To the Graduate Council:

I am submitting herewith a dissertation written by Wendy Carlton Shea-Messler entitled "Why Am I Still Here, You Ask? A Phenomenological Study of the Lived Experience of Nurse Managers." I have examined the final paper copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Sandra P. Thomas, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Dean of the Graduate School

"WHY AM I STILL HERE, YOU ASK:" A PHENOMENOLOGICAL STUDY OF THE LIVED EXPERIENCE OF NURSE MANAGERS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
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Wendy Carlton Shea-Messler
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DEDICATION

This research is dedicated to all nurse administrators. May you never forget what it is like to take care of patients. May you never forget what it is like to be a nurse.

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ABSTRACT

Fewer people are entering the profession of nursing. There is already a shortage of nurses, yet, many abandon the bedside for lucrative ways to practice their art and for respected positions less inhibited by bureaucratic initiatives. A significant percentage of nurses will soon retire, further diminishing the number of experienced caregivers.

Good nurses require great leaders. A primary goal of organizations is to retain and recruit effective nurse managers. This study provides insight to the needs of nurse managers and aspects that keep them from leaving their jobs. The purpose of this study was to gain a differentiated understanding of the nurse manager role, one that is multifaceted and challenging. Some might consider management as prestigious, even powerful, yet nurse managers reveal the contrary. They speak of frustration and job barriers. They feel isolated in an unsupportive work environment and overwhelmed by pressures of administration and demands of staff and patients. During this study, they ask, "Why am I still here?" and provide the answer.

A phenomenological approach was used to interview eight nurse managers. From their language emerged a five-category thematic structure against a bureaucracy unconcerned with their challenges. The five categories included Organization, Administration, Nurse Manager, Nursing Staff, and Patients. The top category, Organization, had one major theme, Outdated Norms: A Good Old Boys' System. Administration also had one major theme, They: An Unsupportive Entity. The middle category, Nurse Manager, had four themes: (1) In the Middle: Bosses on Top and Bosses on the Bottom, (2) Being Separate: Feeling Alone, (3) *So* Unprepared: Forging My Own Trail, and (4) Why Am I Still Here, You Ask? The fourth category, Nursing Staff, consisted of three themes: (1) The Part I Like the Least: Counseling, (2) Bent Over Backwards: Staffing & Scheduling, and (3) Clock In, Clock Out: A Lack of Professionalism. At the bottom of the structure, Patients had one major theme, I Never Forget What It's Like to be a Nurse. In the midst of describing endless challenges, nurse managers unveiled their dedication to nursing and an undying commitment to their profession.

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CHAPTER I

INTRODUCTION

On the face of today's health care organizations lies an expression of fear and financial uncertainty. Underlying this expression is the reality of escalating health care costs and insufficient reimbursement for services rendered. Deeper within these organizations, striving for their survival, are health care leadership teams continually monitoring processes and implementing stringent cost-containment strategies. A dominant factor contributing to health care expenditures is the cost of labor. Restructuring and downsizing as a means to reduce expenditures has led to the elimination of personnel in clinical areas, such as nursing, therapy disciplines (speech, recreation, occupational, physical), and ancillary departments, as well as in non-clinical areas, including upper and middle-management, human resources, research, marketing, education, and administrative support. Elimination of these various personnel has left the nurse manager with a larger span of control, an increasing number of responsibilities, more accountability than ever before, and the bearer of one of the most, if not *the* most, complex role within the health care organization.

The American Nurses Association (1995) has identified key functions of nurse managers. A few of them are as follows:

> Nurse managers allocate available resources to promote efficient, effective, and compassionate nursing care, provide input into executive-level decisions, and keep staff informed of executive-level activities…They facilitate an atmosphere of interactive management and the development of collegial relationships among nursing personnel and others. They serve as a link between nursing personnel and other health care disciplines throughout the organizations. Nurse managers have major responsibility for the implementation of the vision, mission, plans, and standards of the organization and nursing services…Nurse managers are accountable for the environment in which clinical nursing is practiced…They contribute to the strategic planning process, day-to-day operations, and attainment of goals of the organization (p. 8-9).

Nurse managers must delegate, master the art of negotiation, maneuver among organizations' political forces, and, while in the midst of it all, exhibit financial savvy and effectively manage one or more patient care units. They must strive to satisfy their staff members while ensuring patient satisfaction and delivery of quality patient care.

Traditionally, nurses acquired management positions only after earning the respect of superiors and other nurses by exhibiting the qualities of an excellent clinician. Peterson (1994) refers to this historical period as the head nurse era. The traditional nurse manager usually was in charge of a single unit and was expected to deal only with the problems generated within that unit. She/he would not have participated in any sort of organizational planning, nor have had any input to or influence over any organizational change. Medicine and administration had the primary say in such topics. Such "bureaucratic mentality" (Peterson, 1994, p. 209) remained dominant in health care organizations until the 1980's. Prior to this time, nurse managers acquired leadership

skills, effective or ineffective though they might be, predominantly by observing the actions of their immediate supervisors (Peterson, 1994).

Also prior to the 1980`s, micromanagement was encouraged and supported. The nurse manager controlled every function and process within the unit and was the principal problem-solver and decision-maker. The manager would participate in patient care. However, even when working along side the nursing staff, the manager, right or wrong in her/his ways, had the ultimate power and control over nursing practice.

The 1980`s brought about significant changes to the nurse manager role and how nurse managers were perceived by nursing staff and organizational leadership. With the introduction of managed care`s diagnostic related groups (DRGs) came the focus on allocation of resources and cost-containment as these resources became more and more precious. Reimbursement from third-party payers declined as diagnostic and treatment criteria became more stringent. With the business and financial responsibilities of the nurse manager increasing there was less time allowed for the manager to be on the floor performing and closely monitoring patient care. Thoughtful allocation of patient care products and services became the responsibility of the nursing staff. Staff nurses took on the identities of principal decision-makers and problem-solvers for issues related to patient care.

Throughout the last fifteen years nursing management styles have evolved to those of a more participative philosophy. The move toward multidisciplinary teams and patient focused care has increased the need for strong leadership within the nursing staff. Staff registered nurses (RNs) have taken on the functions of traditional nurse managers and are now the delegators and negotiators of patient care. Today, in more progressive organizations, they are the ones responsible and held accountable for methods to ensure budget control. Nurse managers, who are now in charge of two or more units, spend much of their time performing administrative functions such as scanning the external environment to assess for revenue-producing opportunities and planning strategically for their departments. Change is the only constant in the nurse manager`s world. Every day is different from the day before and though some problems seem to always exist, the methods to solve them are seldom the same.

Any general search of the literature related to the role of the nurse manager reveals an abundance of anecdotal writings that describe the history of nurse managers, how their roles have evolved, and how they occupy one of the most complex positions in the healthcare industry. In contrast, a search for scientifically grounded fact is less productive. Studies are usually conducted from a positivist stance and address personal attributes of the nurse manager (Drayton-Hargrove, 1993; Hansen, Woods, Boyle, Bott, & Taunton, 1995), the multi-faceted roles of the nurse manager (Haas & Hackbarth, 1997; Purnell, 1999), job satisfaction (Bunsey, DeFazio, Brown, & Jones, 1991), nurse manager leadership behaviors (Drayton-Hargrove, 1993; Englebardt, 1976; Hern-Underwood, 1991; Manfredi, 1996), or the effects that those behaviors can have on staff nurses` job satisfaction, job tension, empowerment, work effectiveness, or organizational commitment (Laschinger & Shamian, 1994; Laschinger, Wong, McMahon, & Kaufmann, 1999). Other studies have explored managers` language (Jackson-Frankl, 1989), their concept of power (Daghestani, 1991; Reimer, Morrissey, Mulcahy, & Bernat, 1994) or the relationship between their intuitive ability and their use of intuition (Janney, 1993).

An overview of this research allows one to form an accurate conceptualization of the ideal nurse manager with regard to his or her intellectual makeup, educational background, approach to management, interventions used to promote staff satisfaction and retention, and actions taken to fulfill ever increasing daily responsibilities. Statistical analyses of the various constructs examined, no matter how reliable or valid the instruments used, fail to reveal what nurse managers feel when such phenomena are taking place. There is little knowledge of what nurse managers experience in their lives as administrators.

Naturalistic research on real-life experiences of nurse managers has revealed what is personally invested during the implementation of change (Brannon, 1994), managers' ideas about necessary skills and education (Brannon, 1994; Horvath et al., 1997; Lindholm & Uden 1999), and views regarding leadership (King 1999, 2000). Processes that ensure managerial success (Brannon, 1994) have been brought to the surface. Differences in how nurse managers implement their roles have been highlighted (Aroian, et al., 1996) and likenesses, such as shared practices, have been discovered (Brannon, 1994). This body of research has revealed what is especially meaningful to nurse managers in their practice (Brannon, 1994; Westmoreland, 1993) as well as what is particularly challenging (Swanson, 2001). Challenges unique to nurse managers in other countries due to political upheaval (Gmeiner & Poggenpoel, 1996) and oppressive work environments (Lindholm, Uden, & Rastam, 1999) have been identified. Despite what is known, there are gaps in the research and a need to further define the lived experience of nurse managers.

Gaps in the Research

While reviewing extant research relative to the experience of nurse managers, several gaps were identified. In her groundbreaking research, Brannon (1994) asked participants to write about a time in their lives that illustrated what it meant to be a nurse manager. In their narratives, nurse managers described conversations, daily encounters, and what is involved in resolving various issues. This researcher touched upon a pristine area of inquiry. This researcher believed in the exploration of what the nurse managers had to say about their lived experience.

Brannon (1994) used theories from other disciplines to guide the discussion of her findings. Other researchers have used frameworks from the disciplines of management and industrial and organizational psychology to guide data analyses (Aroian et al., 1996; Coulson & Cragg, 1995; Westmoreland, 1993). According to Horvath et al., (1994) frameworks from these disciplines are simply "not sufficient to capture the skilled practices and pragmatic concerns of nurse managers" (p. 39). What about examining the data in and of itself, untouched by outside influences?

As will be evident in the next chapter (Chapter II), some of the research was performed in other countries and/or within social contexts very different from those in America. Some of the studies leave the reader questioning what analytic methods were actually used. These same studies, as well as others, leave the reader wondering about the validity and reliability of the findings.

Researchers of nurse managers have used written narratives, questionnaires and semi-structured interviews as ways to collect data leaving doubt that the essence of the lived experience has been captured. Why not use an unstructured interview method? Why not remove conversational constraints? Allow the participants to say what they want to say about what it is like to exist in the world of the nurse manager and not be led by the researcher.

The Researcher`s Perspective

The rationale for exploring the lived experience of the nurse manager is simply this: We are at a critical time in health care where the focus is no longer solely on the outcomes of our patients but also on the corporate bottom line. The nursing profession is experiencing a decline not only in its direct care workforce, but also in its leaders, in its professors, and in its successors. I have witnessed situations where nurse managers get frustrated and, in the midst of a crisis or dilemma, proceed to a patient care area for the purpose of actively providing care to patients as if to revitalize their altruistic reasons for entering into the nursing profession. One of my greatest fears is that if nurses do not fully understand what is involved in the experience of implementing effective nursing leadership, our discipline will not achieve a successful passage through the next century. Frustrated front-line leaders will disperse and be absorbed by other disciplines, and nursing leadership will consist of business-oriented professionals who have never experienced the satisfaction that comes from effectively intervening at the bedside. This scenario is already occurring in too many organizations. Are these non-nursing, business oriented professionals really the sort of leaders we want to be making decisions that impact nursing care?

Purpose

The purpose of this study was to gain a more differentiated understanding of the lived experience of nurse managers. This qualitative study involved the existential phenomenological approach of Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002) to guide the researcher`s inquiry of nurse managers. What the nurse managers said about their lived experience was preserved within the context which it was spoken.

Nurse Managers Operationally Defined

Nurse managers were defined in this study as managers who were RNs and were responsible for managing one or more patient care units. Their positions within their organizations were those of middle management. The titles of these nurses varied according to the model of patient care used in their organizations. Titles included, but were not limited to, nurse manager, unit manager, or health team leader.

Nurse managers in this study were employed by metropolitan general hospitals, each one a part of an integrated health care system. These hospitals contained an array of inpatient and outpatient care settings and specialty care areas and included adult, child,

and neonatal intensive care units, various medical and surgical units, and psychiatric units. Nurse managers managed not only their staff but also had as part of their responsibilities one or more of the key functions listed earlier as described by the American Nurses Association (1995).

Delimitations and Limitations

Participants for this study were delimited to English speaking RNs. The RNs were employed full-time as nurse managers in the Southeastern United States. Participants were required to practice in a hospital setting.

A potential limitation existed related to the perceptions of the participants. If the participants perceived that their anonymity would not be maintained or that somehow their good-standing with members of their administration would have been compromised by anything discussed during the interview, they would have chosen not to reveal significant incidents or would have felt repressed in the telling of their stories. To alleviate such perceptions, the participants were notified of all actions taken to protect them and to ensure confidentiality. This limitation seemed to have been minimized in most of the interviews as evidenced by comments such as, "I wouldn't just say this to anyone, but…" and the nurse manager would go on to reveal his/her thoughts and feelings about a given topic.

Significance

This study focused on the lived experience of nurse managers. No other studies had been found utilizing existential phenomenology to interview and explore the lived experience of nurse managers. Previous researchers of nurse managers used frameworks from business administration and industrial and organizational psychology to guide their analyses of narratives and/or interview data. This study involved constant comparative analysis of one-on-one interviews to establish a thematic structure of the nurse manager's live experience based solely on the data within those interviews.

This exploration into the lived experience of the nurse manager produces implications for research, practice, education, and professional development of nurse administrators. It has been said that further research of health care management is needed to inform decision-making and thus improve nurse managers' practice (Hill, Beattie, and McDougall, 1999). Understanding the lived experience could stimulate research on how to enhance nurse managers' working environments and facilitate their effectiveness as leaders. Increased knowledge of the lived experience could make nursing administration educators more adept as they help their students prepare for the challenges of their roles. Lastly, understanding the lived experience could assist other nurse managers in acknowledging aspects of their own practice and recognizing that they are not alone in how they perceive their positions within or contributions to their organization. All these implications are possible.

The existential phenomenological method used in this study was derived from the work of the French philosopher Merleau-Ponty (1945/1962). While establishing precedence for phenomenology, Merleau-Ponty (1962) wrote, "the whole universe of

science is built upon the world as directly experienced, and if we want to subject science itself to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by reawakening the basic experience of the world of which science is the second-order expression" (p. viii). This study has attempted to fulfill this mandate by reexamining nurse managers through their own perceptions, through their own narratives of the lived experience.

CHAPTER II

REVIEW OF THE LITERATURE

There is an abundance of non-empirical and anecdotal literature related to the nurse manager role. In fact, there are entire journals dedicated to the publication of such documents which address what nurse managers do, how they should do it, and what skills, education, and organizational characteristics are required to do it adequately. A small body of research addresses personal attributes, role characteristics, and leadership qualities of nurse managers. What is of utmost importance to this study is an even smaller body of knowledge that speaks to the lived experience of nurse managers. Research on nurse managers can be categorized into six areas: (a) managers' impact on nursing staff, (b) managers' preparation and development, (c) managers' successful performance, (d) managers' perceptions of power, (e) coping with challenges, and (f) what it means to be a nurse manager. The purpose of this literature review is to discuss the above areas of research, to discuss the need for further investigation of the nurse manager's lived experience, and, in conclusion, to explain how this study contributes to nursing science.

Managers' Impact on Nursing Staff

Research has long revealed that behaviors of nurse managers affect staff nurses. For example, nurse managers who exhibit a participative management style are more likely to have staff nurses who are satisfied with their jobs (Lucas, 1991; Moss & Rowles, 1997) and who intend to stay in their positions (Boyle, Bott, Hansen, Woods, & Taunton, 1999; Volk & Lucas, 1991). In other words, nurse managers who perceive the input of their staff nurses as important, share information, and have confidence in their nurses have nurses working for them who are more satisfied with their jobs. Job satisfaction has been a major determinate of staff nurse turnover. Taunton, Krampitz, and Woods (1989) confirmed that nurses who worked for nurse managers who involved them in making important decisions were more likely to be satisfied with their jobs and to remain in their positions. On the other hand, nurses who reported to nurse managers who exhibited coercive power or award power were less satisfied with their jobs and less committed to remaining in their positions.

Researchers Brewer and Lok (1995) found that middle managers (nurse managers) had a greater influence on nurses' commitment to their organizations than did executive level managers. Their sample of Australian nurses (n=475) reported that the more participative the work environment and the management strategies implemented by nurse managers, the greater nurses' trust, identity with their organization, and influence they had regarding what goes on in their organization. Sixty-one percent of the nurses perceived their managers as supporters of participative decision making. Overall, these nurses were happy with their workplace, intended to remain in their current positions, and trusted middle management but not executive management.

Laschinger, Wong, McMahon, and Kaufmann (1999) studied the impact of nurse managers' leadership behaviors on staff nurse empowerment, job tension, and work effectiveness. A survey method was used involving staff nurses (n=537) who had recently

experienced a merger of two large tertiary hospitals. Findings determined that the nurse managers who had confidence in the employee and fostered autonomy among employees were the most empowering. Empowering behaviors of nurse managers led to work empowerment of nurses directly and indirectly through both formal and informal power. Nurses who experienced work empowerment reported a lesser degree of job tension and a higher degree of work effectiveness. Inversely, nurses who tended to report job tension reported lower work effectiveness.

Englebrandt (1993) investigated relationships between nurse manager (n=85) behaviors and characteristics, and nursing staff's (n=447) perceptions of the workplace climate. Multiple regression analysis determined that relationship behaviors of managers have a greater impact of nurses' perceptions of their workplace climate than do structural behaviors, or behaviors that led to goal attainment such as planning, monitoring, and problem-solving. Managers who frequently used teambuilding and problem-solving had staff nurses who felt more positively about their work climate in general, felt better about their relationships with the people whom they worked, and reported lower work stress. Work units were reported to be less stressful when the nurse manager explicitly recognized behaviors of the nurses. Mentoring on the part of the nurse manager was identified as a significant determinant of positive work relations among nurse managers and nurses. Also, managers with more experience had nurses who thought more positively about the overall work climate and work relations. Englebrandt surmised that because these managers had a better understanding of their organizations, they were able serve as buffers, protecting their staff from negative organizational influences. Perhaps they were also better at selecting staff members who would prove a good fit for the unit and organization.

Unlike the findings of research studies conducted in the past, this study found that nurse manager job satisfaction did not affect nurses' perceptions of the managers' behaviors or work unit climate. The nurse managers reported being very satisfied with their jobs and thus, the researcher questioned whether the lack of variability in job satisfaction restricted the findings. Another unexpected finding was that the nurse manager's education was revealed to have no effect at all on the workplace climate. In this sample, there was little variance in the manager's educational backgrounds with 70% being prepared at or below the baccalaureate level and having had no formal management education.

Cara (1997) studied nurse managers' impact on the caring practices of staff nurses. In her phenomenological study, she asked staff nurses (n= 16) to tell their stories about how the nurse manager influenced their ability to "engage in their practice of caring" (p. 110). The importance of trusting the nurse manager was revealed as paramount to supporting a practice of caring. Managers promoted a practice of caring if they exhibited advocacy, compassion, empowerment, competence, a focus on patient care versus bureaucracy, motivation, listening, respect, recognition and more. Some of the negative influences on caring were revealed as bureaucracy and lack of resources, a conflict of opinion with the manager, a dissonance of values between the manager and the staff nurse, distrust of management, a fear of negative criticism, feeling unsupported, a lack of caring from the manager and/or the system, and lack of respect and understanding, and oppression and threat.

Managers' Preparation and Development

Several studies exist related to educational preparation of nurse managers. In Sweden, Lindholm and Uden (1999) chose hermeneutic phenomenology to study how nurse managers (n=13) experienced management direction and the management role after participating in a master's level professional development course. Interviews took place before and one year after completion of the course. The taped interviews were transcribed and comparative analysis was performed. The researchers discovered that after course completion, the nurse managers experienced a change of attitude toward their management role. They had increased awareness of their own management possibilities. This was due to enhanced knowledge of the research process and of research findings relative to their role as administrators. In interviews conducted prior to the course, the nurses perceived themselves as extremely limited in management skills and in their abilities to influence others in the organization. In interviews following completion of the course, these managers referred to themselves as chiefs with financial responsibilities, authority, and domain.

In designing a leadership development program, Sullivan, Bretschneider, and McCausland (2003) utilized focus groups. Following grounded theory methodology, the researchers asked chief nurse officers, chief nurse executives, nurse administrators, and nurse managers (n=94) about the satisfying and challenging aspects of the nurse manager position and the developmental/educational needs of experienced and new nurse managers. Included among the most satisfying aspects of the nurse manager role were autonomy and flexibility, situational power and control, ability to influence and change practice and to effect positive clinical outcomes, peer support/teamwork, mentoring others, opportunity to develop self, direct involvement in patient and family interventions, ability to personally and professionally support staff, receiving administrative support, and respect/pride in institutional reputation. Among the most challenging aspects of leadership was staffing. Managers described having to beg staff to work. They also were forced to take on housekeeping duties to support their staff due to financial constraints. Focus group participants also commented on the different type of nurse entering the workforce today, a nurse whose expectations and demands were quite challenging. The generational differences between the new nurses and the tenured nurses were noted as a philosophical disconnect. Nurse managers described being "caught in the middle" between their staff and administrators and having difficulty establishing where their loyalties lie as well as where they stand on organizational issues.

Developmental/educational needs of experienced nurse managers involved primarily process related issues such as conflict resolution or recruitment and retention. Other needs were information on regulatory and human resource issues, computer skills, negotiation and delegations, budgetary expertise, advanced knowledge of policy making and strategic planning, and maintenance of clinical skills. New managers sought to acquire basic managerial skills such as communication and prioritization, clarification of role expectations, time management, life-work balance management, and introduction to key organizational personnel. All leaders agreed that managers should be offered a thorough orientation program that included a mentoring process.

Horvath, Aroian, et al. (1977) used an interpretive phenomenological approach to identify the learning needs of 29 nurse managers. Categories of learning that emerged included "performance counseling", "intervention vs. coaching", "learning from experience", "the hiring interview", "building a cohesive team/culture", "conflict resolution/negotiation", "managing the change process", and "continued development of expert clinical nurses" (p. 28). Nurse managers with less than two years experience spoke of the benefit they received from formal learning experiences such as didactic instruction and skill-building exercises in communication. These managers requested more instruction on issues that confronted the nurse manager such as dealing with complaints, counseling, and giving feedback. These managers also pointed out specific content of their graduate education that benefited them in their roles such as public speaking, conflict and negotiation, project management, team development, and organizational behavior.

The more experienced nurse managers, on the other hand, did not focus on educational preparation as a key element to their learning. Instead, they voiced having learned from trial and error and intuition based upon experience. For all the managers, learning from experience was a strong theme. Although guidance from a colleague or superior was helpful, the managers voiced that it was rare that they were able to have such opportunities to talk and that critical incidents occurred at any moment without preparation. Therefore, learning from trial and error became necessary as they met the demands of their roles. After the managers dealt with difficult situations, they spoke of feeling isolated and didn't always think about calling someone to discuss an occurrence or to seek validation for what they had done in a given situation.

After a four-day leadership training course using Situational Leadership Theory (Hersey & Blanchard, 1988), Wolf (1996) found that out of 144 RN nurse managers 42% increased their accuracy for diagnosing management vignettes and implementing appropriate leadership styles. It was also found that the nurse manager's ability to change his/her adaptability of leadership styles to meet the needs of the employee was a function of the nurse manager's ability to diagnose management related issues prior to his/her participation in the training program.

Johnson and D'Argenio (1991) conducted a 68-hour training course using Situation Leadership Theory and measured the effects of the course as perceived by both nurse managers and staff. At six months post-training, staff adversely viewed leadership styles as more restrictive. Leadership effectiveness scores revealed that nurse managers viewed themselves better able to select the appropriate leadership styles for given situations than did their respective staffs. The researchers note that the greater the disconnect between the style used and the style that is appropriate, the more likely the employee is to respond in anger. Hence, it is important for nurse managers to be adaptable and utilize a leadership approach that meets the needs of the employee.

In another study, an assertion training course was designed to teach military nurse managers (n=4) to empathically refuse unreasonable requests (McClelland, 1992). It was found that the participants effectively transferred their learning into the work setting as demonstrated in simulated situations in their work environment. Interestingly, these nurse managers continued to report having the most difficulty with being assertive when dealing with their immediate superiors. This was due to the risk involved in refusing

requests made by military superiors. The intentions of this training course, although noble, were not perceived by the nurse managers to be wholeheartedly supported by the institution within which they worked.

In considering the effectiveness of any training program, both short-term and long-term effects should be measured. Also, Wolf (1996) points out that "Ultimately the social system in which nurses practice and nurses' own receptiveness to the changes influence the application of new knowledge." Therefore, if the nurse managers' environment is not supportive of learned changes in behaviors or management strategies, then no training program will prove to be effective. Providing the right environment for the initial learning is also of utmost importance. Daly (1996) identifies the importance of assessing the learning styles of nurse managers days before implementing training programs to ensure that appropriate learning environments are made available for optimal learning. He observes that nurse managers who have more experience and education will learn in a more abstract way. This information has significant implications for health care organizations willing to invest in furthering the education of their nursing leaders.

Managers' Successful Performance

Although adequate experience and appropriate education can contribute to the success of a nurse manager, what is of utmost importance to healthcare executives is the nurse manager's ability to adequately perform the duties required of middle management. Del Bueno, Chaney, Snyder-Halpern, Hiodal, and Kotal (1990) described how four hospitals used the Performance-Based Development System to determine the ability of nurse managers (n=116) to meet performance standards. Each assessment takes seven to eight hours and is performed over a two-day period.

Going through this assessment process proved effective at determining learning needs and developing plans for performance improvement of managers. Managers included in this study were nurse managers of patient care areas as well as managers in other departments. Use of this tool has proven effective in selecting potential nurse managers. Among the skills measured was risk management assessed using video simulations. Priority setting was assessed using an exercise that requires the manager to identify what must be done, what should be done, and what could be done. During this exercise, unanticipated events occur that require the participant to reset priorities. Participants were also asked to take part in selecting from among applicants the appropriate candidate for a given position and to reveal their knowledge of organizational policies. Interpersonal relations skills were assessed using video and audio simulations. Finally, the participants underwent a performance appraisal interview to assess how they reacted to responses from nurses being evaluated. Reliability and validity for each criterion has been established through past studies.

Research supports that nurse managers are more successful as transformational leaders versus transactional leaders (McGuire & Kennerly, 2006). Transformational leaders are those that inspire and motivate the work of their followers. They have a positive outlook on the future and challenge their followers to reach their highest potential through intellectual stimulation. (Bass, 1998). Transactional leaders take an autocratic approach to management where rewards are based upon performance. Workers

simply have to meet a standard of performance before being compensated. While tapping into the expertise of nurses, seeking their input, and motivating them to use their knowledge to improve their working environment, transformational nurse managers are more likely to have nurses who are committed to their organizations (McGuire & Kennerly, 2006).

As well as committed nurses, hospital administrators want committed nurse managers, those who support the organization's belief system and are committed to a defined mission and vision. In a Heideggerian hermeneutic phenomenological study, Horvath, Secatore, et al., (1994) asked: How do nurse managers (n=29) translate organizational values into their practice? Data were obtained through written narratives, small group interviews, and field observations. The study design was identified; however, the interview questions asked of the participants were unknown to the reader. The hermeneutic analysis was guided by Beth Israel Hospital's professional nursing practice model, which was value driven and, most likely, supported by the researchers. The data revealed that the nurse managers were "visible and influential culture-bearers" (p. 41) and reflected the organization's values clearly in their practice.

Carrolton (1989) conducted a descriptive study of 116 front-line, middle and executive nurse leaders to determine factors that influenced career success. Personal characteristics found to be most important to facilitating career success were being knowledgeable, competent, responsible, hardworking, and committed, as defined by the Career Success Survey. Educational preparation was ranked second in determining career success. Middle managers viewed their educational preparation as a position requirement, a source of credibility, and as a means to obtain financial rewards, but not as a tool to open new job opportunities, provide prestige, or allow them access to increasingly challenging positions. They viewed their education as an entry requirement instead of a tool for advancement. Being mentored was third while an unplanned situational opportunity ranked fourth as determinants of success.

Another study focused on nurse manager competencies (Chase, 1994). The nurse managers who participated in this study (n=211) were educated primarily at the baccalaureate level or higher with 48% possessing bachelor degrees, 37.5% possessing masters, and a single nurse manager having earned a doctorate. Competencies deemed most important by nurse managers (n=211) were the ability to carry out effective communication, decision making, problem solving, counseling, effective staffing strategies, conflict resolution, performance evaluation, team-building strategies, and delegation. Patz, Biordi, and Holm (1991) found that skills related to human management were most important in determining nurse manager effectiveness. This significant number of complex competencies confirms the challenge presented to any nurse educator who may attempt to create an adequate curriculum to fully prepare the nurse manager for his/her role. Master's prepared managers were shown to possess significantly higher critical thinking abilities than those that were either bachelor's or diploma/associate prepared (Henry, 1992). Therefore, when preparing a nurse manager to be a successful contributor to a healthcare organization, there is clearly a need for that nurse manager to be educated at the graduate level.

Managers' Perceptions of Power

There is a small amount of research on power of nurse managers. Managers (n=27) who report high self-efficacy also perceive themselves as empowered in their jobs (Laschinger & Shamian, 1994). They also see themselves as having more access to power and opportunity than do staff nurses (n=112).

Reimer, Morrissey, Mulcahy, and Bernat (1994) measured power orientation of 120 female nurse and non-nurse managers. No significant difference was found between female nurse and non-nurse managers in any of the power dimensions as measured by the Power Orientation Scale (as cited in Reimer, Morrissey, Mulcahy, & Bernat, 1994). Managers of all levels of education perceived power as positive, exciting, desirable, and motivating. However, doctorally prepared managers perceived power more so as an instinctive drive or as intrinsic to humans.

Sixteen nurse leaders, including nurse managers, shared their perceptions of success and power (Upenieks, 2003). They reported that informal and formal power increased role expectations, advancement within the organization, and keeping nurses informed so that they can effectively perform their jobs enhanced the success of nurse leaders. Interviews were loosely structured and the researcher used content analysis to identity phenomena within the content. The researcher provided a thorough description of the method used to analyze the qualitative data. Participants were predominately promoted from within their organizations and the majority had either Master's or baccalaureate degrees. These leaders reported possessing both informal and formal power in their positions. Their informal power stemmed from their relationships, tenure, which averaged 16 years, and their credibility as professionals. Formal power resulted from the position they held in the organization as well as from their inner strengths and confidence. Fifteen of the nurse leaders were female and reported that their gender had no effect on their power, an interesting finding that contradicts the theory that gender socialization has negative effects on women promoted to executive positions.

Nurse leaders in this study were not solely nurse managers. They were highly educated and from organizational cultures that facilitated their leadership successes and access to power. Not all nurse managers are afforded the opportunity to work in a culture where they are allowed to fully utilized and advance their leadership abilities, positively influence others, and provide an effective work environment for their staff.

Power orientation and power motivation were compared among female nurse (n=27) and non-nurse (n=51) managers in Jordan (Daghestani, 1991). The nurse manager group included 16 executive level managers and 60 middle managers. The non-nurse group included managers from different fields, 16 of which were executive level managers and 35 were middle managers. The number of non-nurse managers from executive management was limited due to the small number of women in Jordan who hold such positions. The managers' average age was 40 years, and the highest percentage (55%) had diploma degrees. Such a degree is awarded following the completion of a three-year nursing program or a two year program in another field. Thirty-three percent (n=41) of the participants had bachelor's degrees while six and a half percent (n=8) had masters. Those with doctorates made up three and two-tenths percent (n=4) of the sample. Most of the nurse middle managers, 74%, had diploma degrees (n=43) while 22.5% had

bachelor degrees. The average management experience of the nurse managers was eight years while the average experience for non-nurse managers was 13.

Most of the non-nurses perceived their professions to be powerful whereas most of the nurse managers perceived nursing as not powerful. They explained their conclusions by attributing lack of power to the nature of the nursing, a lack of autonomy, interference of others in their decision making (mostly physicians), limited resources, rules and regulations, cultural biases against nurses and women managers, lack of abilities, and lack of support from superiors and the community.

Middle managers, nurses and non-nurses alike, rated themselves as having an average amount of power compared to other managers. They also thought they could increase their power by increasing their competency levels, having increased support from superiors including more resources and clarification of regulations, increasing the number of competent, cooperative subordinates, and having increased autonomy. Of factors that reduced power, middle managers identified lack of support, incompetence in the way of managerial skills, and situational barriers.

Relative to managers' perceptions of power are their perceptions of leadership and management. King (2000) explored Ontario nurse managers' paradigms of both leadership and management. The central theme emerging from thematic analyses (Giorgi's method) of subsequent interviews (n=5) was that leadership was more than management. "Thinking leaders used every opportunity to work through people to enhance their growth, potential, and accomplishment" (p. 15-16). The participants perceived themselves as "thinking leaders" as they created and sustained inclusive practice environments, influenced people, and acted "in a manner that reflected and supported integrity" (p. 16). In contrast, managers were thought of as persons who "carried out routine, procedure-driven tasks to run departmental business" (p. 16) and did not consider people as a primary resource for accomplishing daily goals. The researcher did well in the description of her findings and in relating her findings back to literature.

Using this same data, an earlier study by King (1999) had revealed the activities of "scanning and reflecting" as themes within nurse managers' experience of leadership. Participants perceived scanning as sensing cues about themselves, others, and situations. Scanning was a prerequisite for reflecting. When reflecting, the managers contemplated the information obtained from the process of scanning.

A Swedish study focused on the nurse manager role as viewed from four different perspectives: the nurse manager (n=15), the hospital director (n=3), the chief physician (n=11), and the politician (n=3) (Lindholm, Uden, & Rastam, 1999). In Sweden, management positions were traditionally held by physicians. All groups, except for the physician group, favored having nurses in management positions. The hospital directors stated "the present barriers against nurse managers were more or less connected with physicians, their position in the organization and the prevailing sluggishness in the system" (p. 107). Politicians viewed the nurse managers as unable to demonstrate their true leadership because they worked in organizations directed by physicians where "'chief physicians had been kings' " (p. 107). However, all four groups recognized that given the opportunity, nurse managers possessed a motivational force and could promote progress of their units. The phenomenon of power emerged continuously during analysis

of the interviews. Three themes were identified: "power within activities", "being in power", and "freedom to act" (p. 103).

In view of the inhibitors of power for nurse managers, it must be frustrating to attempt to carry out the many responsibilities required of them. With the lack of resources, lack of support, and the unwelcome interferences of others, these managers must experience many challenges and job stress. Job stress has been found to be yet another important aspect of the nurse manager role that is encompassed in the research literature.

Coping with Challenges

The amount of research on stress relative to the nurse manager role is surprisingly small. Skorga (1988) explored the impact of stress on the middle manager (n=113). She found that state anxiety and trait anxiety were positively correlated, especially in situations where there was a perceived threat to the nurse manager's self esteem. State anxiety also positively correlated with role conflict as well as role ambiguity. "Strain in the role of the nurse middle manager increased as the stressors of role conflict and role ambiguity increased" (p. 89-90). Trait anxiety was also positively related to role conflict.

Participation in decision making was found to decrease role ambiguity and role conflict. Hence, simply allowing nurse managers to participate in decisions that impacted their work was found to be an important strategy for nurse executives to implement in order to decrease stress among nurse managers. Nurse managers who participated in less adaptive coping mechanisms, such as behavioral disengagement, reported higher state anxiety. Nurse managers who participated in the adaptive coping strategy of planning showed a decrease in state anxiety, although this relationship was not significant. Adversely, coping by emotional social support led to a significantly increased state anxiety.

In dealing with stress among nurse managers, Joecken (1990) found that progressive relaxation training and a work support group effectively decreased state anxiety in nurse managers (n=78) in Southern California. State anxiety actually increased for nurse managers who received no treatment at all. This study underlined the importance of nurse managers selecting some form of intervention that is effective for relieving job stress. Dealing with stress effectively allows the nurse manager to be productive and to meet the many demands put upon them.

In a grounded theory study, Swanson (2001) asked nursing leaders to describe challenges of their leadership role, responses to those challenges, and self-healing practices in which they engaged. The core variable emerging from the description of leadership challenges was trust. Trust was hindered in unsafe working conditions and cultures that lacked a sense of connection. Aspects that enhanced trust were "intent", "knowing when to let go", and "connections". Self-healing practices that were found to enhance trust were "connections", "consciousness", and "sense of balance".

The following studies were conducted externally to the United States and shed light on nurse managers in other countries. An exploratory, descriptive and contextual study by Gmeiner and Poggenpoel (1996) found that nurse managers in the Transvaal region of South Africa suffered much stress and fatigue. In 1994, a change in the

government had led to the integration of health care services (Gmeiner & Poggenpoel, 1996). Under the new Government for National Unity, the democratization movement led to "labor unrest", or strikes, and strong sociopolitical forces from which emerged much violence. Personal threats by members of activist groups were a part of everyday life as was mistrust among the racial groups.

Gmeiner and Poggenpoel asked both English speaking and African speaking nurse administrators to complete open-ended questionnaires (n=60) that contained questions such as "What problems do you experience in your everyday life outside [and inside] your work situation?", "What is the effect of these problems on your everyday life?", and "How do you manage the problems you experience?" (p. 56). The researchers referenced the contextual analysis method used and made explicit the careful steps they took to identify categories and ensure validity and reliability of their findings. Four major categories emerged from the data. The categories were "fear and insecurity related to the escalating violence", "resistance to change", "intimidation and threats to force into political activism/compliance", and "conflict in relationships with others" (p. 57).

This study actually led the researchers to perform a multiple-case study (Poggenpoel & Gmeiner, 1996) involving the implementation of a support program for these nurse managers. More qualitative data was collected by means of audiotape recordings, written documents, observation, and field notes. Initially, participation in the program caused more stress for these nurse managers, as they were unsure about the researchers' motives or the reasoning behind why they were required to attend. On a pleasant note, upon completion of the program, both African and Caucasian managers expressed appreciation for having participated. Findings revealed that in and outside the workplace, these nurse managers experienced "difficulty in relationship with diverse others", "lack of insufficient group acceptance/support", "value conflict", and "difficulty with self-acceptance" (p. 15). The researchers made explicit the steps they took to ensure validity and reliability of this second study as well.

Needless to say, there is much stress in the nurse manager's life. Yet little is known about the meaning of stress to nurse managers, how nurse managers experience stress, or other stress related phenomena arising during role implementation. Little research has been done on what it means to be a nurse manager and little is known about the nurse manager's lived experience.

What it Means to Be a Nurse Manager

Although small in number, the array of studies pertinent to the real-life experience of the nurse manager was diverse. One study was considered groundbreaking as it was the first one that explored the meaning of nursing management. In her dissertation Brannon (1994) asked nurse managers to respond to the following:

> Tell me about a time, one you'll never forget because it reminds you of what it means to be a manager. Include as much detail as possible and stay in the telling of your story, rather than stepping back and analyzing it or describing it from afar. After you have given the details of your story please describe why this story is important to you and what it means to you. Your story can be a current one or one

from years past. It can be a story of breakdown when nothing went right or one of making a difference (p. 9).

The purpose of Brannon's study was "to describe the shared practices and common meaning embedded in the practice of nurse managers and to discover thematic relationships in these common meanings" (p. 2). In her Heideggerian hermeneutic phenomenological interpretation of 16 written narratives, Brannon observed that "researchers [of management] have focused on tasks and functions commonly found in organizational job descriptions. But the everyday experiences of nurse managers are much more focused on relationships" (p. 75). Brannon's analysis discovered five relational themes. Text taken directly from the narratives provided support for each theme. Of the five relational themes, the most interesting was that of "Process Categories of the Nurse Managers' Role" (p. 80) which included the subthemes of Social Control, Resourcing, Communication, and Facilitating Change. This description of managerial processes gave a broader perspective on what managers do in contrast to isolated discussions of managerial tasks found so many times in the anecdotal literature. The subtheme Social Control was supported by text in the narratives, but the term "social control" seemed to come directly from the sociology literature, specifically from Berger and Luckmann (as cited in Brannon, 1994). Although the other three subthemes seemed to confirm what was already known about managers, they provided substantive evidence and were well supported by the concrete examples provided.

In addition to the five relational themes, Brannon (1994) identified a constitutive pattern. A constitutive pattern is a theme that emerges from all the narratives and involves the critical aspects of the other themes thus linking them. The pattern that emerged in this study was titled "Managing Change" (p. 103). It provided insight on what nurse managers experience as they implement change within their staff. It addressed the significance of "foreknowledge" (p. 107) of change and how issues that are "emotionally charged" (p. 106) are especially difficult to change. This constitutive pattern offered a unique conceptualization of managing change while promoting a nurturing environment.

Another study used a phenomenological approach to interpret significant incidents reported by managers (Aroian, et al., 1996). Narrative and group interview data revealed differences among nurse managers' role implementation during circumstances such as resolving staffing issues or managing conflict. Data analysis was guided by Bradford and Cohen's (1984) Manager as Developer Model instead of staying true to a phenomenological method.

In an interpretive study, nurse managers (n=9) were asked for their perspective on what they found meaningful in their practice (Westmoreland, 1993). The researcher identified her guiding framework as based on assumptions of symbolic interactionism. It would have been beneficial to the reader to have those assumptions clearly stated. After dialectic processes and constant comparative analysis of transcribed semi-structured interviews and field notes, "connection and relationship" emerged as a pattern. Three major themes were identified as "nurse self", "nurse-manager self", and "career self" (p. 61). Doing well to ensure rigor, the researcher made inquiries to nurse managers from various parts of the country as to how well the themes fit their own practice experiences.

Nursing administration researchers in Ontario studied nurse managers' (n=10) perceptions of their role. During analysis of semi-structured interviews, Coulson and

Cragg (1995) used Mintzberg's (1973) industrial and organizational model of management roles as their framework for interpretation. Analysis of semi-structured questionnaires revealed that much of what the nurse managers did fell into Mintzberg`s three major categories of interpersonal relationships, transfer of information, and decision making, each of which had pertinent sub-categories for the nurse managers. However, the researchers found roles unique to the participants. By adding the category "professional roles" the model was made pertinent for managers of nursing. Under "professional roles", new sub-categories included "practitioner", "carer", and "standards maintainer" (p. 6).

Summary

Research on nurse managers has revealed how nurse manager behaviors and leadership styles impact nursing staff and even the nursing care of patients. Performance and educational/learning needs of nurse managers have been studied in order to gain a better understanding of developmental programs required to increase competencies and effectiveness of nurse managers. Other studies have augmented what is known about nurse managers` perceptions of power and job stress.

Research on real-life experiences of nurse managers has added more to the above body of knowledge and has revealed what is personally invested during the implementation of change (Brannon, 1994), managers` ideas about necessary skills and education (Brannon, 1994; Horvath, Aroian, et al., 1997; Lindholm & Uden 1999), leadership (King 1999, 2000), and processes that ensure managerial success (Brannon, 1994). Differences in how nurse managers implement their roles have been highlighted (Aroian, et al., 1996) and likenesses, such as shared practices, have been discovered (Brannon, 1994). This body of research has revealed what is especially meaningful to nurse managers (Brannon, 1994; Westmoreland, 1993) as well as what is particularly challenging (Swanson, 2001). Challenges unique to nurse managers in other countries due to political upheaval (Gmeiner & Poggenpoel, 1996) and oppressive work environments (Lindholm, Uden, & Rastam, 1999) have been identified. Methods utilized in these studies of nurse managers` lived experiences have imposed frameworks from various disciplines and philosophies upon the data. No studies were found using the existential phenomenological approach with the purpose of preserving and staying true to the language and context of data obtained during interviews so that what ensues is a clear representation of the nurse managers` lived experience. The present study was designed to accomplish this purpose.

Conclusion

Nurse managers should be provided with an open forum in which they can voice their opinions, concerns, and describe their lived experiences through the use of their own language and within their own social contexts. No study has simply asked the question what is it like to be a nurse manager? After talking with nurse managers, I have become more aware of how they conceptualize themselves and their roles. When describing her lived experience, one manager appreciated being able to affect care at a different level than that of a staff nurse. Two managers provided images of constraint. One described

herself as an oval squeezed from both sides with administration pushing down from above and the nursing staff pushing up from below. Another manager graphically visualized herself as the creamy filling in the Oreo® that sometimes gets squeezed and oozes beyond the edges of the cookie. Other nurse managers described themselves as a nurse's nurse, as seeking answers that lie within the nursing staff, as a good fit with their positions, solution driven, and the nurse who can deliver bedside in one instance and be heard and valued at the executive table in another. More conceptualizations included the glue that holds it all together, the most knowledgeable, the one who is right there in the trenches who is trusted and esteemed, and…..the one that takes the bullet. These stories of the lived experience of the nurse manager have remained untold in the published literature. I will elaborate on these study findings in Chapter Four.

CHAPTER III

METHOD

The purpose of this study was to gain a more differentiated understanding of the lived experience of nurse managers. The existential phenomenological approach described by Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002) was used to gather and analyze the data. This chapter outlines the method used and contains a discussion of the existential phenomenological approach, the protection of human subjects, the selection of participants and setting, and the data collection and analyses procedures.

Research Design

The methodological procedure selected for this study involved a hermeneutic process of analysis of texts (Gadamer, 1976) and originated from two philosophies, that of existentialism and that of phenomenology. The founder of existentialism, a Danish philosopher named Soren Kierkegaard (1813-1855). was interested in individuality within human existence and found value in identifying essential themes of everyday occurrences (Valle, King, & Halling, 1989). Existentialism developed into a philosophy concerned with defining the essence of life based upon one's awareness and one's choices made over the course of one's lifetime.

The German philosopher Edmund Husserl (1859-1938), known as the father of phenomenology, was a scholar interested in an unbiased inquiry of things (Valle, King, & Halling, 1989). He asserted that to understand a phenomenon fully, one had to comprehend its essence by dwelling with the phenomenon in question, or as he said it, returning "to the things themselves". Martin Heidegger (1889-1976), a student of Husserl, synthesized the efforts of Husserl and Kierkegaard developing a method of seeking the truth, that of existential phenomenology.

The existential-phenomenological method of inquiry used in this study was largely based upon the more recent work of the French philosopher Maurice Merleau-Ponty (1945/1962) whose focus was on the human experience of phenomena as they are perceived by and through the body. Throughout nursing's history, nurses have conceptualized humans as holistic beings of body, mind, and spirit. Merleau-Ponty also believed that body and mind were one and that people shaped their perceptions as they experienced phenomena in the world and gained an awareness of the ambient environment.

Today, nurses continually try to appreciate and understand their patients' perceptions and feelings as patients strive to function in society, experience illness, and are forced to enter into a health care organization. For nurses to become an effective part of a patient's experience, they must seek to understand what the patient's experience is. Only then can nurses effectively alleviate a patient or family's anxiety, ask appropriate questions, and promote an environment conducive to healing. Because the philosophical underpinnings of nursing and existential-phenomenology are congruent, it stands to

reason that the understanding of a patient's experience can be gained through the use of an existential-phenomenological approach.

Thomas and Pollio (2002) described the utility of an existential-phenomenological approach in nursing research. Nurse researchers interviewed patients living with an implanted defibrillator, patients living in chronic pain, patients recovering from a stroke, and more. Applying an existential-phenomenological approach during interviewing and analyses allowed the nurse researchers to understand each participant as a whole human being within his/her own reality as disclosed through dialogue.

This same approach was applied in this research where I sought to understand the reality of the nurse manager. Users of the existential-phenomenological approach, influenced by Gadamer, believe that "language offers a bridge to different areas of everyday reality" (Pollio, Henley, & Thompson, 1997, p. 136). Gadamer states that "understanding is language-bound" and that language is "the mode of the whole human experience" (Gadamer 1976, p. 15). It was through language (via unstructured face-to-face interviews) and the use of an existential-phenomenological research method that nurse managers were able to reveal their experiences of what it was like to exist in the world of middle-management in the contemporary health care system.

Protection of Human Rights

Approval to use human subjects was obtained first from the College of Nursing Human Subjects Committee and then from the Institutional Review Board of the University of Tennessee (see Appendix A). Potential participants were notified verbally and in writing (see Appendix B) that they could choose to accept or refuse participation in the study. After accepting to take part in this study and signing a consent form, participants were aware that they could withdraw from the study at any time. Decisions regarding participation had no effect on professional status or relationships with coworkers, upper management, or any other sector of the organization. The purpose of the study and potential risks, benefits, and estimated time for participating in the study were communicated to participants. Transcriber(s) of the interview signed a pledge of confidentiality. If, as a part of exploring themes and/or ensuring validity, a transcript was read by a multidisciplinary, interpretive team of phenomenological researchers, then each team member also signed a pledge of confidentiality. I used anonymous quotes from the interviews to illustrate themes. Demographic questionnaires were coded using a method known only to me which did not include the names of participants.

To preserve participant anonymity, taped interviews and transcripts are stored in a secured location. The tapes, transcripts, completed demographic questionnaires, and consent forms are stored separately. The only other persons having access to the data, other than myself, are members of the dissertation committee.

All data for this study are being kept for future analyses. It will be maintained in a secured location. Any publications, reports, or presentations of findings will in no way disclose the identity of the participants or link them to the study.

Selection of Participants and Setting

Participants for this study were selected using a purposive sampling design. In confidence I asked English speaking nurse managers of diverse backgrounds working full-time in a hospital setting to participate. A snowball sampling technique was implemented as I asked colleagues and nurse managers if they could identify eligible participants who might be interested in talking about their experiences.

Data Collection Procedure

I participated in a bracketing interview, an essential component of the procedure developed by Pollio et al. (1997). The bracketing interview was analyzed using the existential phenomenological interpretive approach. Findings are discussed in Chapter 4. After informed consent was obtained (see Appendix B), each participant was interviewed one-on-one and face-to-face using the method outlined in Pollio et al. (1997) and Thomas and Pollio (2002). I made the following opening request: "Please tell me about some incidents that stand out to you in your life as a nurse manager."

All interviews were audiotaped. After each interview, participants were asked to complete a demographic questionnaire (see Appendix C). They were asked to provide their age, sex, years of experience in nursing, years of experience in a nurse manager position, educational background, practice background, and some information about the hospital in which they work. All interviews were transcribed. The transcriber signed a pledge of confidentiality stating that (s)he would not discuss the content of the interviews.

Data Analysis

Each transcript was read once to gain a sense of the complete interview. The transcript was read again to identify meaning units, or specific words and phrases that were prominent. Meaning units were then clustered, leading to the development of themes as outlined by Thomas and Pollio (2002). As each additional interview was transcribed and read, constant comparative analysis of the data was performed. Commonalities among the interviews became apparent through the repetition of certain words, key phrases, and topics. Thomas and Pollio described such commonalities as "experiential patterns" (p. 37) which, if recurring across interviews, lead to the development of global themes. When feasible, themes were named by using the actual words of participants. When no further global themes emerged and the categories within those themes became saturated, an overall thematic structure was developed.

Several transcripts were read by members of a multidisciplinary interpretive team. The input of the team assisted in determining whether all the necessary meaning units and themes were being identified. Each team member signed a pledge of confidentiality.

The thematic structure was presented to two of the participants to determine whether or not they felt it described their lived experience as nurse managers. Once the thematic structure was ascertained, I prepared the final report. For a diagram of the existential phenomenological research process see Appendix D.

Validity and Reliability

As has been thoroughly discussed in the collective efforts of Thomas and Pollio (2002), adhering to an existential phenomenological approach assures validity and reliability of research findings. A diverse group of participants was selected for this study to allow for a diverse description of experience. The thematic structure was a clear representation of the lived experience of the nurse managers as it was based upon the language of the participants. Utilizing the participants' words in the naming of the themes allowed the researcher to maintain a certain closeness to the data and diminished the risk of imposing unfounded assumptions. Input from a multidisciplinary interpretive group verified that I had reliably identified essential elements and had developed appropriate themes.

Other steps were taken to preserve the rigor of the study. To ensure that the thematic structure was well grounded and supported by the data, Polkinghorne's (1989) five questions that assess validity of phenomenological studies were used to relieve any doubts in the study's results. The first question addresses whether or not the interviewer influenced participant responses so that actual experiences were not truly conveyed. After making the opening request to "Please tell me about some incidents that stand out to you in your life as a nurse manager," I listened and only spoke to either seek clarification from a participant or to ask for specific examples when the participant brought up a phenomenon. Specific examples were sought to understand how a phenomenon was experienced by the participant and to further understand any unfolding theme.

The second question addresses the accuracy of the transcripts to ensure that each text contained exactly what was said by the participant. Each transcript was meticulously reviewed and any errors of transcription were corrected. Also, notes were added to the transcripts so that it was clear if the participant was laughing, performing hand gestures, or making facial expressions.

Polkinghorne's third question asks about alternative conclusions that could be made from the data. The input of the interpretive group assisted in this task. Possibilities for conclusions about certain themes in a few of the transcripts were discussed and the group always came to a consensus. Upon comparing all transcripts it was found that although some of the participants swayed more strongly towards certain themes than others, all transcripts contained language that connected them to the final themes and, thus, to the overall thematic structure.

In his fourth question, Polkinghorne asks if it is possible to go from the overall thematic structure to specific areas of the transcripts and account for the events described in the transcripts. Again, this proved to be a worthwhile exercise. The researcher was able to take specific scenarios and categorize them in the overall thematic structure. Many scenarios had components of more than one theme.

Polkinghorne's final assessment addresses whether the thematic structure is situation specific or applicable in general to other situations. For nurse managers participating in this study, and for four other nurse managers working in the Southeastern United States who did not participate, it was confirmed that the thematic structure held true for them in general and was a clear representation of their experience as nurse managers.

Summary

This chapter outlined the method to be used in this study. The research design was discussed as well as its origins and philosophy. Methods used to protect participants` human rights were revealed. Contents of the demographic questionnaire were stated. The process for data collection and data analysis were set forth. Lastly, efforts to ensure validity of the study were presented.

CHAPTER IV

FINDINGS

This study utilized an existential-phenomenological research model (see Appendix D) to gain a more differentiated understanding of the lived experience of nurse managers. Following analysis of the bracketing interview, face to face interviews were audiotaped and transcribed verbatim. It was through analysis of the language of the participants that a thematic structure emerged. Based upon feedback from two of the participants and four other nurse managers working in acute care settings, the structure held true to nurse managers' experiences.

A Rude Awakening

Analysis of the bracketing interview brought about the realization that I held many assumptions and suppositions about what nurse managers should be and how they should perform in order to be successful. Many value judgments were made and the role of the nurse manager was somewhat idealized as "exciting and challenging". A significant disconnect was identified after analyzing the interviews of the participants and reviewing the bracketing interview. I believed that successful nurse managers would be those who could: (a) integrate the paradigms of business and nursing, (b) "stay motivated and move forward professionally," and (c) develop the right relationships with colleagues and superiors. In truth, none of these assumptions were supported by what was revealed in the interviews. However, themes that emerged from the bracketing interview, particularly those tied to actual experiences of working with various nurse managers when I was a Master's student, did relate to themes emerging from participant interviews. The bracketing interview process accomplished its goal as I was able to recognize my own values and biases. Reading through the transcribed bracketing interview with members of a multidisciplinary interpretive group (described in Chapter III) aided the identification of values and biases.

It must be said that during the course of this research I experienced a rude awakening. By the third interview, it became apparent how truly frustrating it can be to be a nurse manager, particularly, how oppressive it can be for the nurse manager as well as for nurses at all levels who function within bureaucratic health care institutions. Listening to the stories of nurse managers and reading through their transcripts again and again proved emotionally exhausting and depressing. Congruent with statements made by several of the participants once the tape recorder was turned off, I only hope that administrators will read this study and take notice of what it is like to be a nurse manager as well as develop greater respect and empathy for the role.

Demographics

Eight nurse managers were interviewed: six in their offices, one in a quiet room located in the organization, and one in the nurse manager's home. Seven of the eight were female and seven were Caucasian, one being African American. The mean age of the

nurse managers was 48.13 (range 31-63) and the mean number of years of experience in the nursing profession was 23 (range 10-31). The mean number of years that these nurse managers actually served in a managerial role was 10.69 (range 1.5-25).

Nurse managers were diverse in their educational backgrounds. One began a nursing career as a diploma nurse, while four reported the Associate's Degree in Nursing as their first degree. Three others began as baccalaureate prepared nurses.

Six participants obtained further education. Of the four who began as Associate's prepared nurses, one currently possesses a Bachelor's of Science in Health Administration and one now has a Bachelor's of Science in Nursing followed by a Master's of Science in Nursing. A third has a Bachelor's of Science followed by a Master's of the Arts in Organizational Management. The fourth has obtained a Bachelor's of Science in Nursing.

Two of the three who began as baccalaureate prepared nurses had not pursued higher degrees. In all, three of the participants have obtained a Master's of Science in Nursing. The nurse manager who began as a diploma graduate obtained a Bachelor's of Science in Nursing as a last degree.

Just as their educational backgrounds were diverse, more so were the areas they had practiced as registered nurses. These areas included cardiovascular, intensive care, medical/surgical, emergency, maternal/newborn, postpartum, neurological, renal, dialysis, inpatient surgical, and outpatient surgical. The various areas where these nurses served in a managerial role also included the aforementioned areas.

All of the managers were employed by not-for-profit hospitals that were part of larger health care systems. None of these hospitals had obtained Magnet status, but most had obtained some sort of recognition for outcomes management of certain diagnostic groups. All awards were based upon patient outcomes and financial criteria. The mean number of beds for the hospitals in which these nurse managers worked was 273.63 (range 165-600).

Contextual Ground

Aspects of bureaucracy became figural at any given moment during the various interviews. It came as no surprise that the contextual ground of the nurse manager's lived experience was bureaucracy itself. What was surprising was that the words of the managers did not describe the bureaucracy in the traditional sense as a hierarchical authority, but as a bureaucracy unconcerned with the challenges of the nurse manager, unconcerned with the profession of nursing. What also became figural at any given time were five major aspects within the top-down structure of the bureaucracy. They included Organization, Administration, Nurse Manager, Nursing Staff, and Patients. From the organizational level to the level of patient care, the five aspects of bureaucracy evolved to categories that provided a framework for the development of a thematic structure (see Figure 1).

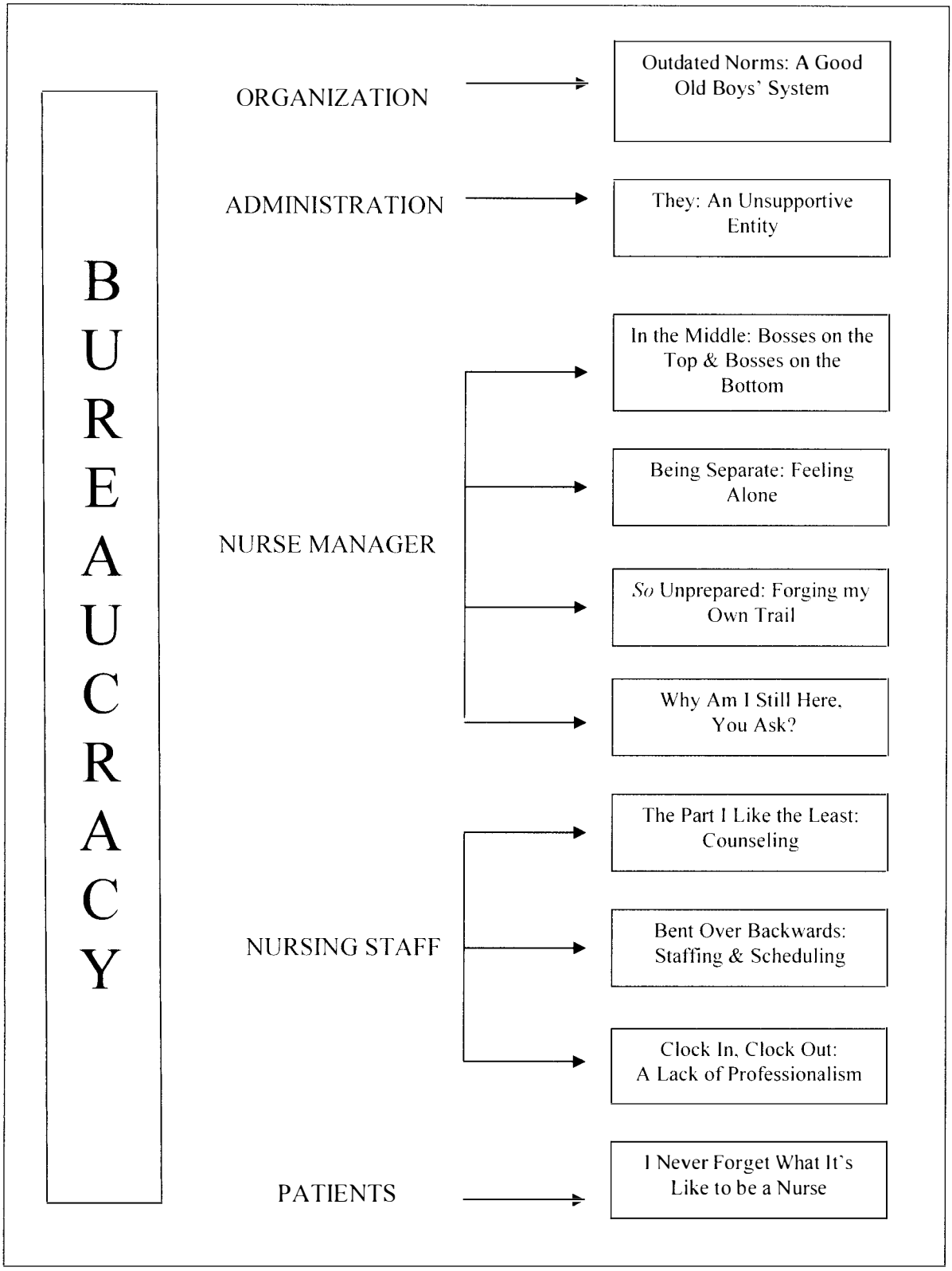


Figure 1: Thematic Structure

Thematic Structure

The five categories of the thematic structure: Organization, Administration, Nurse Manager, Nursing Staff, and Patients, were assigned themes that emerged from the language of the nurse managers. Each theme was a manifestation of the nurse managers' experience of each category and each theme served to further define the nurse managers' experience within the category.

The top category of the structure, Organization, consisted of one major theme, Outdated Norms: A Good Old Boys' System. The second category, Administration, also had one major theme, They: An Unsupportive Entity. The third and middle category, that of the Nurse Manager, had four themes: (1) In the Middle: Bosses on Top and Bosses on the Bottom, (2) Being Separate: Feeling Alone, (3) *So* Unprepared: Forging My Own Trail, and (4) Why Am I Still Here, You Ask? The fourth category, Nursing Staff, consisted of the three themes: (1) The Part I Like the Least: Counseling, (2) Bent Over Backwards: Staffing & Scheduling, and (3) Clock In, Clock Out: A Lack of Professionalism. The fifth and bottom category, Patients, had one major theme, I Never Forget What It's Like to be a Nurse. The following is a description of the emerging themes accompanied by supporting quotations. Most of the names for the themes came directly from the words of the nurse managers.

Organization

Major Theme - Outdated Norms: A Good Old Boys' System

The nurse managers described the oppressive cultures in their organizations. Outdated norms and a lack of communication caused detriment of the managers, their staff members, patients, and to the organization as a whole. Old rules made no sense and impeded important functions such as obtaining resources (human or material) for staff members and patients. Nurse managers had to manipulate people in various areas of health care system to get what they needed. A lack of communication was vast among the organizations. Intentional or not, this failure to share information among organizational layers led to distrust and inhibited the development of healthy relationships among managers and members of the nursing staff.

> …even though nursing historically has been a profession dominated by women, it is a good old boys' system that has run the hospital…Knowing how to manipulate that good old boys system, who to go to to get what we want, has always been the key to everything…You have to understand how to get what you want...You have to learn how to manipulate the system. (Participant 7)

> …my direct manager [director], we go to her, but lots of times she can't get through the bureaucracy…you feel like you're spinning your wheels…(Participant 8)

> …communication in organizations…most of the time, is not very good…I work in a department that is very rigid due to the old organizational norm…"this is the

> rule and this is what we're gonna stick by." I have learned through the years that maybe being more flexible…for the employee…enhanced their trust in me as an advocate…I think that sticking by the rules that we stick by, they encourage people to think "Well, I don't want to work with the mess that's here. I'm gonna go somewhere else." (Participant 6)

This was not the only time that a nurse manager described how the culture of the organization lead to dissatisfaction of staff members.

> There's a lot of times when I have to make decisions and they [staff members] don't understand why…I can't tell them…because I've been told not to share…I'm not allowed to tell them certain things…I hate that…but that's kind of the way the system works. Communication is not the best. It's a very high bureaurchical system. There is a lot of secrecy. Decisions are made and they're not really communicated to people. Reasons why aren't communicated… (Participant 3)

Participant 3 went on to talk about a plan for remodeling the patient care area that she managed. After sharing the plan with her staff, thinking she was serving the best interests of nurses, patients, and the organization, she was reprimanded.

> We're gonna be doing some remodeling…we're [management] trying to figure out how to layout the rooms…what would be best for patient flow…I gave them [nursing staff members] a list with "TENTATIVE" written all over it. You know, "this is what we've proposed, what do you think? What are your suggestions?" Well within a couple of hours I was getting calls from all over this hospital…none of that [the plan] was final and that shouldn't have been released [to the staff]. And I just thought that was kind of ridiculous since the people that do the work probably would know better, would know best how to lay out the system. That…was *very frustrating*. (Participant 3)

Administration

Major Theme - They: An Unsupportive Entity

When nurse managers spoke of members in the executive layer of their organizations, their language portrayed administration as neither supportive nor understanding of what they endured as nurse managers. Nurse managers described how financial initiatives and cost containment strategies overburdened their nursing staff and negatively affected the quality of care. Nurse managers advocated for staff members and patients. When they presented the need for equipment or a higher nurse patient ratio to hospital administrators and were turned down, they felt unheard and devalued. Nurse managers would experience anguish when making difficult management decisions or advocating for staff members mistreated by physicians. Then their decisions would be questioned and unsupported by superiors. At times, managers were reprimanded by members of administration.

> Organization-wide, the upper tier management is so focused on what their goals are they don't realize how a manager may be accomplishing those things. They can't see the forest for the trees. Sometimes the trees have to be in place for the forest to exist. I think, as a manager, you don't, you never get credit for all the good things that go on. Because, they [administration]...have all this anxiety built around "well the budget's not so well right now." They don't understand that the managers are trying to hold things together. (Participant 6)
>
> I think that having the support of administration. I mean we *have* to have that support. And sometimes I think we're lacking in that. And I think some of the decisions that are made that affect us on the units, the folks that are making those decisions do not have a clue as to what is going on on the floor... I need someone to listen...we do not have that as an administration...hospitals are the most competitive places and we're constantly being told that...."we have to show a profit" and so we're cut, cut, cut. You know, supplies, equipment. You need new equipment. That's another thing that's very difficult to get through an administration...Maybe management is beyond my realm now...you've got to keep up. And to me, to not be able to get equipment, I think it, it makes me feel like that I'm losing respect from my staff. (Participant 8)
>
> We've gone from being a service-oriented system to being big business...It's very disturbing to me. It's very irritating to me to be sitting in a meeting and be told by someone who has a degree in finance or accounting how I'm supposed to take care of my patients or how many...RNs I need to do this. They have no concept of what my job is. All they've got is the dollars and cents on the intake/output sheet...I honestly feel like it's destroying our ability to treat patients...My budget is not adequate to take care of the patients...Now I've got choices to make here. Do I live within my budget and put my staff in a position where they are understaffed to care for the...patients...It makes me angry that I'd even be put in that position...It's not right...It's just not right. (Participant 7)
>
> I don't think administration is uhm, behind nurse managers as strongly as they should be. My boss is not even a nurse. To me, nonnurses have *no idea* what nurses do. They have *no idea* how rough it is...one nurse will have ten patients. And even though I've tried to explain [the need for more nurses] to my boss, it, it doesn't click because he's not a nurse. He doesn't understand...you can't understand something that you've never done....The Vice President of Nursing, I don't feel like she remembers what it's like. I don't think she has [taken care of patients] in a long time. (Participant 1)

This participant goes on to describe a situation where his/her actions were dissuaded by administration after he/she confronted a physician's inappropriate behavior toward a staff nurse.

> One of our doctors was very ugly to one of the staff members….he made a lot of derogatory statements and he was just, I mean, was really, really, it was *bad*. I demanded that he apologize to her and I went to administration and they ended up getting upset with me for trying to make a doctor apologize to a nurse. Well I'm sorry, they would make us [nurses] apologize or maybe even *terminate us*…I felt like he owed her an apology and I, I mean, I was gonna demand that he apologize to her, which he did. But not because of administration. He apologized to her because of [other staff members]. We sat down and had a talk and he did apologize. But it wasn't anything that the administration was gonna do to help us. (Participant 1)

Nurse Manager

Theme One - Being in the Middle: Bosses on the Top and Bosses on the Bottom

The nurse managers perceived their positions in the organization as being in the middle, between the organizational layers of executive administration and the nursing staff. Instead of being what others might presume to be a leadership position of prestige and power, being a nurse manager felt insignificant and powerless. Nurse managers had to promote hospital directives that they may or may not agree with while having to deal with ongoing personnel issues. There were pressures to meet budgetary goals while meeting the demands of staff and patients. Being in the middle was quite a challenge and the nurse managers often felt overwhelmed.

> You think, "Oh! Nurse manager! Oh, great power!" (Laughs.) But when you really get to looking at what we really do on a daily basis, not so impressive…I mean, that's just it. It's a position where you have no power, but you're not on the level with the staff either. You know, so it's, it's this kind of in between layer that okay, you know this day you're this. You're on the floor taking care of patients and the next day, you're doing what somebody else up here (holds her hand, palm down, above her head) needs you to do. It can be a lot of up and down, bouncing around. And you're the first one shot when things go wrong (laughs)! (Participant 4)

> The one thing that comes to mind is an Oreo. Sort of that cream filling that's in the middle. (Pause.) And there's two layers, there is one above and one below. And sometimes, depending on how people eat that Oreo, they can actually squish the middle out on the side…I am the part that gets squished (pause) *a lot*! (Laughs.)…It's sort of a, in fact, twixt-in-between place that's clearly undefined…You're responsible to everyone on both sides. You become that liaison on both sides. But it becomes sometimes a very thankless place…Nobody knows what I do (pause) until I don't do it (pause)…You take more stuff than anyone can absolutely imagine…And she [the manager] will be squooshed (pause) one way or another from the top or from the bottom. (Participant 5)

> I think it's the most important thing for a nurse manager to know, or to remember, that as a staff nurse, you have one boss. As a manager, you have bosses on the top and bosses on the bottom. (Participant 6)
>
> No matter what you do, somebody's not gonna like it...Not that my job is to make everybody happy, but I thought if I did a good enough job, that everybody would be happy...that I would please people and it would be a good place to work...but anytime you make a decision, somebody is not gonna be happy and that...has been hard for me to just understand and let it go. (Participant 3)
>
> I am the complaint department from the staff perspective, I'm the complaint—from the patient's perspective...If my DON (Director of Nursing) has an issue, then I'm the complaint—[department]... I felt very saturated and it was a very uneven table...I felt like I was truly being sheared. (Participant 5)

Managers described being in the middle as being surrounded by the demands of others, not the support of others. Constantly giving of themselves personally and professionally and not having access to a strong support system, they evaluated their positions further.

Theme Two - Being Separate: Feeling Alone

This theme emerged as nurse managers further expressed feelings associated with middle management. They felt alone when making decisions related to personnel management and separated from others as they fulfilled their responsibilities to the organization. When they lead or contributed to successes within their organization, their efforts were unappreciated. When things went wrong or outcomes were undesirable, they felt singled-out and blamed. Nurse managers expressed despair, isolation, and frustration.

> The thing I think about the nurse manager role is that it's a fairly thankless job (laughs). You are middle management. You carry a lot of personal liability as well as professional liability, but your financial reimbursement is very limited for the amount of time and effort that you put into it. So, you have to be in it for some other reason...And most of us went into nursing for other reasons. (Participant 7).
>
> I don't know if it's the same way in all institutions, but as far as being in... management...this is not the best place to be...this is not a very well respected role in this facility...You get overlooked...you don't get a lot of credit for a lot of the things that you do...You know you have good ideas. You know you've been an asset and you've done a lot of good. And you don't get recognition for it...I'm okay to do [the director's job] when somebody needs me to do in the absence of someone else. But when they're there, I go back to my position as nurse manager, you know. And that's hurtful, very hurtful...And you're the first one shot when things go wrong! (Participant 4)
>
> It becomes a very thankless place...You're not in the midst of the executive layer (pause)...you interface with them [executives], and yet you're still directly there

> in the trenches, on the front-line… previously been one of them [nurses] and yet they see you set apart…you're still very, still feel very much apart…I believe the front line is still the hardest place 'cause that's where you get shot first. If you ever look at a funeral and a flat crate coffin, it's probably the front line leader!...That's who's going to get shot first. (Participant 5)

> I really had a lot of lofty expectations…I really thought that we [staff members and I] could just sort of all be, I don't know, equals is not the right word but that's the best one that I can think of. But then you find out, you know, that you can't just be. You have to kind of separate yourself.…The overall experience has been that you really need to get your support. You can't get your support from your staff and you can't expect to get it from the staff...that's probably been one of the mistakes that I've made is thinking that, you know, I would be supported by them always. (Participant 3)

Feelings of being separated from others and feeling alone came as a surprise to the nurse managers after taking on their roles. As it turned out, there were many other surprises to behold as they learned their roles.

Theme Three - So Unprepared: Forging My Own Trail

The nurses enthusiastically took on their roles as managers only to realize that they lacked the skills and experience to deal with difficult and unforeseen circumstances. One new nurse manager said, "I just can't believe that management should be this difficult." Most learned from doing and by making mistakes versus having a formalized introduction and orientation. Many were expected to be successful as nurse managers simply because they had been exemplary nurses. The past has informed us that good nurses are not necessarily effective nurse leaders. Too many nurse managers fail due to inexperience and lack of preparation.

> Well, to begin with I've always been up to a challenge. So when I first became a nurse manager, head nurse was the title then, but the same role. It was on a unit that had gone through *multiple* head nurses. Our managers were new like every year. And I had worked on that unit as a charge nurse and a staff nurse for a *long* time. So I was the next person to ask, "Would you mind trying this?"…Up to a challenge, always routing for the underdog, I, I took the role. I was green as anything. You don't have the training, but you don't know that. You don't know what all is involved. You, you learn day by day and by experience and by mistakes as I did…It was several years later, or, well, two or three years later that I learned…I truly had no clue. (Participant 2)

> That was a hard transition for me having been a clinician and a bedside nurse for a long time. I could get my warm fuzzies at the bedside. You don't get them. Typically you become the complaint department. It's where I initially started feeling that I made the transition. In fact, I was asked to *move* into management because of being a clinician all those years. And you continue to have rapid

> turnover of managers. I ended up in a management position by default…no one would stay. And it seemed like I always did. So, I found myself dancing on both sides of the track and being the first born and in absence of instructions, I would forge my own trail and (pause) pull things together and make it work. (Participant 5)

> It's been really hard because I was a staff nurse for eight years before I took this job and I was just, I could say, "Finally I was a very good staff nurse." I was organized. I was excellent. And sort of looked at as an expert. When I came into this job, it had nothing to do with being what I would say a nurse…I was *so* unprepared. Uhm, from what it entailed, it's just, none of my nursing skills as far as my hands-on clinical skills and my judgment and my assessment skills really, uh, mattered anymore…I was just *so* unprepared…I didn't have any idea about organizational theory or…more technical things like scheduling, staffing, payroll type issues, human resource issues. I didn't know any of that and I, you know, I hear that from other nurse managers that it's kind of like, "Oh, if you're a really good staff nurse then you'll be a really good nurse manager." But really the two things don't seem to have a lot to do with each other…some days I get frustrated because I feel I'm not even a nurse…I feel guilty saying I'm a nurse. (Participant 3)

At this point, after reading through all the above text, the reader probably wonders, how is it that these nurse managers stay in their positions as long as they do? The nurse managers ask and answer that very question in the following theme.

Theme Four - Why Am I Still Here, You Ask?

All of the nurse managers sought success in their roles. However, after telling their stories, they seemed to realize that most of their descriptions were negative. Participants changed the focus of the dialogue to an aspect of their work that provided incentive to return day after day. For some, it was a glimpse of appreciation for their efforts, the difference they made in the health care system, the support from peers, or knowing that they had the choice to leave at any time. For others, it was a long-term financial incentive.

> I go through, (laughs), one day I say, "I'm quitting this job. I can't take it. I'm not doing it anymore," and the next day I think, "I love it. This is where I'm supposed to be," you know, "This is finally where I'm supposed to be."…It may be when I come in and, uh, you know, I do get a "thank you" from the staff or, or somebody says to me, you know, "You did a really good job with that, or, you know, "Thank you for supporting me on that."…I've gone through this thing, and it, it's a, I thought I was the only one that did it but, you know, I have to cry about once a week in this job. And apparently that's just a normal nurse manager thing. (Laughs.) But when I do, there always seems to be somebody, whether it's staff or my supervisor that comes along and says, "Yeah, you're doing a good job." (Participant 3)

I probably might not still be here doing what I do if it weren't for supportive people around me, other managers…my management peer group…I'm very fortunate to have that…it is imperative that you have it so that you can either vent, what's going on that day, or praise each other for what they are doing on their, with their unit. (Participant 2)

If I didn't have the clinician, I guess I'd die! (Laughs.)…She's excellent. She helps a lot…I have learned a lot in the past two years…it hasn't always been wonderful. It's been rough. Some days I come home and think, "I'm never going back there." But then I sleep, I get up the next day and I go back…When I get the bad days, I'll come home and I'll say to myself, "I don't, I just can't do this anymore. I can't do this."…And then I get to thinking, "Well, you know, when I've had enough I'll just tell them, 'I'm not going to do it anymore, you know, I just want to go on to something else. It's time.'" And knowing I can quit at any point in time. Nurses can find jobs anywhere. So knowing that I don't *have* to do this makes me go back everyday….I do have staff that tell me that they are so glad that I'm there and they are so glad that, you know, that I care about them and that I try to make a difference. (Participant 1)

The thing that keeps me going every day, coming back, is not what goes into the bank at the end of the month. It is the difference that I can make in the whole system. That is valuable to me as a person. That makes me feel like when I put my head on the pillow at night, that I can sleep and I can bear to look at what reflects back in the mirror in the morning…I've worked at this hospital for 27 years. I'm close to being able to have enough years in that I can retire. But even today, I think it's important for people to remember, you still have a choice. You don't have to come in here and do this job if you don't want to…. You still have choices. You can still walk away. You do not have to do it. Nobody's holding a gun to my head saying, "You have to come in here and do this. But I get frustrated. (Participant 7)

(Laughing.) Why am I still here, you ask yourself? Well, I had a commitment…We built this hospital. And I was very involved in the planning, the layout, everything. And I appreciated that. I was committed to make the move, get through the move. In fact, during the move, my husband had to have open heart surgery (laughing). It was tough. It was tough, but we survived it. I'm proud of that…my other thing is, uh, I'm a year and a half away from retirement…you can't just walk away from that. I've been here 18 years. You can't just walk away from that…I would like to stay here, I would like to think that they value me enough in this institution that they would like to see me better myself…people see you in a role that you've been in for so long that that's what, who you are and what you will always be. So I either will stay right here (laughs). Or I will break out and probably have to move on. (Participant 4)

Nursing Staff

Theme One - The Part of My Job I Like the Least: Counseling

The nurse managers described confrontations with nursing staff members regarding performance issues. This was truly an aspect of their jobs that they liked least. Nurse managers ruminated over counseling sessions with employees and the outcomes, especially when the result was termination of an employee. As they told their stories there was hesitation in their speech accompanied by expressions of concern on their faces. Their voices held either tones of remorse or uncertainty.

> "Counseling became probably a *very huge* part of what I did. I listened to more stories about why they couldn't come to work and it, it became really phenomenal some of the things that I heard (Participant 5)."

> Another part of my job that I really don't like, that I hate having to do is counseling on their [the employees] issues and problems. That's one of the harder things for me. Um…I think I do a good job, but I really think that that's the part of my job I like the least. (Participant 4)

> I had a situation; I had this girl who was excessive absenteeism. And I had counseled her. I'd talked to her, you know, and I tried to tell her how important it was for her to be here. And it, it got worse and worse so I had no choice but to write her up and go through the disciplinary process. And eventually it led to her, uh, being terminated…I'm going to court because of this. And, uh, I really think I did what I should have done. (Participant 8)

> I dealt with employees that have, um, narcotic problems and have to discipline them…working with the employee who you thought was probably very good, and realizing what they were doing was being deceptive, is heart-wrenching. But you learn as a manager, uh, that happens. (Participant 2)

> I worked at one organization where I worked for two years, um, just trying to rehabilitate…to work through an employee and it finally ended up in a termination situation. And, uh, in that time period went through hell and high water knowing that this person is detrimental to the department…But it finally ended in termination. Which I think was healthy; it was very healthy for the department. (Participant 6)

Counseling was just one of the aspects of the nurse managers' role that took up much of their time. No task was simple and it was seldom that goals were met with a single attempt. Efforts required interactions with various people and, many times, emotions were involved. Another aspect of the nurse manager role that required much time, effort, negotiation, and emotion was that of staffing and scheduling.

Theme Two - Bent Over Backwards: Staffing and Scheduling

The most important part of the nurse manager's role is to staff their units with the appropriate number of skilled nurses and ancillary staff. If the manager does not have an assistant, he/she spends hours upon hours putting together schedules. When there are not enough nurses to provide adequate care (e.g., staff vacancies or employees call in sick), the nurse manager is the person responsible for somehow ensuring that patients' needs are met.

The nurse managers desired to keep everybody happy. They did everything they could to accommodate the needs of nursing staff members so that they could work certain hours. Some managers found that if they were flexible with their nurses, then the nurses were more likely to reciprocate when the nurse manager was in a bind and needed someone to cover a shift.

> We're doing a lot of flexible scheduling these days…In my past experience, you either work that 8 hour shift or you work the 12 hour. And there was *no* in between. Now I do not care when you work (laughs). If you will come in and work for me for four hours, if you'll come in, and a lot of the nurses today have babies and children. If you get your child off to school at 8:00, come on in. If you pick that child up at 3:00, you leave at 2:30. So we're being *very* very flexible… (Participant 8)

> I learned when making out a schedule, asking them [staff members], "What day do you prefer to have off," then when I came to say, "Gosh we're in a bind on this date, on Friday. Do you think you could work then?" And they're like, "Gosh yeah! You gave me off all these other days." (Participant 2)

> A lot of young nurses are in school...we have a lot of problems with scheduling them with their school days off and I make every effort to make sure that they have their school days off. I try to give everybody what they need and want and that's an overpowering job sometimes when you're trying to make everybody happy. So this particular lady who I really felt in my heart, I bent over backwards to give her time, give her what she wanted, change her schedule…she wanted to go prn [work when she is needed and when it is convenient for her]. And we have so many prn staff that it was just impossible to allow anyone else to do it…We really have no control over them. They can tell you "no [I can't work]" and there's nothing you can do about it. So she just resigned…that was very tough on me because she's a good nurse. She's a wonderful person and I hate to lose her. (Participant 4)

> I have responsibility to the facility to make sure that staffing is adequate and that it's, and that all shifts are covered. So I try to be real considerate of people who have family tragedies or family troubles and I try to work with them. This particular nurse, uh, I had worked with for three months because her husband had a stroke…she had to take him, and still does have to take him, to therapy three times a week. So um, I helped and worked for her sometimes and tried to help her

through this. Got the shifts covered so that she could be with him and, and of course she was very very appreciative until it came time for me to ask for something in return. And then she got upset. (Participant 1)

Many of the nurse managers ended up working as staff nurses, taking care of the patients themselves. Although staffing the unit resulted in the neglect of management responsibilities, it was reflected upon with a sense of pride and reward.

> Sometimes there is a need to be staffing. So a lot of days if it's really crazy busy, this job goes to the back burner and I'm out there. And I love doing it. I really do. To me, patient care is the most important thing and if that's what I need to be doing, that's what I'm doing. And they [the nursing staff] just have to understand if the schedule comes out late, it's because I was on the floor helping them. I've gotten out of my bed and come in at night…I've come and worked 12-hour night shifts to be here for them when they're short staffed. So I think they know that I really do care about them and that I'm there for them. (Participant 4)

> Last night we did a cadaveric kidney transplant. They needed another nurse…it doesn't cost me anything to do this because they [Administration] are going to pay me whether I'm here last night, today, or whenever…I'm on salary…I have the experience, and I can use it as a learning opportunity to teach the staff that's here new things, different things. Plus, I can show them that someone recognized that they were in need and responded to….yeah, I'm gonna be tired the rest of the day, but I've bought myself a lot of loyalty…they could deal with their patients and not have to feel spread so thin. Plus, I don't have to worry about what happens to that transplant. I know what happens to it because I did it.

The nurse managers had empathy. They sought to understand the needs of their employees. Nurse managers did not put their job responsibilities before the needs of their staff members realizing that "they have other stressors in their lives which should be more important than just their work" (Participant 6).

Nurse managers strove to make everyone happy, yet their efforts were not always reciprocated. One proclaimed, "I've reached the point now where I've accommodated and I've done as much as I can. I've gone overboard" (Participant 4). When they could not convince staff members to pick up shifts or improve their performance, the professional dedication of their employees was questioned.

Theme Three - Clock In, Clock Out: A Lack of Professionalism

The nurses expressed a concern regarding nursing's current status and future. Nurse managers described negative behaviors and a lack of work ethic among nursing staff members. Others talked of the need to improve nursing's image and the need for nurses to evaluate why they entered the profession.

> I am really worried about nursing, you know, our future. And I think that we're not in a very healthy state right now. I think that nursing is viewed as a really

stupid profession. And I would like to see nursing as a whole…become more professional. Being viewed as a more attractive profession by people, men and women…I have never regretted my decision to do it…people will say, "Oh! You're just a nurse." And how many times have people been at our mercy (laughing) or in our care, looked to us for survival? Because it's not the physicians that's at the bedside taking care of the patient and knowing what's going on with the patient. It's the nurses. (Participant 4)

I can't pay nurses what they're worth and what they're education has prepared them for. So, consequently, and I would never say this out on the unit because it would be insulting to my staff. I have two sets of staff. I have staff that have been here with me for a long, long time that have vested interest in this institution, who need retirement and they need to keep going. And most of those ladies and gentlemen are extremely good, dedicated individuals. Then I have a group that can't make up their debts. That's who will accept the working conditions that I have available at this time and the salaries that I'm able to give. The real go-getters, the real shining stars of today have moved on. There are too many other fields that we can use nursing degrees in…And though our public really needs good, smart, aggressive nursing care in the acute care hospital that is not what they're getting. What they're getting is a mean age of nurse somewhere between 42 and 45 years old that has experience. And then there are the very young that have gone from job to job to job to job primarily for the top dollar. And that's very disturbing to me. (Participant 7)

Another thing I've seen a big change in is work ethics. You do not have the caliber of people, and I don't mean that derogatory, you know. I'm just saying they are here to clock in and clock out. And, "Don't ask me to go for an in-service out of town." Uh, "Don't ask me to get a certification," you know. It, it's just an entirely different type of work ethic. You've got to constantly tell some of them, RNs and others, unit secretaries, nursing assistants, "Have you done this? Have you made sure your patient has water?" A simple thing as that…and that really is a reflection on our quality of care. (Participant 8)

Not everyone is the nurse you thought they should be. (Participant 2)

I don't feel that people in nursing right now understand as much of the calling side to nursing. Nursing is a called profession whether they realize it or not. I think if somebody is in this profession and doesn't feel that, then, they might want to look at themselves…if we don't understand nursing to be a calling, everything we do is mundane. Everything we do is task oriented. And tasks are something that we like to put off and not do…I do think it's a calling. And I think that whether people have a religious belief or not, I think that they had to feel something there to be at an exact point in their life they decided on nursing…there's a lot of anxiety about when our nurses get older and retire…I think that every nurse had that one particular incident, or something that happens

that causes them to be a nurse. I think we're all concerned about nursing…I worried about nursing. And I, even though it is the pillar of healthcare, I will say that over and over and over again. Because nursing's always done what nobody else wanted to do…I think that it'll be, it'll be a lot more difficult to be a nurse in the future. Like I've said, we have a *lot* of people not have that calling. (Participant 6)

The former nurse manager believes that there is a reason nurses choose nursing, or perhaps nursing chooses them. Nurses who deem their profession a good fit value the time spent with their patients. As we have seen in this study, nurses who become nurse managers still value their time at the bedside. Some even long for it.

Patients

Major Theme - I Never Forget What It's Like to be a Nurse

It was clear that these nurse managers were committed to their patient focused profession, a common theme found throughout the eight transcripts. In a chaotic, unconcerned bureaucracy, doing what was right for the patients was worth the risk whether it be terminating a nurse, challenging administration's decision to not purchase equipment, or not getting sleep because they had worked side by side with their staff the night before. Patients were the priority. Some managers longed for the hands-on experience of caring for them, something that was no longer possible because of their numerous responsibilities.

To me, patient care is the most important thing and if that's what I need to be doing, that's what I'm doing. (Participant 4)

There's a part of me, myself, me, that from time to time, I think I miss that staff side. I miss the patient contact. I miss-, and that's because I have the role as a manager. (Participant 6)

I'm a good patient advocate…but that avenue of working with patients is just one little, itty, bitty piece of the nurse manager's role. (Participant 2)

Indirectly I'm affecting the patients because I truly believe that if you take care of the staff, that's the best way to take care of the patients…but that direct hands-on care, you know, I miss that part of it. And I still do it sometimes but, but you can't do that and do this at the same time well. Because this is a whole different set of responsibilities. (Participant 3)

I came from the old school where we really were into patient care. And uh, maybe I feel frustrated from those experiences that I've not been able to have the hands-on…I don't mean everyday, but just being able to get out of the office enough that I can go visit each room and see that everything's okay… (Participant 8)

> I really do enjoy teaching young nurses how to take care of patients…I do enjoy seeing patients that are critically ill and being able to have some effect, to turn around and give them a better quality of life. I do enjoy that. So, those are the positive things that are in this position. (Participant 7)

> I never forget what it's like to take care of patients. And I never forget what it's like to be a nurse. (Participant 1)

Summary

A bureaucracy unconcerned with the challenges of the nurse manager served as the contextual ground for every participant. A total of 10 themes emerged from the transcripts and were assigned to one of five categories that existed within the bureaucratic environment. The five categories provided a framework for the thematic structure. They were: Organization, Administration, Nurse Manager, Nursing Staff, and Patients. The themes were actually manifestations of how the nurse managers experienced each of the five categories. The overall experience of the nurse manager could be summarized as one of frustration, isolation, and a lack of appreciation.

CHAPTER V

DISCUSSION

The purpose of this study was to gain differentiated understanding of the roles of nurse managers. Eight nurse managers were interviewed. Through the implementation of an existential-phenomenological research process, a thematic structure was developed (see Figure 1). The contextual ground of the structure was a bureaucracy unconcerned with what nurse managers strove to accomplish. Five major categories: Organization, Administration, Nurse Manager, Nursing Staff, and Patients, formed the thematic structure and among them emerged 10 defining themes. Each theme was a manifestation of how the nurse managers experienced each category.

In the Introduction of this dissertation, there was a discussion of the "bureaucratic mentality" (Peterson, 1994, p. 209) that dominated healthcare organizations prior to the 80's. The managers in this study reveal that bureaucracy has a stronghold today as organizations face financial uncertainty. As nurse managers discussed what stood out to them in their roles, the overall description of their lived experience was that of despair and isolation. It was clear that each nurse manager desired to be successful in his/her role. However, barriers within the bureaucracy, such as no support from administration and difficulties with staff members, made headway difficult. Styles (1982) described the conflict that may occur among health care professionals and bureaucratic organizations. As professionals attempt to gain autonomy and make decisions about their practice, the difference in values (patient outcomes versus finances) becomes apparent. Professional peers struggle with organizational superiors for control. This scenario held true for the nurse managers in this study.

Nurse managers spoke of learning about their roles from trial and error just as the more experienced nurse managers described in the study by Horvath, Aroian, et al. (1997) in which learning from experience was a strong theme. Critical incidents could occur at any moment without preparation of how to deal with them. Nurse managers in both studies spoke of feeling isolated and feeling the need for validation after making difficult decisions.

With what we already know about nurse managers, the negativity surrounding the nurse manager role was not a new finding. What was surprising were their statements about what it was that kept them coming back day after day despite the hardships. These nurse managers had a commitment to their profession, a common theme linking the dozens of situations described by the participants, prominent against the ground of an unconcerned bureaucracy.

Nurse managers in this study sought meaning in what they did. They described their desires to positively impact the health care system and to make a difference. They had the sense that what they did everyday was for the benefit of nurses, patients, families and for the profession as a whole.

Styles (1982) described a framework of a defined set of beliefs about nursing that could guide how nurses view their work and make practice decisions. Shared beliefs offer nurses the sense that they are a part of an important, collective, professional body of colleagues. Nurses' personal meaning and self actualization through their work

existed with a deep dedication to the profession. Nurse managers in this study were indeed dedicated to nursing as a profession. However, they lacked the sense of being part of a unified cause.

Nurse managers described why they returned to their positions everyday. Why am I still here, you ask? After reflecting on the negativity of the incidents they describe, nurse managers ask this question and answer it. Nurse managers are still here because of: feeling that they made a difference in the system, the few words of appreciation for their efforts, feeling supported by immediate peers, knowing that they have the choice to leave at any time, and finally, being financially vested and awaiting retirement. The last two reasons are rather bleak and render a sense that these nurse managers are holding out as long as they can.

In the category Patients, nurse managers describe their longing for contact with patients. The desire of the nurse manager to be at the bedside is not surprising since every aspect of nursing holds a common consideration for the patient. While other tasks required much time and repeated efforts, being at the bedside offered instant gratification. This gratification came from knowing that the patients received good care. It also came from the respect and appreciation gained from the staff members. The many demands of the nurse manager role made this source of gratification infrequently accessible.

Findings of this study were congruent with other findings on nurse managers. Just as staff nurses have experienced bureaucracy, lack of resources, feeling unsupported, lack of respect and understanding, and a lack of caring from the managers and/or organization as barriers to the administration of caring practices (Cara, 1997), so did the managers in this study experience the same phenomena as inhibitors to the implementation of their roles. Sullivan, Bretschneider, and McCausland (2003) had nurse managers identify staffing as a most significant challenge in leadership. This was supported by the managers in the current study who, many times, ended up taking care of patients themselves when unable to effectively influence staff members to work. "Bending over Backwards: Staffing and Scheduling" for staff became the emerging theme as the eight nurse managers described their experiences with staffing and scheduling.

Another congruency was found between the current study and Sullivan, Bretschneider, and McCausland's findings. Nurse managers in both studies described the phenomena of being caught in the middle. The congruent theme was actually, "Being in the Middle: Bosses on the Top and Bosses on the Bottom." This implied that the managers were consistently trying to fulfill responsibilities to both administration and nursing staff, many times experiencing conflict and being unsure of where their loyalties should lie: the budget (administration) or quality nursing care (nursing staff). A manager in Thomas's (2004) research described being in the middle as being "in this sandwich of making peace with all" (p. 138) when arbitrating among nurses and physicians.

Another similarity between Sullivan, Bretschneider, and McCausland's study and this study involved the comments made by nurse managers about new nurses and their expectations, demands, and work ethics. The theme that emerged in the current study was that of "Clock In, Clock Out: A Lack of Professionalism". One nurse manager described how she had two types of staff, those who were dedicated and committed to

remaining in their positions, and the newer, usually younger nurses who seek maximum compensation and move from job to job. Sullivan, Bretschneider, and McCausland's nurse managers also described new nurses as a different type of nurse.

Managers in Thomas's (2004) research, like managers in this study, spoke of the frustration caused by negative behaviors of their staff members. Both sets of managers described nurses who did not seem concerned about performing at a high level and lacked enthusiasm. Similarities among these managers further support the theme "Clock In, Clock Out: A Lack of Professionalism". Thomas also found nurse managers in her study to feel isolated and lonely, supportive of the theme, "Being Separate: Feeling Alone". Just as in this study, Thomas's managers felt a lack of support and inadequate feedback regarding their performance.

Some of the hardships related to oppression experienced by nurse managers in other countries were similar to those of the nurse managers in the current study, although perhaps not to the same degree. Still, oppression was a very obvious aspect of the nurse managers' working environment. Unlike the nursing leaders, managers and executives, in Upenieks' (2003) study who experienced both informal and formal power in their organizations, the nurse managers in this study felt powerless due to the bureaucratic restraints.

The American Nurses Association (2004) eloquently defines Scopes and Standards of Practice and Performance for nurse managers. When one reads through the scopes and standards for nurse managers, one might view the nurse manager role as challenging, exciting, even powerful. In reality, managers are unable to perform at their highest level if they work in organizations where they are not respected, and their input is not valued. Whether it be assessing the effectiveness of data collection systems or evaluating processes surrounding patient care in a particular service line, the extent to which nurse managers successfully address all areas within their scope is dependent upon the culture within which they work. In unpleasant, hostile work environments nurse managers are prevented from fulfilling their roles.

In this study, nurse managers, due to lack of resources, were prevented from accomplishing tasks at the middle management level because they had to stop and address staffing needs. It was within the nurse managers' scope of practice to establish their budgets for the following year. Nurse managers experienced frustration when told by executives that equipment desperately needed to ensure patient safety, such as wheelchairs or a security system for an obstetrical/newborn unit, could not be purchased. On a positive note, when ineffective processes were interfering with patient care, such as medications or patient care supplies not being available to the nurses, one nurse manager used her creativity and assertiveness to bring together leaders from different departments. As a result, processes were improved and the nurse manager achieved feelings of accomplishment. When nurse managers were able to accomplish professional goals successfully and feel they made a difference, they experienced feelings of satisfaction. These feelings of satisfaction were equivalent to those experienced by managers in another study (Thorpe & Loo, 2003). However, in this study, such stories were few. Nurse managers tended to focus on the frustrating experiences where they met barriers and were unable to fulfill their roles. As participants discussed their endless challenges, they provided insight to what nurse managers need.

What Nurse Managers Need

The thematic structure provides a framework for health care organizations to consider when developing recruitment or retention programs for nurse managers. From the top level of the thematic structure, Organization, to the bottom, Patients, nurse managers revealed what they lacked in their lived experience. They revealed what they desired culturally and what they required from the top executive levels to the patient level where nursing transpires. The following paragraphs list the needs of nurse managers in the order of the categories and their themes as illustrated in Figure 1.

Nurse managers need a culture where innovation, flexibility, and equality are the norms and where processes flow steadily, uninhibited by bureaucracy. They want to work with an administration that values their input, guides and/or supports their decisions, and is in line with the philosophy of putting patients first. While feeling in the middle, nurse managers want administrators to understand managers' rights and responsibilities as nurse leaders to advocate for their staff members and patients. At the same time, nurse managers want staff members to be aware of the budgetary challenges, organizational goals, and the importance of teamwork and meeting the needs of patients. As impossible as it may sound, nurse managers want to feel supported by their superiors and their staff members. They also want to have the support of their peers and a forum where they receive encouragement, validation, and a feeling of collegiality amidst the chaos of multiple demands.

Instead of learning from their mistakes, nurse managers need to be prepared for what they face as leaders. They want access to further education so that they can learn the skills needed to thrive in their position within the organization. Nurse managers need to feel they are making a difference through their efforts. They need recognition as they make sacrifices and work long hours taking care of patients in addition to fulfilling their management responsibilities. Even if delivered as a simple "thank you" from superiors, colleagues, or staff members, a small amount of recognition goes a long way with these dedicated leaders.

Nurse managers need adequate preparation and encouragement as they deal with difficult situations involving their employees. When difficult decisions are made regarding personnel, managers need to feel supported. Nurse managers also need assistance with making out work schedules for their staff members and someone to deal with day to day staffing issues. Instead of constantly worrying about adequate staffing, nurse managers need to be able to focus of their responsibilities as leaders within their organizations.

Nurse managers want nurses and other personnel that value their work and represent the nursing profession well through their actions and by upholding a high standard of practice. They want staff members who are dependable and who work hard to meet the needs of their patients. Lastly, nurse managers need to be with patients. They need to feel that what they do has a connection with what happens at the bedside. Even more specifically, they want to be at the bedside. If not to actually care for the patients, then to converse with them to make sure that they are being provided more than adequate care. Knowing what nurse managers need leads to many implications for hospital administration and nurse manager practice, education, and research.

Implications for Nursing

Administration

Based upon the findings of this study, many conclusions can be drawn about the implications for hospital administration. Nurse managers want to be heard and treated as professionals. For nurses to be able to adequately take care of their patients, nurse managers need to be afforded the power and prestige to move forth in an organization and negotiate resources for their staff. No care will ever be cost effective if it does not meet the needs of the patients. Listening to nurse managers can be a primary step to optimal nursing care at the bedside.

A strong nursing voice must be present at the executive level to assist hospital administrators in understanding how their operational and financial decisions impact nurses and nursing care. The nurse executive should promote a culture where nurse managers feel valued and heard, even when requests for resources cannot be granted. Research shows that staff nurses are more satisfied if they are empowered to make decisions about their practice. How can staff nurses feel empowered if their nurse manager feels powerless? When nurse managers do not feel supported in decision making, confidence dwindles and they begin to question themselves.

> I have to come to some very difficult decisions sometimes…and people don't understand…I constantly try to reevaluate what I'm doing and how I'm doing it, and, if I'm being bad. (Participant 6)

Organizational cultures need to be facilitative of what leaders are trying to accomplish. Bureaucracy of some form always exists within an organization, but it should not be so prevalent that it produces barriers to professional practice. Problems can be resolved and processes can flow more efficiently if professionals are granted the opportunity to provide input. Organizational structures such as that of shared governance could relieve some burdens of the nurse manager and others members of leadership. In fact, in these organizations, all health care professionals, not just those in management, are expected to be involved in decisions made about their work. Employees are held accountable for their decisions and the work environment is nonpunitive. There is shared accountability for what goes on at the unit level regarding staffing, scheduling, absenteeism and other negative behaviors. Theoretically, a shared governance model can allow nurse managers to focus on the leadership aspects of their jobs such as strategic planning and the development of leadership among their staff members.

Practice

As the nurse managers spoke, the separation between the upper level of administration and their levels of middle management became clear. Just as Styles (1982) discussed, this bureaucratic separation became evident when different professional priorities (financial versus patient care) became figural. Nurse managers are often faced with the need to bridge this separation as they advocate for staff members and patients.

Although a certain amount of assertiveness is required, nurse managers can adopt savvy ways to dialogue and communicate their needs. Being knowledgeable of their scope and standards of practice (American Nurses Association, 2004), nurse managers can feel reassured that they are practicing within their realm when expressing the needs of their patient care areas.

Because of the volatile nature of the financial environment in health care, many times nurse managers' efforts will be thwarted. Nurse managers will not agree with some executive decisions. However, making an effort to understand executive mandates incongruent with the worldview of the nurse manager can ease the sting. Although it may seem otherwise, saying "no" to managers' requests is a financial and business based response not intended to be a personal insult.

Employees of the organization are constituents of administration. The administrative body belongs to all and is an entity accountable for ensuring the viability of the health care system and hence the jobs of nurse managers and staff members. Members of this executive entity were selected because of their skills and talents. Strive to form relationships with them and learn from them. Ask them to visit patient care areas and meet the staff members and patients. While in their presence take the opportunity to share what is needed to make patient care areas environments of stellar practice, what it will cost, and how it will benefit the organization. Stay informed on current events affecting health care systems (health system and insurance provider contracts, health system acquisitions and mergers, etc.) Show an interest in the challenges that executives face. Perhaps dialogue with them will provide an opportunity to help them understand the pressures experienced by managers from upper and lower levels.

As described by Styles (1982), perhaps in addition to standards of practice, nurse managers should make explicit their beliefs about their practice, and define what is meaningful. Discuss these beliefs with colleagues so that common ground is reached from which strength can be drawn during difficult times. Also, seek professional development opportunities in and outside of their organizations.

Nurse managers, surround yourselves with allies. Offer and seek support amongst your peers. You are nurses, and you know how to take care of others. Take time to take care of yourselves.

Education

In the review of the literature it became clear that graduate level education is an asset to nurses who have an interest in management. Schools of nursing teach nursing, not organizational theory and finance. For nurse managers to be prepared and armed with the appropriate knowledge to effectively implement their complex roles, they need a curriculum that introduces them to the many aspects of human management including effective leadership styles, organizational theory, finance, delegation, negotiation, and the selection of successful employees. Nurse managers should be given a realistic job preview so that they know what to expect as they take on their roles. Nurses are nurturers and aim to please everyone. Since nurses are predominately women, female gender characteristics enhance their drive to meet everyone's needs. Nurse managers need to be prepared with the mindset that they are not expected, nor should they try, to base their

success on the satisfaction and happiness of others. Educators should integrate coping skills and methods to acquire adequate support for nurse managers in the nurse manager curriculum so that when times are difficult, nurse managers can take action and take care of themselves (and one another).

Research

More research is needed on the implementation of mentoring programs for nurse managers as well as retention programs. Work environments and organizational factors should be studied to determine promoters of satisfaction among nurse leaders. If nursing cannot retain its leaders, how can it expect to retain its nurses? In the face of a nursing shortage, retention of nurses and their leaders is paramount to the delivery of nursing care as well as to the success of healthcare organizations. Until researchers can identify methods to provide adequate support for nurse managers and healthcare administrators are convinced of the importance of such methods, nurse managers will continue to experience hardship and, ultimately, disdain for their jobs. This is a tragedy when one considers that the profession of nursing has so much to offer. However, the future holds promise if nurse managers can obtain proper training, adequate support mechanisms, and continue to communicate their needs to executive levels, always keeping in mind that their purpose is to take care of their staff and, indirectly, take care of the patients.

Conclusion

Through their willingness to participate in this study, nurse managers' experiences have been recorded and their stories shared. A thematic structure of their lived experience has been developed. Nurse managers have much to say. Despite feeling in the middle, isolated, and unsupported, these leaders have so much to contribute to their organizations. Their undying commitment to their profession is to be revered. I hope the findings of this study leave the reader with a deeper appreciation and understanding of nurse managers.

It is with the words of a nurse manager that I will close. As she reflected on her journey as a leader, she was proud of all she had endured and accomplished. She summarized her image of the nurse manager as:

> She's *right* there in the trenches, so she's truly trusted. And she is somehow *esteemed*...that front line manager, that one that wears the tennis shoes and the scrubs and can flip (she snaps her fingers) over in a minute and become a bedside nurse...but can also sit at those big tables with those big people and actually talk. She's a *weird* kind of blend...she's in*credibly* versatile. I see her as (pause) the glue that actually holds it together...She is such a *vital* piece of what really goes on. (Participant 5)

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APPENDICES

APPENDIX A

IRB FORM B

FORM B

IRB # _____

Date Received in OR _____

THE UNIVERSITY OF TENNESSEE

Application for Review of Research Involving Human Subjects

I. IDENTIFICATION OF PROJECT

1. Principle Investigator
Wendy C. Shea-Messler
8955 Meadow Road West
Greenback, TN 37742
Home Telephone: (865) 856-3336
E-mail Address: Alwenmess@aol.com

Faculty Advisor:
Sandra P. Thomas, PhD, RN, FAAN
College of Nursing
University of Tennessee
1200 Volunteer Boulevard
Office Telephone: (865) 974-7581
E-mail Address: sthomas@utk.edu

Department:
College of Nursing, University of Tennessee

2. Project Classification: Dissertation

3. Title of Project: Within the Chaos: A Phenomenological Study of the Lived Experience of Nurse Managers

4. Starting Date: Upon IRB Approval

5. Estimated Completion Date: May 2003

6. External Funding:
Sigma Theta Tau Gamma Chi Chapter

II. PROJECT OBJECTIVE:

To gain a finer understanding of the lived experience of nurse managers.

III. DESCRIPTION AND SOURCE OF RESEARCH PARTICIPANTS

Nurse managers are defined in this study as managers who are RNs and are responsible for managing one or more patient care units. Their positions within their organizations are those of middle management. The titles of these nurses may vary according to the model of patient care used in their organizations. Titles may include, but are not limited to, nurse manager, unit manager, or health team leader.

Nurse managers in this study are employed by hospitals, each one a part of an integrated health care system. These hospitals contain an array of inpatient and outpatient care settings and specialty care areas and may include adult, child, and neonatal intensive care units, various medical and surgical units, and psychiatric units.

The sample for this study will be selected using a purposive sampling design. The researcher will ask, in confidence, English speaking nurse managers to participate whom she already knows, who are of diverse backgrounds, and who are working full-time in a hospital setting. The snowball sampling technique will be implemented as these nurse managers will be asked to suggest any other nurse managers that might be interested in participating.

IV. METHODS AND PROCEDURES

The researcher will participate in a bracketing interview. The bracketing interview will be analyzed using the existential phenomenological approach and the findings will be reported. After informed consent is obtained, each participant will be interviewed one-on-one and face-to-face using Pollio, Henley, and Thompson's (1997) method of existential phenomenology. The researcher will make the opening statement: "Please tell me about some incidents that stand out for you in your life as a nurse manager?" Subsequent questions will be asked primarily to encourage elaboration and clarification.

The interviews will be audiotaped. After the interviews, the participants will be asked to complete a demographic questionnaire (see Demographic Questionnaire). They will be asked to provide their age, sex, years of experience in nursing, years of experience in a nurse manager position, educational background, practice background, and some information about the hospital in which they work. The questionnaires may be coded according to the institution in which they practice, but the method of coding will be known only to the researcher. The interviews will be transcribed. The transcriber will sign a pledge of confidentiality stating that (s)he will not discuss any words or phrases within the content of the interviews.

Each transcript will be read once by the researcher to gain a sense of the whole interview. The transcript will then be read again to identify meaning units of words and phrases.

Themes emerging from the meaning units will be identified. As each new interview is transcribed and read, constant comparative analysis of the data will occur as the researcher continuously compares the content of every transcript. When no more themes emerge and the categories within those themes are saturated, then a thematic structure will be developed. The researcher will present the thematic structure to at least three of the participants to determine whether or not it holds true for them in their lived experience as nurse managers. For rigor, several transcripts will be read by a multidisciplinary phenomenology team who will determine if the investigator is identifying all the necessary meaning units and themes. When a transcript is read by the team, then every team member present at that time will sign a pledge of confidentiality. Once the thematic structure has been ascertained, the researcher will prepare the final report.

In order to maintain participant anonymity, taped interviews and transcripts will be stored in a secured location separately from the consent forms. Any publications, reports, or presentations of findings will in no way disclose the identity of the participants or link them to the study. The researcher will use anonymous quotes from the interviews to support the themes. Demographic questionnaires will be coded using a method known only to the researcher and they will not include the names of participants. The only other person having access to the data, other than the original researcher, will be the researcher's dissertation committee members. The data for this study will be kept for future analyses and will be maintained in a secured location.

V. SPECIFIC RISKS AND PROTECTION MEASURES

Participation in this study involves minimal risks. There is the unlikely potential that a participant may become emotionally distraught during the interview. In such an event, the investigator will remain with the participant until they are stable, offering emotional support. If necessary, the researcher will refer the participant to a mental health nurse practitioner for treatment.

VI. BENEFITS

There may be no benefit to participating in this study, although previous research has determined that talking about ones experiences can be therapeutic. The findings of this study could have implications for research, practice, education, and professional development of nurse administrators. Understanding the lived experience of nurse managers could stimulate further research on how to enhance their working environments, facilitate their effectiveness, and generate better outcomes of their practice.

It has been said that research of health care management can inform decision making and thus improve nurse managers' practice. Increased knowledge of managers' lived experiences could make nursing administration educators more adept as they help their students prepare for the challenges of their profession.

VII. METHODS FOR OBTAINING "INFORMED CONSENT" FROM PARTICIPANTS

Potential participants will be notified verbally and in writing (see INFORMED CONSENT FORM) that they may choose to accept or refuse to take part in this study. After accepting to take part in this study and signing a consent form, any participant may withdraw at any time. No decision regarding (non)participation in the study will have any bearing on an individual`s standing with coworkers, upper management, or any other sector of the organization. The purpose of the study and potential risks, benefits, and estimated time for participating in the study will be communicated.

VIII. QUALIFICATION OF THE INVESTIGATOR TO CONDUCT RESEARCH

The investigator has completed all course work required of a Doctor of Philosophy student in the College of Nursing and has passed the comprehensive final exams. As part of the curriculum, the investigator has taken a leading role in the conduct of several research studies of the nursing workforce. The investigator has also had academic preparation and practice in utilizing the existential phenomenological approach selected for this proposed study.

IX. FACILITIES AND EQUIPMENT TO BE USED IN THE RESARCH

The participant will be interviewed in a quiet, private location where there will be no foreseeable interruptions. A tape recorder will be used so that all the words of the participants are captured. A transcription machine may be utilized by the transcriptionist of the interviews along with a personal computer.

X. RESPONSIBILITY OF THE PRINCIPAL INVESTIGATOR

By compliance with the policies established by the Institutional Review Board of The University of Tennessee the principal investigator subscribes to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee. The principal investigator further agrees that:

1. **Approval will be obtained form the Institutional Review Board prior to instituting any change in this research project.**
2. **Development of any unexpected risks will be immediately reported to the Research Compliance Services Section.**
3. **An annual review and progress report (Form R) will be complete and submitted when requested by the Institutional Review Board.**
4. **Signed informed consent documents will be kept for the duration of the project and for at least three years thereafter at a location approved by the Institutional Review Board.**

XI. SIGNATURES

Principal Investigator: Wendy C. Shea-Messler

Signature _____ **Date** _____

Student Advisor: Sandra P. Thomas

Signature _____ **Date** _____

XII. DEPARTMENT REVIEW AND APPROVAL

The application described above has been reviewed by the IRB departmental review committee and has been approved. The DRC further recommends that this application be reviewed as:

[ ] Expedited Review – Category(ies): _____

[ ] Full IRB Review

Chair, DRC: Maureen Groer

Signature _____ **Date** _____

Department Head: Joan Creasia

Signature _____ **Date** _____

Protocol sent to Research Compliance Services Section for final approval on (Date)
_____

Approved:

Research Compliance Services Section
Office of Research
404 Andy Holt Tower

Signature _____ **Date** _____

APPENDIX B

INFORMED CONSENT FORM

INFORMED CONSENT FORM

Within the Chaos:
A Phenomenological Study of the
Lived Experience of Nurse Managers

INTRODUCTION

You are invited to participate in a research project. The purpose of this project is to gain a finer understanding of the lived experience of nurse managers.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

You will be interviewed. The interview will be tape recorded and transcribed verbatim. After the interview you will be asked to complete a demographic questionnaire asking you about your age, sex, and educational and professional background.

The amount of time for the interview may be one or more hours depending on how long you want to talk or how much you want to say about your experiences. You may be asked to participate in a follow up interview. During this follow up interview the researcher will reveal her findings and ask you to verify or deny that the findings hold true for you in your lived experience as a nurse manager. The follow up interview should take one hour or less.

RISKS

Participation in this study involves minimal risks. In the unlikely event that you become emotionally distraught, the researcher will remain with you until you are stable and, if necessary, will refer you to a mental health nurse practitioner for treatment.

BENEFITS

There may be no benefit to participating in this study, although previous research has determined that talking about ones experiences can be therapeutic. The findings of this study could have implications for research, practice, education, and professional development of nurse administrators. Understanding the lived experience of nurse managers could stimulate further research on how to enhance their working environments, facilitate their effectiveness, and generate better outcomes of their practice.

It has been said that research of health care management can inform decision making and thus improve nurse managers' practice. Increased knowledge of managers' lived experiences could make nursing administration educators more adept as they help their students prepare for the challenges of their profession.

_____ Participant's Initials

Lastly, understanding nurse managers' lived experiences could assist other nurse managers in acknowledging aspects of their own practice and recognizing that they are not alone in how they perceive their positions within or contributions to their organization. All these implications are possible. However, analysis of the data must be completed and a final thematic structure of the data developed before the true implications of this study are known.

CONFIDENTIALITY

Every effort will be made to maintain your anonymity. The transcriber will sign a pledge of confidentiality stating that no words or phrases from the interview are to be discussed. Any proper names or places stated during the interview will be renamed in the transcript. If your transcript is chosen and read by a multidisciplinary team of researchers, members of the team will also sign a pledge of confidentiality.

Taped interviews, transcripts, and demographic questionnaires will be stored in a secured location separately from the consent forms, which will be securely stored as well. Any publications, reports, or presentations of findings will in no way disclose your identity or link you to the study. The researcher may use anonymous individual quotes from your interview but only group results of the data will be revealed. The demographic questionnaire will not include your name. Other than the original researcher, the only person having access to the data will be the researcher's dissertation chairperson, a member of the University of Tennessee faculty. Upon completion of the study, the data will be maintained in a secure location and kept for future analyses.

EMERGENCY MEDICAL TREATMENT

The University of Tennessee does not "automatically" reimburse subjects for medical claims or other compensation. If physical/mental injury is suffered in the course of research, or for more information, please notify the investigator in charge, Wendy Shea-Messler at (865) 974-7581.

CONTACT INFORMATION

If you have questions at any time about the study or the procedure, (or you experience adverse effects as a result of participating in the study,) you may contact the researcher, Wendy Shea-Messler, at (865) 549-4246 or her dissertation chairperson, Sandra Thomas, at (865) 974-7581, 1200 Volunteer Boulevard Knoxville, Tennessee 37996-4180. If you have questions about your rights as a participant, contact the Research Compliance Services Section of the Office of Research at (865) 974-3466.

_____ Participant's Initials

PARTICIPATION

Your participation in this study is voluntary: you may decline to participate without penalty. This study is being performed independently of your employer. Your decision, whether or not you participate, will have no bearing on your employment status or your good standing with coworkers, upper administration, nor any other sector of the organization. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled.

CONSENT

I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant`s signature _____ Date _____

Investigator's Signature _____ Date _____

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Directions: Please answer the following items by either writing the correct response or checking the appropriate box.

Age: _____ Sex: F ☐
M ☐

Years of Experience in the Nursing Profession: _____

Years of Experience in a Nurse Manager Position:_____

First Degree in Nursing: Diploma ☐
ADN ☐
BSN ☐
MSN ☐

Additional Degrees in Nursing: ADN ☐
BSN ☐
MSN ☐
Ph.D ☐

Please list any other Degrees: _____

List patient care areas where you have ***practiced***: _____

_____

In chronological order from past to present, what patient care areas have you ***managed***?

_____

_____

Has the hospital for which you currently work ever achieved Magnet status? _____ Yes
_____ No

If so, during what time period was the hospital recognized as a Magnet facility?

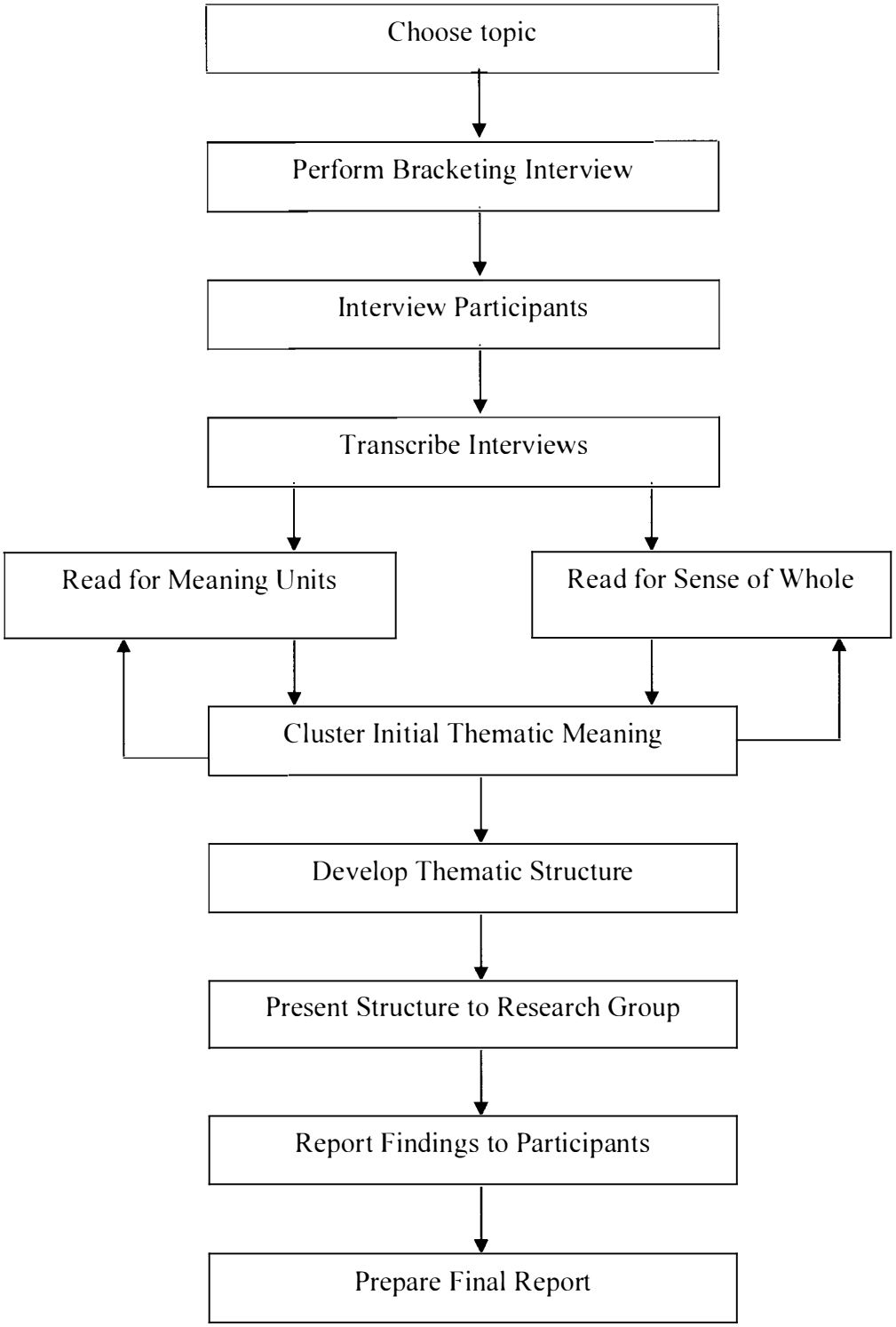
From _____ to _____ and (if applicable)
Year Year

From _____ to _____
Year Year

Is the hospital for which you now work a profit or not for profit organization?
_____ Profit
_____ Not for Profit

APPENDIX D

THE EXISTENTIAL PHENOMENOLOGICAL PROCESS



Original Copyright, 1997, Pollio, Henley, and Thompson. Permission obtained to duplicate.

VITA

Wendy Shea-Messler was born in Nashville, Tennessee on May 6, 1968. She grew up in Lenoir City, Tennessee and was graduated from Webb School of Knoxville in 1986 where she attended middle and high school. She received her Bachelor of Science in Nursing from The University of Tennessee, Knoxville in 1990. After eight years of practicing in various settings and managing the care of diverse patient populations, she received her Master of Science in Nursing also from The University of Tennessee, Knoxville in 1998 with a focus in Nursing Administration. Wendy was, again, graduated from The University of Tennessee, Knoxville in May of 2007, receiving a Doctor of Philosophy in Nursing Science.

She is former-chair of the Knoxville Area Council of the Tennessee Organization of Nurse Executives (TONE) and member of the TONE Board. She has served several terms as Treasurer of the Gamma Chi Chapter of Sigma Theta Tau, International, and is an active member of the Tennessee Nurses Association. She has presented research at local, regional, and national conferences.