CNE Image Refers to any reference to the image of the CNE or the status of the position within the organization. Image was used when staff referred to a lack of status for nursing during the team structure when no CNE position was present.

CNE & Education Refers to CNE and her collaborative relationships with educational partners in the community.

CNE and Community Refers to community relationships as part of the CNE role. It may be referred to generically or specifically such as the CNE needs to be involved in the health care needs of the community.

CNE & Legislation CNE role is legislative activity.

CNE Professional Practice Advancing professional practice is mentioned by some participants as a goal of nursing or responsibility of the CNE.

CNE Reporting Relationships Generally refers to the reporting relationships of the CNE, those she reports to and those who report to her.

CNE Role Relationships Relationships with other members of senior leadership, managers, or others.

CNE Qualifications CNE qualifications is a general reference to qualifications of the CNE. It may include reference to either education or experience.

CNE Qualifications Education CNE qualifications include both education and experience. This code is used when reference is made specifically to the qualification of education.

CNE Qualification Experience This code specifically refers to experience as a qualification of the CNE.

Finance Any comments or reference to finance.

Gender Overt or covert indication that gender may be a factor in the discussion. Most segments coded with gender suggest that gender is influencing but not conscious on the part of the participant. Often coded in reference to the need to make physicians happy or satisfied with the system.

Goals Reference to nursing or organizational goals.

Goals & Nursing Refers to any comments referencing goals of nursing.

Organizational Goals Specific reference to organizational goals versus discipline specific goals.

Leadership General reference to leadership responsibilities of the CNE.

Negative Talk A negative reference to the CNE, history of the organization, or nursing in general. Includes comments in which nursing is 'used' to help the organization get by but without recognizing the need for an official nursing position.

Organizational Context References to the environment during the recent past and current time. For example, participants may refer to financial concerns or the need to attract physicians to the facility.

Past History The organization, people, or structure of the past. This refers to anytime speakers provided information about the past.

Decision Making Team This is a reference to past history of team structure when participants identified decision making as generally cumbersome and slow.

Nursing Practice Inconsistency Inconsistency in nursing standard compliance.

Past History Team Negative Negative references to the team structure. Any time informants made negative comments about the team structure.

Prior CNE Comments about the prior CNE.

Success Refers to any description or measures to identify or evaluate CNE success.

Appendix F

Categories of Code Words

CNE Role
- CNE Clinical
- CNE Image
- CNE & Education
- CNE & Legislation
- CNE Professional Practice
- CNE Reporting Relationships
- CNE Role Relationships

- CNE Qualifications
  - CNE Qualifications-Education
  - CNE Qualifications-Experience
- Goals
  - Goals Nursing
  - Organizational Goals
- Past History
  - Decision Making
  - Nursing Practice Inconsistency
  - Past History Team Negative
  - Prior CNE
- Finance
- Leadership
- Success
- Leadership
- Organizational Context
- Negative Talk

Codes, Categories, Contextual Factors, and Themes

Code Words	Categories	Contextual Factors	Themes
CNE Role CNE Clinical CNE Image CNE & Education CNE & Community CNE & Legislation CNE & Professional Practice CNE Reporting Relationships CNE Role Relationships	CNE Role	Limited understanding of the CNE role Dichotomy between administrative role vs nursing	***Organizational Culture***
CNE Qualifications CNE Qualifications-Education CNE Qualifications-Experience	CNE Qualifications	Organizational Uncertainty	
Goals Goals-Nursing Goals-Organization	Goals	Absence of disciplinary goals	
Organizational Context	Organizational Context	Gender	***Gender***
Finance	Finance	Organizational priority on finance	
Past History Decision Making Nursing Practice Inconsistency Past History Team Negative Prior CNE	Past History	Finance as a determinant of success	***Clinical-financial tensions***
CNE Success	Success		