PROFILES, FUNCTIONS, AND CAREER EXPERIENCES OF SELECTED HOSPITAL NURSE EXECUTIVES IN THE UNITED STATES (1988)

by

Darnell H. Cockram

Dissertation submitted to the Faculty of the

Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

in

Education Administration

APPROVED:

L. J. Weber, Co-Chair

M. B. Harder, Co-Chair

M. A. Hopkins

D. J. Parks

W. M. Worner

October, 1992

Blacksburg, Virginia

PROFILES, FUNCTIONS, AND CAREER EXPERIENCES OF SELECTED HOSPITAL NURSE EXECUTIVES IN THE UNITED STATES (1988)

by

Darnell Hughes Cockram

Larry Weber, Martha Harder, Co-Chairs

(ABSTRACT)

The purpose of this study was to describe the profiles, functions, and career experiences of hospital nurse executives in the United States. A descriptive survey method was used. Data were collected from a random sampling of hospital nurse executives and chief executive officers. A self-developed questionnaire was mailed to 400 nurse executives and 300 chief executive officers. The response rate was 40% for the nurse executives and 51% for the chief executive officers. Descriptive statistics (frequencies and percentages) were used to report the findings.

Results of the study revealed:

1. The profile of the hospital nurse executive was female, caucasian, married with children, and between 41 and 50 years old. Nurse executives have more baccalaureate and master's degrees than the general nurse population. Seventy-seven percent of nurse executives have a master's degree in nursing and/or related fields. Nurse executives are in a transitional role from middle to top-level hospital management with title changes, additional responsibilities and increased compensation.

2. The functions of the nurse executive position rated as very important by nurse executives and chief executive officers were similar in the categories of finance, human resource, and nursing management, and less similar in hospital/organizational management. Nurse executives were not satisfied with educational preparation in financial and hospital/organizational management.
3. The career path to the nurse executive position was identified as the traditional clinical pathway. The majority of nurse executives had worked in six or less institutions, had seven or more positions and had 13 years or more of work experience. Nurse executives stated major factors in career advancement were mentors, networking, education, management experience, strong interpersonal and communication skills, and clinical background. Nurse executives described their career planning as both internally and externally determined. Only a small number planned their careers, and over one-half were determined by the organization. Nurse executives perceived themselves as successful. Recommendations for further research were offered.

ACKNOWLEDGEMENTS

First of all, I am extremely grateful to my co-chairs, Dr. Martha Harder and Dr. Larry Weber, for their assistance from the beginning to the end of this doctoral program. Their expert advice, continued support and unending patience throughout the writing of this dissertation was invaluable. Many thanks are extended to my committee members Dr. Hopkins, Dr. Parks, and Dr. Worner for their patience, support, and professional guidance.

Next, I thank all the nurse executives and chief executive officers who participated in this study. Their interest and cooperation made this study possible. Also, I extend gratitude and appreciation to my friends and colleagues, especially my co-workers Amanda, Adrienne, Kris, Eleanor, and Scottie for their encouragement and inspiration these past four years. In addition I would like to thank the faculty and staff of The Memorial Hospital of Danville School of Nursing for their encouragement, support, and positive attitude.

Last, I thank my family, especially Jane and Theresa, my sisters; Vada, my mother; Linda, my daughter; and Lauren, my grand-daughter, for their continuing love, support, and encouragement.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Nurse executives employed in hospitals are undergoing major changes in their roles and functions as a result of unprecedented changes in the health care system. In the decade of the 1980s, hospitals were faced with new prospective payment systems, diversification, competition, advanced technology, and changing demographics of the population. In response to these changes, hospitals are adapting by moving from a total non-profit status to a corporate mode resulting in multihospital systems, mergers, and corporations. Nursing, as a part of the health care system, is experiencing the impact of these social, economic, and political pressures at a time when the nursing profession is undergoing major internal changes related to the nursing shortage, the educational entry level issue, the declining enrollments and graduations of nursing programs, and the expansion of and the resistance to traditional nursing roles (American Hospital Association Guidelines, 1985; Aydelotte, 1984; Fralic, 1987; Gother & Rosenfield, 1986; Porter-O-Grady, 1986).

The nurse executives in hospitals are experiencing more acutely the impact of these societal and professional pressures. As hospitals are restructuring to the corporate

environment, director of nursing positions are being advanced from the level of middle management to that of senior management. As a result, an array of titles for the top nursing position exists ranging from vice-president of nursing to assistant administrator of nursing to director of nursing. In this new executive role, nursing managers must have preparation and expertise in such areas as policy development, fiscal management, marketing, and administration. This transition to corporate level management indicates that the nurse executive needs to develop or obtain appropriate preparation, skills, and abilities parallel to those required of hospital administrators. In addition, nurse executives must have the ability to manage large and complex multilateral corporate divisions (Brown, 1987; Carter, 1987; Fine 1983; Freund, 1985; Porter-O-Grady, 1986; Strasen, 1987).

Background of the Problem

Historical

Traditionally, Directors of Nursing were promoted to their positions because clinical skills were valued higher than management skills. Their career path followed a linear pattern beginning with staff nurse and progressing to headnurse to supervisor to assistant director to director of nursing. These directors functioned as department heads at the middle management level. These earlier work

responsibilities and functions were much simpler as department heads when directors of nursing implemented policies determined by hospital administration. Directors of nursing rarely functioned as members of the top management team. These earlier directors functioned in their roles with preparation mainly from hospital schools of nursing and hospital work experiences (Ashley, 1976; Fralic, 1987).

Current Role of Nurse Executives

As a result of increased competition and changing economics related to the various reimbursement payment systems by Federal and State governments and insurance companies, the 1980s represented an era of major role changes for hospital nurse executives. In response to these changing health care economic conditions, nurse executives experienced dramatic changes in their functions and work responsibilities. The nurse executive is defined as the person holding the top nursing position who has responsibility for overall management of nursing divisions and for clinical practice of nursing throughout the institution (AHA guidelines, 1985). As health care organizations are forced to operate as business organizations, nurse executives are not only expected to have business and administrative skills parallel to other hospital administrators but also are held accountable for

having the same competencies (Brown, 1987; Fralic, 1987; Fralic, 1992; Porter-O-Grady, 1986).

The scope and complexity of the nurse executives' role today require that they:

1. exert greater control over their departmental resources as well as manage scarce resources of capital, people, and equipment hospital wide;
2. participate in decision-making affecting the financial health of the hospital organization;
3. serve on hospital governing boards, medical staff committees, and top hospital management committees, and,
4. assume responsibility for additional departments or divisions within the hospital organization.

To carry out the functions in this new role, nurse executives must have the business skills necessary for cost accounting, sophisticated budgeting procedures, personnel management, strategic planning, policy development, and systems design. Thus in the 1980s, the traditional role of director of nursing began to become obsolete with replacement of a highly sophisticated administrative role (Aydelotte, 1982; Fralic, 1987; Fralic, 1992; Mark & Turner & Englehardt, 1990; Reynolds, 1987; Scalzi & Wilson, 1990; Strasen, 1987).

Educational Dilemma

As a result of increased responsibilities of nurse executives, the educational preparation necessary to function in the executive role is being scrutinized by the nursing profession and by hospital chief executive officers. There is confusion in the nursing community about the courses as well as the graduate degrees required for nurse executives. One conclusion from the literature review is that nurse executives must have the same kind of graduate level preparation in business or health care administration as hospital administrators. This concept is supported in the nursing advertisements. Hospital chief executive officers are requiring nurse executives to have a master's degree in either nursing administration, nursing, business, or health administration. Some large and complex hospital corporations are requiring the doctoral degree for nurse executives. As a result, nurse executives are seeking graduate degrees in business schools rather than in graduate schools of nursing where clinical practice is the primary focus of the program (Anderson, Thurkettle, & Fitzpatrick, 1984; Aydelotte, 1984; Carter, 1987; Fralic, 1987; Porter-O-Grady, 1986; Scalzi & Anderson, 1989; Tilbury, 1992).

Thus, a concern for the nursing profession, more specifically for graduate schools of nursing, is that employers, not nursing, are beginning to determine the

levels or types of educational preparation that will constitute the future qualifications required of nurse executives. As a result, nursing schools are rapidly changing their curricula to incorporate the business knowledge and skills required (Boerstler & Suver, 1989; Mark, Turner, & Englehardt, 1990; Simms, 1989).

Role Transition

As the nurse executive moves from middle management to the top-level hospital management team, the nurse executive needs to acquire the management knowledge and skills and to be socialized into the executive role (Traska, 1982). Porter-O-Grady (1986) states that the scope of the nurse executive role today and in the future is beyond the nurse's ability who has not been specifically prepared to perform the leadership role in a complex hospital corporation.

In addition to appropriate qualifications, an executive's success is also determined by his/her personal career experiences. Two major career experiences cited from the literature that have an impact on successfully reaching and maintaining a top management position are socialization practices and career advancement patterns as determined from work histories (Campbell-Heider, 1986; Jennings, 1967; and Schein, 1968). An explanation of these career experiences will help to determine how one is socialized into the executive role, how one plans for advancement, and how one's

work history contributes to the successful attainment of the top nursing positions.

Socialization refers to the process of "learning the ropes" of any job. As one enters and stays in the work world, the values, norms, and behavior patterns of the organization are learned both formally and informally, enhancing both job performance and organizational goal attainment (Clark & Corcoran, 1986; Feldman, 1976; Schein, 1968; Van Maanen, 1978).

Furthermore, most powerful and successful managers report having had a mentoring relationship in their careers. Jackall (1983) states that "to advance, a manager must have a patron, also called a mentor, a sponsor, a rabbi, or a godfather. Without a powerful patron in the higher echelons of management, one's prospects are poor in most corporations" (p. 124). These patron networks are primarily experienced in the male work culture; moreover, women have lacked socialization for and experience in this type of work relationship (Campbell-Heider, 1986; Shapiro, Haseltine & Rowe, 1978; Speizer, 1981; Vance, 1982).

Vestal (1983) suggests that nurses who aspire to the top levels of nursing management must plan and manage their careers to be successful. Previously, the career advancement pattern in nursing valued clinical skills with less emphasis on management skills. With the rapid changes

in the nurse executive's roles and qualifications, the traditional career advancement path is being challenged with many new and nontraditional career paths. For example, what is the entry level position for the nurse with a graduate degree in business or nursing administration? What is the entry level position for nurse executives today? Jennings (1967) stated it takes 20 years for a person to reach the top position. Also, he adds that a person during this time period will change positions eleven times, will change geographic locations seven times, and will be assigned numerous project assignments. He further states that the mobility patterns of managers can be determined by a retrospective study of their work histories. Since most hospitals are now requiring graduate degree preparation, business skills, and preferably management experience in other institutions for promotion to any managerial position, career planning in this turbulent period may be problematic for the nurse executive (Fralic, 1987; McBride, 1985; Scott, 1984; Wintz, 1987). This study provides baseline information about the specific career experiences of socialization practices, and the career advancement patterns of the hospital nurse executive as they relate to the nurse executive's changing roles and responsibilities.

Statement of the Problem

As a result of the changing role of the nurse executive

in the 1980s, the chief nursing officer in a hospital is required to function in the executive role which requires qualifications and competencies comparable to those of other vice presidents. In addition to the nurse executive's position being in a process of transition from middle level management to top level management in hospitals, the career factors of socialization practices and career advancement patterns become essential factors for the nurse executive to consider and to plan for as he or she advances to the top nursing position.

In the 1980s, nurse executives faced two dilemmas related to their education and role transition to the top nursing positions:

1. Aydelotte (1984) stated that the nurse executive's functioning is now a vital part of the hospital's executive management and leadership team which demands a management orientation for which, until recently, few practicing nurse executives had been formally educated (p. 94).
2. Traska (1982) stated the role transition of the nurse executive from middle level management to top level management requires the individual to have certain skills and abilities and to be socialized into the executive role (p. 57).

Traditionally, nurses have not been prepared for this

new executive role in either baccalaureate or graduate nursing programs (Strasen, 1987). Also, little has been written about the career experiences of nurse executives that contribute to their successful advancement to the top nursing position.

Several studies found that nurse executives lack business preparation for their role. For example, Reynolds (1987) found that nurse executives report that they feel least prepared in fiscal management and legal matters. Likewise, Johnson (1987) found that nurse executives ranked fiscal management as most important for them to know and to be included in nursing graduate programs. Also, nurse executives reported that they gained financial management and training mainly by work experiences (on-the-job training), continuing education, and self-study (Price, 1984). She also found that graduates of a nursing administration program felt administrative and management components were more important than clinical nursing, and they ranked management and administration first with financial management and budgeting second as essential components of nursing curricula.

From the review of the literature, these two assumptions are made:

1. that nurse executives are not being adequately prepared in nursing schools with the business and

management skills necessary to fulfill the job requirements in the nurse executive role; and

2. that nurse executives' career experiences lack both socialization into the executive role and planning for advancement to the top nursing position.

With the multiple changes in the health care environment, the roles, functions, and qualifications of nurse executives have undergone a period of dramatic changes in the 1980s. Therefore, the problem of this study arose from these two questions:

1. What education and experience qualifications do nurse executives need as chief hospital nursing officer?
2. What career experiences contribute to the nurse executive's advancement to the top nursing position in hospitals?

Purpose of the Study

The purposes of this study were to:

1. Update the nursing literature by describing the professional, educational, and demographic profiles of hospital nurse executives.
2. Identify the most important functions hospital nurse executives are expected to perform in the nurse executive role.
3. Provide career data for advising nurse managers

aspiring to the nurse executive position in hospitals.

4. Provide data for the nursing profession about the career mobility of hospital nurse executives.

Research Questions

The following research questions were formulated to guide this study:

1. What is the current profile of hospital nurse executives?
2. What functions do nurse executives and chief executive officers rate as important in the performance of the nurse executive's role?
3. What career experiences do nurse executives report that contribute to their advancement to the top nursing position?

Significance of The Study

It is clear that the role of the nurse executive changed dramatically in the 1980s. The nurse executive or chief nursing officer in hospitals must be prepared for total participation in the organization which requires knowledge and skills in business administration (Johnson, 1987; Porter-O-Grady, 1986; Reynolds, 1987; Strasen, 1987). Although the nursing literature in the late 1970s and in the early 1980s began to address the education and career issues of nurse executives, there is little research on the

qualifications, functions, and career experiences of contemporary hospital nurse executives. This study adds to the body of nursing knowledge that could be beneficial for nurses in both nursing education and nursing practice.

This study also provides information that should be useful for these three groups of nurses:

1. the current nurse executives who can identify and assist potential nurse managers;
2. the nurses who aspire to the top administrative position to plan their careers for appropriate education and work experience; and
3. the nurse educators who plan and provide graduate nursing administration curricula and who counsel graduate students in planning a career in nursing management.

Operational Terms

For this study, the following terms have been operationally defined as:

1. Nurse Executive (NE) is "defined as that registered nurse on the hospital executive management team who is responsible for the management of the nursing organization (nursing department, nursing division, etc.) and for the clinical practice of nursing throughout the institution" (AHA guidelines, 1985, p. 1).

2. Hospital/corporate environment refers "to the hospital being divided into several corporate entities, with each entity or division having responsibilities, objectives, and processes for the delivery of its services. Each corporate entity or division assumes individual responsibility for its role in fulfilling the defined corporate goals within the framework of the services and functions that are the work of the corporate segment" (Porter-O-Grady, 1986, p. 93).
3. Hospital Chief Executive Officer (CEO) is the person responsible for managing the hospital and reports to the governing body.

Limitations

Limitations of this study are:

1. the data is four years old, and
2. due to the low response rates of 40% and 51%, the results of this study cannot be generalized beyond the sample.

Organization of the Study

This study is organized in five chapters. The first chapter includes the introduction, problem, and statement of the problem, purposes, general research questions, and operational definitions for the study. Chapter two contains a review of the literature as it relates to the profile,

functions, and career advancement, of hospital nursing executives. Chapter three describes the methodology, the research design, the population, the instrumentation, and the research questions to be answered. Chapter four presents a report of the analysis, findings, and answers to the research questions. Chapter five includes a discussion of the findings, conclusions, and recommendations for future research in nursing.

CHAPTER 2

LITERATURE REVIEW

The focus of this study was on the hospital nurse executives' professional profile, changing role functions, and career advancement. Because this study focused on the changing profile and role functions, the first section will discuss the historical perspective of nurse managers. The next section will discuss the educational preparation of nurse executives. The last section will explore the career concepts related to career advancement, career mobility, and career pathways.

Background

The 1980s were a decade of unprecedented changes in the health care environment. Health care institutions were faced with changing reimbursement payment methods, cost-control measures, alternative health care settings, shift of inpatient care to outpatient care, manpower shortages, and increased competition. All of these forces led to changes in health care agencies that paralleled business and industry such as downsizing restructuring, consolidation, mergers, acquisitions, and forced closures. As a result of these social, political, and economic forces in the health care environment, the role and functions of the nurse manager in hospitals has changed dramatically. The role of

the top nursing manager was evolving from the traditional title of director of nursing to the contemporary title of nurse executive, and from a member of middle level management to top level hospital management. In this new executive role, nurse executives must have the education and expertise that is parallel to that of hospital administrators. In addition, nurse executives must have the ability to manage large and complex multilateral corporate divisions (Fine, 1983; Freund, 1985; Mark, et. al., 1990; Porter-O-Grady 1986; Strasen, 1987).

During this period, two major questions surfaced for the nursing executives:

1. What were the new roles and functions of nurse executives?
2. What educational preparation would be necessary for nurse executives to cope with or adapt to the rapid changes in hospitals and in the health care environment?

These questions served as the basis for this study with an additional question, what career experiences were important for career advancement to the top nursing position? This study provides empirical data as a baseline for describing the current profile, functions, and career experiences of hospital nurse executives.

Freund (1985) and Andrica (1988) stated that nurse

executives are expected to be leaders of the nursing department, while at the same time, working with colleagues at the top-level of management. They are also expected to assume a broader scope of responsibilities as well as to develop programs and services that ensure high quality patient care and increased revenues. Also, they are expected to reduce costs and at the same time increase productivity and retention of staff.

Likewise, Singleton and Nail (1988) agreed that as the responsibilities of the hospital management team have changed, many nurse executives have accepted promotions, title changes and new roles and responsibilities. Also, additional hospital departments have been added to their responsibilities such as pharmacy, dietary, social service and home care. During this period of change, the chief executive officer recognized the expertise of the nurse executive as demonstrated through past experiences of managing the largest department with a large percentage of the hospital budget.

Historical Development

Traditionally, the director of nursing was the title of the position of the nurse who was responsible for the nursing department in hospitals. These directors functioned as department heads at the middle management level. As the Director of Nursing, they implemented policies that were

determined by hospital administration. They rarely functioned as members of the top management team (Ashley, 1976).

Directors of nursing were usually promoted to their positions because they demonstrated outstanding clinical skills which were valued higher than the management skills. During this earlier period of nursing, nurses began their position as a staff nurse (entry level position), then were promoted to head nurse, then nursing supervisor, then to assistant director of nursing, and last to director of nursing. This career pathway of advancement appeared to be a linear pattern of promotion that was based upon the clinical abilities of the nurse rather than the management abilities. These directors functioned in their roles with their educational preparation primarily from hospital schools of nursing (diploma) and from their hospital work experiences (Ashley, 1976; Fralic, 1987).

Ashley (1976) has stated that historically, the role of the nurse has been perceived or portrayed as one of caring for the "hospital family." Nurses have been responsible for providing patient care in the most efficient and economical manner, while being loyal to the institution, and preserving the institution's reputation. Thus, through service and self sacrifice, nurses worked continuously to keep the "family" happy. All of the hospital departments, from wards

to operating room to storerooms and kitchens, were dependent upon the 24 hours continuous presence of nurses with many of these departments closed at night and on the weekend. As a result, nurses had to be versatile and to be able to take care of any problems or needs that occurred such as caring for patients, housekeeping, dispensing drugs, or supervising in the kitchen. Nurses, then, were responsible for meeting all of the "family" needs of the hospital.

During this early period of nursing, physicians, hospital administrators, and trustees of the hospital boards formulated policies and made decisions for the nursing department. Nurses had little if any responsibility for policy making. This period in nursing history is described as "paternalistic" by Ashley (1976).

Thus, the role of nurse executive in the early period included care-giver, educator, and supervisor of employees who were then mostly students. Also, they ran the laundry and supervised housekeeping and dietary activities. Their broad scope of responsibilities included delivery of nursing care, nursing education and hospital operations.

As hospitals became more complex, the nurse administrator focused on those activities related to delivery of nursing care. And nursing education began to move into the colleges and universities. Then, in the 1930s, the responsibility for hospital operations and

administration moved from the nurse administrator to the creation of hospital and health care administrators (McCloskey et. al., 1988).

Educational Preparation

The earlier education of nurses was in hospital schools of nursing or diploma schools where apprenticeship was the mode of learning in which the students were used as manpower, thus decreasing costs. However, in the early 1900s, nursing education began to move gradually from the hospital to the collegiate or university setting (Ashley, 1976). In the 1980s, the educational qualifications for nurse executives came under scrutiny not only by nurses but also by hospital administrators and governing boards. It was also reported that many nurse executives lacked the educational preparation for such an expanded role. In the nursing literature, educational preparation for the nurse executive position was debated with a lack of agreement whether the master's degree should be in business or nursing administration. Some nurses and administrators propose that nurse executives need a doctorate to be prepared for their position. Also, there is discussion that the educational preparation for the nurse executive position be a dual degree, one in nursing and one in business administration. (Anderson et. al., 1984; Boerstler & Suver, 1989; Decker & Strader, 1992; Fralic, 1987; Scalzi &

Anderson, 1989; Tilbury, 1992).

Graduate education in nursing administration began in 1899 at Teachers College, Columbia University. It was a two semester program designed to "prepare capable nurses for advanced responsible positions in hospital work and thoroughly trained superintendents who were capable of taking charge of small hospitals and training school" (Simms, 1989). In the 1920s, the graduate programs in nursing administration developed with areas of study in hospital and public health administration. In the 1950s, the Kellogg Foundation made funds available that developed thirteen graduate programs in nursing administration. Then in the late 1970s, the Kellogg Foundation again provided funds to nine universities for the development of interdisciplinary masters program in nursing administration with schools of business, public health, and health administration (Simms, 1989).

Despite this growth in nursing administration programs, the emphasis in graduate education began to shift from nursing administration to the development of clinical expertise or clinical specialization with the preparation of clinical nurse specialist. Then in the 1960s, many nursing leaders felt that nursing graduate preparation should focus on clinical practice. As a result, graduate programs offered clinical majors rather than education or

administration. Some graduate programs continued to offer education and administrative majors, but more emphasis was on the preparation for advanced clinical practice (Freund, 1985).

Also, at this time, there was a great disenchantment with nursing administration. Generally, nurse administrators were then blamed for problems in nursing departments (Simms, 1989).

The decade of the 1980s has been one of renaissance for nursing administration as a respected part of nursing practice and education. The traditional role of the nursing administrator is rapidly becoming obsolete. As Aydelotte (1982) reported, nursing service administrators are obtaining graduate degrees, being appointed to hospital governing boards, using position titles that reflect corporate responsibilities, and assuming responsibility for additional departments or hospital divisions.

Fine (1983) spoke to the lack of a sufficient supply of qualified nursing administrators to meet the need in a changing health care environment. She described the nursing situation as having a limited nursing pool from which to draw nurse administrators. While there was a need for a marked increase in educationally prepared nurse administrators, the financial support for students in graduate schools declined. She recommended that with the

increased responsibilities of nurse administrators and the complexities of the changing health care system, nursing administrators must be prepared at or above the masters' level.

In the late 1970s, McClure (1979) was one of the first that supported the educational preparation of nurse executives be at the advanced level of both nursing and business. Since the late 1970s, much has been written in the nursing literature about the educational preparation and roles and functions of hospital nurse executives with little research conducted in this area.

Wilhite (1988) reported that the Council of Graduate Education for Administration in Nursing (CGEAN) is attempting to define and describe the different levels of managers in nursing administration. They found that there is a blurring of definitions and descriptions of nurse managers. The results of a survey to its members showed that nurse managers and nurse executives are defined by titles, by reporting relationships, or by functions and responsibilities.

Scott (1984) stated, "nurses are in a position of advantage if they choose to climb the corporate ladder" (p. 58). She suggested that the challenge for women in management may be better for nursing administrators because nursing is essential both to health care institutions and to

controlling cost and productivity. She acknowledged that the move may not be easy as the nurse administrator becomes a member of the top management team.

She further stated that the top nursing manager's primary responsibility is to give leadership to nursing by using administrative knowledge and skills. Thus, the combination of advanced study in nursing and in business is an absolute requirement.

McCloskey, Gordner, Johnson, and Maas (1988) in their study of nursing service administrators stated that the contemporary nurse executive must be prepared for multiple roles and must be able to do the following:

1. relate to higher corporate management, colleagues in other settings and other professional groups, to community and consumers, to nursing staffs and ancillary personnel, and to clients within the hospital and home settings,
2. set the pace for a wide variety of management activities including the determination of appropriate rewards and incentives for staff, the design of the structure for the work of professional nurses, the establishment of systems to measure and ensure the quality of care, long-range strategic planning, negotiation with their departments, and responses to external regulating

bodies (pp. 93-94).

The role models for top nursing managers grew in the 1980s, and this was the decade for locating these nurse executives and learning from their experiences. The collective gains for nursing belong to those persons who continue to make new career paths to the top by increasing their work responsibilities beyond the traditional limits of nursing administration, education, research, and clinical practice (Fralic, 1986; Scott, 1984; Spitzer, 1982).

Therefore, the field of nursing administration is in its early stages of development. In recognition of this development, The American Association of Colleges of Nursing and the American Organization of Nurse Executives issued this joint statement on graduate education in nursing administration:

> Educational preparation for nursing administration should take place in collegiate schools of nursing offering specialized graduate programs in nursing administration.... This preparation integrates concepts from the disciplines of nursing, business, and management resulting in a unique and specialized configuration of knowledge.... The synthesis and application of this knowledge is essential to the development of nurse executive leadership for professional nursing practice (McCloskey, et. al., 1988, p. 263).

del Bueno, and Walker (1984) speak to the opinion that there is a growing agreement that nurses in management need to have special preparation and training for their roles but that there is even less agreement on what and how that

preparation is to be provided. In their nurse management development program, these ten desired characteristics and skills were identified for nurse managers:

1. interest and motivation,
2. flexibility in use of management strategies and style,
3. problem solving/priority setting skill,
4. high self-esteem,
5. ability to deal with frustration and anger,
6. skill in written and oral communication,
7. ability to set realistic, achievable goals,
8. willingness to take risks,
9. skill in group process,
10. perseverance and tenacity (p. 9).

In a market survey study conducted by Scalzi and Anderson (1989), both nurse executives and chief executive officers stated that their preference for educational preparation for nurse executives was the dual degrees of nursing and business. The nurse executives (75%) chose the dual degree more frequently than the chief executive officers (65%). The remaining respondents preferred the masters' in nursing administration. Few nurse executives (8%) and chief executive officers (2%) saw the doctoral degree as necessary preparation for nurse executives.

In this same survey, chief executive officers stated

the important qualifications for the nurse executive positions were: (a) previous experience as a top level nurse executive, (b) previous nursing experience, (c) interpersonal skills, and (d) advanced education at the masters level of above.

Fralic (1987) suggested that "the contemporary nurse executive is truly a hybrid - a blend of nurse and businessperson" (p. 37). She further states that the work of the nurse executive is the manager of scarce resources of capital, people, equipment, and systems, and that this work includes such skills of "cost accounting, predicting, marketing, sophisticated budgeting procedures, variance analysis, personnel management, strategic planning, policy development, and systems design and evaluation (Fralic, 1987, p. 36).

Price (1984), in a study of graduate programs in nursing administration, found that the essential components of a nursing service administrator curriculum were the following in decreasing order of importance:

1. administration and management,
2. financial management and budgeting,
3. organizational theory,
4. labor relations and human relations,
5. economic and political aspects of management,
6. research,

7. a generalist approach to clinical subject matter (p. 17).

In a study by Freund (1985), of chief executive officers and directors of nursing in a sample of university-affiliated hospitals, respondents were asked the reasons for the directors of nursing effectiveness, and the educational and work experiences of both the chief executive officers and the directors of nursing. She found chief executive officers stated the most frequent reasons for the directors' effectiveness were knowledge of general management, health, and nursing, balanced with human resource skills, and a total organizational perspective.

Fruend (1985) also found that 66.2% of the directors of nursing earned their basic nursing education in associate degree or diploma schools with 31.1% in baccalaureate programs, while 73% had obtained further degrees. Whereas, 92% of the chief executive officers reported advanced degrees as their educational background.

In addition, she found that the management experience of chief executive officers averaged 19 years while directors of nursing averaged 13 years. Fifty-nine percent of the chief executive officers reported 16 or more years of management experience; 73% of the directors of nursing reported having 15 years or less of management experience.

Johnson (1987) in his study of nurse executives

preparation recommended that financial management be integrated into nursing curricula in both masters' and baccalaureate programs. And, he recommended that continuing education programs and self-study materials be developed for persons unable to attend college courses or for those who need to update their financial knowledge. He stated that both the financial and nursing content are important and necessary for the preparation of the nurse executive role.

Reynolds (1987) in her study of nurse executives found that they had the greatest difficulty in the areas of fiscal management and legal matters. She also found that nurse executives had accepted their position because they viewed it as a challenge.

Duffy and Gold (1980) in a study of nursing administrators compared the graduates of both nursing administration and non-nursing administration masters' program. She found that the graduates of the non-nursing administration majors perceived their preparation as better in budgeting, marketing, and statistics. They recommended further research be conducted.

The literature reveals that there are differences of opinion about the appropriate educational preparation as well as the knowledge and skills essential to the role of nurse executive. The results of this study will provide empirical data about the current nurse executives'

educational background and their perception of the knowledge and skills essential to their role.

Profile of Nurse Executives

In 1982, members of the American Society for Nursing Service Administrators (ASNSA) were surveyed by Aydelotte to update the 1977 data base. Her study provides a comprehensive profile with changing trends of nursing service administrators. The resulting data produced the following profile:

1. Titles - 36.5% held the title of director of nursing, 19.1% held the title assistant administrator and 17.1% held the title of vice-president for nursing;
2. Salary - Salaries ranged from $15,000 to more than $65,000. 52.4% earned more than $35,000;
3. Age and sex - 96.2% were female, 3.8% were male, 55.6% married, 42.8% were 40-49 years old;
4. Educational preparation - 69.1% in diploma schools, 22.9% baccalaureate and 4% associate degree. 61.6% had earned a masters' degree and 2.0% a doctorate;
5. Reporting relationships - 39.2% reported to the administrator, 15.3% to the president, and 11.8% reported to the executive vice-president.

In 1986, a national survey of nurse executives in

hospitals was conducted by Witt Associate, Inc. The resulting profile showed the following:

1. 93% female, 7% male, 74% under 50 years of age, 54% married;
2. Educational - 73% had a masters' degree with 44% masters in nursing. 4% had doctoral degrees;
3. Titles - 45% had title of vice president either of nursing or patient care services. 25% had title of director of nursing;
4. Reporting relationships - 49% reported to chief executive officers, 42% reported to chief operating officers;
5. Salary - average salary was $56,000 with a range of $35,000 to $139,000;
6. 50% of the nurse executives attended meetings of the hospital board of directors;
7. Scope of responsibilities included the traditional nursing units, plus the emergency room and the operating room and other patient related services such as physical therapy, social work, respiratory therapy and occupational therapy (Andrica, 1988).

Another finding in this survey were the expectations that chief executive officers had for the nurse executive position. The key expectation was strong leadership skills. Other expectations were: (a) ability to motivate nursing

staff, (b) strong management and communication skills, (c) ability to work with different groups such as the medical staff, (d) understanding of the total hospital operation, (e) possession of financial/marketing knowledge, and (f) characteristics of results-oriented and flexibility.

Rawson (1988) conducted a study in Australia about the characteristics and educational needs of The Chief Executive Officer (CEO), Director of Medical Services (DMS) and Director of Nursing (DON). Most of the hospitals in the Australian health system are managed by these three executives. Results of his study are:

1. 83% of directors of nursing were women, 92% of chief executive officers were men, 90% of directors of medical services were men;
2. None of the directors of nursing earned more than $50,000 (Australia); 36% of chief executive officers and 87% of directors of medical services earned salaries higher than that amount;
3. Respondents stated the knowledge and skills that contributed to serving as a senior manager were personal and interpersonal skills, and management knowledge. Both the directors of nursing and medical services placed a strong emphasis on clinical background experience;
4. Directors of nursing had deficiencies in financial

planning, analytical and statistical skills. They relied on assistance from other departments in financial, personnel, industrial relations, analytical, statistical and information systems. He suggested there is a need for education in management for nurse managers.

Career Development

There is a paucity of research about the actual career experiences of nurse executives. This study will describe selected factors related to the nurse executives' career mobility such as the career path to the top nursing position, the socialization practices engaged in career advancement, and future career goals.

In general, "careerism" is beginning to enter the field of nursing. Nursing articles about career development began to surface in the late 1970s and early 1980s, at the same time the roles and functions of nurses begin to change in response to the changing health care environment. New careers and new jobs in nursing emerged, and many of the traditional jobs were reshaped. The need for career development programs in nursing would assist nurses in making conscious planned career decisions and would assist them in preparing for challenging roles which motivate and fulfill personal interests. For the nurse manager the potential and desire for leadership preparation needs to be

developed early in the nursing career if more nursing leaders are to be prepared. By planning one's career, the necessary educational and experiential credentials can be obtained for the desired position. Career planning involves the interaction of one's personal goals, one's lifestyle, and one's job. Therefore, career development is a process that occurs throughout one's life. As a result, one's work history will develop, but a successful career is no accident (Keough, 1977; McBride, 1985; Nowak & Grindel, 1984; Smith, 1982; Vestal, 1983).

Vestal (1983) stated that the "careerism" in nursing emerged during the severe nursing shortage of the early 1980s. It forced nursing organizations to identify clearly if career pathways existed to keep nurses at the bedside. During this period, career advancement in nursing was the movement of the nurse from the bedside to management that did not always meet the career goals or interests of the individual nurse. As a result, many career ladder programs were developed that allowed the nurse to stay at the bedside yet advance in clinical practice.

Wintz (1987) indicated that the future of nursing rests with those nurses who forge ahead into new career paths by expanding their responsibilities beyond the traditional roles of nursing. She further stated that nurse executives can assist others in career development by reviewing their

own career development, identifying their career moves that were the most valuable, and describing their career experiences that promote advancement.

Nursing career is defined by Morrison and Zebelman (1982) as a combination of career with a general philosophy of nursing. They define nursing career as "a life-long professional commitment to excellence in practice in which the individual nurse can be flexible in meeting the needs of work, self, and family as these needs vary throughout adult life" (p. 62).

There is also a shortage of research in the area of career development in nurse executives. This study provides empirical data related to the factors involved in career advancement of nurse executives.

Since there was a limited amount of research available, concepts from the fields of sociology and psychology are discussed. The concept of career has importance and meaning for most individuals in our society. Hall (1976) stated that a career represents a person's entire life in the work environment which includes all of the following: a) advancement, b) profession, c) lifelong sequence of jobs, and d) lifelong sequence of role related experiences. Likewise, he defined career as the "individually perceived sequence of attitudes and behaviors associated with work experiences and activities over the span of the person's

life (p. 4)." Super (1980) also defined career as the "combination and sequence of roles played by a person during the course of a lifetime (p. 282)." The commonalities of Hall's and Super's definitions are that they are both developmental, occurring over time, and sociological, recognizing the interaction between an individual's expectations and the work environment.

Because a large amount of a person's life revolves around work, people tend to choose work that will enable them to fulfill their needs, interests, and self-expression (Super 1957, 1984). However, work or career is viewed differently by men and women. According to Hennig and Jardim (1976), women see careers as a means for personal growth, satisfaction, self-fulfillment, and contributing to meeting the needs of others; whereas, men see careers as a progression of jobs leading to rewards and recognition. Traditionally, women have been thought of as the central force in the home and family. Even though women have worked, they have not thought of themselves as having careers. Herr and Cramer (1984) report this trend is changing as more women are entering the work force, are receiving more education, and are entering male dominated occupations.

With more women working, the composition of the work force has changed mainly due to antidiscrimination laws,

executive orders, and the consciousness - raising of women in relation to their careers. Women tend to confront problems typical of any newcomer entering an established setting such as acceptance, role conflict, socialization behaviors, and obstacles of mobility within a work situation (Herr & Cramer, 1984; Nieva & Gutek, 1981; Shapiro, et. al., 1978). Nursing as a female dominated profession is involved in these changes as they affect all women in the work environment.

Career Mobility

A very important aspect of one's career is the mobility or advancement patterns from the entry level jobs to the top position in an occupation. Although there is very little research about the actual career advancement patterns of nursing managers, the subject is currently being addressed in the nursing literature and nursing practice. The focus of the nursing career development is on the need for career planning. Planning a lifelong career allows individuals to manage their career so that they can achieve both success and job satisfaction (Morrison & Zebelmen, 1982; Nowark & Grindel, 1984; Scott 1984; Vestal, 1983).

General Career Mobility

Career mobility is the movement from one position with the progression to a more responsible position or positions. The components that may determine one's advancement in a

career are parental influence, socioeconomic status, advancement or fast-tracking, and self-fulfillment (Hall, 1976; Hall, 1986; Jennings, 1967).

Jennings (1967) pointed out that the premise for the new generation of managers is, "mobility equals competence" (p. 2). He stated that most jobs can be mastered in a year and a half to two years, and that when one moves from job to job and masters each job, then one has gained more intensive training and development than the manager who stays in a job long after mastering it.

Veiga (1981) found in an examination of career histories that the average manager spent 3.5 years per position - with only one in four managers staying longer than seven years in a position.

Hall (1976) also stated that studying the mobility patterns of managers and executives in an organization brings a degree of precision and refinement to managerial development. The mobility patterns are done by a retrospective review of managers which includes the routes taken, the number and distribution of managers, and the slow and fast movers.

Although Jenning's (1967) model was based upon male managers, nursing managers could benefit from his concept of "mobilography" (p. 5). By examining nurse managers' work histories, the mobility or career pathways of nurse

executives can be identified. This information would be valuable for nurses in three ways: a) in planning their careers in management, b) in identifying potential nurse managers, and c) in developing management programs for potential and aspiring nurse managers. The data in this study will identify the career pathways of the nurse executives currently employed in hospitals.

However, according to Hall (1976), not all people are seeking advancement, but are more concerned with freedom, mobility, personal fulfillment, and shared authority. Also, many mid-career executives and professionals are reexamining career goals and changing fields, which suggest a new career ethic is emerging. Hall (1976) suggested that many individuals are concerned with the freedom to find challenges in a wider variety of organizations that also match their lifestyles and life experiences. In addition, he describes this new career ethic as one in which the individuals manage their own career rather than allowing the organization to manage their career. Thus, the career is shaped by the individual and not the organization which may be redirected from time to time to meet the individual's needs.

Therefore, career mobility is the upward progression in an occupation which may follow the traditional pattern with the organization being dominant. Or career mobility may

follow a nontraditional pattern where the individual's own self-fulfillment is dominant.

Nursing Career Paths

There are few research studies in the nursing literature on the career paths or career development of nurse executives. The literature is beginning to address career development as an essential facet of nursing. There are some studies which focus on the career patterns of nurses who are not executives or managers. The results of some of these studies are discussed briefly as they demonstrate the career information that is available.

Knopf (1983) carried out a fifteen year study of nurses from all three programs, diploma, associate degree, and baccalaureate. The survey revealed biographical differences at the time of entry to the nursing schools. The diploma and baccalaureate students were single, young, white women who were in the top half of their high school classes. The associate degree students were of two groups: (a) the young, single, post high school students, and (b) the older, usually married or divorced students. Also, the associate degree program had a larger number of men and minorities, and the parental characteristics were different. Parents of the baccalaureate students had more education and were frequently professional or managerial workers with higher incomes.

The nurses in this study dropped out of the work force between one and five years after graduation from all three programs. More nurses were working at ten years than were at five years. And at fifteen years a slightly higher proportion of the nurses were working than had been at ten years.

Knopf also found that married nurses who had pre-school age children often stop working, or work part-time. After fifteen years, 75% of the nurses were working.

In her study, 61% of the associate degree and diploma nurses had obtained a baccalaureate degree. Over 76% of the baccalaureate nurses had a master's degree in nursing or in a non-nursing major. The nurses who had more education and working were more likely to be nurse administrators or to be in an extended nurse role position. The completion of a degree was related to the work status or work position.

Nolan (1985) studied the work patterns of 47 midlife female staff nurses, aged 45 to 59, who graduated in the 1950s from one diploma school. She found that nurses took jobs to be compatible with family demands or to maintain their skills. Over 50% of the nurses were working in the same positions they held when they were first employed. These nurses followed a horizontal career pattern which seemed to reflect their movement in and out of jobs due to family situations. Little upward mobility was seen unless

the nurse obtained a baccalaureate degree. Nolen suggests that most of these nurses had not planned for career advancement or had long-range career goals.

Hanson and Chater (1983) investigated the relationship between the interest in management roles, personality, demographic, and career background of 122 female graduate student nurses. The subjects were divided into management and nonmanagement groups based on the business management scale of the Strong Campbell Interest Inventory. They found that those who exhibited managerial interests were more practical-minded, sociable, conforming, dominant, expressive, and had more occupational interest than those who did not demonstrate such interests. Women lacking managerial interests showed greater preference for "feminine" low status occupations. There were no significant group differences found in the demographic and career background variables.

The findings from their study suggested that faculty could identify graduate students who showed a potential for managerial roles. As a result, faculty could advise those students so that the appropriate knowledge and skills could be pursued to enhance the nurse's success in seeking and advancing to management roles. Their study also suggested that interest inventories are one way of identifying potential nurse managers which could serve as a guide to

career planning.

Price, Simms, and Pfoutz (1987) in a small study of 12 top level nurse executives in both education and service, looked at their reasons for career choices, progress of positions held, influence of others on career advancement, and elements of job satisfaction. They found that 83% of the respondents in nursing administrative chose these positions because the opportunity had arisen. Other reasons given were the benefits, and a chance to affect nursing practice, or to influence nursing. The nursing executives in their study had progressed from staff nurse to head nurse or similar middle management positions as well as various administrative positions.

Price, et. al. (1987) also found that 83% of the respondents reported that others were influential in their career advancement. The respondents stated nursing service administrators and deans were the most important. Also several of the nurse executives stated involvement in professional networks such as support groups and professional organizations were a significant factor in their career advancement.

They also found that satisfaction with the nurse executive role was a significant factor in career advancement. Even though the sample size of the study was small, they concluded that deliberate career planning and

education in administration were lacking and that these nurse executives learned their skills mainly by on-the-job training.

Socialization

The nursing literature reveals little research on how nurse executives are socialized into their roles as they advance in their careers from middle management to top level management. Socialization is generally defined as the process of "learning the ropes" in a new job (Schein, 1968). It involves learning the values, norms, and behavior patterns of the organization one is entering which enhances one's performance and goal attainment (Clark & Corcoran, 1986; Schein, 1968; Schein, 1971). Schein (1968) states that socialization occurs in school, in the first job after school, in any lateral or upward job changes, and in any changes such as going back to school and/or back into the work world. Also, Van Maanen (1978) states that the obvious socialization strategies occur when a person first enters an organization, when a person is promoted, or when a person changes assignments or locations. He further emphasizes that socialization occurs in each transition a person makes across organizational boundaries. Both formal and informal socialization occur as one enters the work world and as one stays within the work world (Feldman, 1976; Van Maanen, 1978). Thus, one's career is a combination of

organizational socialization and resocialization. Schein (1968) also points out that the speed and effectiveness of socialization affects the employee's loyalty, commitment, productivity, and turnovers.

In addition to organizational socialization, Clark and Corcoran (1986) describe professional socialization. Professional socialization occurs in three stages: (a) anticipatory, including choice and recruitment; (b) occupational entry and induction; and (c) role continuance. In anticipatory socialization, the person begins to act, to dress, and to adopt the group values of the organization one aspires to join. It is a period of testing for the congruence of one's interests and desires with the organization's requirements. In the entry and induction stage, the person obtains or has the required formal education or training for the occupation or learns while doing. In role continuance, the person internalizes the role behaviors, develops a sense of work satisfaction, and demonstrates a high degree of job involvement, commitment, and career maturation. These three stages of professional socialization suggest an "ideal progression" of a career path, but in actuality one's career path may or may not follow these stages.

Berlew and Hall (1966) in a study of organizational socialization, found that the first year is a critical

period of learning. It is the time when the employee is ready to develop or change to meet the organization's expectations. He also found that job challenge and individual performance in the first year are strongly related to later job success and performance.

Feldman (1976) in a study of 118 hospital employees, found that the first days in an organization can have a major impact on new recruits. He found that it took new employees three months to feel comfortable and six months to feel competent.

Kotter (1973) describes the assimilation of new employees into an organization as the "joining-up process" (p. 91). He also found that experiences in the joining-up period had a major effect on the person's later career in an organization as well as an effect on job satisfaction, attitude, productivity, and turnover.

Louis, Posner, and Powell (1983) did a study on the availability and helpfulness of socialization practices. Their findings are:

1. That peers are the most important factors in helping newcomers to feel effective.
2. That supervisors are the major contribution to the process of acculturation.
3. That the supervisor's involvement with newcomers is seen to affect job satisfaction, commitment, and

tenure.

4. That a mentor relationship is significantly correlated with job satisfaction but did not affect commitment or tenure.

Mentors

Another important aspect of socialization is the concept of mentors in relation to career advancement. The concept of mentors, role models, sponsors, guides, and/or coaches is described extensively in the literature. The "Patronage" system of socialization for managers ranges from mentors to peers, with role models, sponsors, guides, and coaches in between. Mentors assist their proteges to gain new skills and confidence to take professional risks which may greatly accelerate career growth. This relationship is the most intense one between a manager and his protege. Sponsors, coaches, and guides, because of their higher professional status and position, can provide the novice employee with valuable information about the organization in a less intense relationship (Campbell-Heider, 1986; Kanter, 1977; Louis, Posner, & Powell, 1983; Nieva & Gutek, 1981; Rosenfeld, 1979; Schein, 1971; Speizer, 1981; Vance, 1982).

The significance of patrons for managers who are advancing in their careers is summarized by Jackall (1983) as:

> To advance, a manager must have a patron, also called a mentor, a sponsor, a rabbi, or a godfather. Without a powerful patron in the higher echelons of management, one's prospects are poor in most corporations. The patron might be the manager's immediate boss or someone several levels higher in the chain of command. In either case the manager is still bound by the immediate, formal authority and fealty patterns of his position; the new - although more ambiguous - fealty relationships with the patron are added.
> A patron provides his "client" with opportunities to get visibility, to showcase his abilities, and to make connections with those of high status. A patron cues his client to crucial political developments in the corporation, helps arrange lateral moves if the client's upward progress is thwarted by a particular job or a particular boss, applauds his presentations or suggestions at meetings, and promotes the client during an organizational shake-up. One must, of course, be lucky in one's patron. If the patron gets caught in a political crossfire, the arrows are likely to find his clients as well (p. 124).

Mentorship is common in the male work environment with most powerful executives stating that they had mentors in the work setting and attributing much of their success to their supportive relationship. Campbell-Heider (1986) states that "women have lacked socialization for and experience with this type of employment relationships" (p. 110). She also suggests that individuals in female-dominated professions have under-utilized these important career advancement strategies and that women in male-dominated field have lacked models and skills for developing successful mentoring relationships.

Collins (1984) studied career supports and barriers of

top and middle level managers in social work, education, and nursing. Her findings indicate:

1. That support from fathers was given to the ones in social work and education, but that nurses exhibited low father support.
2. That women in the study did not opt for a totally career-centered lifestyle, but met family responsibilities as well, often experiencing difficulty in trying to meet demands in both areas.
3. That this group of women administrators scored low in mentor relationships.

Vance (1982) studied 71 influential nurse leaders and found that 83% had one or more mentors and that 93% reported they were mentors to others. Of their mentors, 70% were nurses, 79% were women, and 21% were male. Vance (1982) advocates that women professionals need mentors in their career because of special problems such as juggling multiple roles in private life and careers, traditional sex-role conditioning, lack of career planning, deficits in self-esteem, lack of access to formal and informal processes in organizations, low values assigned to traditional women's work and the need for academic credentials. She concluded that nurses in all areas need to share ideas, make contacts, learn the ropes, test the political waters, get feedback, and find support for their ideas (p. 12).

Specific behaviors involved in socialization that are key to career advancement as outlined by Autonberry (1988) are:

1. displaying positive attitude and professional image,
2. developing and growing through education,
3. exhibiting leadership,
4. networking with colleagues,
5. serving as officer in a professional organization,
6. publishing an article or writing a book,
7. increasing visibility and image,
8. joining community organizations,
9. developing presentations,
10. establishing mentor relationships (p 42).

Scott (1984) suggested that aspiring nurse managers who are planning for upward mobility must learn the corporate values and norms, and must be able to speak as much of the language of the organization as possible. She suggests that "it is a good idea to act, dress, think, and talk at the level which you plan to move rather than adjusting to your current level" (p. 62).

Bruzek-Kohler and Carpenter (1985) further supported the development of nurse executives. They suggest that it is important to identify early those nurse managers who demonstrate management potential and provide them with both

formal and informal education.

Summary

A review of the literature related to the careers of nurse executives employed in hospital is very limited. The roles, functions, and educational requirements for the position of nurse executive became wide spread beginning in the 1980s as the nurse executive became a member of the top senior management team. Also during this time, the nursing literature began exploring and stating the need for career development for nurses (Hanson & Charter, 1983; Keough, 1977; Nolan, 1985; Vestal, 1983).

There is little research related to the career paths that nurse managers follow to reach the top nursing position in hospitals. Two studies of nurses in general by Nolan (1985) and Knopf (1983) suggested that nurses seek a more horizontal work pattern with little upward mobility.

Two important factors related to careers are career mobility and socialization practices. Jennings (1967) describes career mobility as following a traditional pattern in a career in which one progresses upward in a series of positions until the top executive position is obtained. Whereas, Hall (1976) describes a nontraditional mobility pattern in which one changes jobs for one's own self-satisfaction.

Socialization practices are essential to successful

careers (Jackall, 1983; Kanter, 1977; Schein, 1971; Scott, 1984; Vance, 1982). Socialization behaviors practiced in career advancement involve learning the values, norms, and behavioral patterns of the organization. Thus, Schein (1968) describes socialization as "learning the ropes" of any job which may be prior to assuming a position, or while in a position, or when changing a position. Within the rubric of socialization, mentors, sponsors, coaches, and peers are influential in assisting newcomers to learn both the formal and informal organization. Women administrators in general have lacked the socialization in the work environment that has traditionally been experienced by men (Campbell-Heider, 1986; Speizer, 1981; Vance, 1982).

Nursing Literature Update

To update the nursing literature in this study, a review of the nursing literature of the 1990s was conducted. The nursing literature revealed that articles about career development are related more to nursing education than hospital nursing practice. For example, Redmond (1991) studied the life and career pathways of deans of nursing programs. Raul and Peterson (1992) studied the influence of mentors on the career development of nursing education administrators in baccalaureate and higher degree nursing programs. They found mentoring was important but not as important as the appropriate educational background and

experiential base.

Lask (1992) explored in depth the career attainments of nurses with doctorates in academia.

Two studies on the careers of hospital staff nurses were conducted by Porter and Porter (1991) and Gardener (1992). Porter and Porter (1991) looked at the self-image of hospital nurses. They found significant differences in self-image between beginning and expert nurses, between BSN and MSN, and between full and part-time nurses. They found that nurses' self-concepts become stronger and more positive through career advancement and advanced education.

Gardener (1992) explored the concept of career commitment and its relationship to turnover and work performance in 320 newly employed registered nurses in one hospital. She defined career commitment in nursing as "the intent to build a career that is a meaningful part of a lifelong pursuit (p. 155)." She found that career commitment dropped significantly over the first year; and, that there is a weak direct association between career commitment and job performance.

The review of the nursing literature on career experiences of hospital nurse executives revealed one study by Sorrentino (1992) profiling the chief nursing officer in Florida hospitals. She did a survey comparing the ideal versus the real educational preparation, professional

experience, essential competencies of the hospital chief nursing officer as described by both CEOs and CNOs. In this profile she found that:

1. 82% of the CNOs had master's degrees,
2. CNOs had work experiences in positions of staff nurse, head nurse, supervisor, assistant director of nursing, and director of nursing.
3. The top five competencies ideally expected were leadership, interdepartmental communication, budgeting, conflict resolution, and JCAHO standards compliance.

The review of the nursing management journals: Journal of Nursing Administration, Nursing Management, Nursing Economics, and Nursing Administration Quarterly, revealed topics that are primarily related to the functions performed by nurse managers. For example, some of the topics were: restructuring nursing delivery systems, managed care, cost control, staffing, recruitment, total quality management, ethics, shared governance, and informatics.

The educational preparation for nurse executives is still being debated in nursing literature. Discussions are focused on the types of degrees and graduate programs, whether it should be nursing, business, or both, that provides the curricula to educate nurse executives to be effective in their positions. (Decker & Strader, 1992;

Fralic, 1992; and Tilbury, 1992.)

Fralic (1992) best summarizes the profile of the effective nurse executive of the 1990s as:

> "Successful nurse executives will be well credentialed and properly experienced, and they will have built solid track records. They will be able to manage a number of demanding and sometimes conflicting relationships simultaneously. Tomorrow's nurse executives will master the art of decisiveness in highly ambiguous environments. They will build high performance teams.
>
> Top nurse executives will have mastered board room behavior, sound governing board and medical staff relations, and impeccable bottom line skills. Trust, integrity, and credibility will continue to be indispensable, and nurse executives will look and act the part (p. 15)."

CHAPTER 3

METHODOLOGY

Purpose

The purpose of this study was to describe the profiles, functions, and career experiences of nurse executives currently employed in hospitals in the United States. This study provides data about the educational backgrounds and work experiences of nurse executives. Also, this study identifies selected responsibilities related to the changing role of hospital nurse executives. Lastly, the study describes the career experiences that contribute to the advancement to the top nursing position in hospitals. This study provides empirical data about the profiles, functions, and career experiences of contemporary hospital nurse executives. The following research questions guided this study:

1. What is the current profile of hospital nurse executives?
2. What functions do nurse executives and chief executive officers rate as important in the performance of the nurse executives' role?
3. What career experiences do nurse executives report that contribute to their advancement to the top nursing position?

Research Method

The research design for this study is the descriptive survey. According to Best (1977), "A descriptive study describes and interprets what is. It is concerned with conditions of relationships that exist, opinions that are held, processes that are going on, effects that are evident, or trends that are developing. It is primarily concerned with the present, although it often considers past events and influences as they relate to current conditions" (p. 116). This type of research is commonly used in nursing as it generates theories and questions for further research.

The survey was conducted using Dillman's (1976) method for mailing questionnaires. The questionnaire was mailed with a cover letter explaining the study (See Appendix A). Enclosed with this letter was the questionnaire with the return address and postage on the back of the questionnaire. The questionnaire was printed commercially. (See Appendix B). A follow-up postcard was sent two weeks later to the non-respondents. Four weeks from the first mailing a second cover letter, and self-addressed questionnaire was mailed. The questionnaire was coded for identification purposes only. Those who wished to receive a summary of the results of the study were asked to place their names and addresses on the back of the returned questionnaire.

The questionnaire was the survey instrument developed

for data collection. The questionnaire consisted of three sections: (a) demographic data, (b) selected functions and responsibilities, and (c) career experiences. This three part questionnaire was mailed to the hospital nurse executives. Only Section 2 with the selected functions and responsibilities plus two open ended questions about the educational and work requirements for the position of nurse executive was mailed to hospital chief executive officers. A cover letter was included. (See Appendix C and Appendix D).

Population

The population was the nurse executives who were the 1988 members of The American Organization of Nurse Executives (AONE), an affiliate division of The American Hospital Association at that time, and who:

1. were registered nurses,
2. had overall responsibility for the nursing department, and
3. functioned as a member of the hospital's management team.

The population of chief executive officers in hospitals was members of The American Hospital Association as published in The American Hospital Association Guide, (1988).

Sample

The sample for the nurse executives was taken from the reported 4000 membership of the American Organization of Nurse Executives (AONE). Since the membership list contained both nurse executives and assistant nurse managers, only the subjects were chosen with titles that reflected the top nursing manager in acute care hospitals. Using random numbers, 400 subjects were chosen for the sample.

Four hundred questionnaires were mailed in November 1988. One hundred and sixty questionnaires were returned. A follow-up mailing with a reminder postcard after 2 weeks resulted in only 3 responses; two of the returned envelopes had written on them that the subjects were no longer at the hospitals. Telephone calling was attempted, but each call resulted in the respondent being out of the office or unavailable; a message was left with the secretary with no results. A second mailing of the cover letter and questionnaire was mailed in December 1988. There were no results from the second mailing. This low response rate may be due to the questionnaire being mailed just prior to the Thanksgiving holiday and follow-up questionnaire mailed during the Christmas holiday. Of the 163 responses, 158 were usable for a 40% response rate.

The sample size of chief executive officers of acute

care hospitals was taken from The American Hospital Association (AHA) membership of hospitals published in The AHA Guide (1988). Since all types of hospitals are listed in the guide, six acute care hospitals from each of the 50 states or 300 hospitals were chosen using random numbers. The 300 questionnaires were mailed to the CEOs in December 1988. The number of questionnaires returned was 158. A card was sent two weeks later for the only follow-up with two responses. One response stated the person was no longer at the hospital. Of the 160 responses, 153 were usable for a response rate of 51.0%. The timing of the mailing of the questionnaires may have also affected this response rate.

Instrumentation

Questionnaire

The 29 item questionnaire included both open-ended and closed questions. The respondents reported their answers on the questionnaire. The questionnaire consisted of three major sections:

1. demographic data (work, personal, and educational),
2. selected functions and responsibilities,
3. career experiences (work histories, socialization, and advancement factors).

The first section consisted of the work, educational, and personal data. The work profile included the title of the respondent's position, title to whom the respondent

directly reports, additional department responsibilities, salary, type of governance, and bed size of the hospital.

The educational data included the respondent's basic nursing education, graduate and/or advanced education, and certification in nursing administration. Also, respondents were asked if they are currently working on a degree.

The personal data included the respondent's age, gender, race, marital status, number of children, and parent's occupation.

The second section included selected functions and responsibilities which nurse executives perceive as important to their role of the nurse executive. These selected functions consisted of a partial list of contemporary functions from advertisements in nursing management journals, from a panel of five chief executive officers, and from a review of the nursing literature. This panel of six chief executive officers employed in regional hospitals were asked to state the knowledge, skills, roles, education, experience, and responsibilities they considered necessary for the position of the top nursing person to perform. Five chief executive officers responded.

The functions were then grouped into four broad categories. These categories were: (a) financial management, (b) human resource management, (c) hospital/organizational management, and (d) nursing

department management. Each category contained from six to ten responsibilities with a total of 30 responsibilities. Respondents were asked to respond to three questions: (a) Is this function important to your role as nurse executive? (b) How important is this function to your role as nurse executive?, and (c) Were you educationally prepared for the four categories?

The content validity of the questionnaire was determined with the assistance of a panel of nurse executives who expressed their professional judgment with comments. This panel consisted of:

1. Clara B. Adams-Ender, Brigadier General, U.S. Army Commanding General. Fort Belvior, VA;
2. Patricia Cushnie, Nurse Consultant, Former Director of Nursing at Medical College of Virginia Hospitals. Richmond, VA;
3. Marjorie Byers, Corporate Director of Nursing and Quality Assurance, Sisters of Mercy Health Corporation. Farmington Hills, MI.

After reviewing this panel's comments, the questionnaire was revised. The revised questionnaire was sent to ten nurse executives in hospitals in Virginia as a pilot study for further refinement of the questionnaire.

Pilot Study

A pilot study was conducted to assess the questionnaire

for validity, clarity, and utility. The 33 item questionnaire was sent to 10 members of the Virginia Organization of Nurse Executives (VONE), a state constituent of American Organization of Nurse Executives. The subjects in this pilot study were not included in the study. Six respondents returned the questionnaire.

From their responses and comments, the questionnaire was revised and refined to include 29 questions.

Research Questions

The data from the questionnaires were coded numerically and transferred to a computer data file for statistical analysis using the Number Cruncher Statistical Program.

The research questions noted in Chapter I, along with subsidiary questions are outlined in this section. These subsidiary questions served as the basis for the questionnaire.

Question one: What is the current profile of hospital nurse executives?

Subsidiary questions

1.1 What are the current titles used by nurse executives?

1.2 What are the titles of the person to whom nurse executives report?

1.3 Are nurse executives responsible for other hospital departments?

1.4 What is the hospital's governance or classification and bed size?

1.5 What are the current salaries of nurse executives?

1.6 What are the gender, age, race, marital status, number of child, and parents' occupations of nurse executives?

1.7 What is the basic nursing education of nurse executives?

1.8 What are the academic credentials of nurse executives?

1.9 Are nurse executives currently working on a degree?

1.10 Are nurse executives certified in nursing administration by American Nurse's Association?

1.11 What topics do nurse executives report as essential for the nurse executive's role?

1.12 What factors do nurse executives rate as important in obtaining management knowledge and skills?

Question two: What functions do nurse executives and chief executive officers rate as important in the performance of the nurse executive's role?

2.1 What functions do nurse executives report as the most important in the four categories:

1. financial management,
2. human resource management,
3. hospital/organizational management,
4. nursing department management,

2.2 Are the nurse executives educationally prepared for each of the four categories?

2.3 What functions do chief executive officers report as most important in the four categories?

1. financial management,
2. human resource management,
3. hospital/organizational management,
4. nursing department management

2.4 What are the educational requirements as stated by CEOs for the nurse executive position?

2.5 What are the work/management experiences as stated by CEOs, required for the nurse executive position?

Question three: What career experiences do nurse executives report that contribute to their advancement to the top nursing position?

3.1 What are the work histories of nurse executives?

3.2 What are the career paths of nurse executives?

3.3 What are the socialization behaviors nurse executives engage in for their career advancement?

3.4 What experiences do nurse executives report as

contributing the most to their career advancement?

3.5 Does being active in professional and civic organizations enhance the career advancement of nurse executives?

3.6 Do nurse executives plan their career?

3.7 What reasons do nurse executives state for choosing careers in management?

3.8 Do nurse executives perceive themselves as successful in their careers?

3.9 What are the future career goals of nurse executives?

Data Presentation and Analysis

These data were coded and analyzed using the Number Cruncher Statistical Computer program. The descriptive statistics used for data analysis were percentages and frequencies.

CHAPTER 4

RESULTS OF THE STUDY

Currently, as a result of their changing roles nurse executives in hospitals are required to function in roles that requires qualifications and competencies comparable to those of hospital vice presidents in top level management. The 1980s reflect the nurse executive's role transition from middle management to top level management. As a result, the factors related to career advancement become essential for the nurse executive in this transition and for nurse managers who are planning to advance to the top level nursing position. This study presents empirical data that describe the professional, educational and, demographic profiles, selected functions, and career experiences of nurse executives employed in hospitals in the United States.

In this chapter the results of the mailed questionnaires to the hospital nurse executives (NEs) and the hospital chief operating officers (CEOs) are presented. The CEOs only responded to the questions about the function of nurse executives, their education, and experience qualifications. These data were coded and analyzed using the Number Cruncher Statistical computer program. The descriptive statistics used were percentages and frequencies.

This study responded to the following research

questions:

1. What is the current profile of nurse executives?
2. What functions do nurse executives and chief executive officers rate as important in the performance of the nurse executive's role?
3. What career experiences do nurse executives report that contribute to their advancement to the top nursing position?

Research Question One

What is the current profile of nurse executives?

The analysis of data taken from section A of the questionnaire describes the professional, educational, and demographic profiles of the current nurse executives employed in hospitals in the United States.

Professional Profile

Stated in Table 1 are the titles used by nurse executives in hospitals. Over one-third (35%) of the respondents use the title of vice president, and one-fifth (20%) still use the title of director of nursing. The rest of the respondents use a variety of titles that include the words executive and/or administrator. Therefore, in this study, 80% of the nurse executives have a title of vice president, executive, or administrator. These changing titles of nurse executives reflect the changing roles and responsibilities of nurse executives in the hospitals in the

Table 1

Current Hospital Nursing Executive Titles (n=158)

	Frequencies	Percentages
Vice President of Nursing	55	35
Vice President of Patient Services	29	18
Vice President of Nursing and Patient Services	2	1
Director of Nursing	32	20
Executive Director of Nursing, Nurse Administrator, Assistant Administrator	40	25

1980's. Traditionally, the title of director of nursing was used for the top nursing position in hospital departments of nursing. However, the title of director of nursing reflects the same nursing management responsibilities in smaller hospitals or hospitals that have not undergone corporate restructuring. In hospitals that use vice president as the title for the top nursing position, then the director of nursing is generally the position below the vice president.

With the increasing shift of nurse executives to the top level of hospital management there is a change in the title of the person to whom the nurse executive reports. In Table 2, almost one-half (41%) of the respondents report directly to the chief executive officer/president who is the top management person in the hospital organization. Almost 20% of the respondents report to the administrator in which this position in some hospitals is equivalent to the chief executive officer/president.

In this study, over 50% of the respondents have titles of vice president, and 60% of the respondents report to the top management position in hospitals. This shift in both title changes and reporting reflects corporate restructuring and suggests nurse executives are considered a member of the top level management team.

Nurse executives are assuming responsibility for more departments than nursing, as seen in Table 3. In addition

Table 2

Title of Person to Whom Nurse Executives Report (n=157)

	Frequencies	Percentages
Chief Executive Officer/ President	65	41
Executive Vice President	26	17
Chief Operating Officer	15	10
Administrator	29	19
Other	22	14

Table 3

Additional Hospital Departments for Which Nursing Executives Assume Responsibility (n=89)

Departments	Frequencies	Percentages
1	15	17
2	19	21
3	21	24
4	14	16
5	8	9
6	5	6
7	4	5
8	1	1
9	1	1
16	1	1

to the nursing department, over one-half (N=89) of the nurse executives are responsible for other hospital departments. The number of additional departments range from one to sixteen which includes such departments as housekeeping, respiratory therapy, and cardiac catheterization laboratory.

The respondents work in a variety of hospitals which are classified according to the type of control such as public or private, profit or nonprofit, and governmental. The most frequent type of control of hospitals in this study, as seen in Table 4, was the private and nonprofit classifications.

Respondents work in hospitals with a bed capacity ranging from 51 to over 1000. In Table 5, over one-half (63%) of the nurse executives work in the medium size hospital with a bed size of 101-500; about one-fifth (19%) work in hospitals of 100 beds or less; and the rest are employed in hospitals larger than 500 beds.

The type of control classification and bed size of the hospitals where the nonrespondents worked was obtained from the AHA Guide (1988). The classification and bedsize of these hospitals where nonrespondents were employed showed a very similar pattern to the respondents. For example, the hospitals were private (17%), public (7%), profit (5%), nonprofit (63%), governmental (14%), and other (4%). Also, the nonrespondents tended to worked in hospitals that are

Table 4

Hospital Classification by Type of Control (n=158)

	Frequencies	Percentages
Private	75	47
Public	25	16
Profit	10	6
Non-profit	129	82
Governmental	9	6
Other	2	2

Note. Respondents checked more than one classification

Table 5

Hospital Bed Size (n=156)

	Frequencies	Percentages
51-100	29	19
101-300	59	38
301-500	39	25
501-1000	26	17
Over 1000	3	2

private and nonprofit.

The bedsize of the hospitals where the nonrespondents worked showed a similar pattern to the respondents. The nonrespondents worked in hospital with bed capacities of 51-100 (12%), 101-300 (37%), 301-500 (37%), 501-100 (13%), and over 1000 (1%). As with the respondents of the study, over one-half (74%) of the nonrespondents worked in the medium size hospitals of 101-500 beds.

The salary of nurse executives in this study ranged from less than $30,000 to over $80,000 as seen in Table 6. Approximately one-third earned between $30,000 and $50,000, one-third earned between $50,000 and $60,000, and one-third earned greater than $60,000.

In Table 7, the relationship of salary to bed size is that respondents with the higher salaries above $50,000 work in the hospitals with a capacity of over 300 beds. Although hospitals with a bed size of 101-300 beds had the most frequent (n=31) salary of nurse executives in the $50,000 to $60,000 range. The nurse executives working in the hospitals with more than 1000 beds had salaries greater than $70,000. In the smaller hospitals (51-100 beds), the nurse executives reported salaries of less than $30,000 to a high of $60,000, with the most frequent salary range being $30,000-$40,000 (n=14).

Table 6

Salary Range of Nurse Executives (n=155)

	Frequencies	Percentages
Less than $30,000	2	1
$30,001-$40,000	21	14
$40,001-$50,000	30	19
$50,001-$60,000	49	32
$60,001-$70,000	23	15
$70,001-$80,000	17	11
Over $80,000	13	8

Table 7

Comparison of the Hospital Bed Size to the Nurse Executives Salary Range (n=153)

	Response Frequency				
	Bedsize				
Salary Range	51-100	101-300	301-500	501-100	> 1,000
< 30,000	3				
30,001-40,000	14	1	3	1	
40,001-50,000	8	16	4	1	
50,001-60,000	3	31	13	2	
60,001-70,000		5	8	9	
70,001-80,000		3	5	7	1
> 80,000		1	6	6	2
TOTALS	28	57	39	26	3

Salaries were compared to the educational level of the respondents as seen in Table 8. In this study, 112 (72%) respondents reported the master's degree as the highest academic credential; 32 respondents earned below $50,000; and 80 respondents earned above $50,000. Seven respondents had doctorates; three earned between $40,001-$60,000, and four earned above $70,001.

Only 36 respondents had not obtained academic credentials beyond their basic nursing education. Only four respondents had the associate degree and earned between $30,001-$40,000. Of the five respondents with diplomas, four earned below $50,000 and one earned between $70,001-$80,000. The 27 respondents with baccalaureates earned between $30,001-$70,000. These data suggest there is a tendency for respondents with more education to earn higher salaries.

In comparison to Aydelotte's (1982) study of nurse administrators, 30% of the respondents earned $35,000 or less and 11% earned $50,000 or more--whereas, in this study 56% earn over $50,000. In this six year period, the salaries earned by nurse executives indicate a marked upward trend in salaries for the top nursing position in hospitals. Since the data in this study are somewhat dated (1988), salaries are likely higher today. Also, the salary range of less than $30,000 to greater than $80,000 in the

Table 8

Highest Academic Credential of Hospital Nurse Executives Compared to the Salary Range (n=155)

	Response Frequency				
	Education				
Salary Range	DI	AD	BS	MS	DR
< 30,000	1			1	
30,001-40,000	2	4	5	10	
40,001-50,000	1		6	21	2
50,001-60,000			13	35	1
60,001-70,000			3	20	
70,001-80,000	1			13	3
> 80,000				12	1
TOTALS	5	4	27	112	7

NOTE: DI - Diploma, AD - Associate Degree,
BS - Baccalaureate, MS - Masters, DR - Doctorate

questionnaire may have been lower than the salary of the respondents; and, the geographic location was not considered. Andrica (1988) reported nurse executive's salaries ranged from $35,000 to $139,000 in the Witt survey which was conducted shortly before this study. The salaries reported here have not been adjusted for the inflation rates for this time period.

Educational Profile

The educational background of the respondents includes the basic nursing education, the academic credentials earned, the process of obtaining a degree, and the ANA certification in nursing administration.

The educational preparation of nurse executives is reported in Table 9. Almost the same number of respondents had diplomas (47%) and baccalaureates (44%) with only 9% having associate degrees as their basic nursing education.

Further academic credentials earned beyond the basic education were baccalaureate degrees in nursing and non-nursing fields (n=78), master's degrees in nursing and non-nursing fields (n=122), and doctorates in nursing or related fields (n=7). A small number of the respondents (n=13) chose a master's degree in business administration, and/or nursing administration. Some of the respondents also reported they are working on a master's degree in business administration or stated a future goal was to obtain a

Table 9

Educational Profile of Hospital Nurse Executives (n=158)

Basic Nursing Education	Frequencies	Percentages
Diploma	74	47
Associate Degree	14	9
Baccalaureate	70	44

Academic Credentials Earned Beyond Basic Education	Frequencies	Percentages
Baccalaureate in Nursing	52	33
Baccalaureate in Related Field	26	16
Master's Degree in Nursing	73	46
Master's Degree in Related Field	36	23
Master's Degree in Business Administration	8	5
Master's Degree in Nursing Administration	5	3
Doctorate in Nursing	1	1
Doctorate in Related Field	6	4

NOTE: Respondents checked more than one degree earned. Respondents with dual degrees are counted only once.

master's degree in business administration or health care administration or to obtain a doctoral degree.

In this study, 93% of the respondents have baccalaureate degrees in nursing or related fields; 77% have master's degrees in nursing, business, or related fields; 5% have doctorates in nursing or related fields.

In Table 10, one-fifth of the respondents reported that they are working on baccalaureate, master's, or doctoral degrees in a variety of fields in addition to nursing such as business, health care administration, long-term care, and counseling. A small number of the respondents reported that they are obtaining a master's degree in business or health care in addition to a master's degree in nursing, commonly referred to as dual degrees.

Also seen in Table 10, one-third of the nurse executives are certified by the American Nurses Association (ANA) a national certification program in nursing administration.

The basic nursing education of nurse executives has changed since Aydelotte's earlier study in 1982. At that time 69% were from hospital schools, 4% from associate degree schools, and 23% from baccalaureate schools. In this study, 47% of the respondents' basic education was in hospital-based schools of nursing, 9% in associate degree nursing programs, and 44% in baccalaureate college programs.

Table 10

Nurse Executives Currently Obtaining Formal Education and National Certification

Working on a Degree (N=157)	Frequencies	Percentages
Yes	32	20
No	125	80

Certification (N=158)	Frequencies	Percentages
Yes	54	34
No	104	66

These data show that almost twice as many nurse executives now receive their basic nursing education in collegiate nursing programs.

In the Seventh Report to the President and Congress (1990), the distribution of the registered nurse population by the type of basic nursing education in 1988 was 49% diploma, 28% associate degree, and 22% baccalaureate degree. This national report also stated that "...only about 20 percent of the 98,400 nurses with administrative position titles have at least a master's degree, and only about 29 percent have a baccalaureate degree." (p. viii-21). For clarification, the number of nurses in this report refer to all levels of nurse managers in all types of health care settings. Therefore, the respondents in this study have a higher percentage of master's and baccalaureate degrees than both the general registered nurse population and the total population of nurse administrators. These data suggest advanced education is an advantage for the candidate for the NE position.

Demographic Profile

In this study, as reported in Table 11, the demographic data showed that 96% (n=151) of the respondents were female and 4% (N=7) were males. Also, 97% were Caucasian--with very few being minorities; only three respondents were black and one was Hispanic. Two-thirds of the respondents (67%)

Table 11

Demographic Characteristics of Hospital Nurse Executives

Race (n=156)	Frequencies	Percentages
Caucasian	151	97
Black	3	2
Hispanic	1	1
Indian	0	0
Other	1	1

Marital Status (n=157)	Frequencies	Percentages
Married and living with spouse	105	67
Other	52	31

Number of children (n=112)	Number	Percentages
1	17	15
2	52	46
3	25	22
4	10	9
5	7	6
6	1	1

Gender (n=158)	Frequencies	Percentages
Males	7	4
Females	151	96

are married and living with their spouse. Seventy-one percent of the respondents have children--the number of children ranged from one to six with 52 respondents reporting having two children.

The age of nurse executives in Table 12 ranges from under 30 to over 55. Over 40% of the respondents are between the ages of 41 and 50. Three respondents were under the age of 30 and twelve over 55. When they assumed their first position as nurse executive, the majority (53%) of the respondents were in their thirties--while almost one-fifth were in their twenties and almost one-third were in their forties. The median age of the respondents at the time they held their first nurse executive position was 38.

The nurse executives in this study come from family backgrounds (see Table 13) in which almost 40% of the fathers' occupations are skilled such as plumber or electrician and another 50% are in professional (law, medicine, own their own business) and semi-professional occupations (such as middle management). The mothers' occupation for almost one-half (45%) of the respondents is domestic (mainly housewife), and the other half are in semi-professional and skilled occupations.

Research Question Two

What functions do nurse executives and chief executive officers rate as important in the performance of the nurse executives role?

Table 12

Age Range of Hospital Nurse Executives

Age (n=157)	Frequencies	Percentages
< 30	3	2
31 - 40	48	31
41 - 50	67	43
51 - 55	27	17
> 55	12	8

Age at first nurse executive position (n=155)	Frequencies	Percentages
22 - 29	29	19
*30 - 39	82	53
40 - 48	44	28

*Median age = 38

Table 13

Parents' Occupation of Hospital Nurse Executives

Mother (n=154)	Frequencies	Percentages
Professional/Management	5	3
Semiprofessional	49	32
Skilled	30	19
Domestic	70	45

Father (n=153)	Frequencies	Percentages
Professional/Management	38	25
Semiprofessional	40	26
Skilled	56	37
Domestic	19	12

Note - Explanation of occupational categories

Legend:

Professional/Management = Law, doctor, military, owns a business

Semiprofessional = Middle Management, supervisor, nurse, librarian

Skilled = Specific trade skills such as plumber or electrician

Domestic = Farmer, housewife

Functions

The selected responsibilities of nurse executives, shown in Table 14, were constructed from the analysis of data from Section B of the questionnaire for nurse executives and from the questionnaire sent to the chief executive officers with the same list of functions. Also, the chief executive officers were asked to state the required education and experience qualifications for the nurse executive position.

The table includes only the functions rated as very important to the position of the nurse executive as reported by the chief executive officers and the nurse executives. The last column in Table 14 shows the difference between the ratings of the chief executive officers and the nurse executives. The investigator established a criterion of 10% difference as being significant or important between the responses of chief executive officers and the nurse executives. Items identified as "very important" by 80% of the respondents were deemed to be "significant."

The nurse executives' responses to the functions rated as being very important to their positions range from a low of 42% to a high of 99%. The chief executive officer's responses were similar with a low of 35% to a high of 97%.

The nurse executive respondents rated 18 of the 30 functions above 80%; whereas, the chief executive officer

Table 14

Percentage of Responses by Nurse Executives and Chief Executive Officers Rated as Very Important for Nurse Executives' Position (n=158)

	Functions	Nurse Executive Percentages	Chief Executive Officer Percentages	Difference of Nurse Executive to Chief Executive Officer Percentages
FINANCIAL MANAGEMENT				
1.	Allocate nursing resources	98	95	- 3
2.	Prepare nursing department budget	92	87	- 5
3.	Use cost-containment strategies for nursing department	94	88	- 6
4.	Participate in the hospital-wide budgeting process	82	61	-21
5.	Comply with external regulations such as Medicare and 'JCAHO	90	91	+ 1
6.	Know the 'DRG reimbursement system	56	48	- 8
HUMAN RESOURCE MANAGEMENT				
7.	Recruit and retain nursing staff	85	93	+ 8
8.	Know nursing staffing patterns	59	75	+16
9.	Evaluate staff for personnel decisions	51	64	+13
10.	Oversee nursing staff development and training	51	52	+ 1

'Joint Commission On Accreditation of Healthcare Organizations. 'Diagnostic Related Groups

NOTE: NE > CEO = minus number; CEO > NE = plus number

Table 14 cont'd.

Percentage of Responses by Nurse Executives and Chief Executive Officers Rated as Very Important for Nurse Executives' Position

Functions		Nurse Executive Percentages	Chief Executive Officer Percentages	Difference of Nurse Executive to Chief Executive Officer Percentages
11.	Possess strong written and oral communication skills	98	90	- 8
12.	Possess good interpersonal skills	99	97	- 2
13.	Serve as spokesperson for the nursing department	93	91	- 2
14.	Know collective bargaining	42	35	- 7
HOSPITAL/ORGANIZATIONAL MANAGEMENT				
15.	Participate in policy development at the top management level	95	81	-14
16.	Participate in allocation of hospital resources	81	65	-16
17.	Serve as a member of the hospital executive team	96	90	- 6
18.	Serve as a member of selected medical committees	84	79	- 5
19.	Serve as a member of the governing body	58	41	-17
20.	Participate in strategic planning for hospital	89	78	-11

Table 14 cont'd.

Percentage of Responses by Nurse Executives and Chief Executive Officers Rated as Very Important for Nurse Executives' Position

Functions		Nurse Executive Percentages	Chief Executive Officer Percentages	Difference of Nurse Executive to Chief Executive Officer Percentages
21.	Participate in identifying long-range and short-range goals for hospital	92	76	-16
22.	Know hospital information systems	55	39	-16
23.	Manage planned change for hospital and for the nursing department	91	86	- 5
24.	Know litigation/health care law	54	45	- 9
NURSING DEPARTMENT MANAGEMENT				
25.	Keep current in nursing practices	42	67	+25
26.	Oversee quality assurance and risk management programs	70	62	- 8
27.	Administer a patient classification system	56	49	- 7
28.	Provide leadership for the nursing department	97	96	- 1
29.	Oversee a documentation system in nursing	51	58	+ 7
30.	Manage the nursing department in a comprehensive manner	94	93	- 1

respondents rated 13 of the 30 functions above 80%. In the **financial management category**, both respondents rated four of the six functions above 80%: (a) allocate nursing resources, (b) prepare nursing department budget, (c) use cost-containment strategies for nursing department, and (d) comply with external regulations such as medicare and Joint Commission on Accreditation of Health Care Organizations (JCAHO). The function, know the DRG reimbursement system, was rated below 60% by both respondents. The nurse executives rated participating in hospital wide budgeting process higher than the CEOs with a 21% difference.

In the **human resource category**, both respondents rated four of the ten functions above 80%. These four functions rated by both respondents were; (a) recruit and retain nursing staff, (b) possess strong written and oral communication skills, (c) possess good interpersonal skills, and (d) serve as spokesperson for the nursing department. The functions rated below 80% by both respondents were staffing patterns, evaluation of staff, staff development, and collective bargaining.

In the category of **hospital/organizational management**, the nurse executives rated seven of the 10 functions above 80%; whereas, CEOs rated three of the 10 above 80% Both respondents rated these three functions above 80%: (a) participate in policy development at the top management

level, (b) serve as a member of the hospital executive team, and (c) manage planned change for hospital and nursing department. Nurse executives rated these four functions above 80% and the chief executive officers rated them below 80%: (a) participate in allocation of hospital resources, (b) participate in identifying long-range and short-range goals for hospital, (c) serve as a member of selected medical committees, and (d) participate in strategic planning for hospital. The three functions rated below 60% by both respondents were: (a) serve as a member of the governing body, (b) know hospital information systems, and (c) know litigation and health care law.

Six of the ten functions that showed a 10% difference are in this hospital/organizational management category. The six functions rated higher by nurse executives than chief executive officers are:

1) participate in policy development at the top management level (14%),
2) participate in allocation of hospital resources (16%),
3) serve as a member of the governing body (17%),
4) participate in strategic planning for hospital (11%),
5) participate in identifying long-range and short-range goals for hospital (16%),

6) know hospital information systems (16%).

These data suggest nurse executives are a member of top management but are not yet fully participating members in the overall hospital policy making in their role. Also, this difference reported between the chief executive officers and nurse executives reflects this period of transition or evolution as the nurse executive role moves from middle to upper level management.

In the **nursing department management category**, both respondents rated the same two of the seven functions above 80%. These two functions were, provide leadership for the nursing department, and manage the nursing department in a comprehensive manner. The five functions rated below 80% were: (a) keep current in nursing practice, (b) oversee quality assurance and risk management programs, (c) administer a patient classification system, and (d) oversee a documentation system in nursing. Only one function, keeping current in nursing practice, showed a 25% difference with CEOs rating this function higher.

Ten of the 30 functions show a 10% difference between the NEs and the CEOs response, with six of these 10 functions being in the hospital/organizational category.

Three of the thirty functions rated highest by both the NEs and CEOs were: (a) possess good interpersonal skills (NE, 99%; CEO, 97%), (b) provide leadership for the nursing

department (NE, 97%; CEO, 96%) and (c) allocation of nursing resources (NE, 98%, CEO, 95%).

The functions which were rated above 80% by the NEs are considered to be the essential responsibilities in their roles. The functions rated below 80% by the nurse executives are probably the ones that nurse executives assume overall responsibility for, but delegate to nurse and/or departmental managers.

Nurse executives were asked if they felt that they were prepared educationally for these functions. In Table 15, the majority of respondents felt they were educationally prepared for the management of the nursing department (70%) and human resources management (64%). Over one-half of the respondents reported they did not feel they were educationally prepared for hospital/organizational management (63%) and financial management (58%). It is interesting to note that even though 82% of the respondents have advanced degrees (masters and doctorates), they did not feel educationally prepared in hospital/organizational management and financial management, which are two major components of the executive role. About 30% of the respondents also reported they were not educationally prepared for nursing department management (30%) and human resources management (36%). The respondents were not asked specifically when they felt they were not prepared

Table 15

Responses of Nurse Executives' to Their Being Educationally Prepared For Each of the Four Management Categories

	Yes		No	
	Frequencies	Percentages	Frequencies	Percentages
Financial Management (n=158)	66	42	92	58
Human Resources Management (n=157)	100	64	57	36
Hospital/ Organizational Management (n=157)	58	37	99	63
Nursing Department (n=158)	111	70	47	30

educationally. It could have been in their first position as a nurse executive, or before they obtained a graduate degree, or even after a graduate degree if management topics were not included in the curriculum.

It is suggested that these functions may provide additional data for graduate nursing programs to consider as topics to be included in graduate programs preparing nurses for a management position, especially those functions rated highest by both nurse executives and chief executive officers.

Chief executive officers were asked in two open-ended questions to state the educational and experience qualifications for the position of nurse executive.

Chief executive officers state the educational qualification for the position of nurse executive is primarily the graduate degree as seen in Table 16. The overwhelming majority of the CEO respondents (n=94) require a master's degree with much variation such as a master's degree in nursing, business, health administration, or public health administration. A few respondents require a masters in business administration with a baccalaureate in nursing, and a small number prefer a dual degree of master's in both nursing and business. Some respondents stated they preferred graduate preparation but not necessarily in nursing.

Table 16

Summary of Responses by Chief Executive Officers for the Educational Requirement for the Hospital Nurse Executive Position

	Frequencies
Registered Nurse but prefer Baccalaureate or Master's in nursing	13
Baccalaureate degree or equivalent	37
Baccalaureate degree with ANA certification	2
Master's Business with Baccalaureate in Nursing	2
Master's Degree Nursing	32
Master's Nursing Administration	5
Master's in Nursing, business, or health administration with Baccalaureate in nursing	12
Master's not necessarily in nursing	12
Master's in nursing or master's in Business	5
Master's preferred or equivalent	24
Master's in nursing and master's in business	1
Master' public health or business	1
Doctoral Degree	2
Doctoral Degree preferred	2

About one-fourth of the CEO's require a baccalaureate in nursing but did state they prefer a graduate degree. A few stated R.N. only but preferred a baccalaureate. Only four respondents stated doctoral preparation--two required a doctorate, and two stated that they preferred a doctorate.

Chief executive officers stated the experience required for the position of nurse executive ranges from a minimum of two years to ten years of management experience as seen in Table 17. Within this eight year range is a wide variation of the years of experience required. The majority of respondents (n=78) require from two to five years of experience; whereas, some respondents (n=30) require five to ten years of experience. Another group of respondents (n=19) require experience in upper level management. Some individual responses stated were "five years in nursing and three years in top level management," "ten years in clinical practice and five years in top management," "varies with each individual," and "demonstrated success in increasing responsibility in a nursing management position." Some of the respondents stated that the only experience requirement was "progressive management experience".

Essential Knowledge and Skills

Nurse executives in this study were asked in an open-ended question to state topics that they considered the essential knowledge and skills to function in their current roles. In Table 18, the top responses were ranked and

Table 17

Summary of Responses by Chief Executive Officers to a Management Experience Requirement for the Hospital Nurse Executive Position

Management Experience	Frequencies
2 - 3 years	9
Minimum of 5 years	48
Progressive Management 3-5 years	21
Progressive Management 5-10 years	15
7 - 10 years	7
8 - 10 years	3
10 years	5
Upper level Management Experience	19
Miscellaneous	26

Table 18

Summary of Responses by Nurse Executives About Topics Considered Most Essential to the Hospital Nurse Executive Position (n=158)

	Frequencies	Percentages
FINANCE		
Health Care Finance	55	35
Financial Management and Budgets	46	29
Nurse Resource Allocation	7	4
Reimbursement System	6	4
HUMAN RESOURCES		
Human Resources Management	45	29
Communication Skills	26	17
Interpersonal Skills	16	10
Problem Solving	9	6
Negotiation and Control	8	5
Group Dynamics	7	4
Recruitment and Retention	7	4
Conflict Management	6	4
MANAGEMENT		
Hospital/Administrative Management	27	17
Organization Behavior Theory	21	13
Strategic Planning	14	9
Managing Planned Change	12	8
Management Information System	9	6
Long-Range Planning	8	5
Quality Assurance	8	5

grouped into three categories: (a) finance, (b) human resources, and (c) management. Over 60% of the respondents stated that health care finance or financial management was most essential to their jobs. The next highest number of responses (29%) was in the area of human resources management-such as interpersonal skills, communication skills, negotiation and group dynamics, and conflict management. The third largest number of responses (17%) was administrative or management topics such as hospital management, organization behavior theory, strategic planning, management information systems, and problem-solving. Some of the miscellaneous topics stated were shared governance, role development, mentoring, empowerment, and interpretation of trends. See Appendix E for the summary of topics stated by the respondents.

In Section 2 of the questionnaire, respondents reported the factors important in obtaining their management knowledge and skills. In Table 19, only the very important responses are reported. Over 80% of the respondents reported that they obtained their management knowledge and skills from the management experience received in their prior position. The second most important methods were on-the-job training in the present position (64%) and management training programs attended in the current position (64%). This on-the-job training may refer to the many everyday duties and responsibilities that have to be performed or experienced in their position for learning to

Table 19

Responses of Nurse Executives About the Most Important Method for Obtaining Management Knowledge and Skills

	Rated as Very Important	
	Frequencies	Percentages
Management Experience in Prior Position (n=158)	134	85
Management Training Programs (CE) in Current Position (n=156)	100	64
On the Job Training in Present Position (n=154)	99	64
Management Training Programs (CE) Prior to Present Position (n=157)	92	59
Self-development Courses (n=156)	88	56
Self-study Courses/Activities (n=155)	85	55
Graduate Degree Prior to Present Position (n=158)	81	51
Graduate Degree Obtained in Present Position (n=158)	31	20
Doctoral Degree (n=154)	9	6

occur. Also rated highly by the respondents (59%) are the management programs attended in their previous positions.

In addition to formal education, informal education such as self-development courses and self-study courses were reported by over one-half of the respondents as very important. These data verify that on-the-job training and education, both formal and informal, are important ways nurse executives obtain their management knowledge and skills.

A graduate degree obtained prior to the present position is rated very important by 51% of the respondents, with 20% stating that the graduate degree obtained in the present position is important. These respondents were working on a graduate degree. Only 6% of the respondents stated that a doctoral degree is very important. These data reflect the respondents who had their doctoral degrees or who were pursuing one.

These data reveal there are a variety of ways in which nurse executives gain management knowledge and skills for their position.

Research Question Three

What career experiences do nurse executives report that contributed to their advancement to the top nursing position?

The nurse executives described career experiences in their advancement to the top nursing position in hospitals. The career experiences in this study included data from the

work histories, socialization practices, role of professional/civic organization, career planning, reasons for pursuing management, and future career goals.

Career Path

In Section 3 of the questionnaire, respondents completed a work history which included the positions held prior to the top nursing position with the length of time in each position and the number of institutions. These positions were numerically coded and listed in order of entry level position to the current position. From this list of coded positions the career pathway to the top nursing position in hospitals was identified. Little or no research has been conducted on the actual career pathways of nurse executives.

From the work histories of the respondents as seen in Figure 1, an upward career path was identified from the respondents positions of staff nurse, then head nurse, then nursing supervisor, then assistant director of nursing, then director of nursing, then assistant vice-president, then to the top nursing management position of vice-president. Over 88% (n=134) of the respondents began their careers in the entry level position as a staff nurse. Only 7% (n=11) of the respondents did not have a staff nurse position listed in their work histories. Eight percent (n=12) of the respondents began their nursing careers in the entry level position of head nurse or nursing supervisor. Another 4% (n=6) began as nursing instructors. These three entry level

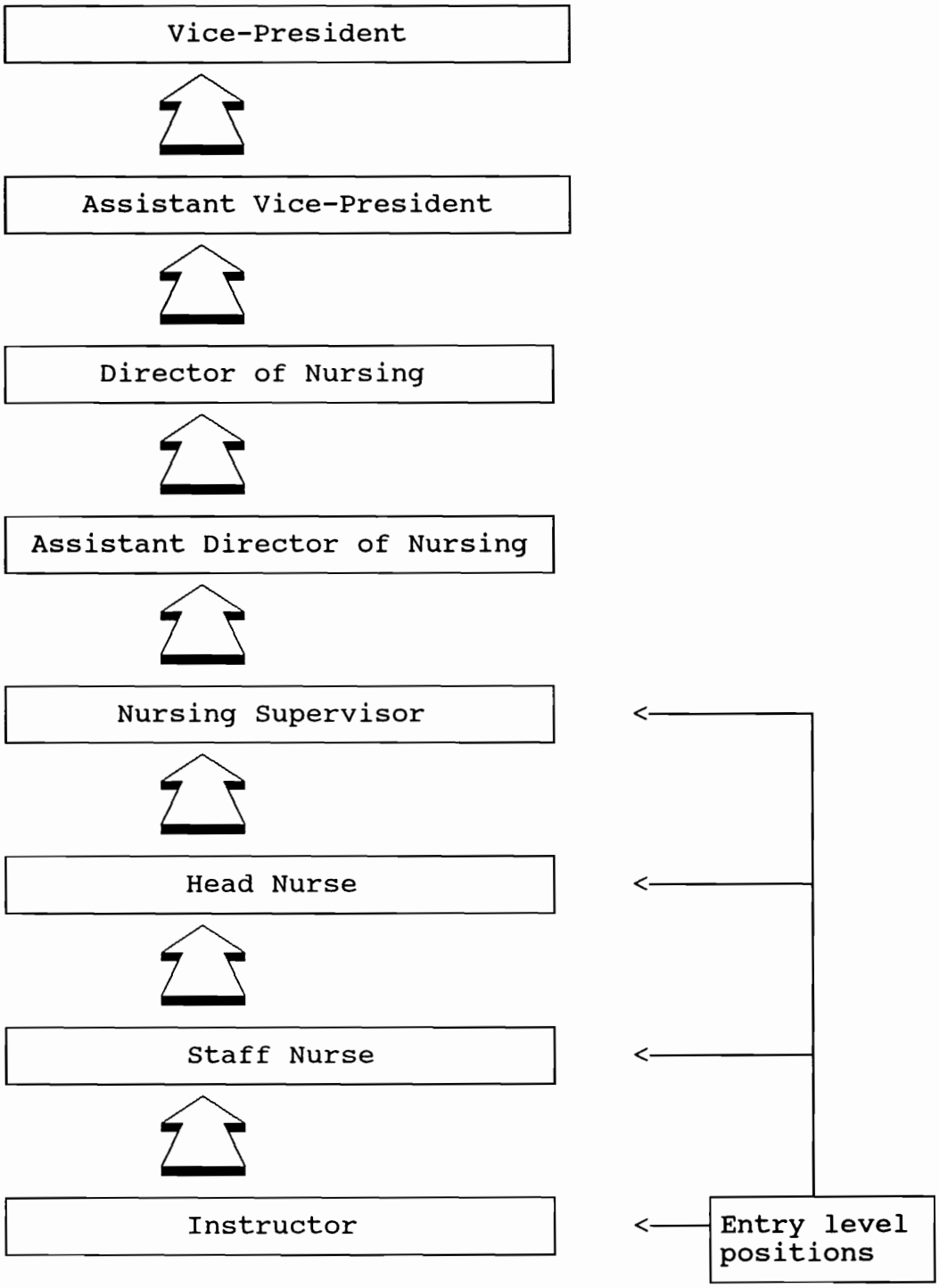


Figure 1. Career Path to Vice-President of Nursing

positions were the only ones reported by the respondents. The career path to the position of nurse executive as identified from this study is the traditional clinical pathway. This career pathway is consistent with Ashley's (1976) description of the pathway to the top nursing position.

The work histories show that progressive management experience is evident. Over 40% (n=66) of the respondents have been an assistant director of nursing, and 88% (n=133) have been a director of nursing.

Within this upward linear progression of management positions, there was much variation in the positions held by the respondents. About 57% of the respondents did not always progress to the next highest management position; for example, they had staff nurse positions after having been a nursing supervisor. About 43% of the respondents did show progressive management experience by advancing to the next management position in an upward linear pattern. These data also reflect that the respondents have a very strong clinical nursing experience background.

From the work histories as seen in Table 20, the number of institutions the respondents have worked in ranged from one to 10 with 80% of the respondents having worked in six or less institutions. The number of years that the respondents reported working ranged from three to 32 before reaching the top nursing position, with 69% of the respondents having worked 13 years or more prior to the top

Table 20

Frequencies and Percentages of Number of Positions, Institutions, and Years Worked Prior to Current Nurse Executive Position

Number of Positions Prior to Current NE Position (n=151)	Frequencies	Percentages
3 - 6	58	38
7 - 8	56	37
9 - 10	37	25
Number of Institutions (n=142)	**Frequencies**	**Percentages**
1 - 3	61	43
4 - 6	52	37
7 - 10	29	20

Table 20 cont'd.

Frequencies and Percentages of Positions, Institutions, and Years Worked Prior to Current Nurse Executive Position

Number Years Worked Prior to Current NE Position (n=152)	Frequencies	Percentages
1 - 3	1	0.6
4 - 8	12	8
9 - 12	33	22
[a]13 - 16	42	28
17 - 20	26	17
21 - 24	16	11
25 - 28	18	12
29 - 32	4	3

[a]Mean number of years is 16.

nursing position. The number of positions held by the respondents ranged from three to 10 with 62% of the respondents having had seven or more positions. It is interesting to note that eleven respondents had four positions and three respondents had three positions prior to the top nursing position. In summary, 62% of the respondents had seven or more positions, 80% had worked in six or less institutions, and 69% had 13 years or more experience in both clinical nursing and nursing management.

These data from the work histories verify an upward mobility pattern to the position of top nursing executive in hospitals. This upward pattern consists of beginning as a staff nurse with much variation in the different nursing positions held after entry level such as head nurse, nursing supervisor, nursing instructor, assistant director of nursing, director of nursing, assistant vice-president, and last, vice president. These data also indicate a pattern of progressive management experience. Further study is warranted to examine in more detail the career pathway for nurse managers. These data can assist aspiring nurse managers to plan their careers, and to enable them to seek the appropriate education and the management experiences for attaining the nurse executive position in hospitals. These data can be beneficial to faculty of graduate nursing management programs in counseling graduates about career

mobility.

Socialization Practices

Another component of career advancement is socialization practices. In Section 3 of the questionnaire, respondents were asked to state the socialization practices they engaged in while advancing to their current position. In Table 21, the top four behaviors practiced by 70% of the nurse executives were attending management seminars/workshops, increasing networking, increasing visibility/recognition in the work setting, and participating more in professional organizations. All of these behaviors are a form of being more visible or becoming better known in the management world.

The next two behaviors practiced by over one-half of the nurse executives in advancing to their positions were attending continuing education courses and obtaining the required formal education. Fifty-six percent of the respondents began to adopt the values of the job desired; whereas, less than one-half of the respondents engaged in increased community activities, or changed their dress, or imitated the work behaviors of the person in the job desired.

These data indicate that nurse executives do participate in a variety of socialization behaviors and consider them important in their career advancement. All of

Table 21

Responses by Nurse Executives Regarding Socialization Practices in Preparation for their Current Position (n=158*)

Socialization Practices	Frequencies	Percentages
Attended Management Seminars/ Workshops	116	73
Increased Networking Behaviors	114	72
Increased Visibility/Recognition in Work Setting	113	72
Participated More in Professional Organization	108	68
Increased Continuing Education	92	58
Obtained Formal Education Required	91	58
Began to Adopt Values of Job Desired	88	56
Increased Community Activities	73	46
Changed Dress	64	41
Imitated Work Behaviors of Person In Job Desired	47	30

Note. More than one response was given by all respondents.

the respondents reported participating in more than one behavior. It is interesting to note that visibility in a variety of ways is one of the socialization behaviors that is most frequently engaged in as the nurse respondents advanced in their careers. Additional study may be warranted in this area of visibility to determine what socialization practices are most effective in promoting visibility in career advancement for nurse managers.

In response to an open-ended question, subjects stated the experiences they perceived as the most essential to their career advancement. The responses were grouped according to the frequency, as shown in Table 22. The most important experiences reported by one-fourth of the nurse executives were mentoring/networking and education/ continuing education/credentialing. One-fifth of the respondents again stated previous management experience had contributed to their career advancement. Clinical background in nursing was cited as being important by 10% of the respondents as well as getting along with the medical staff (7%). Another 11% of the respondents cited that strong interpersonal skills and/or communication skills helped contribute to their advancement. The complete list of responses is in Appendix F.

It could be that respondents actively engaged in these behaviors for advancement to the position of nurse executive

Table 22

Summary of Responses of the Nurse Executives Regarding Experiences Perceived as the Major Contributions to Career Advancement (n=148)

	Frequencies	Percentages
Mentoring/Networking	40	27
Education/Continuing Education/ Credentialing	37	25
Previous Management Experience	29	20
Strong Interpersonal Skills/Communication Skills	17	11
Clinical Background	15	10
Getting Along With Medical Staff	10	7

and that this questionnaire allowed the respondents to reflect and to identify the socialization behaviors they had used.

In Section 3 of the questionnaire, respondents were also asked to state the importance of professional/civic organizations/activities in career advancement. The professional and civic organizations/activities that respondents reported as very important to advancing to the nurse executive position are seen in Table 23. The top two professional activities stated by the respondents were being a member of a nursing management organization (37%) and speaking to public and/or professional groups (37%). Also, important was serving as an officer in nursing (19%), management (16%), and civic (11%) organizations. Only thirteen respondents stated that published research and/or articles were important.

A very small number of the respondents reported that being a member of the American Nurses Association (n=9) and the National League for Nursing (n=3) was very important for career advancement. All of these activities are methods which promote being visible, which again raises the question of visibility and its importance to career advancement. Is visibility a major factor to consider when planning one's career advancement? Also, do nurse executives plan their careers based upon the socialization behaviors and

Table 23

Responses of Nurse Executives Regarding the Very Important Professional and Civic Activities That Contributed to Their Career Advancement

	Frequencies	Percentages
Member of Nursing Management Organization (n=156)	58	37
Speaking to Public/Professional Groups (n=153)	57	37
Officer in Nursing Organization (n=154)	30	19
Officer in Management Organization (n=152)	24	16
Officer in Community/ Civic Organization (n=152)	17	11
Published Research and/or Article (n=153)	13	8
ANA Member (n=151)	9	6
NLN Member (n=152)	3	1

professional organizations/activities that promote visibility? This role of visibility in nursing career advancement suggests further research is warranted.

Career Planning

In response to describing their careers in nursing administration, as seen in Table 24, one-fourth of the respondents reported they planned their careers. About one-half chose their careers for self-fulfillment. Because respondents checked more than one description of career planning, most of the respondents positions were determined externally, i.e., right time/right place, determined by the organization, or just happened.

These data show that respondents use a combination of both internal and external choices and/or decisions throughout their career as they advance to the top nursing position. Further study is warranted in this area of career planning.

In Table 25, almost 80% of the nurse executives in this study perceive themselves as being very successful. The other 20% see themselves as somewhat successful.

Reasons for Choosing Management Positions

As a component of career development, certain people choose management positions. Little research has been done on the reasons nurses choose nursing management positions. To help identify specific reasons and to serve as a guide

Table 24

Responses of Nurse Executives that Best Describes Their Career Planning (n=158)

	Frequencies	Percentages
Self-fulfillment	72	46
Right Time/Right Place	65	41
Determined By the Organization	50	32
Planned	39	25
Just Happened	19	12

Note. - More than one response was stated.

Table 25

Responses of Nurse Executives Regarding Their Perception of Success in Current Position (n=155)

	Frequencies	Percentages
Very Successful	122	79
Somewhat Successful	33	21
Not Successful	0	0

for aspiring nurse managers who have the same desires to enter management, respondents in this study were asked to state the major reasons they chose management careers. A variety of answers were stated, and their responses are categorized into five areas: (a) influence, (b) financial, (c) career opportunity, (d) self-fulfillment/ recognition, and (e) miscellaneous.

The largest number of nurse executives (47%) stated influence as a major reason for choosing a management position. "Influence of change" or "change agent" was frequently stated, as well as just the word "influence" and "impact on patient care." These data suggest a major reason the respondents wanted to advance to the highest nursing position in hospitals was the desire to make an impact through being able to make a change in patient care and the delivery of nursing care. They desire to be in a position where their voice is a factor in determining policies and procedures for the delivery of nursing care. By seeking ways to improve nursing care, the respondents stated that the "profession of nursing felt the impact".

About 30% of the nurse executives stated that money, perks, and monetary reward for hard work were their reasons for choosing management careers. Comments such as "personal career satisfaction," "enjoy the management environment," "like to lead," "job satisfaction," "enjoy problem solving

and decision making" were categorized under career development. Others stated "upward mobility", "develop meaningful career goals", and "business/management skills". These comments suggest nurse managers are career oriented and enjoy the role of being in the top nurse management position in hospitals.

In the category of self-fulfillment respondents stated "challenge", "recognition", "autonomy", "creativity", "sense of accomplishment", "self-actualization", "independence", "growth", "prestige", and "exciting", as reasons for choosing a career in nursing management. These data suggest that nurse managers are motivated to achieve based upon their stated desires to be in management. These reasons seem to coincide with the large number of nurse executives who change positions for self-fulfillment as seen in Table 24.

Some of the miscellaneous comments that the respondents stated for choosing management are "good political/social skills," "role model," "day shift", "power", "seeing a need to upgrade nursing", "ego," "enjoy the fast pace", "enjoy learning management skills", and "being a trailblazer." The summary of the responses are in Appendix G.

Future Goals

The respondents were asked in an open-ended question to state their goals for the future. The future goals of the

respondents are categorized into these five areas: (a) continuance, (b) education, (c) consultant, (d) hospital administration, and (e) miscellaneous. Over 30% of the respondents state that they want to continue in a nurse executive position but in a larger institution, a larger city, or a large teaching acute care facility. A very small number (n=7) want to continue in the same institution. And a small number (n=13) plan to retire.

About 20% of the respondents plan to continue their education. Specific graduate degrees stated were in the fields of business, health administration, nursing administration, and law. A few respondents plan to obtain a doctoral degree. It is speculated that these nurse executives feel the need to obtain this degree for their current position or for a nurse executive position in a larger institution.

Over 10% of the respondents are interested in consulting work. Another 9% (n=14) stated a future goal was to be a hospital administrator or a chief operating officer.

About 20% of the respondents stated a variety of future goals such as teaching, entrepreneurship, writing, research, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveyor.

Only four respondents were undecided about the future or did not state any goals. In Appendix H is the summary of

the respondent's goals.

Overall, the respondents of this study were goal-oriented and thinking ahead as to where they want to go and what they want to do. It is possible that this survey could have helped the respondents define their goals for the future.

In this chapter the professional, educational, and demographic profiles of nursing executives were discussed. The most important functions nurse executives are expected to perform in their positions were described by both nurse executives and chief executive officers. Lastly, the career experiences were described including identification of one career pathway and related socialization factors in career advancement to the nurse executive position.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

As presented in Chapter 1, the purpose of this study was to investigate the answers to these three research questions:

1. What is the current profile of nurse executives?
2. What functions do nurse executives and chief executive officers rate as important in the performance of the nurse executive role?
3. What career experiences do nurse executive report that contribute to their advancement to the top nursing position?

Chapter 2 examined the selected literature of hospital nurse executives with emphasis on the historical development, educational preparation, and career mobility. Chapter 3 outlined the design of the study. Chapter 4 presented the findings based on the data reported on a questionnaire mailed to a random sample of 400 nurse executives who were members of the American Organization of Nurse Executives. Survey response rate was 40%. The second section of the questionnaire was mailed to a random sample of 300 chief executive officers of acute care hospitals listed in the AHA Guide (1988). The response rate was 51%.

Chapter 5 offers a summary of the data collected and analyzed in Chapter 4. Recommendations and conclusions are

also included in Chapter 5.

Discussion

The role and responsibility of the hospital nurse executive changed dramatically in the 1980s. As NEs moved from middle management to top level management, nurse executives are expected to have the preparation and expertise in finance and business comparable to those required of hospital administrators. In addition to appropriate qualifications for the top nursing position in hospitals, socialization practices and career advancement patterns have a major impact on successfully reaching and maintaining the top nursing position. The nursing literature has not yet studied the career development patterns of nurse managers who aspire to and who reach the nurse executive position in hospitals. The results of this study will provide baseline empirical data about the career advancement of hospital nurse executives.

Professional Profile

The professional profile of the respondents indicate that the role of the nurse executive is in transition with a shift in title changes, increased scope and complexity of responsibility, increased compensation, and participation as a member of the hospital top management team. About 80% of the respondents have the title of vice-president, executive, or administrator with nearly one-half of them reporting to

the hospital president or chief executive officer. About 60% of the respondents work in private, nonprofit medium size hospitals (101-500 beds) with 56% of the respondents responsible for one to sixteen additional hospital departments. The salaries reported by the respondents fell into three almost equal groups from below $30,000 to over $80,000. As expected, salaries tended to increase with graduate education and with larger hospitals. These data are consistent, except for the salaries, with the earlier studies of Aydelotte (1982) and Andricia (1988). According to these studies, the salary range reported was $15,000 to $65,000 in the early 1980s; while it was $35,000 to $139,000 in the late 1980s. These salaries have not been adjusted for the inflation rates during this six year period.

In this six year period, there has been an incremental increase in the number of nurse executives with changing titles, reporting relationships, and increasing salaries. It is expected that this trend will continue in the 1990s as nurse executives will have increased administrative responsibilities for nursing plus other hospital departments resulting in increased institutional responsibilities.

Educational Profile

The educational profile of the respondents in this study reveals NEs have more education at the baccalaureate and master's level than the general nurse population.

Ninety-three percent of the respondents reported a baccalaureate degree (basic or advanced) in nursing or related fields.

The master's degree was the predominant educational degree of the respondents (77%). Almost one-half of the respondents (46%) reported a master's degree in nursing, and the other one-third (31%) reported degrees in a variety of other fields such as business, health administration, nursing administration, and public health. In addition, one-fifth of the respondents were working on a baccalaureate, master's, or doctoral degree. These data support the following trends reported in the nursing literature:

1. that there is a lack of agreement in nursing education as to one graduate degree that best prepares one for the responsibilities and functions of the nurse executive position.
2. that nurse executives are seeking business or business related graduate degrees either in addition to nursing or in place of nursing which results in a dual degree.

Since the early 1980s, there has been a 15% increase in the number of nurse executives with graduate degrees from 62% (Aydelotte, 1982) to 77% reported in this study. This increase in graduate preparation for the nurse executive position reflects the need to be prepared for the increased

administrative responsibilities as well as to meet the educational requirement for the job. These data support and fulfill Aydelotte's (1984) earlier statement "...The nurse executive's functioning is now a vital part of the hospital's executive management and leadership team which demands a management orientation for which, until recently, few practicing nurse executives had been formally educated (p.94)."

In this study, 82% of the respondents reported advanced education at master's and doctoral level. Since much has been written and debated about the appropriate education for nurse executives, the respondents stated their perception of the topics essential for the job. In addition, they stated the methods used to obtain their management knowledge and skills and their satisfaction with their education preparation.

The respondents stated the essential topics for their roles were in the areas of finance, human resource, and management. Specifically, some of the topics were:

1. Finance: health care finance, financial management, allocation of nursing resources, budgeting, and reimbursement systems.
2. Human Resource: communication and interpersonal skills, negotiation and control, group dynamics, conflict management, recruitment, and retention.

3. Management: managing planned change, strategic and long-range planning, and organizational behavior theory.

These data are consistent with the reports in the nursing literature that nurse executives need both financial and management knowledge and skills to perform in their role as hospital nurse executives (Blair & O'Brian, 1990; Forster & Boerstler, 1990; Fralic, 1987; Johnson, 1987; Mark et. al., 1990; Scalzi & Wilson, 1990; Strasen, 1987).

The findings in this study revealed that the respondents gained their management knowledge and skills by formal and informal education, previous management experience, on-the-job training, and self-study courses. Over 60% of the respondents stated that prior management experience, continuing education management programs, and on-the-job training were the most important methods. Over 50% of the respondents reported having a graduate degree and continuing education prior to their current position along with self-development/study courses as important. These data were consistent with Johnson's (1987) findings that nurse executives gain management education by work experiences (on-the-job), continuing education, and self-study.

To verify the educational and work experience required for the nurse executive position in hospitals, chief

executive officers were asked to state the educational requirements. The CEOs stated a variety of educational requirements ranging from a registered nurse to a doctoral degree, with most (n=94) requiring a master's degree. Thirty-nine respondents required a baccalaureate degree. Again, there is lack of agreement on the degree, but CEOs accept master's in nursing, nursing administration, business, health administration or simply a master's degree. Five respondents required a master's in business and nursing or a dual degree. These data confirm a lack of consensus about the type of degree that CEOs require for the position. These data suggest that nurse executives need to obtain more education in business. Also, it is interesting to note that nurse executives seem to need two master's degrees (MSN and MBA) while the other members of the top hospital management team need only a masters degree in health administration (MHA).

The work experience stated by the CEOs required for the nurse executive position ranged from two to 10 years, with 48 respondents requiring a minimum of five years, 36 respondents requiring progressive management experience of 3-10 years, and 19 respondents requiring upper level management experience. These data suggest experience in clinical nursing and progressive nursing management experience are essential requirements for the NE position

now and for the future. This information can be helpful for aspiring nurses to use to plan their education and work experiences for career advancement to the top nursing position.

Demographic Profile

The respondents in this study were primarily female (96%,) caucasian (97%), married with children (70%), and are 41-50 years old. The majority of the respondents assumed their first nurse executive position in their thirties with the median age of 38. Only three respondents were under 30; twelve were over age 55. The age, gender, race, marital status, and number of children are consistent with the demographic profiles in Aydelotte's (1982) and Andricia's (1988) studies. Also, the respondents in this study were representative of the general nurse population which is traditionally a female dominated profession.

Selected Functions

The results of this study indicate that both NEs and CEOs are more similar in agreement as to the important functions of the NE job than different. Both respondents rated four of the six functions in the financial category above 80%: (a) allocate nursing resources, (b) prepare nursing budget, (c) use cost containment strategies, and (d) comply with external regulation of medical and Joint Commission on Accreditation of Healthcare Organizations

(JCAHO). However, they differed by 21% in the function of participating in hospital wide budgeting process. This large difference suggests that nurse executives are responsible for the nursing department budget which is one of the largest in the hospital and that CEOs may not expect the nurse executives to have further input into the hospital-wide budget. Also, this difference may reflect the nurse executive is viewed as a junior member and is not yet a full participating member of the top level hospital management team.

The respondents, both CEOs and NEs, rated four of the 10 functions in the human resource category above 80%, (a) recruit and retain staff, (b) possess good communication skills (c) possess good interpersonal skills, and (d) serve as spokesperson for nursing. Two of the 10 functions showed a 10% difference, know staffing patterns (+16%) and evaluate staff for personnel decisions (+13%), with CEOs rating these functions higher than the NEs. While both of these functions are below the 80% criterion, CEOs apparently view these functions as the overall responsibility of nurse executives, whereas the nurse executive may delegate these functions to nurse managers.

The category of hospital organizational management revealed the largest difference between the responses of the NEs and the CEOs. Seven of the ten functions were rated

above 80% by the NEs; whereas, CEOs rated only three out of 10 above 80%. The NE respondents rated all 10 functions 5-17% higher than the CEO respondents. It is significant that six of the 10 functions show a 10% difference. These six functions were:

1. participate in policy development at top management level (16%)
2. participate in allocation of hospital resources (16%)
3. serve as a member of the governing body (17%)
4. participate in strategic planning for hospital (11%)
5. participate in identifying long-range and short-range goals for hospital (14%)
6. know hospital information system (16%).

This difference in the hospital-wide management category indicates that even though NEs are a functioning member of the top management and with increased responsibilities, they are not yet a full participating member as their colleagues in the total hospital management. This difference in the hospital-wide management category indicates that the NE is perceived by the CEOs as the junior member of the top management team. Even though NEs are considered a functioning member of the top management and over one-half of the NEs have increased responsibilities,

they are not yet a full participating member as their colleagues in the management of the total hospital. Also, since 97% of the NEs are female, the "good ole boys" network could be responsible for some of this difference by the CEOs which are predominantly male. This difference reflects that the CEOs expectations for the NEs are slightly different which could be problematic during this transition period as the NE moves into upper level management. Clearly, nurse executives, prior to employment, need to ascertain the CEOs expectations of the roles and responsibilities they are to perform as nurse executive and as a member of the top hospital management team. Another factor which could account for some of this difference is whether the hospital is centralized or decentralized or a combination of both. It could be that as NEs assume responsibility for additional hospital departments and/or divisions, they will have more administrative and institutional responsibilities that are included in the hospital/organizational category. These data also suggest that the role of the nurse executive is transitional and evolving with more changes occurring in the 1990s as nurse executives assume more institutional responsibilities. These results indicate further study is warranted.

In the nursing management category, both respondents rated these two functions above 80%, provide leadership for

nursing, and manage nursing in a comprehensive manner. Only the function, keeping current in nursing practice, showed a 25% difference with CEOs rating this function higher. The CEOs again may expect NEs to keep up to date in nursing, whereas NEs may keep current in practice but delegate to nurse managers the implementation of nursing practice.

It is interesting to note that the three highest functions considered the most important were rated about the same by both NEs and CEOs. These functions were:

1. possession of good interpersonal skills (NE 99%, CEO 97%),
2. provision of leadership for nursing (NE 97%, CEO 96%),
3. allocation of nursing resources (NE 98%, CEO 95%).

The functions rated below 80% by both respondents indicate they are important, but that those functions may be delegated to nurse managers such as staffing and documentation, or those functions may be performed by other departments such as accounting or information systems.

These data are consistent with reports in the nursing literature that the responsibilities of NEs are increasing in scope, complexity, and sophistication in finance and hospital management to a level comparable with the nonnurse members of top level hospital management. Also, these data suggest the functions of the NEs are in a dynamic state, and

their responsibilities will continue to increase in the financial, administrative and organizational dimensions of hospital management. It seems that the 1980s have been the decade of transition and growing into a new role for the top nursing manager in hospitals; whereas, in the 1990s the nurse executive will be known as the leader in hospital nursing practice and hospital health care administration.

Career Experiences

In this study, baseline data were obtained about the career pathway and the socialization factors that the respondents used in advancing to the top nursing position in hospitals.

A major finding from the work histories of the respondents revealed that the career path to the nurse executive position is the traditional clinical pathway. This clinical path consists of the entry level position of staff nurse, then head nurse, then supervisor, then assistant director of nursing, then director of nursing, then assistant vice-president, and finally vice-president. This clinical career path to the top nursing position in hospitals compared with Ashley's (1976) description, remains essentially the same with the addition of two positions, assistant vice-president and vice president. An overwhelming number of respondents (88%) began their careers as a staff nurse. Only a small number (n=18) of the

respondents began their careers as a head nurse, supervisor, or educator. Also, the work histories revealed the respondents held a variety of positions that were categorized as either progressive or nonprogressive management experience. Forty-three percent of the respondents revealed a pattern of upward progressive management experience in which the respondent was promoted to the next management position such as head nurse, then supervisor, then assistant director of nursing, then director of nursing, then vice-president. However, 57% of the respondents did not show an upward progressive management pattern, i.e. the respondent held a position of supervisor then the next position was a staff nurse or instructor, then other management positions. These data agreed with Wintz's (1987) beliefs that nurse executives are in a position to assist others in career development by outlining their own career development, and defining the valuable experiences and education that allowed them to progress in their career development.

Additionally, the work histories revealed that 80% of the respondents have worked in six or less institutions, that 62% have held seven or more positions, and that 69% have 13 years or more of work experience (a mean of 16 years) before reaching the top nursing management position in hospitals. These data were compared with Jennings (1967)

findings that it takes 20 years, 11 different positions and seven different institutions to reach the top management position in an organization. The respondents in this study were younger, worked in fewer institutions, had fewer positions and worked less years to reach the nurse executive position.

These data support Freund's (1985) findings that 73% of the directors of nursing had 15 years or less of management experience. In this study, the total work experience was a mean of 16 years. The respondents' work histories revealed that the first years of their careers are spent in clinical nursing positions and then they moved into upper level management positions. Therefore, the respondents work histories consisted both of clinical and management positions which are consistent with the requirements for the nurse executive position.

Socialization Practices

These findings indicate that the respondents engaged in a variety of socialization behaviors in their career advancement. The outstanding feature of these respondents is the role of visibility in their career advancement. These data support the importance of nurse executives seeking activities early in their careers where they can be visible and become known in the management world. For example, over 70% of the respondents reported that

management seminars, networking/visibility, and memberships in professional organizations are most important for advancement. Also, over 50% of the respondents reported formal and informal education next in importance. Over 50% of the respondents reported that they began to adopt the values of the desired job; whereas, less than one-half did not change their dress or imitate the behaviors of the person in the job. These data are consistent with Autonberry's (1988) and Scott's (1984) that socialization behaviors are essential for career advancement.

The socialization behaviors reported by the respondents can be grouped according to the three stages of professional socialization by Clark and Corcocan (1986):

1. Anticipatory socialization (first stage): almost 50% of the respondents imitated the behaviors of the person in the job, adopted the organizational values, and changed their dress style.
2. Entry and induction (second stage): over 70% of the respondents had obtained formal education for the job, and 64% learned by on-the-job training.
3. Role continuance: in this stage individuals internalize the role behaviors, and develop a sense of work satisfaction, job motivation, and commitment. In this study 79% of the respondents felt that they are very successful, and 21% felt

somewhat successful in their jobs.

In addition to the above socialization practices, 10-25% of the respondents stated that these factors greatly contributed to their career advancement: (a) mentors, (b) networking, (c) education, (d) previous management experience, (e) strong interpersonal and communication skills, and (f) a good clinical background.

These findings support Traska's (1984) position that nurse executives need to be socialized into the executive role and that current nurse executives are participating in a variety of socialization behaviors both in their advancement and in their current positions.

These data disagree with Campbell-Heider's (1986) position that nurses have lacked socialization for and experience with a mentor type of employment relationships and that women in female dominated professions have under utilized mentoring skills as a career advancement strategy. Since 25% of the respondents reported mentoring/networking as the top factor in career advancement, it may be that nurse executives are aware of the need for a mentor and also recognize the importance of a mentor in career advancement.

The empirical data obtained in this study about the socialization behaviors that nurse executives engaged in as they advanced to or even as they continue in their roles, either planned or unplanned, can be most helpful for

aspiring nurse managers and for nurse executives.

Role of Professional/Civic Organization

In addition to the previous data on socialization behaviors, the role of membership in organizations was examined. Over 30% of the respondents report visibility gained as a member of a nursing management organization and public speaking was very important in their advancement. Another 46% of the respondents report serving as an officer in a nursing, management and civic organizations was important. It is interesting to note only a small number felt membership in ANA and NLN (n=12) and published research/articles/(n=13) was important. It is surprising that the professional nursing organizations (ANA and NLN) are not seen as significant as the nursing management and civic organizations in career advancement. This role of visibility seems to be a major concept related to leadership that is widely written about with little research to document its significance in career advancement.

These data support Autonberry's (1988) report that serving as an officer, joining community organizations, and increasing visibility are key to career advancement. Therefore, from the results of this study, nurses aspiring to the top nursing position should be counseled by faculty and nurse executives to obtain graduate education, to have progressive nursing management experiences, to seek a

mentor, to increase networking, to join and serve as an officer in nursing management and community organizations, and to participate in public speaking. Also, nurse executives are in an excellent position to identify potential nurse managers and to serve as mentors to them in their career advancement.

Reasons Nurse Executives Choose Management

The respondents in this study stated a wide variety of reasons for choosing a career in nursing management. Six major areas stated by the respondents were: (a) influence, (b) financial, (c) career opportunity, (d) self-fulfillment, (e) recognition, and (f) miscellaneous. Almost one-half of the respondents wanted to influence or be a change agent which would impact patient care. Another one-third of the respondents went into management because of the monetary rewards and the perks of the nursing executive position. Other reasons stated were the "opportunity to advance," "like to lead," "enjoy problem-solving," "decision-making," and "upward mobility." Self- fulfillment reasons cited were the need for "challenge, recognition, autonomy, self-actualization, growth, and prestige." Whereas, some respondents stated that they chose management because they had "good political/social skills", were a "role model", and enjoyed being a "trailblazer." These NEs characteristics support the ones described by deBueno and Walker (1984),

Scalzi and Anderson (1989), and Reynolds (1987).

These data indicate NEs enter management for a variety of reasons with ability to be influential in the care of patients as a major reason. NEs also enjoy the monetary rewards of upward career mobility while at the same time meeting their needs for self-fulfillment.

These data can be used by nurse executives to identify and encourage nurses who display these characteristics to seek management positions which, in turn, will increase the pool of potential nurse managers.

Future Goals

The respondents stated a variety of goals for the future which are summarized as (a) continuance in the role of nurse executive, (b) educator, (c) consultant, (d) hospital administrator, and (e) miscellaneous. Almost one-third of these respondents are satisfied in their roles because they plan to continue in the role but wanted it to be in a larger institution, or a larger city, or a larger teaching acute care facility. Only a small number (n=17) want to continue in the same institution, and another smaller number plan to retire. Almost one-fifth of the respondents plan to obtain a masters degree in business, law, health administration, or a doctorate. A small number of respondents (n=21) want to be consultants or hospital administrators, or chief operating officers (n=14). Some

respondents want to be a teacher, a writer, an entrepreneur, a researcher, and a JCAHO surveyor. Only four respondents did not state any goals.

These data suggest the respondents are goal-oriented with a variety of future goals expressed. Participation in this study may have helped some of the respondents to define and state their goals.

Career Planning

The respondents in this study described their career planning in a combination of ways. Only 39 respondents stated they had planned their careers. Almost one-half of the NEs stated their position was due to external factors such as being determined by the organization, just happening, or being in the right place at the right time. Most respondents (N=72) chose the nurse executive position for self-fulfillment. These data support Hall's (1976) writings that many individuals choose their careers and or jobs for their own self-fulfillment in which the individual, not the organization, determines the career direction. This combination of NE findings of both external and internal determinants of career positions supports findings in the literature that planning for one's nursing career is not a deliberate process (Keough, 1977; McBride, 1985; Morrison & Zebelman, 1982; Price, et. al, 1987; Smith, 1982; Vestal, 1983; Wilhite, 1988).

The majority of nurse executives described their career planning as self-fulfillment which meets their needs. These data support Henning and Jardin's (1976) and Morrison and Zebelman's (1982) writings that women view careers as work that allows flexibility to meet the needs of work, self, and family. However, in this study, the respondents career planning involved a combination of internal and external factors.

All of the respondents in this study perceived themselves as being successful. Over three-fourths stated they were very successful, with the rest of the respondents stating they were somewhat successful. These data are consistent with Clark and Corcoran's (1986) and Kotter's (1973) findings related to socialization.

Summary of Conclusions

Based upon the data collected and analyzed in this study, the major findings with conclusions about hospital nurse executive's profiles, functions, and career experiences seem warranted.

Profiles

The professional profile revealed that the majority of hospital NEs have titles of vice-president, executive, or administrator, have responsibilities for additional hospital departments, and have increased compensation. The NE tends to report to the CEO and works in a medium sized (101-500

beds) hospital that is private and nonprofit. As a result, the role of the hospital nurse executive is still in a transitional period with changing titles, increasing responsibilities, and increasing compensation comparable to their colleagues at the top management level.

The educational profile of the hospital NEs revealed that NEs have more baccalaureate and master's level education than the general registered nurse population, and that the predominant degree of NEs is the master's degree in nursing, business, and/or related fields. It is interesting to note that some NEs have dual degrees and some are also working on a second master's degree. Nurse executives mainly learned their management knowledge and skills by formal and informal education, previous management experience, and on-the-job training. Also, the majority of NEs stated they were not educationally prepared in the financial and hospital/organizational management categories. Therefore, NEs predominantly have a master's degree, while a small number of NEs have dual graduate degrees in nursing and business and another small number of NEs report working on a second master's degree. There is a lack of consensus as to the one degree that prepares NEs for the educational needs that meets the role and responsibilities in the nurse executive position. Faculty of graduate nursing schools need to study in more detail a nursing administration

curriculum that integrates the financial and hospital/organizational management functions with nursing. As a result, the graduate would then be prepared for the NE role without having to obtain two graduate degrees. Also, NEs who choose to work in large complex multi-hospital systems may benefit from or may be required to have a doctoral degree in the future.

Functions

The very important functions performed in the NE position were rated by the NEs and CEOs in the four categories of financial, human resources, hospital/organizational and nursing management. Both CEOs and NEs' ratings were more similar in financial, human resource, and nursing management, and were less similar in the hospital/organizational management category. Ten of 30 functions showed a 10% difference between the NEs and the CEOs responses. Six of the ten functions were in the hospital/organizational category with the NEs ratings higher than the CEOs. Therefore, the NE is considered to be a junior member of the top hospital management team who is not yet a full participating member in hospital policy development, allocation of resources, and strategic planning. NEs new to their positions or interviewing for a nurse executive position need to ascertain the CEOs expectations related to hospital management in their role as

nurse executives.

Career Experiences

The work histories of hospital nurse executives revealed that NEs have traditionally worked in six or less institutions, have held seven or more positions, and have had 13 or more years of experience before reaching the top nursing position in hospitals. The work experience of most of the NEs consisted of both clinical positions as staff nurses, and management positions as head nurse, or supervisor, or assistant director of nursing or director of nursing. Therefore, one career pathway to the nurse executive position was identified which was the traditional clinical pathway that consisted of clinical and management positions. These data indicate that this clinical pathway for nurse executives will continue in the 1990s; however, it is interesting to speculate if changes will occur for nurses who obtain their graduate education before they seek employment.

The socialization practices that NEs participated in that promoted their career advancement were attending management seminars, increasing networking, being a member of a nursing management organization and speaking at public and professional organizations. Also, NEs reported having mentors, increasing networking, gaining appropriate education, having clinical and management work experience,

and possessing strong interpersonal and communication skills as major contributions to their career advancement. Therefore, nurse aspirants to the nurse executive position in hospitals should be counseled to seek visibility by having the appropriate education, by having both clinical and management work experience, by serving as a member and officer in a nursing management organization and by speaking to professional and community organizations. In addition, aspirants should also be counseled to seek a mentor, to increase their networking, and to have excellent communication and interpersonal skills.

The results of this study revealed that nurse executives choose their position for a variety of reasons such as influence, financial, career opportunity, recognition and self-fulfillment. The results also showed that nurse executives are successful and goal-oriented with specific goals stated for the future. While a small number of nurse executives planned their careers, the majority described their careers as occurring in a combination of ways such as luck, just happened, self-fulfillment, and/or chosen by the organization. Therefore, nurse executives seem to be involved in their career development which is determined both by the individual and the organization. This career development of the nurse executive in the 1980s did not seem to reflect careful planning and deliberation.

However, nurses aspirating to the NE position in the 1990s will need to carefully plan their career advancement which must include appropriate graduate education, both clinical and progressive management experience, and socialization practices.

Recommendations

Based on the results of the study, the following recommendations for nursing practice are offered:

1. Nurses aspiring to the top nursing position should obtain graduate education and management experience.
2. Nurse executives should identify potential nurse managers with similar characteristics as stated in this study.
3. Nurse executives who are now in their positions and nurse managers who aspire to nurse executive positions should plan for and provide on-the-job management training.
4. Nurses aspiring to the nurse executive position should plan for ways to be more visible in career advancement.
5. Nurse executives new in the role and aspiring nurses to the nurse executive position should seek additional education in financial and hospital/organizational management topics.

6. Faculty of graduate programs should plan curricula that will meet the educational needs of nurse executives for their roles and responsibilities.
7. Faculty of graduate schools should incorporate into the curricula career development components with career counseling for nurse managers.

Based on the data and conclusions, the following recommendations for further research are offered:

1. Examine the hospital/organizational management responsibilities/functions of the nurse executive role.
2. Examine the curricula in graduate nursing schools for the inclusion of the financial and management topics necessary for the nurse executive position.
3. Examine on-the-job training in relation to learning the functions of the nurse executive role.
4. Examine the socialization practices of visibility related to career advancement.

LITERATURE CITED

American Hospital Association. (AHA Guide, 1988 Edition). American hospital association guide to the health care field. Chicago, IL.

American Hospital Association. (1985). Roles and functions of the hospital nurse executive. Chicago, IL.

Anderson, R. M., Thurkettle, M. A., & Fitzpatrick, J. (1984). The new breed. Nursing Success Today, 2(3), 4-8.

Andrica, D. C. (1988). Changing profile of nurse executives. Nursing Economics, 6(3), pp. 112-115.

Ashley, J. (1976). Hospitals, paternalism, and the role of the nurse. New York, NY: Teachers College, Columbia University.

Auttonberry, D. S. (1988). The emerging role of the master's-prepared nurse in marketing. Nursing Management, 19(9), 40-42.

Aydelotte, M. K. (1982). Report of the 1982 survey of nursing service administrators. Chicago, IL: American Hospital Association.

Aydelotte, M. K. (1984). A survey of nursing service administrators - part 1. Hospitals, 58(11), 94-100.

Aydelotte, M. K. (1984). A survey of nursing service administrators - part 2. Hospitals, 58(12), 79-80.

Berlew, D. E., & Hall, D. T. (1966). The socialization of managers: Effects of expectations on performance. Administration Science Quarterly, 11, 207-223.

Best, J. W. (1977). Research in education (3rd. ed.). Englewood Cliffs, NJ: Prentice-Hall, Inc.

Blair, E. & O'Brian, R.A. (1990). Deliberations on nursing administration practice. Nursing and Health Care, 11(10), 514-515.

Boerstler, H. & Suver, J. (1989). Management preparation for nurse executives: The dual degree option. Nursing Administration Quarterly, 13(2), 19-23.

Brown, B. J. (1987). Editorial about nursing 2000 A.D. Nursing Administration Quarterly, 11(2), vi-viii.

Bruzek-Kohler, C. M. & Carpenter, D. (1985). Build business sense. Nursing Success Today, 2(7), 29-33.

Campbell-Heider, N. (1986). Do nurses need mentors? Image: Journal of Nursing Scholarships, 18(3), 110-113.

Carter, M. A. (1987). Is nursing ready for the future? Journal of Professional Nursing, 3(2), 80.

Clark, S. M., & Corcoran, M. (1986, January-February). Perspectives on the professional socialization of women faculty. The Journal of Higher Education, 57(1), 20-43.

Collins, S. K. (1984, Summer). A comparison of top and middle level women administrators in social work, nursing, and education: Career supports and barriers. Administration in Social Work, 8(2), 25-33.

Decker, P. J. & Strader, M. K. (1992). Nursing administration programs: Hard choices. Journal of Nursing Administration, 22(3), 11-22.

del Bueno, D. J. & Walker, D. D. (1984). Developing prospective managers. Journal of Nursing Administration, 14(4), 7-10.

Dillman, D. A. (1978). Mail and telephone surveys: the total design method. New York, NY: John Wiley & Sons.

Duffy, M. E. & Gold, N. E. (1980). Education for nursing administration: What investment yields highest returns. Journal of Nursing Administration, 10(9), 31-37.

Feldman, D. C. (1976, September). A contingency theory of socialization. Administrative Science Quarterly, pp. 433-450.

Fine, R. B. (1983). The supply and demand of nursing administrators. Nursing and Health Care, 4(1), 10-15.

Foster, R. & Boerstler, H. (1990). Integration of nursing and business issues in curriculum development. Nursing and Health Care, 11(10), 518-521.

Fralic, M. F. (1986). Patterns of preparation: The nurse executive. In Patterns in Specialization Challenge to the Curriculum. New York, NY: National League for Nursing.

Fralic, M. F. (1992). Nurse executive practice - into the next millennium: From limbo dancer to pole vaulter. Journal of Nursing Administration, 22(2), 15-16.

Freund, C. M. (1985). Director of nursing effectiveness: DON and CEO perspectives and implications for education. The Journal of Nursing Administration, 15(6), 25-30.

Gardner, D. L. (1992). Career commitment in nursing. Journal of Professional Nursing, 8(3), 155-160.

Gother, A. M., & Rosenfield, P. (1986, December). Nursing education update: Enrollments and admission trends. Nursing and Health Care, 7(10), 555-559.

Hall, D. T. (1976). Careers in organizations. Pacific Palisades, CA: Goodyear Publishing Company, Inc.

Hall, D. T. (1986). Career Development in Organizations. San Francisco, CA: Jossey-Bass.

Hanson, H. A., & Chater, S. (1983). Role selection by nurses: Managerial interests and personal attributes. Nursing Research, 32(1), 48-52.

Hennig, M. & Jardin, A. (1976). The managerial woman: The survival manual for women in business. New York, N.Y. Pocketbooks.

Herr, E. L., & Cramer, S. H. (1984). Career guidance and counseling through the life span systematic approaches(2nd ed.). Boston, MA: Little, Brown & Corporation.

Jackall, R. (1983, September-October). Moral mazes: Bureaucracy and managerial work. Harvard Business Review, pp. 118-130.

Jennings, E. E. (1967). The mobile manager. Michigan: Bureau of Industrial Relations. Graduate School of Business Administration the University of Michigan.

Johnson, M. S. (1987). Preparing nurse executives for financial management. Nursing Administration Quarterly, 12(1), 67-73.

Kanter, R. M. (1977). Men and women of the organization. New York, NY: Basic Books.

Keough, G. (1977). The need for career development. The Journal of Continuing Education in Nursing, 8(3), 5-6.

Knopf, L. (1983). Registered nurses fifteen years after graduation: Findings from the nurse career pattern study. Nursing and Health Care, 4(2), 72-76.

Kotter, J. P. (1973). The psychological contract: Managing the joining-up process. Harvard Business Review, 15(3), 91-99.

Lash, A. A. (1992). Determinants of career attainments of doctorates in nursing. Nursing Research, 41(4), 216-222.

Louis, M. R., Posner, B. Z., & Powell, G. N. (1983). The availability and helpfulness of socialization practices. Personal Psychology, 36, 857-866.

Mark, B. A., Turner, J. T., and Englehardt, S. (1990). Knowledge and skills for nurse administrators. Nursing and Health Care, 11(4), 185-189.

McBride, A. B. (1985). Orchestrating a career. Nursing Outlook, 33(5), 244-247.

McCloskey, J. C., & Gordner, D., Johnson, M., and Maas, M. (1988). What is the study of nursing service administration? Journal of Professional Nursing, 4(2), 92-98.

McClure, M. L. (1979). The administration component of the nurse administrator's role. Nursing Administration Quarterly, 3, 1-12.

Morrison, R. S., & Zebelman, E. (1982, Fall). The career concept in nursing. Nursing Administration Quarterly, pp. 60-68.

Nieva, V. F., & Gutek, B. A. (1981). Women and work: A psychological perspective. New York, NY: Praeger Publishers.

Nolan, J. W. (1985). Work patterns of midlife female nurses. Nursing Research, 34(3), 150-154.

Nowak, J. B., & Grindel, C. G. (1984). Career planning in nursing. Philadelphia, PA: J. B. Lippincott Company.

Porter-O-Grady, T. (1986). Nursing practice in health and organization of the future. In NLN (Ed.), Looking Beyond the Entry Issue: Implications for education and service. (Publication No. 41-2173). New York NY.

Porter, R. T. & Porter, M. J. (1991). Career development: Our professional responsibility. Journal of Professional Nursing, 7(4), 208-212.

Price, S. A. (1984). Master's program preparing nurse administrators. What are the essential components. Journal of Nursing Administration, 14(1), 11-17.

Price, S. A., Simms, L. M., & Pfoutz, S. K. (1987). Career advancement of nurse executives: Planned or accidental? Nursing Outlook, 35(5), 236-238.

Rawson, G. (1988). Directors of nursing in Australia: A profile. Nursing Outlook, 36(4), 198-202.

Redmond, G. M. (1991). Life and career pathways of deans in nursing programs. Journal of Professional Nursing, 7(4), 228-237.

Reynolds, B. J. (1987). Directors of nursing service: How well prepared are they? Nursing Outlook, 35(6), 274-287.

Rosenfeld, R. A. (1979). Women's occupational careers. Sociology of Work and Occupations, 6(3), 283-311.

Scalzi, C. C. & Anderson, R. A. (1989). Dual degree: Future preparation for nurse executives? Journal of Nursing Administration, 19(6), 25-29.

Scalzi, C. C., & Wilson, D. L. (1990). Empirically based recommendations for content of graduate nursing administration programs. Nursing and Health Care, 11(10), 522-525.

Schein, E. H. (1968, Winter). Organizational socialization and the progression of management. Industrial Management Review, 9, 1-15.

Schein, E. H. (1971). The individual, the organization and the career: A conceptual scheme. Journal of Applied Behavioral Science, 7(4), 401-426.

Scott, P. P. (1984). Executive career planning. Nursing Economics, 2(1), 58-63.

Seventh Report to President and Congress on the Status of Health Personnel in The United States. (March 1990). U.S. Department of Health and Human Services.

Shapiro, E. C., Haseltine, F. P., & Rowe, M. P. (1978). Moving up: Role models, mentors, and the "Patron system." Sloan Management Review, 9(3), 51-58.

Simms, L. (1989). The evolution of education for nursing administration, In B. Henry et. al. (Ed.). Dimensions in Nursing Administration, (pp. 459-467). Boston: Blackwell-Scientific.

Singleton, E. K. & Nail, F. C. (1988). Nursing leadership: The effects of organizational structure. Journal of Nursing Administration, 18(10), 10-14.

Smith, M. M. (1982). Career development in nursing: An individual and professional responsibility. Nursing Outlook, 30(2), 128-131.

Sorrentino, E. A. (1992). Profiling a chief nursing officer. Nursing Management, 23(1), 32-34.

Speizer, J. J. (1981, Summer). Role models, mentors, and sponsors: The elusive concepts. Signs: Journal of Women in Culture and Society, 6(41), 692-712.

Spitzer, R. (1982, April). The nurse in the corporate world. Supervisor Nurse, pp. 21-24.

Strasen, L. (1987). Key business skills for nurse managers. Philadelphia, PA: J. B. Lippincott.

Super, D. E. (1957). The psychology of careers. New York, NY: Harper Row.

Super, D. E. (1980). A life-span, life-space, approach to career development. Journal of Vocational Behavior, 16, 282-297.

Super, D. E. (1984). Career and life development. In D. Brown and L. Brooks & Associates (Eds.), Career choice and development, (pp. 192-234). San Francisco, CA: Jossey-Bass Publishers.

Tilbury, M. S. (1992). Issues and trends in nursing service administration education. The Journal of Nursing Administration, 22(2), 13-14.

Traska, M. R. (1982, February). Nurses as managers: Acceptance problems may lie with nurses themselves. Hospitals, pp. 57-59.

Vance, C. N. (1982). The mentor connection. Journal of Nursing Administration, 12(4), 7-13.

Van Maanen, J. (1978, Summer). People processing. Strategies of organizational socialization. Organizational Dynamics, pp. 19-36.

Veiga, J. E. (1981, September). Plateaued versus nonplateaued managers: Career patterns, attitudes and path potential. Academy Management Journal, pp. 566-577.

Vestal, K. W. (1983). Career development as a power strategy. In K. R. Stevens (Ed.), Power and influence: A source book for nurses. New York, NY: John Wiley & Sons.

Vestal, K. W. (1983). Nursing careerism: Challenges for the nursing administrators. Nursing Clinics of North America, 18(3), 473-479.

Wilhite, M. (1988). Definitions and descriptions of the nursing middle management nurse executive. Journal of Nursing Administration, 18(10), 6-7, 14.

Wintz, L. (1987). Career paths of nurses: When is a nurse no longer a nurse? The Journal of Nursing Administration, 17(4), 33-37.

APPENDIX A

Dear Nurse Executive:

The roles and responsibilities of nurse executives in hospitals are changing rapidly to include more corporate and administrative functions. Along with the role changes, a more important question is what qualifications are necessary to perform the role of nurse executive in today's hospital system. Also, many writers speak to career planning and socialization practices as being essential for executives to be successful. Yet, little information is available concerning the actual qualifications, functions, and career experiences that lead to the top nursing position in the 1980s.

You have been selected to provide information on the qualifications, functions, and career experiences of nurse executives. Because this is a national study, it is of crucial importance that each questionnaire be returned so that the findings are truly a representation of hospital nurse executives nationwide.

Your assistance in this project is vital to its success. The questionnaire has an identification number for mailing purposes only. You may be assured the responses will be handled with confidentiality and anonymity.

The results of this national study will be available to nurses and other interested persons. If you would like a copy of the results, put your name and address in the space on the return folded questionnaire. Please remember to fold and staple the questionnaire and return to me by November 30, 1988.

Should you have any questions, please contact me at work, (804) 799-4510, or at home, (703) 638-2813. You have my deepest appreciation for your assistance and cooperation.

Sincerely,

Darnell H. Cockram
Director of Nursing Education
Doctoral Student, Virginia Polytechnic Institute and State University

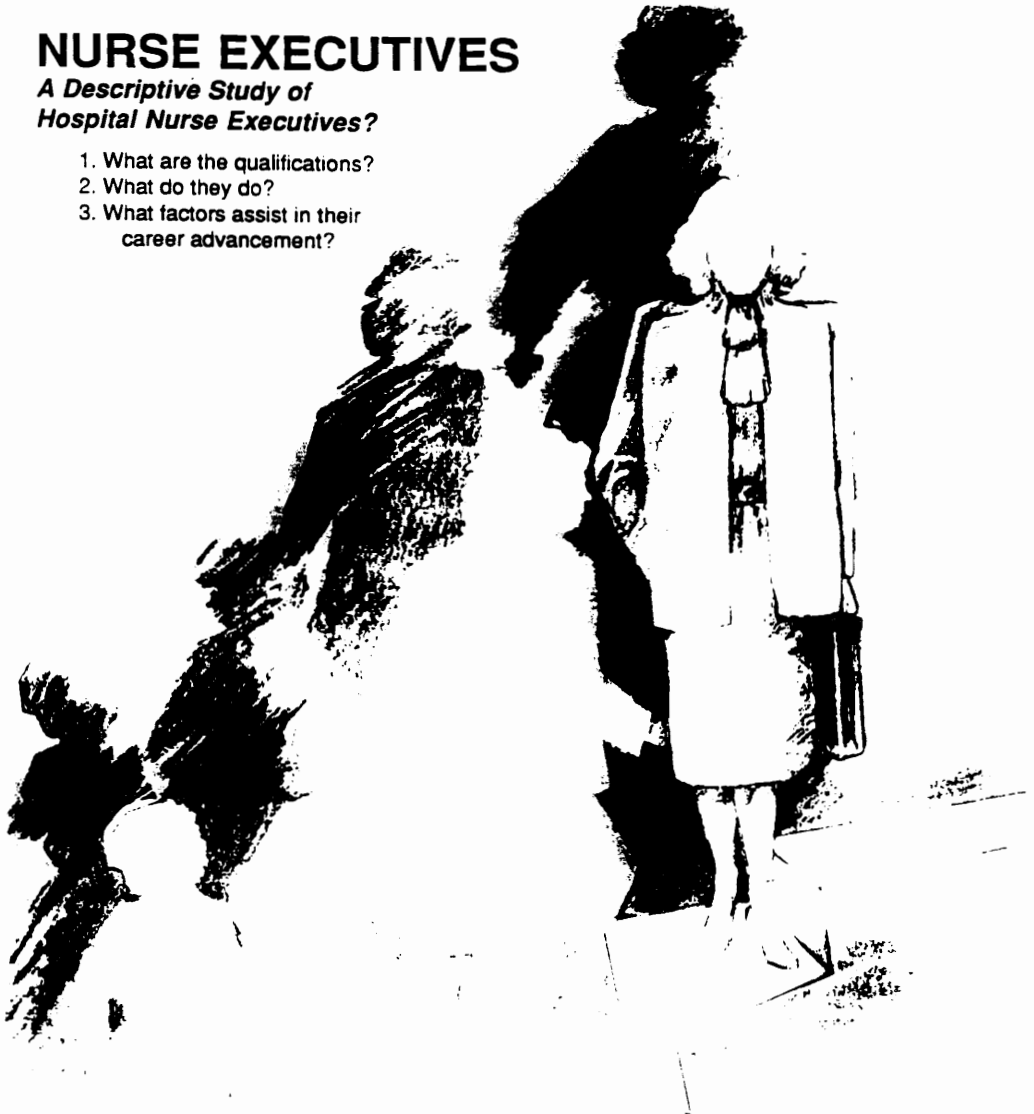
Enclosures

APPENDIX B

NURSE EXECUTIVES

A Descriptive Study of Hospital Nurse Executives?

1. What are the qualifications?
2. What do they do?
3. What factors assist in their career advancement?



This is a nationwide survey done in cooperation with Virginia Polytechnic Institute and State University. We know how busy you are but ask that you take about 25 minutes to help us describe the qualifications, functions, and career experiences of hospital nurse executives throughout the U.S.

Thank you for your assistance!

Darnell H. Cockram
Route 9, Box 86 • Martinsville, Virginia 24112
Work Phone: 804-799-4510
Home Phone: 703-638-2813

HOSPITAL NURSE EXECUTIVES
Nurse Executive Survey Instrument

The role of nurse executives is undergoing a major transition. In order to describe the current and emerging trends in this role transition, we need to collect basic information about their qualifications, functions and career experiences.

Please answer all of the following questions by checking or inserting the appropriate answer(s).

SECTION ONE: Demographic Data

A. Current Position

1. Your present title is _____
2. The title of the person you report to is _____
3. Are you responsible for any departments, in addition to nursing? ____ Yes ____ No
   a. If yes, list the department(s). _____
4. Your hospital classification is: (check all that apply) ____ private ____ public ____ profit ____ non profit ____ governmental ____ other (state)
5. The bed size of the hospital is: ____ 51-100 ____ 101-300 ____ 301-500 ____ 501-1000 ____ greater than 1000
6. Please indicate your salary range:
   ____ less than 30,000 ____ 40,001-50,000 ____ 60,001-70,000 ____ greater than 80,000
   ____ 30,001-40,000 ____ 50,001-60,000 ____ 70,001-80,000

B. Personal Data

7. Gender: ____ Male ____ Female
8A. Your age: ____ less than 30 ____ 31-40 ____ 41-50 ____ 51-55 over 55
8B. Your age when you assumed your first nurse exeutive position. _____
9. Race: ____ Caucasian ____ Black ____ Hispanic ____ Indian (Amercan)
   ____ Other (State) _____
10. Your present marital status ____ Married and living with spouse ____ Other
11. How many children do you have? _____
12. What is/was your mother's occupation? _____
13. What is/was your father's occupation? _____

C. Educational Data

14. What is your basic RN education? ____ Diploma ____ Baccalaureate ____ Associate Degree
15. What academic credentials have your earned? (check all that apply)
    ____ Diploma
    ____ Associate Degree
    ____ Baccalaureate Degree in Nursing
    ____ Baccalaureate Degree in Non-Nursing Field
    ____ Master's in Nursing
    ____ Master's in Business Administration
    ____ Master's in Other Related Field
    ____ Doctorate in Nursing
    ____ Doctorate in Related Field
    ____ Other (Specify)
16. Are you currently working on a degree? ____ Yes ____ No
    a. If yes, specify the degree and the field. Degree _____ Field _____
17. Are you ANA certified in nursing administration? ____ Yes ____ No

SECTION TWO: Selected Responsibilities of Nurse Executives

18. Please mark the instrument to indicate the following

COLUMN A: Is the function mentioned in the item **important** to the role of nurse executive? Circle as follows: YES if the item is important; NO if it is not important.

COLUMN B: **How important** is this function to the role of nurse executive? Circle as follows: "1" Not important; "2" Somewhat important; "3" Very important.

COLUMN A		COLUMN B		
Is This Function important to Your role as Nurse Executive?	FUNCTION	How important is this function to your role as nurse executive?		
		Not important	Somewhat important	Very important
Example: (YES) NO	Monitor Budget Variances	1	2	(3)

COLUMN A				COLUMN B		
Is This Function Important to Your role as Nurse Executive?			FUNCTION	How **important** is this function to your role as nurse executive?		
				Not Important	Somewhat Important	Very Important
			FINANCIAL MANAGEMENT FUNCTION			
1	YES	NO	Allocate nursing resources	1	2	3
2	YES	NO	Prepare nursing department budget	1	2	3
3	YES	NO	Use cost-containment strategies for nursing department	1	2	3
4	YES	NO	Participate in the hospital wide budgeting process	1	2	3
5	YES	NO	Comply with external regulations such as Medicare, JCAHO	1	2	3
6	YES	NO	Know the DRG reimbursement system	1	2	3
			HUMAN RESOURCE MANAGEMENT FUNCTION			
7	YES	NO	Recruit and retain nursing staff	1	2	3
8	YES	NO	Know nursing staffing patterns	1	2	3
9	YES	NO	Evaluate staff for personnel decisions	1	2	3
10	YES	NO	Oversee nursing staff development and training	1	2	3
11	YES	NO	Possess strong written and oral communication skills	1	2	3
12	YES	NO	Possess good interpersonal skills	1	2	3
13	YES	NO	Serve as spokesperson for the nursing department	1	2	3
14	YES	NO	Know collective bargaining	1	2	3
			HOSPITAL/ORGANIZATIONAL MANAGEMENT FUNCTION			
15	YES	NO	Participate in policy development at the top management level	1	2	3
16	YES	NO	Participate in allocation of hospital resources	1	2	3
17	YES	NO	Serve as a member of hospital executive team	1	2	3
18	YES	NO	Serve as member of selected medical committees	1	2	3
19	YES	NO	Serve as a member of the governing body	1	2	3
20	YES	NO	Participate in strategic planning for hospital	1	2	3
21	YES	NO	Participate in identifying long range and short range goals for hospital	1	2	3
22	YES	NO	Know hospital information systems	1	2	3
23	YES	NO	Manage planned change for hosptial and for the nursing dept	1	2	3
24	YES	NO	Know litigation/health care law	1	2	3
			NURSING DEPARTMENT MANAGEMENT FUNCTION			
25	YES	NO	Keep current in nursing practice	1	2	3
26	YES	NO	Oversee quality assurance and risk management programs	1	2	3
27	YES	NO	Administer a patient classication system	1	2	3
28	YES	NO	Provide leadership for the nursing department	1	2	3
29	YES	NO	Oversee a documentation system in nursing	1	2	3
30	YES	NO	Manage the nursing department in a comprehensive manner	1	2	3

31. Were you educationally prepared for the **Financial Management Function**? ____YES ____NO
32. Were you educationally prepared for the **Human Resource Management Function**? ____YES ____NO
33. Were you educationally prepared for the **Hospital/Corporate Management Function**? ____YES ____NO
34. Were you educationally prepared for the **Nursing Department Management Function**? ____YES ____NO

19. Indicate the importance of the following factors in obtaining your management knowledge and skills? (Circle the appropriate number)	Not Important	Somewhat Important	Very Important	N/A Applicable
1. Graduate degree prior to present position	1	2	3	4
2. Graduate degree obtained in present position	1	2	3	4
3. Doctorate degree	1	2	3	4
4. Managment experience in prior position	1	2	3	4
5. On-the-job training in present position	1	2	3	4
6. Self-study courses/activities	1	2	3	4
7. Management training programs (continuing education) prior to present position	1	2	3	4
8. Management training programs (continuing education) in current position	1	2	3	4
9. Self-development courses	1	2	3	4

20. State the management topics you consider the most essential for your current position? (Please specify)_____

SECTION THREE: Career Data

DIRECTIONS: Please complete the following work history by listing all positions held **beginning with entry level to the present.** This data will be used to identify the pathways to the nurse executive position. Also please state the length of time in the position and the name of the institution.

A. Work History Data

21.

	Positions Held By Title	Length Position Held	Name of the Institution
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

B. Socialization Data

22. While preparing for your current position, did you engage in any of the following behaviors? (Check all that apply)

____ 1. changed style of dress to same as person in position desired
____ 2. obtained the formal education required
____ 3. increased continuing education
____ 4. participated more in professional organizations
____ 5. increased visibility/recognition in the work setting
____ 6. attended management seminars/workshops
____ 7. increased community activities
____ 8. imitated work behaviors of person in the job desired
____ 9. began to adopt values of job desired
____ 10. increase networking behaviors
____ 11. other: state_____

23. Which of the following practices were influential in helping you learn about your current role in the organization? (Circle your answer for each practice)

	Not Influential	Somewhat Influential	Very Influential
1. Orientation to the organization	1	2	3
2. Formal education	1	2	3
3. Learning policies and procedures of the organization	1	2	3
4. Participating in professional organizations	1	2	3
5. Continuing education	1	2	3
6. In-service education	1	2	3
7. On-the-job training	1	2	3
8. Networking with peers	1	2	3
9. Management training on-site	1	2	3
10. Management training off-site	1	2	3
11. Association with secretarial/support staff	1	2	3
12. Having a mentor	1	2	3
13. Other (Please specify)_____			

24. What experiences contributed most to your advancement in your position as nurse executive? (Please state)

1._____
2._____
3._____

25. To what degree of importance did the role of professional and civic organizations/activities have on enhancing your advancement to the nurse executive position? (Circle your answer)

	Not Important	Somewhat Important	Very Important	Not Applicable
1. ANA member	1	2	3	4
2. NLN member	1	2	3	4
3. Member Nursing Management Organization	1	2	3	4
4. Officer Nursing Organization	1	2	3	4
5. Officer Management Organization	1	2	3	4
6. Speaking to public/professional groups	1	2	3	4
7. Published research and/or articles	1	2	3	4
8. Officer of Community/Civic Organization	1	2	3	4

26. Reflecting upon your career, which of the following best describes your career?
    ____ 1. Planned (fast track)
    ____ 2. Just happened (accidental)
    ____ 3. Right place at right time (opportunity/luck)
    ____ 4. Changed positions for self-fulfillment (protean)
    ____ 5. Determined by the organization (chosen by management)
    ____ 6. Other: (Please specify)
    _____
    _____

27. State your reason(s) for pursuing a career in management.
    1. _____
    2. _____
    3. _____
    4. _____

28. In your current position, how successful do you consider yourself?
    ____ Not successful ____Somewhat successful ____ Very Successful

29. What are your future career goals? (Please state)
    _____
    _____
    _____

30. Comments:

Thank You!

If you would like a copy of the results of this study, please include a note with your address or write me at the address indicated on the front page.

APPENDIX C

Dear Chief Executive Officer:

I would like to request your assistance with research I am conducting as a doctoral student at Virginia Polytechnic Institute and State University. The purpose of my study is to identify the qualifications, functions, and career experiences that assist nurse executives in handling the scope and complexity of their role today.

Your assistance and cooperation is being sought in determining the educational preparation and work experiences you require of the nurse executive. Also, you are asked to assist in identifying the functions/responsibilities expected in the role of nurse executive.

You may be assured that your responses will be handled with confidentiality and anonymity. The questionnaire has an identification number for mailing purposes only.

Thank you for your cooperation in making this study a success.

Sincerely,

Darnell Cockram, Doctoral Student, Virginia Tech
Director of Nursing Education

APPENDIX D

1. SELECTED RESPONSIBILITIES OF NURSE EXECUTIVES

The role of nurse executives is undergoing a major transition in their functions, qualifications, and career experiences. In order to discover the current and emerging trends in this transition, we need to collect basic information about what functions and qualifications CEO's expect of nurse executives employed in hospitals today.

Please mark the instrument to indicate the following:

COLUMN A: Is the function mentioned in the item important to the role of nurse executive? Circle as follows: YES if the item is important; NO if it is not important.

COLUMN B: How important is this function to the role of nurse executive? Circle as follows: "1" Not Important; "2" Somewhat Important; "3" Very Important

COLUMN A				COLUMN B		
Is This Function Important to the role of Nurse Executive?			FUNCTION	How important is this function to the role of nurse executive? Not Important	Somewhat Important	Very Important
Example:	(YES)	NO	Monitor Budget Variances	1	2	(3)
			FINANCIAL MANAGEMENT FUNCTION			
1.	YES	NO	Allocate nursing resources	1	2	3
2.	YES	NO	Prepare nursing department budget	1	2	3
3.	YES	NO	Use cost-containment strategies for nursing department	1	2	3
4.	YES	NO	Participate in the hospital wide budgeting process	1	2	3
5.	YES	NO	Comply with external regulations such as Medicare, JCHA	1	2	3
6.	YES	NO	Know the DRG reimbursement system	1	2	3
			HUMAN RESOURCE MANAGEMENT FUNCTION			
7.	YES	NO	Recruit and retain nursing staff	1	2	3
8.	YES	NO	Know nursing staffing patterns	1	2	3
9.	YES	NO	Evaluate staff for personnel decisions	1	2	3
10.	YES	NO	Oversee nursing staff development and training	1	2	3
11.	YES	NO	Possess strong written and oral communication skills	1	2	3
12.	YES	NO	Possess good interpersonal skills	1	2	3
13.	YES	NO	Serve as spokesperson for the nursing department	1	2	3
14.	YES	NO	Know collective bargaining	1	2	3
			HOSPITAL/ORGANIZATIONAL MANAGEMENT FUNCTION			
15.	YES	NO	Participate in policy development at the top management level	1	2	3
16.	YES	NO	Participate in allocation of hospital resources	1	2	3
17.	YES	NO	Serve as a member of the hospital executive team	1	2	3
18.	YES	NO	Serve as member of selected medical committees	1	2	3
19.	YES	NO	Serve as a member of the governing body	1	2	3
20.	YES	NO	Participate in strategic planning for hospital	1	2	3
21.	YES	NO	Participate in identifying long range and short range goals for hospital	1	2	3
22.	YES	NO	Know hospital information systems	1	2	3
23.	YES	NO	Manage planned change for hospital and for the nursing department	1	2	3
24.	YES	NO	Know litigation/health care law	1	2	3

COLUMN A				COLUMN B		
Is This Function Important to the role of Nurse Executive?			FUNCTION	How important is this function to the role of nurse executive? Not Important	Somewhat Important	Very Important
			NURSING DEPARTMENT MANAGEMENT FUNCTION			
25.	YES	NO	Keep current in nursing practices	1	2	3
26.	YES	NO	Oversee quality assurance and risk management programs	1	2	3
27.	YES	NO	Administer a patient classification system	1	2	3
28.	YES	NO	Provide leadership for the nursing department	1	2	3
29.	YES	NO	Oversee a documentation system in nursing	1	2	3
30.	YES	NO	Manage the nursing department in a comprehensive manner	1	2	3

2. State the educational requirements of the nurse executive at your institution.

3. State the management experience requirements of the nurse executive at your institution.

Thank you for your cooperation.

APPENDIX E

Summary of responses to the open-ended question as to the topics that are essential to the nurse executive position.

Topics	
Health care finance	(n=55)
Financial management and budgets	(n=46)
Human resources management	(n=45)
Hospital administration management	(n=27)
Communication skills	(n=26)
Organization behavior theory	(n=21)
Interpersonal skills	(n=16)
Strategic planning	(n=14)
Managing planned change	(n=12)
Management information systems	(n=9)
Problem-solving	(n=9)
Negotiation and control	(n=8)
Long-range planning	(n=8)
Quality assurance	(n=8)
Group dynamics	(n=7)
Nurse resource allocation	(n=7)
Recruitment and retention	(n=7)
Reimbursement system	(n=6)
Conflict management	(n=6)
Clinical ethical issues	(n=5)
Presentation o information	(n=5)
Labor relations	(n=5)
Nursing department manaer	(n=5)
Leadership skills	(n=4)
Time management	(n=4)
Program planning and evaluation	(n=4)
Marketing	(n=3)
Alternative systems for delivery of care	(n=3)
Power and politics	(n=3)
Government relations	(n=3)
Risk management	(n=2)
Law and health	(n=2)
Cost-effective and productivity	(n=2)
Interviewing and selection	(n=2)
Counseling	(n=2)
Interpretation of trends	
Legislation	
Recruitment of leadership staff	
Statistics	
Dealing with difficult employees	
Role development	
Decentralization and empowerment of staff nurses	

Summary of responses to the open-ended question as to the topics that are essential to the nurse executive position. (Cont'd.)

Shared governance
Assertiveness training
Team building
Values clarification
Feasibility studies
Mentoring and empowerment
Business plan development and work analysis

APPENDIX F

Summary of responses to open-ended question about the experiences that contributed the most to the advancement in the nurse executive position.

Category 1: Mentoring and networking	(n=40)
Category 2: Personal characteristics	
Education	(n=34)
Strong interpersonal skills	(n=17)
Communication skills	(n=5)
Commitment	(n=2)
Goal setting	
Team player	(n=2)
Intelligent	(n=2)
Credentialing	
Enthusiasm	
Accept responsibility	
Cooperation	
Personal desire	
Willingness to learn	
Problem-solving	(n=2)
Self-assurance and control	
Continuing education	(n=2)
Category 3: Ambition	
Assertive	(n=2)
Taking risks	(n=4)
Willing to work on projects for change	
Ambition	(n=2)
Hard work	(n=2)
Clinical background	(n=15)
Proven track record	(n=4)
Desire to influence	
Desire to achieve	
Organization skills	(n=2)
Leadership ability	(n=5)
Planned ahead	(n=3)

Summary of responses to open-ended question about the experiences that contributed the most to the advancement in the nurse executive position. (Cont'd.)

Category 4: Opportunity

Right place at right time	(n=2)
Opportunity/luck	
Just happened	
Nurse executive management program	(n=3)
Previous experience in management	(n=29)
Know hospital and staff	(n=3)
On the job training	(n=3)
Referred by assistant	
Professor of nursing	
Served in nursing organization	
CN Residency Air Force Program	
Sting desire to advance	(n=2)
Career planning	(n=3)
Listens well	(n=3)

Category 5: Miscellaneous

Participated hospital task force	
Want to see things done properly	(n=2)
Flexible	
Poor administration above me	
Allowed me to advance	
Experience in institution	

APPENDIX G

Summary of the responses to the open-ended question as to the reasons these nurse executives pursue a career in management.

Category 1: Influence

Influence change	(n=10)
Affect change	(n=27)
Impact patient care	(n=14)
Change agent	(n=10)
Influence	(n=14)

Category 2: Career related

Increase mobility	
Self-development as person and professional	
Develop meaningful career goals	
Fulfill my objectives	
Upward mobility	
Growth	
Nursing is a career for me	
Career path	
Personal career satisfaction	(n=2)

Category 3: Recognition/ability

Autonomy	(n=10)
People skills love people	(n=9)
Business/management skills	
Interest in management	
What I do best	
Leadership skills	(n=2)
Decision-making skills	(n=5)
Desire to be a manager	
Enjoy being a manager	(n=3)
Sense of accomplishment/personal rewards	
Like management	
Like working through others	(n=9)
Feel I do better than the others	
Always had leadership positions	
Recognition	(n=2)
Enjoy problem-solving	
What I do best	
Always aspired to lead	

Summary of the responses to the open-ended question as to the reasons these nurse executives pursue a career in management. (Cont'd.)

Creativity	(n=3)
Like to lead	(n=8)
Seemed to rise to leadership position	

Category 4: Self-fulfillment

Self-fulfillment	(n=3)
Enjoy challenge	(n=23)
Need for growth	
Enjoy growth and progress	
Felt had a significant contribution to make	(n=2)
Help people	
Interest in people	(n=2)
Educational experience	
Self-actualization	(n=7)
Fulfill personal and professional goals	
Desire to achieve	
I like what I do	
Exciting	(n=2)
Independence	
Intellectual stimulating	
Job satisfaction	
Risk taking	
Rewarding	
Positive contribution with my life	

Category 5: Financial

Financial	
Increased pay	
Money	(n=22)
Money and perks	(n=15)
Reward for hard work with promotion and increased pay	

Category 6: Miscellaneous

Wanted normal hours to raise son	
Asked to accept the position	(n=3)
Watch others grow	
Boredom	
Not boring	(n=2)

Summary of the responses to the open-ended question as to the reasons these nurse executives pursue a career in management. (Cont'd.)

Role model	
Good political and social skills	
Day shift and flexible hours	
Good team building skills	
Wanted to improve nursing image	
Communication	
Desire to improve nursing and health care	(n=2)
Power	(n=3)
Seeing the need to upgrade nursing	(n=6)
Poor leadership of others	(n=5)
It's fun	
Enjoy fast pace	
Expand to broad base of experiences	
Teach and develop others	(n=10)
Trailblazer	
Enjoy learning management skills	

APPENDIX H

Summary of responses to the open-ended question as to the future goals of nurse executives.

Category 1: Continuance in nurse executive position	(n=60)
Larger institution	(n=17)
Larger city	(n=1)
Same institutions	(n=7)
Expand role and add responsibility for other departments	(n=6)
Large teaching acute care facility	(n=10)
Different institution	(n=2)
University school of nursing	(n=1)
Stay until retirement	(n=13)
Corporate vice-president of nursing	(n=1)
Improve nursing care in rural and community hospitals	(n=2)
Category 2: Education/obtain a degree	(n=33)
Doctorate	(n=14)
MBA, MHA	(n=15)
MSNA	(n=1)
Law degree	(n=1)
BSN	(n=1)
Wharton Post Graduate course	(n=1)
Category 3: Consultant	(n=21)
Category 4: Hospital administrator or chief operating officer	(n=14)
Category 5: Miscellaneous	(n=39)
Teaching/academic full or part-time	(n=11)
Entrepreneur/own business	(n=3)
Write/publish	(n=5)
Research	(n=3)
Upgrade nursing profession	(n=5)
Governmental/international health policy	(n=3)
Management position in health related business	(n=1)
JCAHO surveyor	(n=1)
Undecided/no goals just starting	(n=4)

VITA

NAME:	Darnell H. Cockram, Ed.D., R. N.
ADDRESS:	Rt. 9, Box 86 Martinsville, VA 24112
EDUCATION:	
1992	VPI & State University Blacksburg, Virginia Ed.D., Education Administration
1977	Emory University Atlanta, Georgia M.N., Clinical Specialist/Adult Health Nursing
1971	University of Virginia Charlottesville, Virginia B.S., Nursing
1965	Martin Memorial Hospital School of Nursing Mount Airy, North Carolina R.N., Nursing
EXPERIENCE:	
1978 to present	Director of Nursing Education The Memorial Hospital School of Nursing Danville, Virginia
1978	Assistant Director of Nursing Education The Memorial Hospital School of Nursing Danville, Virginia
1977	Nursing Inservice Instructor Memorial Hospital of Martinsville and Henry County Martinsville, Virginia
1972-1976	Coordinator of Inservice Education Memorial Hospital of Martinsville and Henry County Martinsville, Virginia

1966-1972 Nursing Supervisor, Head Nurse, Assistant Head Nurse, and Staff Nurse
Memorial Hospital of Martinsville and Henry County and Martinsville General Hospital
Martinsville, Virginia

PUBLICATION:

Cockram, D. (1990). Leadership bridging the past with the future. Pilot Log. Pilot International World Headquarters: Macon, GA.

PROFESSIONAL ORGANIZATIONS:

1971-present Sigma Theta Tau, International Nursing Honor Society, Beta Kapper Chapter

1965-present American Nurses Association
Virginia Nurses Association, District VI
Board of Directors (1985, 1974)
President (1975)

1965-present National League for Nursing
Virginia League for Nursing
Nominating Committee Chair (1985)
Board of Directors (1982-1986)

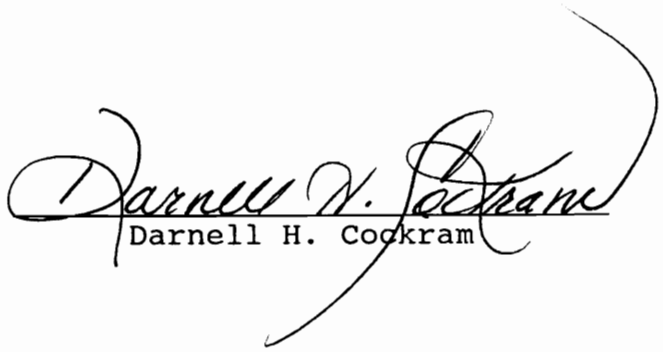
1982-present Assembly of Hospital Schools of Nursing in Virginia
Chair (1990-1992)

1988-present Northeast Coalition of Diploma Schools of Nursing
Nominating Committee, Chair (1990-1992)
Board of Directors (1990-1992)

CIVIC ORGANIZATIONS:

1990-present Danville Area Chamber of Commerce
Danville, Virginia
Board of Directors (1990-1993)
Mini-Grant Education Committee
Chair (1990-1992)

1980-present	Pilot International World Headquarters National Leadership Area, Chair (1990) Board of Directors (1989) Virginia District Pilot International Governor (1988) Governor Elect (1987) Luncheon Pilot Club of Danville, Inc. Board of Directors (1980-1986) President (1984)
1978-present	American Business Women's Association Virginia Piedmont Chapter Vice-President (1992)



Darnell H. Cockram