THE ADMINISTRATIVE ETHOS IN NURSING:

A STUDY OF THE CAREERS OF

CANADIAN AND AUSTRALIAN NURSE ADMINISTRATORS

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ABSTRACT

This thesis presents a sociological portrait of the "typical" administrative career and a typology of the characteristics and beliefs of those who achieve the high status designation "nurse administrator." The thesis contributes to a sociological understanding of the preparation, recruitment, selection and appointment of senior administrators in nursing. This information is important to hospitals and health agencies requiring nursing leaders to shape and advance the objectives of the organization; and to prospective administrators who need to understand career routes to administrative positions, and to recognize attributes rewarded by promotion.

The theoretical framework for the study derives from social psychology as reflected in the symbolic interactionist perspective. Life and organizational contingencies influencing career pathways have been identified through semi-structured biographic interviews. These are used to demonstrate the dominant modes of entry to an administrative career in nursing.

This approach has enabled the isolation and description of a set of beliefs influencing the career decisions of nurses who become administrators. This collective belief system is referred to as the administrative ethos in nursing. Through an exploration of this ethos from the perspective of the nurse administrators interviewed, three variants - the clinical ethos, the management-organizational ethos, and the corporate-executive ethos - are proposed. The

thesis concludes that recognition of these variants is important in understanding how the career and professional practice of an administrator are shaped.

Sixty-two Executive Directors, Directors and Assistant Directors of Nursing, or their equivalents, were interviewed in detail. They were drawn from twenty-five large hospitals across seven major cities in three Canadian provinces and two Australian states. The cross-national comparative element of the study reveals that nurse administrators in both Canada and Australia have comparable beliefs about nursing and administration. While their career paths to an administrative position do not differ greatly, the administrative position is more likely to be a final career position for Australians, while Canadians are more likely to move between senior appointments in clinical service, administration and education, or to have joint appointments.

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I dedicate this work to my children, Anthony and Pamela Moorhouse. For their love and support, I am deeply grateful.

EDITORIAL NOTE

Spelling, editorial and grammatical conventions differ to some extent between Canada and Australia. The "default" usage is Canadian, though there are instances where the linguistic or printed convention of an Australian informant or author is retained.

Most fieldwork forming the empirical basis of this research was done in the period 1983-86. The thesis thus represents a perspective on nursing administration in the two countries at that time. Note also that interviews conducted in Montreal were conducted in English with Anglophone respondents. Where appropriate, statistical data relating to health care in each country has been updated to apply to present circumstances.

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THE RESEARCH PROBLEM AND ITS CONTEXT

INTRODUCTION

This is a study in the applied sociology of work. I have taken the view that occupational sociology has a well-developed body of theory, but that insufficient attention is given to applying that theory to practical problems related to the occupational context.

Health care as work has been a rich source of theory development for sociology. The present study seeks to turn some of that theory back to its source by addressing one practical problem: the recruitment, selection and appointment of the best available nurse administrators. The issue is significant to hospitals and related health care agencies because of their need to appoint the best available administrators who will advance the objectives of the organization. A clearer understanding of the process is important to aspiring administrators because they need to know what attributes are rewarded and what factors influence appointment to such positions.

The research problem is to identify the career paths of those nurses who achieve administrative positions in their profession. A career path can only be

adequately understood in the context of factors that have shaped it. I have identified those factors as "career contingencies."

The thesis gives particular attention to the belief system that orients a nurse toward an administrative career. The system of beliefs guiding action is operationally defined as an "ethos." This study, then, is an examination of the **administrative ethos in nursing** and its impact on the career trajectory of the nurse administrator.

It is important to this topic that we understand how the administrative ethos in nursing is learned and then accounted for in terms of the practical accomplishment of an administrative career in nursing. The theoretical perspective of **symbolic interaction** emphasizes the heuristic value of observing and interviewing actors in real situations. It is used here to help understand how nurse administrators subjectively perceive nursing and how those perceptions influence their career pathways to an administrative position.

The research sought to contribute to an understanding of how the subjective perceptions of senior nurse administrators are shaped, and with what consequences. Accordingly, I interviewed a selection of the nursing profession's designated leaders in Canada and Australia in order to identify shared beliefs about the processes, meanings and priorities of nursing administration. Through this process, I hoped to gain insight into how the careers of nurse administrators are shaped. To assist in sharpening the focus of the semi-structured interviews, a pilot sample of ten nurse administrators was first interviewed. From this first set

of interviews, the possibility of several variants of administrative ethos was identified.

The nurse administrators interviewed are well placed to serve this investigation for two reasons: first, they have successfully negotiated the process of being appointed; second, they are responsible for defining the objectives of their organization and for appointing other nurse administrators - some of whom will become their successors - to achieve those objectives.

In summary, the "research problem" addressed by the thesis is reflected in its **objectives**:

1. To outline the career routes by which nurses in the sample achieved administrative positions and to classify major factors influencing those career routes.
2. To identify the nature and variants of the ethos (dominant belief system) of nursing's designated administrative leaders.
3. To understand the process of adopting the administrative ethos *en route* to the administrative role in nursing.

The thesis is structured around eight chapters. **Chapter 1** outlines the **research problem** and the natural history (background) of the project. The socialization processes pertinent to nursing are outlined to establish a context for the body of the research, which deals with a specific category of nurses - those in senior administrative roles.

Chapter 2 outlines the theoretical precepts which have informed the study and which assist the **search for sociological patterns** in the data. It summarizes symbolic interactionist theory and pertinent literature from the sociology of occupations and professions, sociology of health care and role transition and status passage. The two final sections outline the notions of "career" and "administrative ethos" as analytic constructs central to the study.

Chapter 3 describes the **research method**, setting out the reasons for approaching the research problem as I have. The methodological framework is outlined giving particular emphasis to the biographic interview and comparative research. The interview sample is described, along with issues pertaining to gaining access to respondents.

Chapters 4 and **5** outline the **career paths** by which nurses in the sample have attained senior administrative positions in nursing. The chapters illustrate that the process of becoming an administrator entails a range of **life contingencies** and **organizational contingencies** that influence career paths.

Chapter 6 addresses the process of **adopting the administrative ethos**, illustrating that new definitions of self and of administrative work are learned and articulated in the course of becoming an administrator. This chapter identifies a typology of career-related significant others.

Chapter 7 identifies three **variants of administrative ethos**: the clinical ethos, the management-organizational ethos and the corporate-executive ethos.

They are described in terms of the beliefs and predispositions, which lead people into particular aspects of nursing administration.

Chapter 8 concludes the study with a re-assessment of the original problem in light of what the research has revealed. It presents a summary of characteristics reflecting the administrative ethos of nurse administrators. This is cast as a **portrait of a nurse administrator** that summarizes what has been learned from the research.

NATURAL HISTORY OF THE RESEARCH

This section outlines the natural history of the research (Schatzman & Strauss, 1973), describing the background to the work, the reasons for my interest in the topic and directions taken in the course of the research.

The project stems from a very simple interest: **to understand what makes a nurse administrator different from any other nurse**. As Co-ordinator of an Australian Advanced Nursing Course in 1979-80, I was in direct and frequent contact with 240 new nursing graduates in transition between the student and the professional role. As I witnessed their career-making I was disappointed to recognize that few of them gave serious attention to career planning and that chance was, for a majority, an acceptable basis for their early career path decisions. However, as I followed their careers informally over some years it was evident that even those who had set clear career goals were not necessarily successful in attaining them. Conversely, and paradoxically, a number whom I felt had given little attention to career planning had become

"successful," as measured by attainment of high status positions relatively early in their career. It seemed that career planning and goal setting may not have been as useful predictors of "success" as we commonly believe and that a range of factors, serendipity included, contributed to the ultimate shaping of their career paths. Hence, I became interested in how people make career path decisions from among alternatives available to them, and in how those responsible for making senior nursing appointments identify the best candidates.

My interest in role transitions found expression in work on role adaptation among new graduates in nursing (Moorhouse, 1983a, 1983b, 1992a), on the transition of clinicians to the academic role (Moorhouse, 1992b), and through my appointment to the Committee to Review Nurse Education in the Higher Education Sector in Australia (1994).

Having been periodically consulted on professional role transitions generally, I felt uncertain of the extent to which patterns of role adaptation among neophytes could legitimately be generalized to role transition among experienced nurses. Hence, the present study extends my earlier research interest in new graduates in nursing. By coincidence, five of the respondents in the earlier study of new graduates are now senior administrators in the current sample.

Nurse administrators have been among my colleagues, peers and friends for over 30 years. Among them were my contemporaries who, having started nursing in the late 1960s, grappled in the 1970s and 1980s with the problem of how to balance a commitment to clinical nursing with the wish to influence

practice more broadly through administration or education. What factors, I wondered, accounted for their ultimate career path decisions in a profession having many options and, in the 1980s, a buoyant employment market? A natural extension of this work would be to assess how the same people adapted in the 1990s and the new millennium, to an employment market which is by no means buoyant and in which the demands of senior executive roles have changed significantly because of changes in health policy and patterns of organizing, financing and delivering health care.

In support of the professionalization of nursing, discussed later in this chapter, nurses articulated an ethos of nursing based on caring. Since this ethos - the set of beliefs guiding practice - was apparently so highly valued in nursing, I wondered what happens to it when nurses move away from the bedside. Three possibilities seemed likely:

1. The caring ethos was never a confirmed part of their nursing identity, so they chose the shift away from direct care and adapted readily to the new (non-clinical) role.
2. The caring ethos was manifest in attempts, through the administrative role, to influence nursing care on a larger scale than was possible in direct patient care.
3. The caring ethos evident as a clinical nurse was transformed into a new ethos more relevant to administration than to clinical nursing.

This thesis, then, commences an exploration of the nature of an ethos of nursing as expressed by nurse administrators. In particular, it seeks to demonstrate the impact of those beliefs on career path decisions that have led respondents to the attainment of the high status position of nurse administrator.

THE RESEARCH CONTEXT

This section outlines nursing as the broad context for this study of a subset of nurses. It does so from the standpoint of its **professional socialization** processes, its dominant ideology as the **profession of caring**, and its **professionalization**.

By offering an insight into how nurse administrators perceive their position, symbolic interactionism can help us understand how these perceptions influenced their career pathways:

> The central principle of symbolic interactionism is that we understand what is going on only if we understand what the actors themselves believe about their world. (Charon 1995:206)

As Whyte (1955:323) observed forty five years earlier, it is only possible to comment on a social setting when individuals and groups are considered in terms of their positions in the social structure. Hence, the following description of the social organization of nursing aims to make sense of how the group of nurses in this study learned the culture of nursing which they came, ultimately, to influence as its leaders. The discussion of socialization processes locates the

research within the context of nursing as a profession in flux, strongly influenced by its movement toward professional status.

Professional Socialization: Learning Nursing Culture

The origins of a nurse's beliefs and values are revealed partly through examination of life-course socialization processes. Three forms of socialization are relevant: primary socialization, anticipatory socialization and occupational socialization.

Primary socialization is that process of learning, in childhood, the expectations, values and behaviours appropriate to the social environment in which the child is reared. Of relevance to the present study, it furnishes substantive values that remain evident in later life. The following excerpt from the transcript of an interview with one of the nurse administrators in the study illustrates this:

> **I was brought up in an entrepreneurial family so I was used to being associated with power and with powerful and influential people, so I was very comfortable with that when I came nursing. I was also in a family in which there was no difference between my brothers and myself. There were no limitations placed upon me. What I wanted to do, I was encouraged to do. I wasn't focused in on typical things that women did. It was also important that I go to university. There was no possibility in my upbringing to ever even doubt that I would go to university. So, I came with a great deal of confidence in my own abilities. [Primary] socialization equipped me to interact with a variety of groups of people. I had a self-image that was very positive. (#102)**
>
> (See Chapter 3 for explanation of respondent codes.)

Anticipatory socialization, as it relates to the occupational context, takes the form of inside information from those "in the know." Their tales of work as a nurse help to prepare aspiring nurses for the realities of the job; to give them some idea of what to anticipate as a nurse; to begin the socialization process that will be formalized when they begin nursing. This concept of anticipatory socialization is relevant not only to entry to a profession but also to movement into the strata of the profession. Hence, reference is made to anticipatory socialization for an administrative role in nursing.

The Canadian respondent quoted above explains how, on the threshold of a nursing career, influences in her university education consolidated her self-image as a potential success in nursing:

> **Through the university education process, in a small group of students where a lot of attention was paid to us and our abilities, it was drummed into our heads that we were prepared as bedside nurses, but that we had the potential to go on and be leaders in the profession. (#102)**

Another respondent relates how her early experience of health care gave a sense of what to expect as a nurse. This influenced her subsequent attitudes about the health care system:

> **As a history student with no nursing background, I worked as vacation "replacement" for the nurse in an Arctic nursing station where there were no physicians. You become an independent and confident decision-maker in such settings. Thrust on your own devices you just have to succeed ... I finished my B.A then transferred to do a five-year B.Sc. in nursing. Six years after my first visit, I returned to the Arctic for 2 months - this time with a few skills. (#202)**

This anticipatory socialization experience gave her enough information to be able to set clear career goals. Two divergent experiences - independent work as an untrained person in an isolated setting and subservience in a developed setting - led her to seek the opportunity, through education, to draw together what she saw as the best of her experiences in the Arctic, in France and in Canada:

> **Following registration, I spent six terrible months in a hospital in France. I returned to Montreal convinced that I should do a Master's degree because I couldn't bear the sense of powerlessness ... I couldn't abide the structure of nursing as it existed and the way I was perceived as a nurse ... I found it hard to tolerate the impotence of not being able to change anything, even procedural things that were clearly ridiculous. I was 27... [six years] older [than my peers] and had done other things outside nursing and could see through it. I had spent 5 years [as a student] learning a system of dominance and subservience, but even before I trained in nursing, I had survived in an independent health care setting doing work that mattered and doing it independently - making judgements and being accountable for them; creating a structure where there wasn't one; making things happen without massive power-related blockages ... The paradox coming to the big hospital is that in spite of all the talk about professionalism, the hospital structure takes away all [incentive]. All decisions had to go through higher structures - the team leader to the head nurse to the doctor. You as the initiator were just the staff nurse at the bedside. (#202)**

Occupational socialization is the process by which the culture of the work setting is learned and internalized by individuals to reflect the dominant occupational values. The socialization process for an occupation in transition to professionhood is complex (Styles, 1982). In pursuit of a new identity as a profession, nursing creates the sort of personal identity pressures suggested by the following transcript extract:

> **Nursing is more than just a job. When I speak to staff nurses about their nursing identity, I use the expression 'Nursing is not something you do, it's something you are.' I couldn't leave it ... The career nurse is a professional nurse. (#205)**

The presentation of self as a "career nurse" is a valued attribute in nursing. The term refers to someone who has decided to commit to nursing as a long term career, thus distinguishing the professionally oriented ("career") nurse from the nurse whose motives are utilitarian and whose commitment to the profession is likely to cease when other opportunities, including travel, marriage or maternity, arise (Moorhouse, 1992a: 62-3).

In adopting the set of professional values leading to the attribution of "career nurse" status, an individual needs to avoid acquiescence to the trinity of submissiveness, subservience and passivity:

> **It was not that nurses were overtly socialized in the hospital/diploma programs for a submissive or passive role. But since those mind-sets persist in hospitals they are part of the context of the whole health care system. (#103)**

A consideration of the role of significant others in the socialization process is germane to this brief discussion of the enculturation process. Nurse administrators' significant others were found to have a major bearing on values formation, conceptions of self, and career path decisions. These matters are considered in Chapter 6.

Quotations such as those above provide a rich source of insight into the paradoxes of socialization in and for nursing. While most people succumb to the considerable pressures of occupational socialization, some maintain dominant

values at odds with those promulgated through formal occupational socialization. It was evident from the interviews that the change agents in nursing had resisted or circumvented much of the socialization process and the ritual pathways to power, rejecting the normative order and deviating from the pathways by which chosen ends were generally considered to be achieved within the bureaucratic structure of the hospital and the health care system.

The traditional view of occupational socialization would suggest that those nurses who are most "effectively socialized" as compliant advocates of the professional and organizational *status quo* are most likely to be valued in administrative roles where they can promulgate those values. Adherents to that normative view of professional socialization will find it disturbingly paradoxical that, as we will see in Chapter 6, "deviant" junior nurses were often selected later for influential positions on the basis of that same critical perspicacity which had rendered them difficult to socialize in the usual manner. Well-meaning attempts to "bring them into line" made life difficult for them in junior positions. About 25% of the sample described themselves as having been "difficult" or "trouble makers" during their student and staff nurse days. Since no direct question was asked on this matter, the figure may have been higher. This observation is worthy of further study. Perhaps it is that recalcitrant nurses establish a record for seeing the problems and finding ways to address them - attributes valuable in the administrative role but not so popular at lower levels of the organizational structure of nursing.

Caring as the Dominant Ideology of Nursing

The helping and caring professions (e.g., nursing, teaching, social work and medicine) are often assumed to have an occupational ideology predicated on such generic qualities as goodness, selflessness and a service ethos. The specific notion of caring is most clearly explicated in nursing's ideology. The strongly socialized emphasis on caring sets nursing apart from the civic service professions (e.g. policing), curing professions (e.g. medicine), and the helping professions (e.g. social work and teaching). It was not that other health professionals did not "care," they do - so do judges, ministers of religion, police and shopkeepers. The difference can be identified as the fact that the provision of "hands on" care, on a twenty-four hour per day basis, is a fundamental attribute of clinical nursing (though not all branches of nursing require twenty four hour cover).

In striving to articulate a specific body of knowledge and a domain of independent professional practice, nursing opinion leaders have conceptually refined the notion of nursing as the profession of caring (Benner & Wrubel, 1989; Meleis, 1985; Watson, 1985, 1979; Leininger, 1995, 1981; Pearson & Vaughan, 1986). Hughes (1990), however, notes both the parallels and the uneasy tension between the "ideology of domesticity" and the "ideology of professionalism":

> The ideology of domesticity provided the path of least resistance by which nursing could be recognised as a legitimate occupation for women ... In like fashion, the ideology of professionalism offered nurse leaders the vision needed to elevate the legal and educational standards under which nurses practise...There has been a tendency among nurses to equate the development of nursing as a discipline with its evolution as a profession ...

> Nursing must look beyond this ideology to identify strategies by which it can enhance its social prestige and negotiate for practice-related reforms. Such strategies will succeed, however, only in a society that is able to value caring and recognise its worth, for this is the foundation on which the discipline of nursing rests. (Hughes, 1990:30,31).

More recently, Webb (1998) alerts us to the fallacy that has historically associated the notion of femaleness with caring behaviour: evidence for this, she suggests, is "weak to say the least." (Webb 1998:4)

Although this project commenced with an objective of relating administrators' belief systems to ultimate career paths, it became clear from the pilot interviews that there was no single administrative ethos. Under the rubric of "caring" as the dominant ideology in nursing, there were variants in the ethos, sub-categories in which the belief systems of nurse administrators could be considered in more detail. These variants represent shifts in the locus of caring among nurse administrators as their careers progressed. Personal ambition and interests determine how they care and for whom, but most who go into administration are physically and in other ways removed from direct patient care. This will become evident in Chapters 4 and 5, which examine the career paths by which clinical nurses achieve administrative positions; and in Chapter 7 in which three variants of the administrative ethos are considered.

The Professionalization of Nursing

Interview data highlights the view that nursing warrants, and is accorded, status as a profession. This is congruent with literature on professionalization,

which can be found at the interface between nursing and sociology (Benner, 1984; Hughes, 1990; Olesen & Whittaker, 1968; van Maanen, 1990). The merits of that claim in terms of the criteria of professionhood (Abel-Smith, 1977; Greenwood, 1957; Vollmer & Mills, 1966; Wilensky, 1964) remain a matter for debate (Becker, 1970; Bucher & Stelling, 1969; Bucher & Strauss, 1966; Davies, 1983; Etzioni, 1969a). Since the purpose of this thesis is to present nursing and nursing administration as seen through the eyes of those who do it, the relative merits of the argument on the professional status of nursing will not be debated here. Rather, I have accepted the respondents' view for the present and will defer to their definition of nursing as a profession, while attempting to identify the basis of that definition as expressed by nursing's administrative leaders in two countries.

To establish a credible basis for recognition of professional status, nurses have done four things:

1. Enhanced the level of education necessary for entry to nursing practice, making a university degree the only mode of access to professional registration (National Review of Nurse Education in the Higher Education Sector - 1994 and beyond' (1994, Australia)).
2. Identified a philosophy and an arena of practice unique to nursing and characteristic of the discipline of nursing (Gray & Pratt, 1991).
3. Developed a research-based body of knowledge specific to the practice of nursing.

4. Organized a career structure for nurses, which embodies the professional principles of autonomy, responsibility with accountability and self-regulation.

The growing movement to professionalize nursing has been predicated largely by the argument that the uniqueness of nursing lies in "caring" as the central concern of nurses. In this context, nursing is designated as the profession of caring. Papers published on the topic in the major professional journals of each country, indicate that the movement appears to have reached its peak in the 1960s in the United States, in the 1970s in Canada and in the 1980s in Australia

Progress toward professionhood does not emerge from the occupational culture; it is seeded and nurtured as a notion worthy of endorsement and active support, including pursuit of the criteria by which it is assessed. In this process, the role of education in nursing has been critical. It was emphasized frequently in the interview responses, for instance:

> **As the trend moves toward professionalization of practice, you must build in a system to promote it. That is usually in the form of the education centre or the staff development and in-service education departments. Their role is becoming more important now in terms of assisting the professionalization process rather than merely teaching and upgrading clinical skills ... Many nursing roles now demand skills not solely available from traditional nursing schools. (#205)**

Some senior staff do not survive the professionalization process because its success depends so much on higher education of nurses:

> **The problem is that we have a lot of very senior nurses on good salary who have not kept up their level of education, even in**

> **in-house clinical things, much less their broader education for the profession. (#205)**

Some respondents judged the progress of nursing in terms of its progress toward profession hood:

> **I get satisfaction from looking backward and realizing just how far nursing has come in my [22 year] working life. In that time, we have gone from a menial labour force to a profession. (#302)**

However, not all share the view that professionalization is necessary for nursing, or that progress has been made toward it, or that what progress has been made is for the benefit of patients rather than for the benefit of nurses (van Maanen, 1990):

> **We have not got rid of the handmaiden image of nurses. University education has not made as much difference as we believe. Nurses come to work now [from university] with fewer real skills, but with a greater understanding of professional issues. How does that help sick people get better? (#306)**

> **Professionalization in nursing creates double standards. [Some registered nurses] believe they are serious about quality of patient care, but it is self-motivation that really drives them to it. Many go through the motions [of professionalism] without meeting the criteria. Others, thank God, don't understand it at all; they just want to get on with the business of caring for the sick. (#404)**

Such untoward interpretations of nursing's professionalization nevertheless have at their core a primary concern with quality of patient / client care, a reflection of the persistence of caring as the dominant ideology of nursing.

SUMMARY

This chapter has outlined the genesis and evolution of the research project. It defined nursing in terms of its professional socialization processes and outlined the influence of nurse administrators on that process. The chapter also outlined the emergence of caring as the dominant ideology of nursing and addressed the professionalization of nursing. Thus, the chapter served as the contextual background to the thesis.

CHAPTER 2

THEORY: IN SEARCH OF SOCIOLOGICAL PATTERNS

THEORETICAL PRECEPTS GUIDING THE STUDY

The purpose of this chapter is to outline the theoretical precepts which have informed the study and which assist the search for sociological patterns in the data. The first sections summarize symbolic interactionist theory and relevant literature in the sociology of occupations and professions and the sociology of health care. The later sections outline the theoretical basis of "career" and "ethos" as key analytic constructs for the study.

Although the subject matter lends itself to several forms of sociological analysis, this thesis is primarily a qualitative exploration of individual experiences of nursing through symbolic interactionist analysis. This contrasts, for instance, with analyses of structure, role, function or power relationships in the nursing profession, which would be informed by other theoretical perspectives in sociology. By focusing on how the belief systems of nurse administrators influence their career paths, I seek to identify sociological patterns from the data that will contribute to a broader understanding of factors influencing the careers of nurse administrators.

Theory can be thought of as the "conceptual architecture by which sociologists try to make sense of their findings." (Berger & Berger, 1975:vi). That conceptual architecture is generated from what Blumer (1969:148) calls "sensitizing concepts" which "give[s] the user a general sense of reference and guidance in approaching empirical issues." These sensitizing concepts enable us to identify, differentiate and classify events from the empirical world. By drawing together the conceptual threads from a range of areas of observation, we are able to build progressively more generic concepts to account for social life and behaviour (Becker, 1963). Willis (1993:117) refers to this approach to understanding the relationship between the individual and society as the "sociological quest." However, the pursuit of broadly applicable or generic explanatory concepts does not imply the expectation that we may ultimately reveal a set of deterministic rules governing social process. However, the process of drawing together related issues and social events under conceptual banners does enable us to propose "ideal types" which help in predicting outcomes of social action. Like Schutz's (1961) "typifications," ideal types are:

> Devices intended to institute comparisons as precise as the stage of one's own theory and the precision of his instruments will allow. (Martindale, 1963:34)

Ideal types are, Martindale continues, neither logically inter-related bodies of empirical laws, nor mathematical models. They are versions of the way to interpret a given world. They serve as indicators of the concepts which may be refined to:

- guide the analysis, rather than become a formula for explanation;

- form a basis for comparison;

- relate specific events to the broader context.

This thesis draws heavily upon two concepts from sociological theory: career and ethos. Each is discussed later in this chapter. Together they form the over-arching paradigm within which I have sought to identify typifications of the nurse administrator. A paradigm as described by Kuhn (1962) is:

> ...a collection of logically connected concepts and propositions that provides a theoretical perspective or orientation that frequently guides research approaches towards a topic. (Field and Morse, 1985:138)

The paradigm defined by the notions of career and ethos provides a perspective from which to identify ("discover") typifications ("ideal types") of the nurse administrator through a deductive ("grounded") approach to analysis of interview data (Glaser and Strauss, 1967; Glaser, 1978).

In searching for sociological patterns to define an ethos typifying nurse administrators, I have identified three forms of an administrative ethos in nursing. These "variants of the administrative ethos" are addressed in Chapter 7. This process of differentiation and classification serves to refine the concept of an administrative ethos by reference to typifications among sub-groups of nurse administrators.

Before further discussing the empirical evidence of the study, it is appropriate to outline, in broad terms, the symbolic interactionist tradition and relevant sociological literature informing the study.

Symbolic Interaction

Symbolic interactionism focuses on the idea that humans are dynamic, rational problem solvers, and that society is a process of individuals in interaction:

> The human engages in overt and covert action in the **present** – recalling the past, planning for the future – and the action that takes place between individuals is an important influence on the direction of individuals and societies. (Charon 1995:202)

The basic precepts of symbolic interaction arise from the now classic works of Blumer (1962, 1969), Cooley (1956), Goffman (1959), James (1893), Mead (1934), Thomas (1931) and the subsequent refinements of Huber (1973), Manis and Meltzer (1978), Meltzer, Petras and Reynolds (1975), Stone and Faberman (1981) and others. They may be summarized as follows:

1. Humans generate sets of symbols as the basis of acting toward one another.
2. Reality is socially constructed through the meanings that people attribute to events in the symbolic world in which they are actors. Those meanings are dynamic, individual and not pre-determined.
3. The actions people take with respect to events in their social world reflect the meanings they attach to those events. Hence, social action is primarily a socially constructed phenomenon, not an imposed one.

4. People define themselves and their motives according to the symbols of their world. They use those symbols and their meanings to define their own situation in that social world.
5. Humans exercise control over meanings by using "mind" to select and indicate to others the meanings to which they respond.
6. The sense of "self" is a product of the social process, not an innate quality.
7. The process of social interaction shapes "society" through the shaping of the symbols by which we recognize it.
8. The "self" develops through the ability of an individual to take toward him or herself the organized attitude or perspective of others in the society.
9. People vary their behaviour toward others on the basis of the conception of self and the concept they seek to portray at particular times. The conception of self and its attendant behaviours constitute the identity of the person.
10. When social groups share sets of meanings they have a shared understanding of the world, reflect a collective will and establish common objectives.

There is now a considerable body of sociological literature in, or arising from, interactionist theory. Those elements specifically relevant to this thesis can be summarized as follows:

- conceptions of self (Goffman, 1959:252)
- the definition of the situation (Thomas, 1931:41-50)
-social action on the basis of the attribution of meanings (Blumer, 1969:2- 3,35)
- the reflective capacity of the human actor and action based on how we believe others see us (Cooley, 1956; James, 1893; Mead, 1934)
- transformation of identity (Strauss, 1959)
- occupational socialization (Becker, 1972; Becker and Strauss, 1956)
- role theory (Turner, 1962)
- status passage (Glaser and Strauss, 1971)
- career contingency (Becker, 1963; Stebbins, 1985, 1970)
- phenomenological understanding of the range of meanings that personal and professional experiences have for individuals (Berger and Luckmann, 1971; Bogdan and Taylor, 1975; Davis, 1978; Omery, 1983; Psathas, 1978; Schutz, 1961, 1964).

Symbolic interactionist analysis recognizes the centrality of the individual's construction of social reality: how people define their world and how that definition shapes their actions. (Charon 1995:230) The individual is shaped by, but also shapes, that social reality. Sociologists favouring functionalist modes of analysis might suggest that the constraints and demands of the organization determine individual action (Merton [*et al*] 1957, 1949) and that social reality exists *sui generis* (Durkheim, 1964, 1933). However, social scientists favouring

an interactionist perspective suggest that individuals create their social reality through their relationships and that the social order of which they are a part (as distinct from being merely subject to it) is a complex negotiated order (Blumer, 1962; Huber, 1973; Shibutani, 1962, 1978; Stryker, 1980). The interplay between individual action and social organization is a reality too complex to dissect into analytic units based only on structure, or only on social interaction. This is amply demonstrated in Giddens' (1979) illustrations of the essential relation of social action and social structure as central aspects of social theory. Thus, to adequately explain an occupational belief structure we need to refer to the social and organizational settings - that is, the context - in which those beliefs have been formed.

Interactionist research seeks to understand subjective reality as perceived by individuals living out that reality. From that reality, emergent theoretical constructs may be generated and refined as "grounded" evidence is brought to bear to substantiate it, or repudiate it (Glaser, 1978; Glaser and Strauss, 1971, 1967). Emergent theory can then be tested using congruent and aberrant descriptive cases of natural reality. It can also be progressively modified, in a procedure not unlike the mathematician's "successive approximation," to achieve increasingly generic theories to explain aspects of the social world.

By contrast, the quantitative analytical orientation proposes theory and then tests its generalizability by applying the data to it "objectively." Denzin (1970, 1973, 1978) draws attention to this approach as the "fallacy of

objectivism" - attempting to understand in the general what cannot be properly understood in the specific. His seven principles to guide interactionist research particularly emphasize the researcher's possible impact on data and the necessity to:

> ...link his subjects' symbols and definitions with the social relationships and groups that provide those conceptions. (Denzin, 1970)

Meaning, motives and conceptions of self are learned through the lifelong process of socialization. The extensive body of literature on socialization contributes to our understanding of the origins of the values and belief system of nurse administrators. An important related problem, on which there is much less literature, is to determine whether the administrative ethos is grounded in the occupation itself, or whether it is sensitive to specific social and cultural contexts in which it is learned. To this end I have examined the background of nurse administrators to identify those factors in the socialization process contributing to individual belief systems, which are later incorporated into their shared beliefs about nursing as reflected in the administrative ethos. The comparison of data on nurse administrators from two countries will enable identification of factors in the administrative ethos which transcend national boundaries and which can thus be considered as generic to nursing in western culture.

LITERATURE REVIEW

This review brings together specific research on nursing careers and broad sociological aspects of professionalism, health care and role transition. In

the recent professional literature specifically addressing aspects of career paths in nurse administration, there is an over-riding focus on the changing role of the nurse administrator. Much of the research describes and analyses the impact of escalating costs in health care delivery and of graduate education on nursing careers. (Krejci 1999:21; Allen 1998:15; Pelletier *et al* 1998:23)

Planned career development for aspiring nurse administrators remains a current theme in the literature (Rooney 2000:69-70; Sorrentino 1992:32). The contemporary literature examining how and why nurses actually become administrators reveals the importance, not of planning, but of contingency and choice in the successful development of personal and institutional careers. (Price *et al* 1987:238: Allen 1998:20; Parsons *et al* 1997)

Sociology of occupations and professions

The sociological study of occupations and professions represents a large part of the literature in sociology and is becoming increasingly significant in the professional literature on nursing administration. Carr-Saunders and Wilson (1933) wrote the first enduring classification of the professions and triggered interest in systematic studies of the professions, professionalism and professionhood, such as that by Greenwood (1957). Subsequent work in this genre includes Wilbert Moore's (1970) comprehensive review *The professions: roles and rules*, of which the chapter (with Rosenblum) "The professionalization of occupations" is particularly germane; Abrahamson's (1967) definition of the professional in the organization; Boreham *et al* (1976) profiled the helping

professions in Australia; Etzioni's (1969a) notion of the "semi-professions" which refers specifically to teaching, nursing and social work and his *Sociological reader on complex organizations* (1969b) which extends our understanding of the dynamics of professional practice.

Burgeoning interest in *The Sociology of Occupations and Professions* is reflected in Pavalko's (1971) book of that name and in the journal *The Sociology of Work and Occupations* in which Klegon (1978) summarized the emergent perspective on sociology of the professions. Roth (1974), in the same journal, described professionalism as the sociologist's decoy - a topic to draw the interest and engagement of sociologists.

The study of work has been enriched through interactionist analyses of work realities from the workers', as distinct from the organizations' perspective (Berger and Berger 1975:263). This influence is evident from landmark studies such as Hughes' (1958) *Men and their work*, through Chicago-school analyses in criminology (Sutherland, 1973, 1949; Sutherland and Cressey, 1967) and social survival as work (Becker, 1964; Illich, 1981; Letkemann, 1973; Mars, 1984), to biographies of life and work (Berger and Berger, 1975; Terkel, 1970) and specific studies in the sociology of nursing such as Bucher and Strauss (1966) on the "professions in process", selected papers in Chaska's (1980, 1978) edited collection of papers, and Hughes, Hughes and Deutscher's (1958) notable *Twenty thousand nurses tell their story*. Olesen and Whittaker's (1968) study of the professional socialization of students of nursing was the first of a number of

influential studies on the topic, others being Ida Simpson's *From student to nurse: A longitudinal study of socialization* (1979) and Marlene Kramer's (1974) *Reality shock: Why nurses leave nursing.* These authors related professional socialization patterns to the practical organizational problem of attrition of new graduates. Recruiting students of nursing and stemming the attrition of registered nurses, continue to challenge labour-force stability within the nursing profession.

Allen (1998) identifies and examines factors that influence development of leadership characteristics, skills and expertise, according to insights provided by semi-structured interviews with a sample of 12 registered nurses in administrative positions. She identified self-confidence, innate leadership qualities, the progression of experience and successes, the influence of significant people, and other personal life factors as essential in the career paths of the respondents in her study. (Allen 1998:16)

The emphasis on the role of personal and institutional support in nurturing potential leaders is supported in Parsons *et al* (1997). This study examines career objectives, barriers and paths of aspirants to hospital administrator positions. Survey data from 162 aspirants to these positions led the researchers to conclude that having a mentor is "an essential element" in successful career development:

> Mentors facilitate career enhancement by providing and encouraging learning experiences, being there as a reference, recognizing future potential, making and introducing junior executives to influential leaders, and fostering senior executive contacts. (Parsons *et al* 1997:89)

Price *et al* (1987) compiled interviews and biographic details on the careers of 12 female registered nurses in executive positions in service and educational institutions. Only one respondent from the field of nurse administration indicated that she had made an early deliberate choice to pursue an administrative career, and 83% indicated that opportunity was a major factor in its attainment. (Price *et al* 1987:237) Such indications have informed the direction of the current study.

At the interface between sociology of occupations and professions and the sociology of health care, Elliott Freidson (1970) became a noted critical commentator on the medical profession, introducing into sociological parlance the notion of medical dominance, a phenomenon referred to by a number of respondents as a major feature of their work environment. This theme is expanded and updated in Willis' (1989, 1983*) Medical dominance: The division of labour in Australian health care;* while Johnson's (1972) review of the power implications of professional status is more general. Heraud's (1979) introductory text outlines the role of sociology in analysis of the professions, referring specifically to medicine and the sick role, ideology and planning, the last two of which are specifically relevant to the present thesis.

Such works as these, being expressly in the sociology of occupations and professions, have drawn substantially on health care as a research arena. They have thus contributed much to the sociological understanding of health care.

Sociology of health care

In the last 25 years or so, health care has been a fruitful arena for sociological research. Issues in health care have enabled sociologists to draw on, and contribute to, a range of theoretical perspectives in sociology. The range of topics covered in edited books of "issues in health care" is typified by Aiken and Mechanic (1986), Cox and Mead (1975), Jones and Jones (1975) and Tuckett and Kaufert (1978).

Medical sociology has become a prominent field within the discipline of sociology to the extent that in 1986 the Medical Sociology Section was both the largest and the most rapidly growing of the special interest sections within the American Sociological Association (reported in A.S.A. "Footnotes" 1986 and confirmed in subsequent correspondence with the American Sociological Association). Similarly, in Australia in 1994 the Health Sociology Section of The Australian Sociology Association was the largest and most rapidly growing of the special interest groups.

Symbolic interaction has emerged as a particularly relevant theoretical perspective for addressing issues in health care. Doctors and nurses have been the focus of much interactionist research. Hardy (1985) explains this, identifying similarities in the development of interactionist theory with developments in

nursing science. These include the similar socio-historical contexts in which nursing theory and interactionist theory developed and flourished, and the overlap in substantive focus:

> Thus, the unity of person and environment, concern with persons, social integration, the development of meaning, the embedded-ness of persons in a social context, and the reciprocal social processes engaging persons are foci of considerable interest in nursing today. (Hardy, 1985:37)

Richman's (1987) broad portrayal of medicine and health offers a conservative summary of the traditional domain of medicine. This contrasts with Starr's (1982) critical historical review of American medicine and with Willis' (1989) *Medical Dominance: The division of labour in Australian health care*, and Willis' (1988) critical commentaries on, and the impact of, technology and how we think about health care. While this thesis is not a critical analysis after the style of Starr and Willis, neither is it a non-critical summary of traditional understandings. It seeks to make transparent and to challenge the taken-for-granted assumptions about the basis on which administrators in nursing first choose that line of work and second, are appointed to administrative positions.

As Willis' (1994) collected papers demonstrate, illness mediates social relations in all areas of society. Several works focusing on the careers of patients have been instructive to the formulation of this thesis about the careers of those who care for them. Roth (1963), for instance, studied the ways in which tuberculosis patients structure their days and their lives around institutional realities and life contingencies, a notion explicitly adopted for this thesis. Glaser

and Strauss (1965) analyzed "contexts of awareness" among the dying, a theoretical principle transferable to the present study of those very much alive in the health care system. Goffman's (1961) work on the career of the mental patient influenced by a formal bureaucratic hospital structure and potent inmate and staff culture, has been widely cited because of its relevance to a wide range of sociological issues, including socialization, institutionalization, the sick role, and deviant identities (Zola, 1972). Coser's (1962) participant observation and interview-based study *Life in the Ward*, and Rosenthal, Marshall, McPherson and French's (1980) categorization of the behaviour of "problem patients", portray some of the realities of being ill and caring for the ill. Such works illustrate the context in which nurses learn their job and aspire, in some cases, to become administrators.

Role transition and status passages

Glaser and Strauss's (1971) work on status passages is pertinent to the present study of nurses in the course of a status passage from clinical nurse to nurse administrator. Their work suggests that such status passage is unlikely to be a linear, predictable, irreversible phenomenon. From a number of works in organizational psychology and the sociology of work, we understand the executive and the corporate roles within organizations (Argyle, 1989; Deal & Kennedy, 1982; Drucker, 1982); career dynamics within an organization (Schein, 1978; van Maanen, 1977); and the division of labour in health (Willis, 1989); while there are numerous works adopting the "recipe for success" perspective on

role and status transition (Kiam, 1986; Schein, 1971; Stevens, 1990). Hence, role transition and status passage related to career, are unlikely to be linear, predictable, irreversible phenomena. However, it is not only individuals in health care that can be in transition and status passage. The professions themselves change and adapt to new circumstances as demonstrated by Pawluch (1996) in the case of paediatrics.

Managing other people's bodies is the business of nurses. This is complex and demanding work and we can expect that the transition to work as a nurse will be complex and demanding. Lawler (1991), in *Behind the screens,* graphically demonstrates the complexities and demands of being a nurse in this respect. Nurses learn various ways of coping with the difficult and the unpleasant. These adaptive behaviours, learned in early professional socialization, are transferred to subsequent roles in nursing though they may be mediated by the accumulation of skills along the career path to an administrative position.

The extensive literature on administration in nursing, summarized by Henry and Heyden (1990), includes work on the executive role (McClure, 1989; Stevens, 1985,1981), the nature of nursing administration (McCloskey *et al,* 1988) and professional socialization, though Krugman (1990) claims there is no previous unified theory of nurse executive socialization. In particular, we know little about sociological aspects of transition from the clinical nursing role to the administrative nursing role, although Brenner (1986) has analyzed professional

identity among students and recent graduates from baccalaureate and master programs in nursing, many of whom would be expected to take administrative positions; and McLees (1988) explored the influence of life events, family responsibilities, education, work history and professional and community involvement on the development of career orientations of graduate nurses.

Although there is work to contribute to our understanding of transition to the role of nurse, there is little to inform the transition to the administrative role in nursing. Specifically, little is written about how the belief systems and adaptive behaviours of nurses influence their career paths. Two exceptions are Mellish (1988) who outlines the ethos of nursing for basic nursing students, and Styles (1982), who refers to the belief system of nurses as the basis of their professional identity representing an ideological framework, which should influence nursing policy and practice. Styles' reference to identity, ideology and practice is congruent with what I have referred to, conceptually, as nurses' social action reflecting the ethos of nursing administration.

In the course of their transition from lay person to nurse and from nurse to nurse administrator, the respondents have learned that the relationship between social structure and social action is quite clear within hospital and health care settings. That relationship is clearly elucidated for occupations in general by Hall (1986) in his analysis of the dimensions of work, including horizontal (nature of the job) and vertical (status attainment) dimensions. Work patterns and expectations and role relationships can usually be identified in organizational

charts, policies and procedure manuals, though as Shearing and Stenning (1985) observe, what the organizational chart describes is not always congruent with what one observes and with what people say about the inside workings of their organization.

The necessity for bureaucratic descriptions to be highly developed in health care agencies has made them fruitful areas for social research. However, studies of the structure and function of health organizations are less relevant to the present study than those that have addressed the socialization of the individual within the framework of organizational structures.

Studies of professional socialization are, *inter alia*, studies of how people are prepared for work that, if well done, is rewarded by promotion with its implications for role transitions and status passages. Becker, Geer, Hughes and Strauss (1961) and Haas and Shaffir (1977, 1987), for instance, considered the process of becoming a doctor, focusing on the interactive, subjective aspects of learning and negotiating that social and occupational role. Merton *et al* (1957) also considered the process of becoming a doctor, but gave greater emphasis to the organizational structure within which role learning took place. Bucher and Stelling (1977) considered post-graduate education in medicine and biochemistry; Pawluch (1996) details changes to the clinical speciality of paediatrics; Davis, Kramer and Strauss (1975) studied the subjective experiences of nurses in their professional socialization; Olesen and Whittaker (1968) addressed the social process by which people become nurses by

accepting the identity and meeting the criteria of both the formal and the informal culture of the profession; Benner and Benner (1979), Buckenham and McGrath (1983) and Simpson (1979) have addressed the process of transition from student to nurse. Interest in the present topic is an extension of my own previous examination of role transition and identity transformation among Australian nurses (Moorhouse, 1992a, 1992b, 1983a, 1983b, 1981).

Despite an increasing interest in the general topic of career development among nurses, the professional literature on the subject tends to emphasize aspects of doing the job rather than analysing successful career achievement in nursing administration. The need for us to pay attention to the latter is identified in Ryff's report on "Subjective Experience of Life-Span Transitions":

> To summarize, future research in this area might usefully combine questions of subjectively experienced developmental change with studies of the actual events or critical experiences in people's lives so as to illuminate where outside changes are producing inside changes, and, alternatively, where inside changes are leading to external transitions. In addition, research on possible discrepancies between these two realms will advance understanding of transitional events that have minimal significance for the individual as well as identify emergent, culturally unlabelled events and the private markers people use to identify their own transitions. (Ryff, 1985:110)

By emphasizing the heuristic value of examining actual nurse administrators' career paths, this thesis contributes to the research on how individuals choose administrative work and how they adapt to the social–psychological process of transition to the executive role. Such work has implications for all occupations that draw administrators from practice settings.

CAREER AS AN ANALYTIC CONSTRUCT

The sociological concept of "career" is the foundation unit of analysis in this study. The term may have one of two meanings depending on the context of its usage: *first*, the widely understood notion of the occupational career as a work designation; and *second*, the life career (biography) of the person including, but not restricted to, the work designation.

The structuralist definitions of career as a job that one has within an organizational structure; and the functionalist definition as a job which one does, are static notions that tell little of individuals, motive and social action. These aspects of career are "objective" (Stebbins, 1970) in the sense that we can map a career trajectory in terms of qualifications, appointments and other official achievements. In the present study, examination of documentary evidence, such as the *curriculum vitae*, the position description, and the organizational chart and, in some cases, staff records of respondents, was sufficient to obtain information at this objective level. But it is sterile information in terms of social-psychological aspects of career development. To understand the multiplicity of factors (contingencies) contributing to the objective career path, empirically represented in the *curriculum vitae*, it is necessary to consider personal, emotional, interactive and values-oriented questions - the "subjective" elements of career (Stebbins, 1970).

The symbolic interactionist notion of career as the chronological sequence of life events and their idiosyncratic meanings, is attributable firstly to Hughes

(1937:409) and secondly to labelling theory, a perspective arising from the symbolic interactionist study of deviant behaviour (Becker 1963; Goffman, 1961, 1963a, 1963b; Gove, 1980; Rubington and Weinberg, 1973). In the interactionist view, a person does not have one career, but multiple careers. Some will be concurrent and interdependent; others will be in conflict. The way in which those various careers interact for an individual will determine their ultimate life course; moreover, that very interaction constitutes "the career" of the individual. For instance, one Canadian respondent in this study had one career as Vice-President (Nursing) in a major hospital, a concurrent career as a senior official in the professional nursing association of the province, an immediate past career with the national nursing organization, a part-time career as jointly appointed professor in a university nursing program, an ongoing career as spouse and an anticipated concurrent career as mother. In interactionist terms, all those elements in this person's life collectively represent her career as an individual. In social-psychological terms, we cannot expect to adequately understand any one of those career elements without being aware of the potential impact of other career elements.

Becoming an administrator should thus be seen as a complex social-psychological phenomenon tied to such factors as identity, aspiration, identification, self-esteem and notions of self and other (Nosaw & Form, 1962:284ff, Allen 1998:16). The interactionist notion of career enables us to capture those dynamic, process centred, interactive aspects of life and work as

social action. This study seeks to achieve that through semi-structured biographic interviews to reveal career detail at the subjective (meaning) level.

Pathways to Nursing Administration

To map a person's career path is to identify significant factors and events from the multitude that have contributed to the shaping of the career. Since any individual has multiple careers, some will be more significant to this purpose than others (Stevens, 1990:24; Chaska, 1990). This thesis identifies two career-related concepts as central to our understanding of pathways to nurse administration: turning points and career stages.

Goffman (1961:168) indicates that the moral career of a person may be tracked according to changes in their conception of self (identity), turning points in their world view and consequent changes in their actions toward others. There are parallels between Goffman's "moral career" and the nurse administrators' belief systems. I have thus adopted Goffman's definition of turning points as those subjectively defined states of mind leading to decisions having potential for impact on career direction. Turning points indicate points of readiness to consider a change in career direction, whether or not such a change eventuates. Those points of readiness entail a transformation in identity (McCall and Simmons, 1978), for instance as a person comes to identify her/himself as a potential administrator.

Turning points arise from the conflation of factors salient to both personal and organizational contexts. For instance, the "point of readiness" (e.g., a family

decision that one partner apply for an advertised position) may result in attainment of a new career stage (e.g., accepting a new position or promotion) requiring family relocation. Hence, turning points *may* lead to a change in role or status, or to some other event, which can be objectively defined as the attainment of a *career stage*, but do not necessarily result in such a change.

In her extensive collection of biographic vignettes, Goodman (1979) demonstrates the range of turning points to which people may be subject in the life course. Turning points are essentially about choice, constrained as the choice may be by various aspects of the context in which the choice is made. This is identified in the following synopsis of Goodman's biographies:

> It's a story of growth and loss, advances and retreats. Every crisis, as Erik Erickson wrote, is not necessarily a catastrophe. It may be a turning point.
>
> The first people we'll meet aren't predicting any major new thrust in their lives. They all have, as most of us do, a strong set of reasons for defending the status quo. But many will change. Like flood victims, some won't be able to go home again because home has been washed away. Others will find encouragement in new ideas and support in political movements. Still others will feel compelled to resolve a conflict that is too painful to "live with" any longer. These men and women may find one set of choices closed out behind them and a new set open in front of them. (Goodman, 1979:xii)

Choice is shown by Gerson (1985) to be a complex element in the interaction between an individual's beliefs and desires and the institutional frameworks of their social life. Gerson's biographic study of American women outlines particularly how the emerging patterns of choice between occupational, maternal and domestic desires are creating new social forces, rather than being merely

the response to existing social forces. This view of women as shaping their careers by actively creating opportunities rather than passively awaiting them is borne out in the present study.

Career stages are the markers of achievement in role and status. But whereas turning points are about making choices, career stages are essentially about making changes in the life course. Attainment of various career stages implies a change in self-identity (Berger and Luckmann, 1971,1966:194) and a concomitant change in role identity (Herman, 1985). But as McCall and Simmons (1978:65) point out, people have a number of role-identities only some of which are relevant to a given situation. For example, the role identity of an administrator as "a hard-headed business executive" may be salient in the occupational context, but not at home where the salient identity may be that of parent.

Viney (1980) addressed Australian women's transitions through life and career stages such as to school, to university, to matrimony, to maternity, to illness or to disability, defining all of these transitions as major upheavals. Like Gerson, Viney (1980:8) indicates that transitions for women are not gradual, as they may be for men, but that they are step-wise attainments of various life career stages mediated by multiple contingencies. These contingencies are a powerful force shaping the biographies of women, and this study gives particular attention to these career stages and the events that have influenced their attainment.

Career Contingencies

Those factors that shape the career leading to turning points and career stages can be referred to as career contingencies (Becker, 1963:24; Becker and Strauss, 1956; Bush and Simmons, 1981; Prus and Irini, 1980; Stebbins, 1970). They include factors within and beyond individual control. Studies of career, whether the career of the public school teacher (Lortie, 1975), the police officer (Skolnick, 1966), the criminal (Adler, 1975), the mental patient (Goffman, 1961), the hospital patient (Davis, 1960), or the nurse (Stein, 1978; McClure, 1978), are concerned not only with career path analysis, but also with the circumstances surrounding the career. Some attention has been directed specifically at contingencies influencing the career of, for example, professional football players (Stebbins, 1985), "hookers, rounders and desk clerks" (Prus and Irini, 1980) and psychiatric staff in a mental hospital (Coser, 1962), but the aspect of how contingencies contribute to the shaping of a career is less well developed in the literature.

Life Contingencies and Organizational Contingencies

As Everett Hughes (1958) and Studs Terkel (1970, 1974, 1984) have so vividly portrayed, life and work are inextricably intertwined to comprise biographies; careers as defined here. This study is concerned with the interaction of life contingencies and organizational contingencies because of the impact of that interaction on an individual's achievement of a desired position.

I have used the term *life* contingencies to signify those factors in personal life, including educational and employment background, which either facilitate or block access to desired occupational outcomes. The individual has some influence over the shaping of ~~their~~ his life in particular directions. I have used the term *organizational* contingencies to refer to those policies, events and opportunities in the organization, which are relevant to an individual's ambitions, but over which the individual has little or no control.

Life and organizational contingencies are parallel and interdependent phenomena. For example, a 35-year-old Assistant Director of Nursing in a major Australian public hospital aspired to the position of Director of Nursing. The current incumbent in the Director's position was about five years from retirement so the position would not become available until then: organizational contingency. To improve her chances of achieving her ambition, the respondent had completed a master's degree, considered a distinct advantage for the level of position she sought. To gain relevant experience she was prepared to take a Director's position outside the metropolitan area. To do so would necessitate relocation of family. Her partner was willing to adapt to that proposed scenario, but school age children with an established network of friends, were reluctant: life contingencies. Having reached a personal turning point - she was ready to take the job if it were offered - the question of role salience became dominant in the decision process. She deferred to her perception of the needs of her children for domestic stability and reset her goal around achieving a Director's position in five

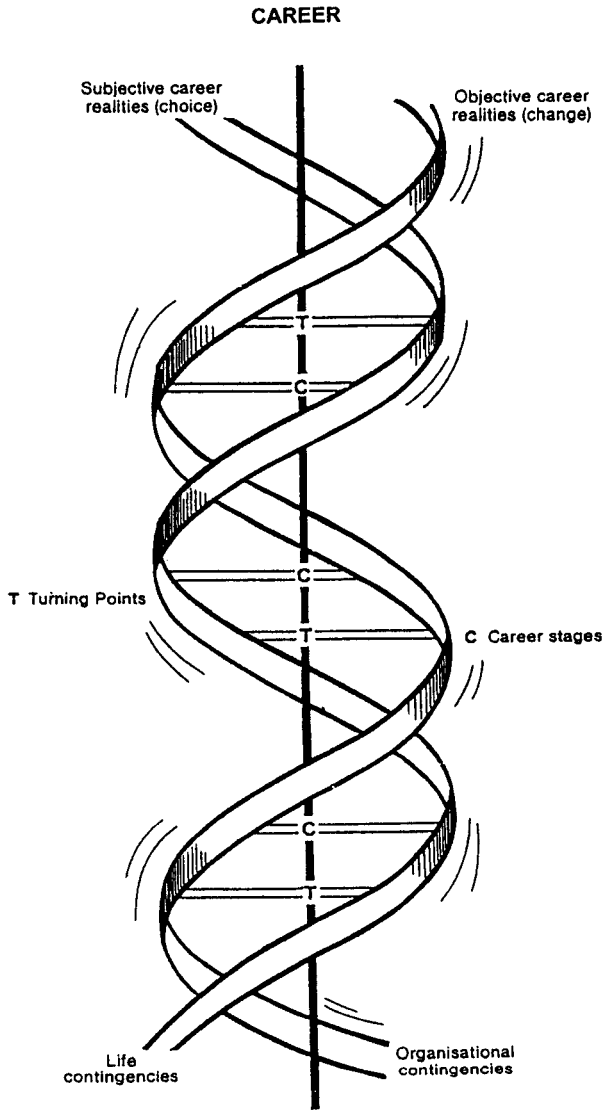
years time when the children were old enough to travel (some distance) to secondary school.

That example underscores the tendency noted by Berger and Luckmann (1971:183) for people to seek "a degree of symmetry between objective and subjective reality." In a sense, this study is about how people achieve that symmetry between subjective career preferences and objective career outcomes. This symmetry around the "career" axis is demonstrated in Figure 2.1 which shows the conceptual architecture for the study: subjective and objective elements of life and organizational contingencies, their relationship to turning points and career stages and the elements of choice and change in the shaping of a career.

This model illustrates that career is not a linear progression from one objectively defined stage to another, but a convoluted path marked by turning points and career stages. It is shown graphically as a double helix which, like the web of life itself, turns in a spiral of two parallel life-lines linked by bonds which maintain form and order in the structure (Watson, 1968:130). "Life contingencies" and "organizational contingencies" form the two long threads running side by side to represent career over the life span. Hence, to properly understand professional careers we need to understand how life contingencies (personal aspects of career) relate to organizational contingencies (structure, function and opportunity) in influencing career pathways.

In the graphic model, life contingencies and organizational contingencies are linked laterally, like the steps in a spiral staircase, by "turning points" which represent subjective points of readiness to make career choices and "career stages" which represent changes leading to objective career attainments.

FIGURE 2.1 CAREER AS AN ANALYTIC CONSTRUCT



ADMINISTRATIVE ETHOS AS AN ANALYTIC CONSTRUCT

An ethos was defined at the outset as a system of beliefs guiding practice. The notion of an administrative ethos is used as a unifying concept to guide the analysis of beliefs that typify administrators in nursing and set them apart, ideologically, from nurses in other occupational categories. Some general reference to ideology in the occupational setting will be useful before narrowing the focus to the administrative ethos in nursing.

Occupational Ideology

An occupational ideology is that system of beliefs which underpins the practice of the occupation and which are shared by a majority of its members and held to be representative of the occupation. Existing literature in the sociology of occupations pays scant attention to the relationship between the dominant ideology of an occupation and the careers of its members. Studies of career, such as those cited earlier in this chapter, tend to treat the existence of an occupational ideology as implicit in career analysis, but as otherwise unproblematic.

Occupational ideology has been studied in two major forms in sociology: that centred on the study of ideology in social systems (Abercrombie *et al*, 1980; Giddens, 1979; Marx and Engels, 1965) and that oriented toward beliefs about work (Hughes, 1945; Mack, 1957; Rossi, 1965). The theme of ideology as a socio-political issue concerned with power, domination and class conflict is frequent in Marxian and conflict theory approaches to analysis of work. While

such issues are certainly pertinent to studies of health care organizations, they are not addressed in the present study. The following portrayal of ideologies as socially constructed definitions of reality is congruent with the tenets of symbolic interaction and suits the present purpose:

> ... ideologies are beliefs about realities that are unexamined and by their nature held in faith. They are held by a substantial proportion of a population; they are not merely private religions, though for each person a privately articulated phrasing of the ideologies prevalent in the society may appear as ideas worked out by each one's own intellect and heart. They do describe the society with varying degrees of accuracy. (Marchak, 1981:xi)

Also congruent with the interactionist perspective on rhetoric and social action is the description of ideologies as those ideas and beliefs by which:

> Men posit, explain and justify ends and means of organized social action, and especially political action, irrespective of whether such action aims to preserve, amend, uproot, or rebuild a given order. (Seliger, 1976:2)

The idea underpinning this thesis is that the occupational ideology of nursing as expressed by nurse administrators, may be understood by analyzing the individual beliefs of those who have achieved administrative positions and seeking typifications of those sets of beliefs. It is those shared beliefs about nursing and its administration, which I portray as constituting the administrative ethos in nursing. In turn, the administrative ethos can be expected to guide administrative practice, which is the social action of nurse administrators. Such a link between ideology as discourse and ideology as social action is theoretically proposed by Giddens who draws attention to the Mannheimian distinction between "particular" and "total" ideologies:

> ... between ideology as referring to discourse on the one hand, and ideology as referring to the involvement of beliefs within 'modes of lived existence' - the practical enactment of life in society - on the other. (Giddens, 1979:183)

Mannheim (1936) also relates ideology to the pursuit of Utopia achieved through modes of belief, which mobilize political activity against the *status quo*. Styles' (1982) elaboration of the ideological basis of nursing's professional identity and its policy directions, is congruent with the Mannheimian view. The present work, however, is concerned only with ideology as discourse in the "symbol-systems" indicative of "belief-systems" (Giddens, 1979:184).

Since nurse administrators constitute a numerically significant group in the social structure of health care, they represent a potent "arena of sectional interests" with an interest in maintaining the existing order of domination (Giddens, 1979:190). It is thus significant in the context of the present study of people in powerful positions in an organization that their shared belief system - what I have called their administrative ethos - makes it relatively easy for them to achieve changes to the *status quo* through mobilization of political activity. The corporate achievement of such occupational ends depends upon a shared vision among the key players. That makes it important to have ways of explaining, justifying, accounting for, and occasionally blaming others for, the things that happen under their administrative jurisdiction. This raises the question of how administrators in the study stated their motives for aspiring to their present positions and for establishing administrative programs and priorities once in the position.

As Mills (1981:326) has suggested, the expression of motive has the purpose of interpreting or redefining something for the benefit of others in the social world. Motives are sought, or given, when questions arise about what is normally taken-for-granted. Motives acquire a language - a special vocabulary - which can be identified as characteristic of individuals or groups in their verbal representation of certain social actions. Scattered throughout the interview transcripts are examples of the rhetoric of motives by which nurse administrators identify what they do as essential to the well being of patients/clients and the nursing profession.

"Accounts" are related to motives as ways of explaining or re-interpreting in order to impart one's beliefs to others. In the present study, administrators give accounts as justifications for their ideological positions and for the things they do, some of which are unpalatable both to them and to others. However, where an outcome is other than intended - when something goes wrong - the account may take the form of an "excuse" in which the responsibility is placed on someone or something other than the person giving the account (Scott and Lyman, 1981). An excuse is made when the preferred ideological position cannot be upheld in particular instances.

Administrative Ideals, Motives and Meanings

This study is concerned with how individual beliefs - ideals, motives and meanings - emerge in the process of a nurse's socialization. Specifically it concerns how the administrative ethos is learned, adopted and modified over the

career of a nurse to provide the circumstances for achieving an administrative position and the intellectual means for accomplishing administrative work. That set of conceptual notions could be drawn together in a single theoretical proposition: individual beliefs about nursing, derived through the process of socialization, contribute to a set of shared beliefs among nurse administrators which constitutes an administrative ethos providing a values framework likely to be reflected in social action in the form of administrative practice. The proposition can be diagrammatically represented as a conceptual framework shown in Figure 2.2, which proposes that the career of the nurse administrator may be characterized by the relationships between socialization (individual beliefs), occupational ideology (shared occupational beliefs), administrative ethos (shared beliefs specifically about nursing administration) and social action (administrative practice). As in Figure 2.1, these elements can be conceptually thought of as turning on the axis of career, thus imparting a dynamic element to the notion of career.

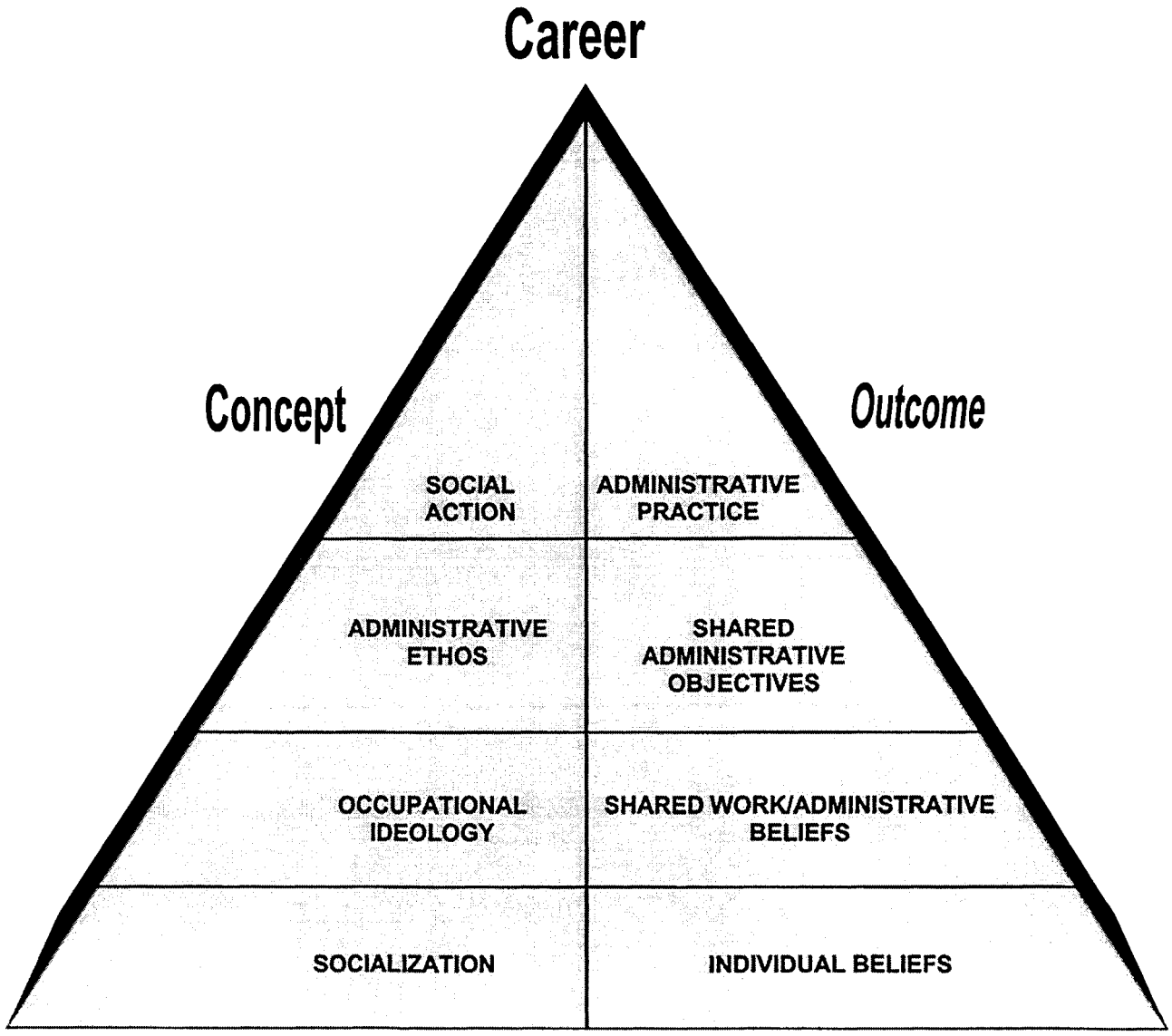
This conceptual framework, at the juncture of the analytic constructs defining career and administrative ethos as central themes in the study, has potential to demonstrate the social and professional factors (contingencies), which promote the convergence of a nurse's self-conception (identity), beliefs (ethos), and career aspiration (ambition), with the formal tenets of the organization. It is posited that when the individual and the organization share a set of beliefs about what is desirable, the individual will feel intrinsically rewarded

- satisfied with the job - and the organization may formally recognize that congruence through promotion to a senior administrative position or by other means available to it. On the other hand, divergences between individual and corporate conceptions of appropriate administrative goals and processes are postulated as the foundation of frustrated career development.

If the aspiring administrator is unable to achieve valued career objectives, or if the organizational ethos is not congruent with the ethos of the individual, it seems likely that the individual will become disgruntled and either seek, or have thrust upon them, a new career direction. This may follow a turning point in their own thinking about their relationship with their work, for example disengagement from active commitment; or it may precipitate a new career stage, such as early retirement or acceptance of an alternate employment opportunity.

Nurses promoted to administrative roles are likely to express administrative ideals, motives and associated meanings that are congruent with the beliefs and values and organizational goals of those who appoint administrators.

Figure 2.2 ADMINISTRATIVE ETHOS AS A CONCEPTUAL FRAMEWORK



SUMMARY

This chapter outlines the theoretical precepts guiding the study. They are located in the context of relevant sociological literature outlined in the first half of the chapter. The second half of the chapter outlines the key analytic constructs "career" and "administrative ethos" which underpin the thesis. Hence, the chapter summarized the theoretical precepts guiding the search for sociological patterns in interview data concerning the relationship between the belief systems and career paths of nurse administrators. Key terms used in this chapter can be operationally defined thus:

> **Career** - the dynamic, interactive, aspects of life and work by which a person's biography can be defined not only in terms of the chronological sequence of life events, but also in terms of their associated idiosyncratic meanings.
>
> **Career contingencies** – those factors that influence and shape the career of an individual.
>
> **Life contingencies** - those factors in personal life that either facilitate or block access to desired occupational outcomes.
>
> **Organizational contingencies** - those policies, events and opportunities in the organization which are relevant to an individual's ambition, but over which the individual has little or no control.
>
> **Turning points** - subjectively defined states of mind signifying points of readiness to choose from among available career options.
>
> **Career stages** - objective markers of changes in the life course, often represented by changes in role and status.

The system of beliefs that can be identified as typifying nurse administrators is referred to as the "administrative ethos in nursing". Fundamental to this study is the relationship between individual beliefs, and those shared beliefs constituting an administrative ethos which influences and

guides administrative practice. This chapter has outlined the theoretical basis of the proposition that:

> **Individual beliefs** about nursing, derived through the process of socialization, contribute to a set of **shared beliefs** among nurse administrators, which in turn constitutes an **administrative ethos** providing a values framework likely to be reflected in **social action** in the form of administrative practice.

CHAPTER 3

THE RESEARCH METHOD

RESEARCH METHOD

This chapter addresses methodological imperatives guiding the research. In particular, it examines the reasons for choosing the biographic interview as the major data source. This precedes sections discussing the research sample, gaining access to interview respondents, ethical considerations and data management.

In order to understand the ethos among nurse administrators, I interviewed 62 of the most senior nurses in Canada and Australia, asking questions about their personal and professional background; their career planning and actual career path; their personal and professional aspirations and ambitions; their preparation for, and entry to, the administrative role; their attitudes toward nursing and administration; their beliefs about nursing and nurses; their perceptions of change in nursing and administration; the influences on their professional and world views; and their influence on other nurses and on the profession itself. This provided a rich data source, only part of which has ultimately been summarized in the thesis. Particular attention is given to the administrators' definitions of ambition; their influence on other successful nurses;

their perceptions of change in nursing; and the relation of their primary, secondary and professional socialization to their administrative style.

The primary data for the study were the records of subjective statements of individual experience given at semi-structured interviews conducted by the author. A uniform framework for this data collection was provided by an interview schedule [Appendix 1] designed to obtain a detailed personal biography and expression of personal and professional beliefs about nursing administration. The schedule was used as a guide to facilitate congruence of questioning, rather than as a prescriptive form to be completed for each "case."

All interviews were conducted, audio-recorded and transcribed personally by the author. Signed consent was obtained for all interviews. Unlike the Australian respondents, Canadians assumed there would be a consent form to deal with as an essential preliminary to the interview. The "raw" data comprises 1,000 pages of interview transcript and interview schedules annotated at the time of interview. All data is stored on microcomputer disk with Zip Disk back up. This gave data security and facilitated coding, sorting, tabulation and access to material. In addition, an extensive file of documentation was accumulated from respondents themselves - articles they had written, professional and media profiles written about them, policy papers, annual reports, and so on. Since this material is formulated, or influenced by leaders in nursing, it is germane to this study of leaders. The ethos of nursing is revealed in its literature and in statements of the "philosophy of nursing" common in most nursing departments.

Such documentary statements present an avenue of discourse analysis illustrating the dominant values among nurses and their objectives for their organization and their profession.

The Biographic Interview as Data Source

Descriptions of work as social interaction may take two forms. First, observational descriptions of the work itself; second, descriptions of what people say about their work. Data for the first are obtained through participant observation in one of its variants (Gold, 1958) and for the second, through interview.

This study is interview-based because I am interested in how nurses articulate their beliefs about nursing and in how they relate their career trajectory to those beliefs. The biographic approach is central to the theoretical perspective of symbolic interactionism:

> The actor lives and knows his or her world ... always it is imperative (for the researcher) to understand from their particular point of view what it was that influenced them to act as they did. (Charon 1995:206)

The biography arising from each interview is a sociologically important story of how a person's life has intertwined with other lives and with broader social structures, to take on a particular shape:

> To approach the intellectual inquiry into our experience of society by way of biographical sequences is ... not just a convenient means of ordering what sociologists have to offer by way of interpretations and materials, but rather follows logically from the inner structure of this experience. (Berger & Berger, 1975:11-12)

In giving their biography, a person locates the story of their life, temporally or thematically, in a social context. For instance, in asking nurse administrators "Who and what made you what you are today?" I am seeking a biographic account in the expectation that it will shed light on the shaping of individual careers and on the nature of the organization as a social setting. Just as people leave a mark on their social environment, so each social setting leaves a mark on the individual. We can thus trace a biography across social and institutional planes.

Hence, biography is more than an intimate personal account; it is the record of multiple complex social interactions "located within history" (Berger & Berger, 1975:11; Bertaux, 1981; Languess, 1965). As Mead (1934) has amply demonstrated, self and society are inextricably linked so that one begets the other. The self as constituted in the socialization process can be represented in biographic form and that historic record of one person's life can be analyzed in terms of its symbolic and thematic features. Adopting the position that the constitution of self is a dynamic process, rather than a static, logical or predictable one, is congruent with the notion of history as a record of change. (Charon 1995:204). The early criticisms of symbolic interactionism as ahistoric (McPhail & Rexroat, 1979) are based on the notion of history as a static record of

the past, rather than a dynamic record of how aspects of various individual pasts interact to determine a present. In using biography as a data form and subjecting it to the symbolic interactionist analytic processes, I am overtly bringing history, albeit in the form of life histories, into focus as an integral part of interactionist sociology. This perspective on the congruence of biography and life history is harmonious with Gubrium's definition of biographical work as essentially historical:

> As far as biography is concerned, the process of describing a life course follows the logic of discovery. Each biographical project is a search, among perhaps disparate sources, for **the** historical meaning of one's experiences. (Gubrium, 1985:11)

But there is an essential fallacy in portraying biographical work as firsthand involvement with the social world, in the sense in which Filstead (1970) describes it. At best, says Gubrium (1985:1), "biographical work [is] the descriptive organization of life history" representing what Giddens (1976:146) referred to as a "double hermeneutic" - a description of life descriptions. Hence, the limitation of biographical work is that the meaning of biography as given is always mediated by the biographic process - by the interpretation and the writing and indeed (as a triple hermeneutic), by the reader's subsequent interpretation of what is written. The biography is a symbolic form of representing life experiences first to the researcher and thence in print to a reading audience. It presents for analysis multiple life experiences - living and working; succeeding and failing; telling this of oneself, but not that; knowing this, but not that; and

having the whole viewed through the cognitive lenses of the biographer. When a number of biographies are collated to distil out common elements, we can generate a system of typifications enabling the presentation of a collective understanding of their lived experience. That is both the mode and the mission of the research reported here.

As a form of representation of the staged experiences of the social, emotional and physical worlds, the biography can usefully be analyzed and presented in terms of the various personal careers that constitute it. Failure to address the complexity of these interacting careers in a person's life ignores the stated purpose of interactionist sociology to address the symbolic importance of just such interactions.

Considering individual biographies and their attendant careers and how people make a difference to their social organizations, either individually or collectively, requires an understanding of those social and occupational worlds. This study is an examination of the personal biographies of a select group of people in hospital management whose very location at the top of the nursing career ladder implies that they are believed to have made a difference to their professional world and are expected to continue doing so. That their influence may transcend institutional boundaries to embrace the nursing profession generally, and that they are themselves changed by their involvement in such work, is an important parallel issues.

To the extent that every institution and the profession itself, has its "official line", one of the problems of the interview as data source is to uncover the personal misgivings about that line, and ambitions for modifying it. This requires a degree of probing which may take hours at a time, does not lend itself to large samples and which ultimately draws more on the ability of the interviewer to open the opportunities for discussion, than on the respondent's story as it might emerge solely through undirected biographic disclosure:

> The quality and quantity of the information secured probably depend far more upon the competence of the interviewer than upon the respondent. (Caplow, 1965:169)

Finally, it is significant that the biographies collated here belong to an elite cadre of people at the top of their professional totem pole. Higsley, Deacon & Smart (1979:90), deferring to C Wright Mills' (1956) injunction concerning the "interplay of biography and history, or self and world" suggest that interplay "is nowhere more complicated than in the case of elite careers." This is a view corroborated in Bottomore's (1964) discussion of the concept and ideology of the elite; and by Spector (1980) and Hoffman (1980) who discussed methodological features of "elite interviews."

The complexity of the biographic enterprise, but also its value, is clearly demonstrated in the autobiographical collection *Making Choices, Taking Chances: Nurse Leaders Tell Their Story* edited by Schorr & Zimmerman (1988). The autobiographies in this collection are of the kind that constitutes the primary data for the present study. It was reassuring to find that these tales of influential

nurses' careers were congruent with stories told me in the course of the present study; to confirm that:

> The consequences of decisions of those leaders in pursuing their ideas markedly influenced the future of nursing.

That:

> Most of these leaders are goal oriented, but the element of good luck cannot be ignored. Being in the right place at the right time in relation to choices and career changes is expressed repeatedly in these pages, as is the willingness to seize opportunities.

That:

> There are common threads in these stories. Many wrote of the influence of nurses they had known. They tell of strong support from parents, spouses, other family members, and close friends.

That:

> Outstanding mentors had a strong impact on the professional and personal lives of many. (Schorr & Zimmerman, 1988:vii-ix).

In summary, biographic interviews have provided a data source which, filtered through symbolic interactionist theory, assists in understanding the everyday experiences of executive nurse administrators in relating their beliefs to the exigencies of their work and the nursing profession generally. My hope would be that the biographic approach achieves the objectives outlined by Schorr & Zimmerman:

> These stories reflect nursing's splendour and frailties. We hope the book will spark debate, stimulate awareness, nudge introspection, and evoke pride. Above all, we think it will bring to life the character and the humanness, the intellect and the modesty, the reality and the vision of these leaders. (Schorr & Zimmerman, 1988:ix)

Comparative Research

Numerous forms of comparison can apply to sociological inquiry, among them comparisons across national, cultural, regional or occupational boundaries, as well as between cases within given categories. These comparisons may be overtly structured and may even be the foundation of a study, but they should be implicit in the everyday research process of thinking through possible explanations for empirical evidence. Glaser and Strauss (1967) have enshrined this principle in the idea of "constant comparative method," in which, at least for purposes of grounded theory development, comparison between categories of data becomes a form of successive approximation toward an accurate reflection of the social facts. In this study of nurse administrators, a cross-national comparative element is introduced in order to establish which phenomena hold true across national boundaries, and which could thus be thought of as generic characteristics, and which can then be said to be idiosyncratic to a particular professional or cultural setting. The theoretical and methodological problems of cross-national research make it complex, unwieldy and costly, but efforts to address those problems are repaid by more widely relevant theory. As Durkheim notes in *The Division of Labour*, comparative study contributes to the transcendence of the descriptive or case study approach to studying social life:

> Comparative sociology is not a particular branch of sociology; it is sociology itself, in so far as it ceases to be purely descriptive and aspires to account for facts. (Durkheim, 1933:139)

The program theme for the 1987 Annual Meetings of the American Sociological Association was "Cross-National Research in Sociology." This reflected a growing interest not only in comparative research generally, but especially in cross-national research. A stated aim of those Chicago meetings was:

> ... to search out social-structural regularities that transcend national borders and to search out the limitations to generalizing across national borders
>
> ... to emphasize research designed to ascertain whether the same social-structural regularities are to be found under different national conditions.

Formal cross-national studies in nursing are scarce, though Leininger's work, at the interface between nursing and anthropology, is directed toward understanding and promoting understanding of "trans-cultural nursing" (Leininger, 1985; 1981; 1978). The International Congress of Nurses at its 1987 triennial meeting in Tel-Aviv, Israel also recognized the need for comparative studies of nursing.

The comparison of systems that operate differently, or similar systems that operate in different parts of the world, is a difficult task fraught with pitfalls. Smelser outlines one of the more significant:

> In this universal tendency to view differences in the mirror of domestic ambivalence lies another tendency - to distort those differences. Insofar as a group reacts to a different group in terms of its own preoccupations, it

> is not likely to perceive the way of life of the different group as that group experiences it. (Smelser, 1976:2)

The methodological problems in comparative research lie not in what one sees, but in what one does not see by not being sensitive to its existence or its significance, or in seeing through culturally constrained lenses an ethnocentric view of the observable "facts". As an Australian nurse observing Canadian nursing and having it interpreted for me by people unfamiliar with Australian nursing, I must have been oblivious to some of the nuances. However, in the time I spent in Canada, spanning just over two and a half years (August 1983 - September 1985, January - May 1986, October 1990, August 2000) I had substantial opportunity in three provinces and 12 major hospitals to garner considerably more insight than would normally be available to a comparative researcher.

Although details of administrative nursing work in Canada and Australia differ, perhaps more noteworthy is the similarity that exists in countries 16,000 kilometres apart in diametrically opposite positions on the globe. By comparison with other countries in which I have visited nursing departments - U.S.A., U.K., Scotland, Wales, Germany, India, Israel and New Zealand - the nursing ideology and the aspirations and frustrations of the profession at all levels, are more similar for Australia and Canada than elsewhere, though New Zealand has similarities to both countries' health systems as they relate to nursing administration.

Among the challenges faced by nursing in both countries are the implementation of new career and salary structures for nurses, the transfer of nurse education into the higher education sector and major revisions to the structure and funding of health care provision. Writing in support of a grant proposal for this research, one Australian Director, who became a respondent in the study, said:

> **The development of the profession in Australia is at the crossroads and the influence and direction taken by other major countries such as the United States, Canada and the United Kingdom will have a major bearing. [Studies such as this] will provide nursing in general with the ability to compare the profession's development in Australia with development in other countries. (Correspondence, #606)**

The standard of health in Canada and Australia is almost identical on the major comparative indicators. At the 1991 census in both countries, the life expectancy of the population was 74.0 years for Canadian males and 74.4 years for Australian males; and 80.6 years for Canadian females and 80.3 years for Australian females. These figures change over time, as Table 3.1 shows. For instance, in Canada in 1992, the life expectancy for males was 74.6 and 75.6 in Australia (1997), 80.9 for Canadian females (1992) and 81.3 for Australian females (1997). The leading causes of death are the same in both countries: cardiovascular disease, cancer and accidents. Both countries have an increasing emphasis in health policy on health promotion, health education and public health. This contrasts with previous emphasis on high technology hospital care. Canada's financial commitment to health care is, however, much higher

than Australia's with total annual spending on health of $67 billion in 1991 (Canada Yearbook 1994:128) increasing to $77 billion in 1997 (Statistics Canada). Total annual spending on health for Australia was $30.9 billion in 1991 (Year Book Australia 1994) and $47 billion in 1997-98 (Australian Bureau of Statistics). That makes Canada's health expenditure as a proportion of gross domestic product 10% in 1991 decreasing to 8.9% in 1997. Australia's health expenditure as a proportion of gross domestic product for the period 1990-91 was 8.1%, rising to 8.4% for the period 1997-98. This translates to per capita health expenditure of $2,474 per person in Canada (1992) and $1,796 per person in Australia during 1990-91, increasing to $2,536 in 1997-98.

In addition to comparabilities in health care and nursing systems, there are demographic and social comparabilities between Canada and Australia:

> Canada is, to a greater degree than other nations, a country comparable with Australia in terms of institutions and traditions, geographical size, economic standing and international outlook. The genuine goodwill established between the two countries has allowed Canada and Australia to co-operate on the achievement of mutually desirable objectives, reflecting individual national interests and competition in certain commercial fields. (Year Book of Australia 1985:61)

Such comparative indicators for the two countries studied are presented as Table 3.1. Australia (Figure 3.1), the world's largest island and its smallest continent, is demographically simple to describe. Its population of 18.7 million (Australian Bureau of Statistics, 1998) is distributed unevenly throughout the six states and two territories with 70% of the total population living in the capital cities or in one of only four other centres over 100,000 persons. Australia's

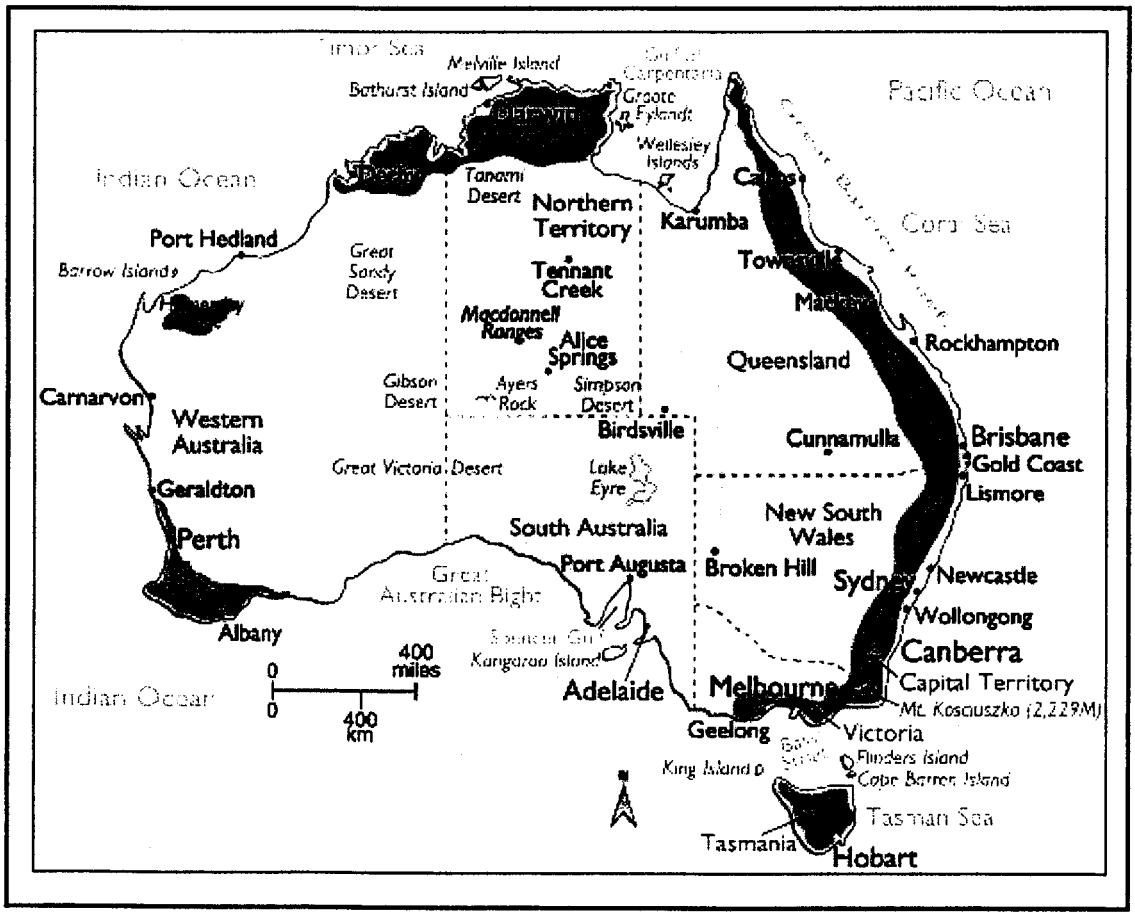
population is relatively stable with an average annual growth rate of 1.3% for the period 1992 – 1997. Australia's population growth from 1999 – 2000 was 0.46 million. (Table 3.1) With the exception of Canberra, the national capital, all capital cities are sited on coastal regions corresponding with higher soil fertility, shipping access and availability of fresh water from mountain run-off, water being a major factor in the country's demographic development.

Canada (Figure 3.2), the world's second largest continent, is demographically similar to Australia, but with greater cultural diversity. Its population of 30.49 million (Statistics Canada, 1999) is unevenly distributed through the ten provinces and two territories, and the majority in a few centres near the more temperate southern border with the United States of America. Canada's population growth from 1999 – 2000 was 0.81 million. (Table 3.1) Ottawa, the national capital, has considerable socio-cultural and political similarities with Canberra, Australia's equivalent seat of government. Canada has an official policy of bi-lingualism for formal documentation and the greatest concentration of French-speaking Canadians is in Quebec province. In Australia, petty rivalry exists between states over minor issues such as sporting prowess, but there is nothing like the inter-provincial rivalry at deep-seated social and political levels that pervades a number of Canadian provinces.

Table 3.1 DESCRIPTION OF AUSTRALIA AND CANADA

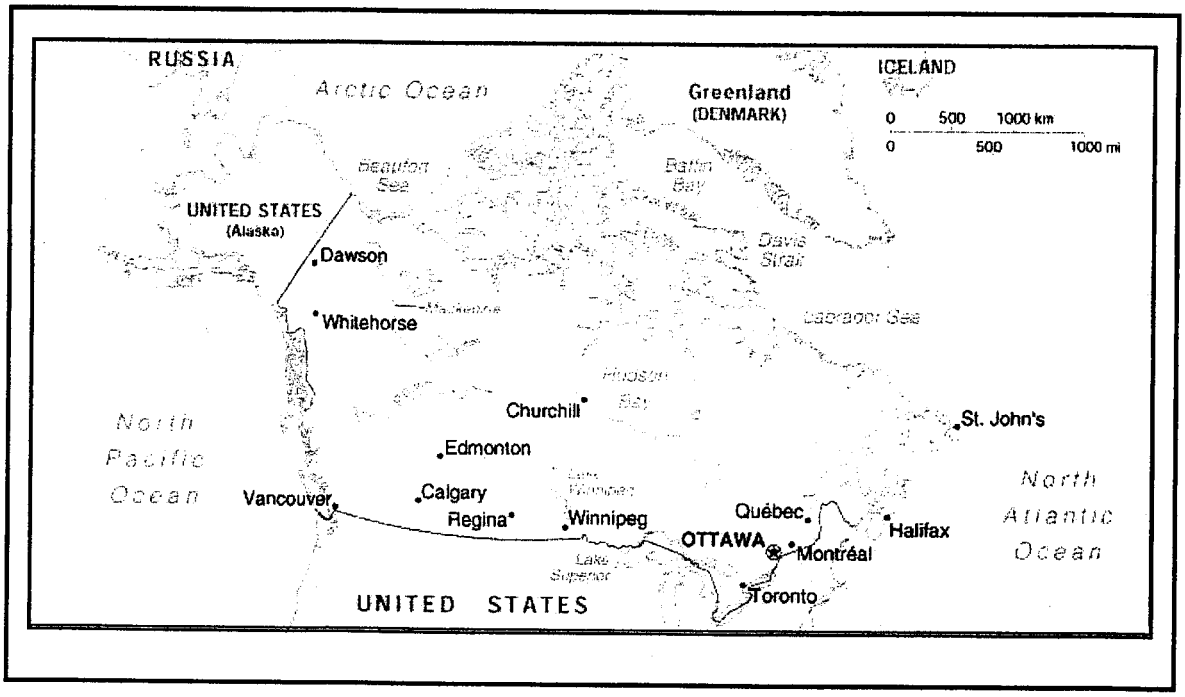
	Australia	Canada
Population	19.16 million (2000)	31.3 million (2000)
Area	7.7 million sq km	9.2 million sq km
Life Expectancy: male female	76.9 years (2000) 82.74 years (2000)	76.02 years (2000) 83 years (2000)
Population Density	2.48 people p/sq km	3.4 people/p sq km
Health expenditure as proportion of GDP	8.4 % (1997-98)	8.9% (1997)
Per capita spending on health	$2536 per person	$2474 per person
Total annual spending on health	$47 billion	$77 billion

Figure 3.1 Map of Australia



Source: www.worldatlas.com

Figure 3.2 Map of Canada



Source: www.graphicmaps.com

DESCRIPTION OF THE SAMPLE

The sample has been drawn from the population of Australian and Canadian nurse administrators according to theoretical interest rather than by random *a priori* selection. Sample selection by prescriptive category representation precludes access to relevant information, which emerges by way of some "snow-ball," or referral effect in which additional respondents are brought into the eventual sample. Where possible advantage was taken of opportunities to balance one conception of respondent reality with another; for instance, the new administrator with the veteran, or the obstetric hospital administrator with the psychiatric hospital administrator. Hence, the eventual sample was built up over time, often by referral of the interviewer from one respondent to others.

The eventual sample of 62 Executive Directors, Directors and Assistant Directors of Nursing, or their equivalents, is drawn from 25 major teaching hospitals and related agencies across seven major cities in three Canadian provinces and two Australian states. Table 3.2 summarizes the distribution of the sample.

Table 3.2 DISTRIBUTION OF INTERVIEW SAMPLE

	INTERVIEW IDENTIFICATION CODE RANGE #	AGENCIES	INTERVIEWS COMPLETED	INTERVIEW HOURS
Ontario				
Toronto	100 - 129	2	4	6.5
Ottawa	130 - 159	1	3	4
Hamilton	160 - 199	2	4	6
Quebec				
Montreal	200 +	3	11	17.5
British Columbia				
Vancouver	300 +	5	10	15.75
CANADA		**13**	**32**	**49.75**
New South Wales				
Sydney	400 +	5	13	19.75
South Australia				
Adelaide	600 +	7	17	27.5
AUSTRALIA		**12**	**30**	**47.25**
TOTAL		**25**	**62**	**97**

Access and Approval: Getting Past the Gatekeepers

Securing agreement from prospective respondents to be interviewed was surprisingly easy. They were interested in the topic themselves! However, the gatekeeping functions of their secretaries served to remind me that I was the one with plenty of time and flexibility, and that I had to engineer a time-slot in the busy schedule of the administrator's week. This was much more difficult since my visits to Montreal, Vancouver and Sydney, in particular, were brief and infrequent - two visits, each of several days, to each of these cities. Adelaide, Toronto and Hamilton were closer to "home" at various stages of the project, and presented fewer difficulties.

Arranging to interview senior administrators requires what Keesing (in Barnes, 1971:238) calls:

> ... professional awareness of the importance of ceremonious behaviour, and of the functions of elaborate hierarchical and other patterned structures.

Wherever possible I used a personal approach to gaining access and permission to interview. An initial phone call was followed with a letter of confirmation and further information on the project. I found that sending a one page formal summary of the research proposal, as I did in the early months, was counter-productive because the project itself became the logical entree to the interview, rather than the career of the administrator. This was because almost all respondents had background in formal research and were interested in

discussing methodological and theoretical issues for their own interest. It proved better to give only the briefest outline of the research design and objectives before introducing the opportunity to talk about personal/professional career matters - an opportunity taken up with alacrity by most.

Having negotiated the ritual procedures considered appropriate in the period leading up to the interviews, I usually found respondents most amenable to the interview. In about one third of cases, I never spoke personally to the intended respondent before interview, having made the appointment with secretaries, in whose judgment the administrators had great faith. In every case the interview lasted at least as long as originally arranged - half to one hour, depending on how much time the administrator could spare - and almost all interviews, at the urging of the respondent, went for longer than booked. The longest interview lasted for 3.5 hours, the shortest for 30 minutes. The mean length of interview was 1.5 hours, and the modal duration was 1.25 hours.

I met all administrators on their own institutional "turf." I was a welcome guest in their hospital/agency, but as a guest, I was subject to their social rules. Whether the meeting began with a casual get-to-know-you stroll to get coffee, or whether it began by pulling hard-back chairs in to opposite sides of a desk was largely the decision of the person I had come to interview. I met most people in their own office. That has the advantage of revealing the integration of the person's social and professional worlds and it facilitates the ice-breaking

comments about the photograph of the children, the view from the cottage, or the latest book to have come across their desk.

Meeting respondents in their actual professional setting is a key element in symbolic interactionist theory:

> To understand someone's career, it is important to ask the actor to reconstruct moments in a stream of action that seem to matter in influencing why he or she took on a certain identity rather than another. (Charon 1995:211)

Key people in the research setting who are enthusiastic about the project become vital sponsors, lubricators of bureaucratic wheels, agents of referral and brokers of respondent confidence in the researcher. Most successful participant observation studies probably have at least one "Doc" to provide the essential insights and contacts (Whyte, 1955:298ff). My Canadian "Doc," having been an administrator before moving into academia, had maintained strong contacts with administrative peers from years before. She had also worked in Australia and provided a point of cross-cultural reference. My initial contacts in Canada (not my native country) were facilitated by her telephone calls to old friends. Referrals to other potential respondents then became self-perpetuating. In Australia, my own circle of professional associates and their referrals to colleagues in other states became the source of respondents.

I was prepared to make use of Douglas' (1976) observation that "all good field researchers are good name-droppers." The opening gambit:

I met [person] last week. She said that I would find you interesting to talk to about [subject] ...

was useful because of the close network among administrators in each country. But such ploys have short-term utility and serve principally to declare oneself not a total stranger and to imply that one is held in apparently good standing by significant others in the respondent's world. Beyond the critical first minutes, the respondent will make her/his own judgments about how wise or foolish, trustworthy or erratic, the researcher is. (Lofland, 1976, 1971; McCall & Simmons, 1969).

Although approval to interview was granted in all cases for which I sought it - and in that sense access was non-problematic - in a practical sense access was difficult. These are very busy people. Their worlds are much larger than their office and hospital environs. Committee, consultancy, public and advisory roles take them well beyond the confines of the hospital and into a range of business, political, professional and community halls of power.

Two people were interviewed during their first week in the job and others as they prepared to leave the job for retirement or greener pastures. In one interview with an Australian Assistant Director, we talked, surrounded by boxes of books, as removalists whisked the trappings of office away to another hospital of which she had been appointed Director. Three respondents confided that they were awaiting news on promotion to jobs in other institutions having completed

the application and interview process. One, who had accepted a new job, had not yet informed her current employer.

Of their willingness to be interviewed, I have three observations. First, that it made a difference to be able to declare myself as a nurse. Second, it made a positive difference that I planned to direct attention to them personally, rather than seeking permission to do research in their hospitals. They accepted with alacrity the opportunity to talk of their own circumstances and career development. Third, what clinched the deal and made it likely that they would get something out of the discussion rather than merely giving, was that I declared myself as an Australian nurse either:

- in Canada on a Kellogg Foundation Fellowship

or

- recently returned to Australia after two years in Canada where I had been doing doctoral research as a Kellogg Fellow.

While none of these three factors carried much weight with secretaries who needed to fulfill the gate-keeper role, they proved useful sources of credibility and identification with the administrators themselves.

Accommodative Morality

There are predictable rites of passage to gaining entry to the inner sanctum of the boss. Having established my *bona fides* to their satisfaction, the administrators were then most generous with their time and their insights, but the value of the *quid pro quo* should not be underestimated. Johnson (1975:113)

advises, "The methodological morality of field research is an accommodative morality." For instance, one's "good faith" as an aware observer/interviewer is demonstrated by willingness to appear helpful by being accommodative with schedules, providing neutral information, and giving evidence of an understanding of the contingencies, constraints and details of the job.

Some of the classic participant observation studies reflect this "accommodative morality" to extraordinary degrees. Among adolescent street gangs, this "good faith" may take the form of pretending not to notice petty crime, providing bail, or visiting boys in jail (Parker, 1974:16, 216); or drinking and flaunting institutional rules when with members of a drug offender's half-way house (Weider, 1974); or doing favours for those on the street and in need (Whyte, 1955:305); and giving tacit approval to other gang behaviour (Dunphy, 1969). Among nurse administrators, accommodative morality was giving indications of my general opinion of the operation of other nursing departments I had visited. While any such assessment could be based only on superficial, public domain information, it does carry the risk of skewing what a respondent might tell me if they assessed the information might not remain confidential. Such "involvement" of the interviewer in the interview process may be viewed as artefact in the data. I have no doubt, however, that it served as an effective lubricant to the interview insofar as the interview itself is an instance of natural social / professional exchange and information gathering governed by conventional rules of social/professional discourse. The researcher who sits

passively absorbing everything but studiously giving no clue of her/his reaction to the proceedings is in default of the normal codes of social interaction and of the code of accommodative morality.

Trust as a Commodity

Elements of crass commercialism are hard to avoid even in the research setting. The research interview is no freer than any other business transaction from the expectation of reciprocal interaction rituals. Even if it is not articulated, the question "What's in it for me?" must be high on the list of questions leading to a decision to consent or refuse the interview, or provide access to an observational sphere. It thus behoves the interviewer to consider what s/he can trade and what can be traded without contravening the code of trust.

The margin of "safety" nurse administrators assessed in talking to me was probably based on their perception that I was "one of them" at least in profession, commitment to contribute, and status, if not in designation. The interest of Canadian administrators in talking about comparative nursing issues with someone from another country was quite genuine. Nevertheless, what I was willing to talk about seemed at least as important to them as what I actually had to say about it.

These verbal peregrinations of the first minutes of acquaintance with a respondent are an essential part of the process of "developing trust" (Johnson, 1975:83ff). Extending the idea of a trade-off of information between parties, Wax (1952) refers to an "exchange" of trust, implying that trust, like information, is a

commodity to be traded, and that unless an adequate basis for its exchange can be negotiated, the interview is compromised. However, trustworthiness is an ethereal quality only judged in subjective and relative terms. As Dean's (1954:233) "individual-morality theory of trust" suggests, the researcher is more likely to be accepted based on personal qualities rather than the purpose and value of the research project. Whyte's experience was similar in the American-Italian slum:

> I found that my acceptance in the district depended on the personal relationships I developed far more than upon any explanations I might give. Whether it was a good thing to write a book about Cornerville depended entirely on people's opinions of me personally. If I was all right, then my project was all right; if I was no good, then no amount of explanation could convince them that the book was a good idea. (Whyte, 1955: 300)

Establishing trust appears in many guises in the literature on field work methodology: getting on good terms, gaining access, establishing rapport, ensuring co-operation and establishing communication, for instance. However the phenomena are labelled, it remains central to the success of the interview or observation process and needs to be carefully attended to by the researcher. An investment of time and energy at this stage will be paid off in fruitful discussion relatively unfettered by the ravages of a respondent's doubt about researcher motives and integrity. Gaining respondent trust is as important in interviewing the knowledgeable and the elite, such as respondents in the present study, as it is in the more obvious case of interviewing children (Deatrick & Faux, 1991:203ff). Contrarily, as Shaffir and Haas (1980:245) warn, an initially

promising researcher-researched contract does not necessarily foretell a trouble-free course. As Ericson (1981) experienced in his research with police, the release of the report may raise its own problems even if access had been gained successfully.

The nurse administrators seemed surprisingly willing to talk to me not *although* I was an outsider, but *because* I was an outsider. They accepted the opportunity to talk with impunity to one in whom the "deep dark secrets" (Goffman, 1959:141ff) of the role might be confided without fear of "losing face", as they might have in front of the home audience. Among groups who have secrets, and that is most groups, the observer undergoes a period of induction when her/his reaction to "off the record" events is tested. Among police patrols, it may be a little drinking on the job, some "roughing up," or some minor graft (Stroud, 1984). It may mean being prepared to keep "lookout" while juveniles do some stealing (Parker, 1974), or while homosexuals indulge in "impersonal sex in public places" (Humphreys, 1970). The less dramatic analogy among the senior nurse administrators was that I remained composed and neither too defensive nor too laudatory, while derogatory - and positive - comments were made about other facilities and people whom they knew I had already spoken with, or had arranged to do so.

Ethical Considerations

Permission to observe the work of, and interview, senior nurse administrators was sought in the first instance from the most senior person in the

Nursing Department. In about half the hospitals/agencies, this person was the first to be interviewed.

In addition to institutional sanction for the research, permission to interview and observe was sought from each potential respondent. Only volunteers were accepted as interviewees and each read the brief explanation of the study and conditions of consent (Appendix 1). Further explanation of the project outlined measures taken to guard security of the data and gave further assurances of confidentiality, particularly that no information would be released to any organization or individual except in the final coded and collated form in which it appears in this report (or its derivatives).

However, some interview data corroborates information and policy decisions already in the public domain through media appearances, journal articles or conference reports by or about the respondent. Hospitals and agencies are not identified by name, though given the limited number of hospitals which fit selection criteria for the study, and the familiarity of many nurses with the career histories of their senior personnel, it seems unrealistic to assume that no correct identifications will be made by those who may read the work. Offsetting this effect, the long lag time between data collection and release of the final report means that a number of people are no longer in the same jobs and that issues topical at the time have lost their sensitivity.

Being "trustworthy" is a quality attributed to the researcher whose manner, background, qualifications and perhaps (though not necessarily) rhetoric, are

sufficient to convince the respondent that the interviewer is sensitive to the ... intricacy of the informant's world. It suggests a certain faith that the information will be treated "appropriately" since, as Roth (1963:284) suggests, sociologists are:

> ... in the same boat with physicians, social workers, prostitutes, policemen and others who must deal with information which is sometimes delicate, threatening and highly confidential.

The details of "appropriate" professional conduct of the researcher may not even be articulated for the respondent since to do so might undermine the delicate fabric of trust for the interview.

I have found that ethical matters are best broached as assurances in formal correspondence prior to the interview. This way, respondents have already made decisions about the level of disclosure they will allow, their feelings about tape-recording, and so on. A large part of the respondent's decision to be interviewed, for how long and about what, is based on quite subjective judgments about the researcher's professional integrity as ultimately manifest in the reporting of the interview. Clearly, this transcends the ethical code of confidentiality to which the researcher glibly (though no less genuinely) proclaims commitment. The indignation of respondents, who feel betrayed by the researcher's ultimate report or by some aspect of the research process, is evident in Ericson's (1981) study of police detectives in Toronto. The trusting relationship leading to the acquisition of data may be irretrievably shattered, making it necessary for the researcher to "cut and run". This may not damage

the particular project or its schedule, but it damages the reputation of the research enterprise and reduces the next person's chances of gaining cooperation.

SUMMARY

In this chapter, the methodological foundations of the research have been discussed. The significance of biography as a data source has been placed in a sociological and theoretical context. The origins and sociological value of comparative research were also considered, whilst key features of the interview process and data management were outlined. Chapter 5 will demonstrate how these biographies circumscribe 'real life' contingencies that shaped the careers of an aspirant nurse administrator.

CHAPTER 4

CAREER PATHS TO NURSING ADMINISTRATION: LIFE CONTINGENCIES

Following registration as a nurse, various career options are available within the profession. One is as a nurse administrator. However, there is no single pathway to an administrative career in nursing:

> **The contingencies that frame your career are not explicitly and solely your own. My father's view was that once you chose a path in life you should stay on it and pursue it as far as possible. I disagreed. You should be encouraged to experience the fullness of life by taking many paths - learning and contributing. I've never deviated from nursing, but have had numerous paths within it. (#302)**

The career of a nurse administrator arises from the intersection of a range of factors that I have classified as life contingencies and organisational contingencies. As defined in Chapter 1, career contingencies are those factors in life, including family, education and employment, that either facilitates or blocks access to desired life and occupational outcomes. This and the following chapter identify those factors for the administrators in this study. Chapter 4 details the life contingencies that locate a person in time, place and career to yield access to an administrative appointment. Chapter 5 addresses the organizational contingencies that give rise to recruitment, selection and promotion of new administrators.

The career biographies of nurse administrators in the sample belie commonly held beliefs about how nurse administrators are selected. In particular, the traditional belief that exemplary clinical nursing and long service are the appropriate precursors to promotion is shown to be less important to nurse executive recruitment than might be assumed. It is still possible in nursing, as in the romantic dream of yore, to rise from being the lowliest deck hand to being the captain of the ship. Ambitious nurses can achieve their ambitions by, as one administrator put it:

> **... having the smarts to read the system and work out the best way to make it work for you.**

Less than one-third of administrators interviewed had foreseen the possibility of their ultimate status in nursing until a short time before their first administrative appointment. With very few exceptions, they came into nursing to nurse, not to be administrators of nursing. Personal circumstances and chance are crucial elements in the creation of access to an administrative career. (Price *et al* 1991:228)

PERSONAL CIRCUMSTANCES

Section I of the Interview Schedule (Appendix 1) sought patterns related to personal background details of respondents. In addition, most respondents spontaneously recounted matters I later classified as personal circumstances influencing work. All the respondents cited in this research were women.

The mean age of respondents was almost the same for Australia (42.6 years ranging from 30 to 59) and Canada (42.5 years ranging from 20 to 56). In neither country does parents' occupation correlate well with respondents' salary and executive status within the occupation. Father's occupation was technical/manual for 82% of Australian respondents and 83% of Canadian respondents Mothers of Australian respondents were more likely to work, or have worked, as nurses (23%) or teachers (18%), than the Canadian equivalents - nurses (8%) and teachers (8%). Australian respondents' mothers were more likely not to have had paid employment (45%), compared with (33%) of Canadian mothers having not had paid employment.

Sixty-five percent (65%) of Australian administrators had earned an academic award at or above diploma level since obtaining nursing registration. Twenty-six percent (26%) held bachelor degrees, none having any higher awards. Seventy-two percent (72%) of Canadian administrators had earned an academic award at or above bachelor level since obtaining nursing registration. Sixty-one percent (61%) held master degrees, none having any higher awards.

MARRIAGE, MATERNITY AND MOBILITY

A trio of career-related factors - **marriage, maternity and mobility** - emerged as significant in my earlier study of new graduates in nursing (Moorhouse, 1992a: 62-3) which identified the three most common reasons for new graduates leaving their first position as a registered nurse as, in order of frequency: pregnancy, travel and marriage.

Canadian administrators were more likely to be married (65%) than their Australian counterparts (39%), though 67% of Australia's 187,000 currently registered nurses are married (Castles, 1990). The interview schedule did not include a question on children because it was not initially considered relevant. However, the significance of children as a factor in career decisions is suggested by the fact that 15% of respondents spontaneously referred to children, often as a factor constraining career mobility involving relocation.

The literature on the specific problems and opportunities faced by women as they establish careers is now extensive. For instance, Rice (1979) addresses social-psychological and psychodynamic aspects of how career people choose partners and how they establish equity frameworks and joint responsibilities within marriage. Sharpe (1984) focuses specifically on the double identity problem for women who combine employment and motherhood, giving particular attention to the complexity of the social-psychological meaning of work in British women's lives. Working women, working wives and working mothers make "hard choices," the topic matter of Gerson's (1985) analysis of how women decide about work, career and motherhood. They experience multiple transitions in the life course - upheavals in the private ordering of their lives - as they adapt to competing demands of work, parenthood, illness, the "empty nest" and return to work after an absence for child rearing (Viney, 1980).

The study of life cycle events has become important to those who study occupations (Hogan, 1978; Spilerman, 1977). Such life cycle events differ for

women and men and an adequate understanding of how to make work more rewarding and more accessible for women requires attention to how they experience these stages.

> Such a life cycle approach is particularly applicable to women, who tend to display greater diversity than men in life event sequences due to their family roles and to labour market opportunities. (O'Rand & Henretta, 1982:365)

Most of the married people in this study said they found nursing administration more compatible with marriage than clinical nursing which imposed the specific domestic demands of shiftwork. Several made the observation that Directors of Nursing were rarely married in the past and attributed that to a now largely defunct belief that such an important job could only be done by someone with the level of commitment only possible for the unmarried.

The conflicts of the dual-career marriage (Rice, 1979) usually related not to the division of domestic labour, which was usually shared and given low priority by respondents in this study:

> **We eat out a lot and I don't burden myself with saying 'My God! The house is not clean'. (#302)**

Missed opportunity for one spouse given the other's occupational relocation or other commitments, was a typical source of domestic tension. One person left an attractive job in Newfoundland to follow her husband to Montreal where she had a lesser job than the one she left. Another, however, had her career unexpectedly enhanced in a move related to her spouse's work:

> **We moved east because of [husband's] job. Had we stayed in Ontario I would not have had the opportunity to be the nurse in charge of a community branch - that gave me my first big start on the administrative trail. (#304)**

Spousal employment, then, becomes a relevant contingency, which can have either positive or negative effects on an administrator's career. Periodic relocation can enhance career prospects, but it is not always possible to control the destination and timing of career moves for one or other partner in a relationship.

The interviews exploded some of the myths about working women generally and women in executive positions specifically. One respondent's comment about her husband's attitude captures the spirit of numerous responses:

> **My husband is proud of what I've accomplished. It's nice to have two good incomes - we get to go on nice trips - we've just come back from Australia. In administration, my busy times mesh with those of my husband who is in business. When I was teaching, our times didn't mesh at all - there is a lot of work to do at home and at weekends in education. In administration, I am much more independent. I do anything I need to at work, then I'm free to read at home, and our weekends are free ... My husband is away for up to half of each month. When he's away, I can blitz on my work, clean up some projects, stay late, and take plenty of work home. That frees me not to do [those things] when he's home. You don't have the same flexibility in education where classes are in and you have to be ready to coincide with predetermined schedules. (#304)**

In spite of the domestic benefits of financial independence and affluence available to these administrators, their executive status can strain conventional marriages:

> **I am now better educated than my husband and I've had promotions. He has stayed with the same company and although he is a part owner, there have not for him been finite levels of achievement like me getting specific new jobs or new titles. He is still doing essentially what he was hired to do 10 years ago. That causes a little undercurrent of resentment, especially when I was beginning to talk about doing my Ph.D. These career decisions are not major issues discussed on a daily basis. They are the sorts of thing we talk about on a weekend away, or on the chair-lift when we are out skiing; those times when you reflect on the question 'What are we going to do with the rest of our lives?' (#304)**

Professional care-givers face particular demands in balancing home and work. Some of these are outlined in Gerber's (1983) analysis of career and family dilemmas in doctors' lives. The professional socialization process in health care work is such as to create conflicts of loyalties between patients, family, colleagues and organizations. Health professionals are generally ill-equipped to deal with such competing demands and unless balance can be achieved in private and professional lives, the tension on marriages may be more than the marriage can stand. Seven percent (7%) of respondents in the current sample were divorced or separated, a life contingency, which in itself, can lead to changed career direction through increased mobility and re-definition of what is possible in career terms.

Some unmarried respondents observed that the competing demands of the family, home and children might compromise the work of married administrators. I found no evidence to support this. Indeed, those with families tended to be the most professionally active outside the substantive role. One very busy nursing department director, professional organization president, and

media spokesperson, conceded that since her husband was equally committed to his work, they had "hired a professional wife"; a nanny to keep the home fires burning and care for their child in the home. Other concessions to "normal" life are also necessary in supporting the two-career family:

> **If we have to entertain, then we order caterers in, but you have to have a certain salary to be able to do that. (#102)**

It quickly became clear from the interview data that nurses who ascended the career ladder most rapidly and avoided a fatal tumble, saw the value of gaining experience in a number of institutions with diverse administrative philosophies:

> **I had grown up in a fishing village in Newfoundland and went to a small New Brunswick university, and later to work at Memorial [University], so I felt a need to find what options the rest of the world offered. I chose Montreal to grow up in professionally. (#203)**

Contrary to a once-popular belief, promotion is not differentially biased in favour of those whose employment record shows unswerving loyalty to one institution. A majority of respondents in both Australia and Canada saw three to five years as the optimum time in each of several jobs leading to appointment to the most senior position. This rationale for job mobility was motivated partly by its apparent advantages for rapid promotion, but was often stated in terms of fear of being locked into jobs as many of their peers were:

> **I have always had little respect for people who stagnate in a job for 15 years. The optimum time, I feel, is 3-5 years. After that, productivity and initiative begin to diminish; they go stale. (#206)**

A high level of occupational mobility among ambitious administrators can be attributed to a number of life contingencies, among them:

- age of respondent
- partner's work and attitude toward relocation
- preferred timing of a job change relative to available opportunities
- obligations to school age children or frail and aging parents
- pragmatic considerations such as mortgages and home ownership or other aspirations.

Some nurse administrators consciously sought the range of experience offered in other hospitals, others moved on because of limited promotion opportunities in their occupational setting at a time when their career plan suggested a change. Regional determinants such as Quebec's French language legislation also influence occupational mobility:

> **One of the problems of a flat hierarchy is that good people can find themselves career-blocked. Their opportunities within the organization are limited so they have to seek other places for their advancement and promotion. There is also a certain amount of movement out of Quebec because of the language legislation. It has become particularly difficult for us [in this predominantly English-speaking hospital] to recruit people from other provinces if they have children who have little knowledge of French. Also, we are supposed to support the bilingual legislation in our staff hiring. That reduces our recruitment options somewhat. (#209)**

It is unfortunate that changing government policy on employment and immigration has almost obliterated the once-popular option for nurses to gain overseas experience soon after graduation, travel being one of the reasons most often given by Australian nurses leaving a particular position in nursing (Castles,

1990; Moorhouse, 1992a: 61; South Australian Health Commission, 1978; Wilkinson, 1991). In Canada, opportunity for broader experience is available closer to home, some going to other provinces, others going to the United States either for work experience or graduate degrees in nursing and related disciplines. The clear association I perceived between geographically, culturally and philosophically diverse experience, and the breadth of experience and perspective brought to a particular administrative job, is typified in this comment:

> **From my university nursing education [Philippines University], it was almost taken-for-granted that you would progress to the U.K. for post-graduate work. All of the teaching and management staff were from the U.K. It was just a question of changing your address because we had been nicely socialised into the British nursing tradition and way of social life. We were managed by British ward sisters and sister tutors, and lectured by British professors in that three-year program. In my class alone, 15 of us went almost immediately to U.K. The thing was to go to famous hospitals. For midwifery, the place was the Simpson Maternity in Edinburgh because we used the Margaret Myles textbook in Jamaica and it was revered; then it was Guy's, St. Thomas', and those renowned hospitals that were the target for those ambitious nurses. We had the most superb role models in West Indies. They were the people you wanted to be like. They were teachers and administrators. (#205)**

Asked about her plans for the next five years, an Assistant Director of Nursing said wryly:

> **What worries me more is where I am going to be in 10 years, because I move fast. I get bored easily and need to create challenges for myself. I'm now 28 and I should achieve all the different things I need to do within the next five years so I can settle down. But if I'm Director of Nursing in the next 2 years, and I do that for, say 8 years before I get bored, what am I going to do for the next 20 years? That really worries me - the thought of not being challenged. I'll have to go into something new and different**

if nursing has run out of things to challenge and excite me. I can't bear the thought of just seeing out my time in a job.

The difference between me and those Directors who have overstayed in a job is that I have options. They may not have. It's important to curry those options so you don't get locked into one position from which you can't escape, and where you just weigh down the position and stop its growth. (#203)

The interest in being consistently challenged was a recurrent theme. One referred to "getting a buzz" out of solving difficult management problems; others liked to be "consistently on a high," "fired up" or "doing high energy work." I wondered if they could predict when they might lose that energy and enthusiasm:

If I stayed and did the same thing too long I'd get bored. If I stayed as Vice-President of Nursing, or as Director, I would lose energy. I'm looking now at what I do want to do. I used to want to be a V.P. of Nursing. I'm not so sure any longer. I will look for something relatively the same as I'm doing now, but on a larger scale, more exciting and with greater opportunity. I'm looking at whether or not to go into politics, whether I put some time at a lower level in the political arena and then work up. I've been offered opportunities to go into the business world in the broader sense of health care. They are things I have to decide about in the next year or so. (#102)

FAMILY OF ORIGIN

The influence of primary family origins on career goals and choices, was another life contingency to emerge from the data:

I was the only one in my family to move to the big city. I take risks and enjoy challenges. I identified most with my father, a managing director of a construction equipment company. He was also the successful one in his family from a fishing village. Perhaps I'm living out some elements of success for him, though he was never happy I went into nursing and not medicine. (#203)

A number of respondents from rural and lower income families referred to the possibility that they were living out the unfulfilled ambitions of one or both parents, or proving that they could do better in a less desirable occupation than they would have in the parentally idealized one. This was more likely where the respondent was an eldest child or where there were no sons. It was a common paradox that attempts to prove something were continued well after the point had presumably been made. Such contingencies are nicely encapsulated in this quotation:

> **My family doesn't understand what I'm doing. I call them often, and if I have an article published, I'll send them a copy. I did this once and they didn't comment. I asked what they thought of the article. They said 'Yeah - but that's a terrible picture of you.' They don't understand the significance or complexity or demands of present-day nursing. To some extent, I guess I want to succeed and show them that I can be at the top of the tree. (#203)**

AMBITION, ASPIRATIONS AND REWARDS

Turner (1962) describes ambition as the pursuit of personally valued ends, which may take the form of:

- material reward (e.g. salary and the trappings of status)
- education (e.g. knowledge and the influence derived from it)
- eminence (e.g. status and recognition).

Table 4.1 includes reference to the primary sources of reward referred to by respondents. It suggests that the opportunity to influence the development and provision of health care and of nursing, specifically, is most often stated as the source of greatest reward. Salary and the power of the position are not

highly rated as sources of reward in the senior administrative positions, though these positions do represent a significant power base and they are the highest paid positions in nursing. Subsequent interview transcripts, however, indicate that knowledge, access to power and a salary level enabling commitment to professional issues without compromising personal and domestic priorities assist the achievement of eminence.

The ambitions of respondents as elicited from Section VI of the interview schedule (Appendix 1) were expressed in terms that paralleled the variants of administrative ethos identified elsewhere in the study, and could be summarized as:

- improving standards of clinical care by developing the staff for whom they are responsible (clinical ethos)
- developing the reputation of the organization (management ethos)
- developing the nursing profession (corporate ethos)

Table 4.1 also summarises respondent perceptions of their ambitions and aspirations and their statements regarding the source of their personal rewards. Sixty-two and a half (62.5%) percent of Australian respondents identified themselves as ambitious, compared with 75% of Canadian respondents. Definitions of ambition differed according to whether or not the respondent defined her/himself as ambitious. Those who did typically gave selfless descriptions of the nature of ambition.

> **[Ambition is] a response to knowing one can contribute more to the profession by achieving a more influential position within the structure. (#402)**

Those describing themselves as not ambitious described it in terms of aggressive and self-centred lust for power. Some respondents, acknowledging themselves as ambitious, sought to disclaim the negative attributions of the term:

> **Ambition means wanting to get ahead. It has negative connotations for many people. A Head Nurse once evaluated me as being ambitious. I was quite upset by that. I [thought she meant] I was pushy enough to elbow everyone else out of the way to get what I wanted; stepping on them to get where I wanted to go. What she meant was that I was competent, career directed, and able to organize the job easily ... She was paying me a compliment. (#304)**

Respondent definitions of ambition by those who declared their own ambition outlined the characteristic of eminence as an avenue for direct influence on the profession. That influence appears to be achieved in two ways:

> **I recognize my ambition now as the fact that I like to be in leadership positions, to have a group for which I can facilitate the work at a high level of competence. I don't any longer want to do good nursing work myself; I want to make sure I can provide the resources and skills necessary for others to do it. I'm goal-directed and it frustrates me to be in a group, which I cannot influence to make a difference to practice. (#304)**

Achieving goal-directed ambitions requires a locus of power through which to influence what others think and do. Respondents see such power as vested in certain positions within an organization. Thus, the attainment of a certain position may not be an ambition in itself, but rather the mechanism for achieving a desired influence within the profession, a means to achieve valued ends, rather than an end in itself:

R: Ambition is the quality necessary to get into a position where you can hold enough power in the organization to achieve nursing goals. I am ambitious in that direction.

I: Does that imply also a desire to influence the direction of the profession?

R: Yes. To the extent that what you want to ultimately develop is the standard of nursing practice, but to achieve that you have to be involved in policy-making and resource allocation and high-level decision-making. We see ambition more among administrators because they have the opportunity to make contact with other high level decision-makers. It is more difficult for Head Nurses and Clinical Administrators ... to establish the network they need to be influential in a broader sense. (#201)

Some respondents described ambition as a diffuse, but none-the-less intense, drive to do highly valued things well:

I'm not ambitious in terms of aspiring to very senior appointments. I've been recruited into every position I've been in [25 years nursing], but it's damned important for me to do my job very well. I strive for that. (#210)

Nevertheless, such striving for excellence paves the way for access to positions of greater status:

Striving, and the manifestations of it, are the very activities which lead to people being noticed and seen as outstanding. It leads to selection for promotion. The more actively involved people are in their work, the more they come to the attention of recruiters, whether it is for committee work, special projects, or for major institutional appointments. Once in this groove of being singled out as "good," "able," "competent" and "willing," the career path, for those who want it, becomes an upward spiral. (#102)

People in the sample identified as "ambitious" tended to plan their career development meticulously:

R: Looking at my own career development, I figured I needed three to four years in an acute care facility as Director of Nursing. With that background and experience, I was looking for a vice-presidency [of a hospital] or a very senior position in a university. That would give me eight years in a position just below the most senior position and I felt that was sufficient time to prepare me.

I: So how long have you been professionally ambitious in that way?

R: Probably since the day I graduated. (#102)

They may also cherish a dream, which sustains them. Usually they described something that was marginally outside their reach without being impossible:

At 47, I'm too old to start a new career. I still cherish a dream to return to the Philippines and speak to my old high school as a role model; to say to them "I set a high goal, aimed for it and achieved it. You, too, can do whatever you want to." I am never satisfied. I always want to do more. (#204)

One respondent referred to such dreams as a "professional fantasy." I borrowed the term:

I: Do you have any "professional fantasy," a dream for your future?

R: One of my fantasies was to be Dean of a School of Nursing. I would have insisted, as I did when I was Department Head [in a college program], that I had teaching time. Being a Director of Nursing does not attract me as much as being a Dean of School. I think I need to be in an environment where knowledge is generated. Being an Assistant anything is not something to be, except as a stepping-stone to something else! (#205)

Ambition and achievement, then, seem to be natural partners, but it helps to be surrounded by other high achievers and in that context, the importance of networks was consistently reinforced in interviews:

> **In high school, I was class president for three years, and graduated with honours from high school. At nursing school, 200 of us started [the five-year program]. I was one of 40 to finish. It was heavily screened each year. We were high achievers then and nothing has changed. Most of the class graduated *magna cum laude* or *suma cum laude*. We are all now successful managers, but only one has stayed in the Philippines. Most are now Directors of Nursing in United States, two in California, two graduated in law, one from Harvard, and one from Columbia. The class was competitive and we have remained that way, but we've stayed close; kept that network going. That's important because it's a very broad network. We have met for reunions every year since 1961. Nine of us are in Canada, 30 in U.S. and 1 in Philippines. Thirty-nine attended the last reunion. (#204)**

Australian and Canadian administrators differed in the proportion declaring a highest aspiration relating to professional, rather than personal achievements. Fifty-three percent (53%) of Canadian administrators held as their highest aspiration developments on behalf of the profession, the community or the particular hospital, while 61% of Australian administrators declared highest aspiration relating to personal matters such as further educational attainment, family development or consolidation of personal circumstances. This difference may relate to the fact that retirement was imminent for six administrators in the Australian subset of valid responses. This factor is also reflected in the section "Likely next position" in Table 4.1 in which respondents planning retirement were included in the "Not administration" category. Excluding imminent retirement as a factor, 50% of both Canadians and Australians expected their next position to be a higher status administrative position.

Respondents aspiring to or anticipating a lower status administrative position fell into two categories. Half, of whom most were Canadians, had spent

several years in roles which had exhausted them, and they now sought a similar though less demanding position. The other half, of who most were Australians, anticipated that organizational changes would lead to redesignation of their responsibilities. This section of the interviews revealed that Canadian nurse administrators were more career mobile and more likely than their Australian counterparts to aspire to career changes out of administration and into, for instance, an academic position, public office or a clinical position.

Table 4.1 AMBITION, ASPIRATIONS AND REWARDS

Ambition	*n**	Ambitious	Not Ambitious	Unsure
Canada	*20*	15.8%	2.1%	3.2%
Australia	*24*	15.3%	8.3%	1.5%
Total	*44*	31.0%	10.4%	4.6%

Aspiration	*n*	Highest Aspiration	
		Personal	Professional
Canada	*17*	8.5%	9.5%
Australia	*18*	11.6%	7.4%
Total	*35*	20.1%	16.9%

Aspiration	*n*	Likely Next Position		
		Higher Status Admin	Lower Status Admin	Non-Admin
Canada	*12*	6.5%	4.3%	2.2%
Australia	*20*	7.4%	4.0%	9.5%
Total	*32*	13.9%	8.3%	11.6%

Rewards	*n*	Source of primary job reward				
		Salary	Status	Power	Influence	Other
Canada	*8*	0.0%	2.3%	0.0%	5.6%	1.2%
Australia	*12*	0.0%	4.3%	1.8%	6.5%	1.8%
Total	*20*	0.0%	6.6%	1.8%	12.1%	3.0%

n = cases for which valid responses were available
Percentile figures rounded to one decimal point

SUMMARY

This chapter identified the life contingencies shaping the career path leading to nursing administration. A range of factors, which can be broadly considered aspects of personal life, emerged as significant in the creation of career turning points and subsequent career decisions. Those life contingencies critical to occupational career include marriage, parenthood, travel and residential mobility, primary family origins, individual ambition and stated sources of personal reward.

CHAPTER 5

CAREER PATHS TO NURSING ADMINISTRATION:

ORGANIZATIONAL CONTINGENCIES

ORGANIZATIONAL CONTINGENCIES

Organizational contingencies are those policies, events and opportunities in the organization which are relevant to an individual's ambitions, but over which the individual has little or no control. This chapter suggests that these contingencies may create the circumstances for turning points and career stages for individual nurses.

The process of recruitment, selection and promotion of nurse administrators reflects organizational contingencies to which the prospective job applicant are subject. An administrative appointment in nursing is attained when life contingencies and organizational contingencies intersect to create an opportunity for which an applicant is available at the right time, in the right place and with qualifications and experience matching those sought by the organization for a particular position.

This chapter reveals something of the attitudes and values current senior administrators seek to perpetuate through the appointment of administrators who may become their successors.

RECRUITMENT: ATTRACTING THE BEST

Recruitment was identified from the data as taking one of four forms:

-unmediated response to an advertised position

-being encouraged to apply by supporters

-being invited to apply by a mentor

-being made a direct offer by a sponsor.

While advertisement is recognized as the appropriate mechanism for scouring the resource pool, recruiters often have in mind, or have referred to them by peers in other places, people whom they invite to apply for consideration:

> **Personal contact, rather than open advertisement, is the way important or problematic positions are filled. (#203)**

In some agencies in Canada, the Vice-President (Nursing) has the freedom to make direct offers in order to get a preferred candidate. The industrial relations climate in Australia is such that options for executives to make discretionary offers of appointment are negligible, the recruitment and selection process being prescribed by policy, influenced, and closely monitored by trade unions.

It became evident from interviews that a complex series of networks was instrumental not only to recruiters for senior nursing positions, but also for those who aspired to such positions. The development of one person's career depends on others and personal careers are interlocked through networks:

> **I knew about the Montreal job coming up because of my sources. I had a network going. I always believed that was important. I have never lost contact with my network. (#203)**

Progressive senior administrators appeared able and keen to attract others who are bound for prominence. Several of the most senior and influential people in the sample referred to the recruitment motive of getting the best people around them because their capacity to attract the best makes them look better:

> **The personal network and series of contacts is important in having your personality and management attributes known by key people who have key positions becoming vacant. If they like what you are about, you'll have a phone call one day when you least expect it. (#304)**

Some respondents referred to the risk of attracting clones of themselves. This was seen as an unhealthy sign. A secure nurse executive sees advantages in recruiting people with different skills from their own, but is less likely to seek people whose beliefs about nursing and its priorities diverge greatly from their own. Networks and career planning were referred to often, especially by Canadians, as the way to identify hospitals or senior personnel with whom prospective applicants might have a shared view of the nursing world:

> **I've always planned things carefully, working toward particular jobs knowing who might be leaving and when. I played the kinds of contacts I knew I would need to achieve those positions. You have to do that to even be recognised as someone in the market for a particular job. I'll be ready to be a Director of Nursing in 2 years, and there should be the right job ready by then. When it comes up, anywhere in the country, I'll get to hear about it through my network. (#203)**

Most nurse administrators interviewed had clear ideas about the sort of person they wanted to recruit to senior positions. For example:

> **We are looking for someone who is a real marvel y'know. We want her, or him, to have organisational ability, to know about**

> **the change process and techniques for promoting change ... and to be flexible so they can adjust to new things that come along. We want them to be able to inspire and lead and establish good interpersonal relationships with other staff ... Personal qualities - someone who projects an air of knowing what she is doing; poise, I suppose. It shows that they will not be taken off balance by things that come along and that they are able to relate to a variety of people. That is crucial. They must project an air of confidence. You must have standards, but I don't think that you can expect everyone to conform to your standards. You have to be able to adapt and be willing to accept people as they are without trying to mould them exactly in your image. (#201)**

"Style," "poise," "grace under pressure," "being able to think on your feet" and "a sense of humour" were also mentioned as attributes valued by the organization. Some of them are nebulous qualities - style and poise, for instance; others seem contradictory - grace under pressure, I was assured, had nothing to do with "giving in", it meant winning the battle as aggressively as need be, but gracefully demonstrating that the outcome was taken-for-granted. Similarly, the tough business of policy negotiation was said not to exclude a sense of humour and tolerance of others' different ways of doing things.

SELECTION: IDENTIFYING THE BEST

Advertisements for senior positions usually give a formal statement of minimum credentials, so it is unlikely that any applicant short-listed for interview does not meet these criteria. Selection, then, can be seen to rest on attributes in addition to such objective criteria as formal qualifications and prior experience. They include attitudes, values and development plans which reflect the administrative ethos preferred by the appointment panel.

There was considerable disparity in approaches to selecting administrators. All Canadian Vice Presidents (Nursing) and Australian Directors of Nursing, were selected by a panel comprising medical, nursing and service administrators from the hospital executive; medical and lay members of the hospital board; and representatives of statutory and funding agencies such as provincial/state ministries of health or health commissions. Selections for positions at Assistant Director of Nursing and below are largely the province of the Vice President/Director of Nursing, though selection panels usually include suitably senior nursing and other personnel (Ertl, 1984). In spite of procedures to ensure objectivity, criterion-based selections, equity and fair and open competition in the selection process, the role of intuition in selection was mentioned frequently. One Canadian Vice-President explained her approach to senior staff selection:

> **I go very much by intuition. I believe in my gut reactions very much, and whenever I go against them, I'm always wrong. So a lot of it is intuitive, if I just sort of take to the person, I like their style, I like what they're saying and their philosophy fits in with ours. They have to be quite achievement-oriented; have a lot of energy, because we demand a lot of people. It's an exhausting business. If I don't see that kind of commitment, then I just wouldn't hire them into this role because they would never make it and they would stand out as being too different from the others. Now, their commitments vary here, and one can look at them and see their different priorities, but they are all pretty committed to the profession and to improving nursing practice. (#101)**

Committed administrators, the same person later explained, rarely do less than their job entails; they invariably do much more. That, she said, is how these ambitious people fit so much into their day, and how they manage to make time

to attend conferences, take courses, give lectures and engage in other professional activities without compromising their administrative responsibilities.

Far from being passively selected for a job, most respondents believed that they had sold themselves the job and they valued that approach among applicants. Most of them were familiar with the swathe of books on success management, corporate success, job promotions and executive "style" (Irish, 1978; Medley, 1978; Peters & Waterman, 1982; Stevens, 1990; Toffler, 1985). As in much pertaining to success, paradox and irony play in important part. Bolles' (1996) caveat from his popular *What Colour is Your Parachute*, now in its 25th annual edition, warns the idealistic applicant of the irony in candidate selection:

> He or she who gets hired is not necessarily the one who can do the job best, but the one who knows the most about how to get hired.

Administrators well recognize the importance of selling their department or their hospital to the community, to the Board and to CEOs' and colleagues in other disciplines. When they need to sell themselves, they have the skills to do so:

> **You can sell yourself and make yourself more desirable to potential employers by knowing what they want and articulating it in terms of what you can specifically offer. I'm at the point now, with a good network operating for me, that I don't have to sell myself so much anymore. I get more invitations to speak or go on this or that committee, take a joint appointment or whatever. But leading up to that is an intensive period of selling yourself. (#203)**

However, reliable recruitment and selection procedures and well-honed interview skills may still result in a poor match between employer and employee. The job seekers may choose a job and sell themselves into it, only to find it unsuitable:

> **The person who appointed me later said she felt she had made a poor choice based on my limited experience, but that I had convinced her in a 3-hour interview to hire me. I left after a year because I didn't have the autonomy and control to develop nursing the way I wanted to. (#203)**

This person may have over-sold herself and paid the price for having aggressively pursued the job before checking out its detail. More common, however, is the interviewer's problem of persuading the candidates to sell themselves enough. The same respondent elucidates this difficulty of the selection interview:

> **When I am interviewing nurses for positions, they never try to sell themselves. They sit there waiting for me to ask them questions. How am I supposed to second-guess what they can offer me? They have to tell me, and come prepared to tell me. Either that or they don't elaborate on a question. They'll answer in a short, sweet, factual way - it's how they've learned to respond to questions at work ... I can get in half an hour of interview what I need to know, the rest is up to them to convince me that I should hire them. (#203)**

In neither country was there a strongly developed conviction that selection for an administrative position is, or should be the reward for clinical excellence. In past years, however, there was a widely held view that the best clinical nurses were lost from the bedside since the only promotion options available to them were into administration or education. It would seem, therefore, that clinical excellence is not identified as warranting special recognition. As one respondent

remarked, nurses are expected to be (clinically) excellent. Nurse administrators appear to want to promote the belief that potential as an administrator, and not demonstrated clinical excellence alone, is an important factor in achieving an administrative career:

> **The distressing thing is that there are people that have the potential, but we do not seem to recognise those people and help them along. We are not futuristic in saying 'That person has some potential, let's nurture her and set up supports for her, or him, and let's bring them along.' (#103)**

Respondents had no doubt that academic qualifications were an increasingly important predictor of success in a job application and ultimately, in the job itself. In formally structured, bureaucratic organizations such as nursing and the police (Munro, J. *et al* 1985), length of service has traditionally been an important consideration for promotion:

> **In the government hospital program, the criterion for promotion was length of service. It had little to do with skill ... But you don't get rewarded because you are a good nurse, you are expected to be good. (#203)**

Changes in the nursing career structure de-emphasise length of service in favour of other measures of excellence or job-specific ability. An Assistant Director of Nursing told me how her promotion was seen to have arisen from a clinical incident in which she was believed to have saved a woman's life by applying bi-manual compression and stemming a life-threatening post-partum haemorrhage:

> **The word got around and at report next morning I had to give a description of how I had saved this woman's life. Within a**

> **week, I was offered promotion. It's that habit of rewarding excellence by offering promotions that sometimes prevents people from making conscious decisions to do administrative work. It is a natural choice for some people, but for others who are promoted it's seen as a reward. (#205)**

That comment has a certain irony given that career structuring in nursing today tends to reward clinical excellence by promotion within the clinical nursing stream, rather than offering transfer into education or administration as a reward for clinical excellence. In addition, data from most hospitals covered in the study does not support her suggestion that clinical excellence is routinely rewarded by promotion to administrative positions. The option now exists to reward it by promotion into new clinical-administrative structures and through appointment to clinical specialist and nurse consultant roles.

The benefit of "new blood" is almost universally recognized now, and industrial relations policies usually provide for open advertisement in most states/provinces, for most positions. Yet, such requirements have added problems of their own:

> **When I came to Canada and had to apply for jobs, I felt affronted because I was used to being [directly] offered them [in a British colonial nursing system]. In the present system of having to post [advertise] every job, you are hampered somewhat in choosing excellence. If someone who is not excellent has the credentials and the experience, they may have to get the job over someone better who doesn't look as good on paper. You have to beware of causing trouble with the union or equal opportunity boards now. As a manager, you lose some of your manoeuvring room in getting the best for your department. (#205)**

PROMOTION: REWARDING THE BEST

With length of service no longer being the major criterion for promotion in nursing, the way is open for bright, young, ambitious nurses to circumvent the ritual ordeal of long periods of clinical nursing *en route* to administrative appointment. They have found that they can now take the "fast-track" to executive positions in nursing. As in Monopoly, it is important to have the right cards, sufficient accrued capital and the right fall of the die. The right cards equate with appropriate formal credentials - a degree in nursing, business administration or a relevant discipline and preferably at masters level, is at least vestigial evidence of the "corporate right stuff" (Deal & Kennedy, 1982:37ff). Tenacity, vision, initiative, defiance of tradition and some acquired status as a hero among those they will influence, are other features increasing the likelihood of promotion to an administrative role.

The accrued capital is a track record in representing nursing in the public forum, for instance, through research and publication, political activity, professional involvement or media coverage. Finally, the fall of the die should not be ignored. Many contingencies affect whether a person is right for this place at this time, in example, whether the organization is at a point in its development to best utilise the person's skills, whether the person appointed has the skill and background sufficiently developed to achieve what the organization wants. These and a host of other factors, many of them entirely subjective, come together to influence the search for, and ultimate acceptance or rejection of, a

potential senior nurse administrator. The following interview extracts bear testimony to such contingencies, and to the significant and quite recent trend for some administrators to be appointed with little clinical nursing experience. Some selectors appear willing to trade that for the academic qualification and what it represents in terms of *ipso facto* credibility and broad problem-solving skills to be applied to administrative work:

> **I was 30 when I started my administrative job. I got a management position without having been an Assistant Head Nurse. There was no precedent for that here, so my peers who are 10-15 years older than me resented me. (#206)**

Few in the under 40-year age group came to their executive positions by the traditional clinical route. In Canada, for instance, 44% had come to their administrative appointment via a teaching career in schools or faculties of nursing following a relatively short time as a clinical nurse. In Australia, 13% had had some teaching experience, but the principal clinical backgrounds were in high dependency nursing areas such as intensive care and coronary care units and operating theatres. Those whose route to administration had been shortest, admit, somewhat sheepishly since it defies the dominant nursing ethos of commitment to direct care, that they have had little interest in clinical nursing:

> **To be honest, I never wanted to work as a staff nurse. I fought hard against that feeling because it didn't seem right. When I first came to this hospital looking for a job, I was told I'd have to do my year in the trenches - it was like a penance. I didn't like the idea so returned to Newfoundland where a new master's-prepared Director took a risk and put me in administrative charge of two psychiatric areas, though I'd had no [practical] experience as a nurse [She had a B.Sc. in biology and chemistry**

> **and subsequently took an M.Sc.N. by which route she was able to register as a nurse.] What made it easier for me was that they had hated the previous boss; also my skills as a group leader and my simple premise that people could enjoy their work and respond to talking about it, helped me to be accepted as an administrator. I respected them for their experience too. But being a nurse at the master's level without ever having being a nurse at all created problems for other people, not unreasonably. We had analytical and other professional skills from a range of other backgrounds, but we were not skilled at nursing procedures that others took for granted as basic to what a nurse was. (#203)**

While for some, the clinical experience, however brief, was seen as a necessary ordeal, about one third of respondents maintained very strong loyalty to the ethos of clinical nursing and kept close links with the "real world" of nursing. In both Australia and Canada, a limited number of programs offer shortened courses in nursing for graduates in other disciplines. Such programs have attracted some of the most promising young administrators. One of the most committed clinically-focused administrators in the sample was an Australian Assistant Director who took a two-year nursing registration program following graduation from the prestigious London School of Economics.

There is no evidence that "fast-trackers" have sought an easy way out by avoiding the intensely physically demanding work of clinical nursing. In five cases in the sample a career in nursing administration either came to their attention or was virtually thrust on them because they were redeployed to light duties following back injuries sustained in the course of bedside nursing. On the contrary, they have firm beliefs about what nursing should be and they have strong personal resolve to get into positions from which to help the profession

achieve its corporate goals. Typically, they make extraordinary commitments of time and energy to professional nursing issues:

> **R: I did clinical nursing for only seven months and that was in psychiatry. I found it very restrictive, confining. When I looked at the system, there were not enough changes in nursing in the direction I believed it should have been going, so I sat back and asked myself "Well, how does one make change? One makes change in influential positions." I then decided that that was where I was going to go. I first went into teaching and was very active very quickly at the policy level. Looking at my teaching experience I decided we were preparing a graduate for one system, but sending them to work in a system that was not yet ready for what they had to offer. The system had not yet changed. I recognised that I needed to go back to school [university] to broaden my focus and to get expertise in nursing and also business in order to accelerate those changes. So I started my M.B.A. [Master of Business Administration degree] to develop my business acuity because I believe that is sadly lacking in nursing.**
>
> **I: How do you respond to the inevitable criticism that you are running a nursing department but that you've had almost no experience as a bedside nurse?**
>
> **R: There is no question that if your important criteria are to have clinical skills and the manual dexterity and the current knowledge in the clinical component, then I do not have that. What I do have is the theoretical understanding of what nursing is, its role in health care and the increasing complexity of its inter-relationships in a broader system. What I have recognised is the importance of having extremely competent people to work with me who <u>are</u> clinical experts. (#102)**

Discussing her rapid rise to glory, she outlined the careful planning of her attack on the system, executed by a series of key appointments:

> **I only became a member of the professional associations [after graduate school] because I thought, "If I'm going to go for influential positions I really need to be involved." When I went to a chapter meeting, I decided that, "well if I am going to be influential here I'm going to have to be chapter president." From becoming**

chapter president, I was on the Board of Director's within two years. Once I was on the Board of Directors, I decided that I would become President [of the provincial professional nurses' association]. So I had a very fast rise through the professional association, which to me is a very positive thing. Nursing encourages people who have the potential to rise very quickly through the system if they are willing to put the time and energy and knowledge into it. There are very few organizations in which you can be, as I was, President Elect within three years. It's possible in nursing to have that sort of rise in prominence.

I: Why is that possible in nursing while it is not so for other organizations we might think of?

R: Partly it's because nursing does not have a huge cadre of nurses who see it as a career and are willing to spend the time and effort - it's an horrendous amount of time and effort - so if you have the leadership skills and you are willing to spend the time, then it can happen. It's also having good contacts and an active network. I also have an extremely supportive group of colleagues. (#103)

Other respondents chosen for rapid promotion nominated their visibility in public settings as the key to their career ascendancy:

As an Acting Head Nurse in [community nursing organization] I had to give a report to a major meeting attended by 'heavies' from across the country. I was nervous and went to a lot of trouble to prepare that speech very carefully ... It was a great success, and I was immediately promoted. I thought 'Goodness, I'm the same person I was half an hour ago. What has changed?' What changed was that I had been seen as able to perform in the public forum. My public profile had commenced and I never looked back. It bears out my belief that personality counts for a whole hell of a lot in the selection process. Presenting favourably at interview is of critical importance, over and above past record of performance in some cases. (#108)

The ability to represent the profession and the organization in public fora is an increasingly valued and utilised characteristic of senior nurse administrators.

Effective communication skills and a public presence clearly count in selection for promotion.

THE INTERSECTION OF LIFE AND ORGANIZATIONAL CONTINGENCIES

When life and organizational career contingencies intersect to create a potential new career direction, the individual has reached a turning point. Career turning points are forks in the road, which demand decisions likely to alter the course of that career. Respondents were easily able to pinpoint critical turning points in their career. For most, they were appointments to increasingly senior positions, which allowed them more professional independence to achieve their personal and professional goals.

Life and organizational contingencies influence the decision-making process and on occasions, competing opportunities and obligations demand decisions among alternatives, each of which would set the individual on a different career path:

I: Where do you go from here?

R: You are asking me at a real cross-roads. I've been offered another job. I was offered a teaching job last year but turned that down because I believe that the clinical area needs people who can carry through the university education and principles into the work setting. I have only university prepared nurses on my staff and I see their tremendous need for help in operationalizing what they know only in relatively abstract terms. The present job offer is to cover surgical areas at the [major teaching hospital] and I'd like the opportunity to work with [that particular Vice President of Nursing]. Competing with that is my wish to complete the PhD (nursing) full time instead of part-time as I am now doing it. (#202)

Here we see evidence that people who cultivate a range of options in their career development make career decisions often. For such people, the more interested they show themselves to be in various career options, the more options appear to become available to them.

The intersection of life and organizational contingencies may create turning points for individuals, which in turn could result in new career stages. In a bureaucratically controlled occupation characterized by high turnover, career stages can be readily identified in terms of attainment of positions within a hierarchy of status, salary and influence.

SUMMARY

This chapter continued the examination of factors shaping the pathway to an administrative career in nursing, this time focusing on aspects of the organization relevant to, but largely beyond the control of, the aspirant administrator. The impact of organizational contingencies on career path were retraced through an examination of recruitment, selection and promotion processes. The final section of the chapter dealt with the intersection of life and organizational contingencies to yield career turning points and career stages.

The interview data has generated a range of possibilities for predictive studies on typical career time-lines and the sequence of career stages for nurse administrators. They are not developed further in this study, but present opportunities for useful future analyses.

Chapter 6 will begin to focus on the manner in which adoption of an administrative nursing ethos is influenced by the processes surrounding the development of a career identity. The focus will broaden to include some of the influences that significant others, both personal and professional, contribute to the socialization of nurses, and their 'transition passage' toward an administrative outlook.

CHAPTER 6

ADOPTING THE ADMINISTRATIVE ETHOS

RE-DEFINING ADMINISTRATIVE WORK

Having earlier defined ethos as a set of beliefs guiding action, this chapter will focus on how that ethos is adopted *en route* to an administrative career, and how it is expressed through administrative practice. Key sociological themes in the chapter are (re) definition of the situation, transformation of identity and role adaptation.

Through a summary of respondents' loci of beliefs about nursing, I have sought evidence of re-definitions, transformations and adaptations that contribute collectively to the process of adopting the administrative ethos in nursing. These conceptual categories arise from the following questions:

1. What are the dominant values and beliefs of nurse administrators about nursing practice and nursing administration? (Beliefs about work)
2. How are those beliefs reflected in career plans and preferences? (Preferred work)
3. How are these beliefs altered (re-defined or transformed) in light of realities of the current employment? (Actual work).

Just as new graduates re-define the nursing role as they come to understand the reality that nursing as learned by a student differs from nursing as practised by a professional registered nurse (Kramer 1974; Moorhouse, 1992; Oleson & Whittaker, 1968), so new administrators' definitions of administration can be expected to change as they learn and adapt to the role. Leatt (1981, after Thwaites, 1977), for instance, has identified the diminution in clinical focus with attendant increase in the administrative focus among administrators. The distinction is made between the professional dimension of the administrator's role and the corporate dimension of the role.

Alterations in occupational alignments corresponding to change in status are not specific to nursing. This is widely recognized by "shop floor" workers who observe new patterns of behaviour among promoted colleagues. Reuss-Ianni's (1983) analysis of "street cops and management cops," for instance, illustrates the problem of police administrators being seen to have defected from the real work of policing. Similarly, nurses no longer engaged in clinical nursing are sometimes disparaged by bedside nurses as "out of touch", or having "forgotten what it's really like down here". Thus, there is a stigma attached to higher status work. People are seen by co-workers to change when they are promoted, or move into a different line of work. The following sub-sections argue that such behavioural changes are predicated by the transformation of a person's identity as they re-define their views of, and beliefs about, administrative work in order to achieve congruence between personal beliefs and occupational reality.

TRANSFORMATION OF IDENTITY

Personal identity is tied to career identity. Career identity is an individual phenomenon, sought by nurses in their quest for what Cohen (1981) and Watson (1981) refer to as "professional identity." Asked, "What do you do?" most people respond in terms of their occupational role. A nurse for whom bedside nursing is the most valued source of personal reward is likely to talk about patient-related tasks as being of central importance. Most could be expected to legitimate their work in a particular branch of nursing in terms of its contribution to their broader motives and interests. One attribute of career commitment among administrators appears to be broad career interests, which form part of their personal career identity. Asked, "What do you do?" nurse administrators in interviews have answered, "I'm an administrator in [program] *but I also* [have other professional responsibilities]." Like the strongly committed, the weakly committed tend to put nursing as one in a range of personal career identities thus: "I nurse in [setting], but I'm also a sky-diver." They may tell of their primary career, using the "but" conjunction to disclaim that this is their sole and over-riding interest in life. Such statements give clues to the preferred identity of respondents. They are qualifiers which contribute to the person's presentation of self as having an identity broader, better, or different from just a nursing identity. It is possible that the perceived need to qualify one's statement on occupational career relates to ambition to achieve higher status positions, or at least to portray an image of competence in specific aspects of nursing (e.g. intensive care, community health,

administration), or in areas outside nursing (e.g. parenting, skydiving, aerobics instruction).

The social-psychological literature on identity suggests the existence of such multiple identities. Extending the analogy to Schutz's (1961) broader phenomenological notion, we can regard these multiple identities as reflections of the multiple realities that people construct for themselves in order to give sense and meaning to their social world.

Images of self are transformed in the course of transition to new roles and status in life and in the workplace. In the process of transition to new occupational roles, there is a disruption of self-concept and an alteration in the understanding that the individual has developed of their occupation through their membership is a certain branch of it. The initial professional construction of self, it is proposed, is first negated and then re-constructed in altered form as the new role is learned. This, then, is an acknowledgment of the phenomenological thesis that role conceptions are learned, unlearned and relearned in the process of transition between roles (Schutz, 1961; Berger & Luckmann, 1971).

Unintended aspects of that process mediate the impact of the formal occupational socialization process, which allows personal predisposition to be incorporated into an individual's conception and execution of the job. This view challenges time-honoured assumptions about how formal, prescribed training influences people beginning a new stage of an already familiar career (Oleson & Whittaker, 1968). It suggests the relevance of non-prescribed influences outside

formal education, on the personal style an administrator brings to her/his work. Since a person's identity is tied to their belief system, it might be reasonable to expect that a transformation of identity be accompanied by a transformation in the belief system, or ideology. In adopting an administrative role and its ethos, the individual does not abandon previous values and beliefs; rather, s/he adds beliefs pertinent to the new occupational context.

TRANSFORMATION OF PROFESSIONAL IDEOLOGY

This thesis proposes that the dominant nursing ideology of "practitioner" is transformed to become an "administrator" ideology for those people who move away from bedside nursing and take up executive or administrative roles in nursing. Changes in professional ethos - beliefs, ideals and ambitions - align with attainment of various career stages. This re-shaping of ideology in the course of a personal-professional career can be thought of as a transformation as one invests more of the self in an identity aligned with new or anticipated roles.

Bureaucratic orientations are first learned, and later either adopted, modified or rejected by individual administrators. It is therefore important to consider personal and attitudinal changes occurring at times of role transition, which imply the emergence of a new conception of self and the realities of nursing administration. We are interested then, in social and professional interactions within the occupation in order to define how nurses appointed to

senior administrative positions come to alter (if they do) their conceptions of the job - its function, purpose and priorities.

ROLE TRANSITION AND STATUS PASSAGE

Descriptors such as "nurse," "assistant director of nursing", "executive director" are not only role labels, but also analytic categories. They represent stages in the professional transformation of nurses and give some framework against which to compare the features of different peoples' transition through career phases. Glaser & Strauss' (1971) work on status passages has prepared us to find that transition is not a linear, predictable, irreversible phenomenon. Indeed, some status passages are temporary. Transitory passage through temporary contexts does not entail transformation of identity, but may inform the person of what potential roles entail and thus serve as anticipatory socialization (Merton, 1949).

The emphasis given to different occupational settings will differ with circumstance and individual, but "identification" with the role (Foote, 1951) is most likely associated with a strong personal motivation to achieve that role (McHugh, 1975), and with permanence in it. For example, a Head Nurse may be a "temporary," "relieving" or "acting" Assistant Director of Nursing in the absence of the appointed person. Her usual ward-based work setting is temporarily de-emphasized, but it emerges as the primary nursing context again on the return of the Assistant Director. The Head Nurse role as defined in the particular contexts remains foremost since this person knows that she will return to that

substantive position. That predominant role-conception with its associated self-conception is transformed only when the person is formally appointed to the permanent role and position description of Assistant Director of Nursing. If this ultimately occurs, the earlier concept of "nursing" - largely patient-centred, clinical and caring - is re-ordered to reflect the altered context of meaning of the administrator. The role transition carries with it the likelihood (indeed, for success in the new role, the necessity) of a personal transformation in identity from that of ward manager to that of hospital administrator. The loci of influence, responsibility and control alter considerably in both the occupational transition between roles and in the personal transformation of identity. For present purposes, then, the role labels Head Nurse or Charge Nurse and Assistant Director of Nursing, for instance, signify a history of passage through contexts, roles, meanings and responsibilities, which can be regarded as stages in the transformation of identity as a nurse.

ADOPTING THE ADMINISTRATIVE PERSPECTIVE

The professional resocialization accompanying an individuals' status passage from clinician to administrator involves partial transformation of their dominant caring ideology as a nurse. As the new administrator identifies more strongly with the new role and learns the expectations of it, the "practitioner" or "clinician" ethos is overtaken by the "administrator" ethos. In this resocialization process, some of the learned values of the clinical nurse are replaced with the priorities of the administrator. In turn, this implies some reshaping of belief

patterns. Thus, learning the administrative culture is, in part, about learning to fit in as an administrator (Ritti & Funkhouser, 1982).

Adopting a new perspective - in this case the dominant perspective of the cadre of nurse administrators - is essential to gaining membership of the cadre and acceptance within it. Sutherland and Cressey (1978) demonstrate this with respect to those who embark on a career of crime - they must first learn the techniques required to belong, but they must also adopt the motive of others engaged in the activity. We see parallels to this phenomenon among nurses in transition to new roles:

R: Five to seven years ago you certainly would not have heard the statement that, yes, it takes not only a new graduate one year to fit into a new environment, but it also takes a staff nurse who has worked in one organization for several years and then moves to another area, such as critical care, [it takes her] one year too. We have come to recognise it with the new graduate, but we now recognise that it takes someone with five years of experience another year to fit within a different role.

I: Do you find that the change in role is accompanied by an alteration in focus?

R: Yeah, no question.

I: Talk about that transition for a while.

R: Well, central to my transition from [previous place of employment] to this institution was recognizng the relevance and power of the other disciplines, and the shift in emphasis necessary to work in that broader administrative arena. This is a prominent research organization and because of its integrated structural matrices, there were no single key players. Certainly, medicine was influential, but no more so than nursing or physiotherapy. It

took a year for me to understand the different way I had to operate in an open system such as that. (#102)

TOWARD A TYPOLOGY OF CAREER-RELATED SIGNIFICANT OTHERS

We may now discuss in more detail the influence of several types of significant other in the formulation of work-related beliefs and in the shaping of ultimate career paths. This section demonstrates that the categories of significant other identified in Chapter 2 - role-models, supporters, mentors and sponsors - are instrumental both in an individual's definition of turning points in their life course, and in the adoption of an administrative ethos.

A range of significant others contribute to the initial decision to enter nursing and to the process of becoming a nurse and for some, ultimately, an administrator in nursing. Significant others mediate the process of learning norms and expectations as individuals move from one life or occupational stratum to another. They do so by influencing the formulation of the individual's attitudes, values, beliefs, ambitions and predilections about nursing in general, and administration in particular.

The role of significant others in the lifelong socialization of nurse administrators is summarized in Figure 6.1. This model proposes a typology of significant others as defined in the parlance of administrators themselves. With scarcely an exception, the respondents made unsolicited mention of one or more of role models, supporters, mentors, or sponsors as they traced for me the influences of others on their career development. Discussion of the impact of

these significant others is thus clearly pertinent to the present inquiry into the emergence of an administrative ethos.

Figure 6.1 A TYPOLOGY OF SIGNIFICANT OTHERS IN THE LIFELONG SOCIALIZATION PROCESS

Socialization	Significant Others
Primary	Parents Teachers Close Family
Anticpatory	Extended family Prior experiences Inside informants Literature and media
Occupational	Formal education (teachers) Informal education (colleagues and superiors) *Supporters *Role models - positive - negative *Mentors *Sponsors

* Types of significant other specifically influential in shaping the administrative career and its associated ethos

Supporters

Supporters are those in occupational and personal milieus (e.g. professional environment, stage of life, social surroundings) who enhance the self-confidence of the respondent, encouraging them and giving them the impetus to do certain things such as apply for senior positions. It may be a quite non-specific role predicated on some diffuse faith in them to do a good job. At a fundamental level, they are people who simply like the respondent and see no reason why they shouldn't do well:

> **People I've worked with have always encouraged me to apply for the positions I've been successful in. They often see in you things that you don't see yourself. Two of my friends are here in senior positions. One of them influenced me to apply for this job and now I'm her boss, but it hasn't changed anything for us. (#304)**

People in the supporter category may be personal friends. Friendships influence how people see themselves and their work. For reasons partly associated with the demands of shift-work, nurses often do not have a wide circle of friends from other occupations. However, the administrators in the study have differed considerably from this norm, having a wide range of friends in areas other than nursing. Some are in interesting, unique or influential positions; others are in entrepreneurial, commercial or corporate ventures; others in the worlds of art, literature and drama. Their influence frees and broadens the thinking of the administrators, encouraging the breadth of perspective that several mentioned as an important requirement for administrative work:

> **With friends outside the job, you become part of a larger community and have the benefit of points of view on a range of social issues, some of which relate directly to health care. People in nursing administration live in a broader world and if we are to understand that world, we need to cultivate friendships to reflect it. (#209)**

Several references were made to nurses not caring sufficiently for or about one another. Within this context, it becomes clearer that the kind of diffuse support I have alluded to for success-oriented people is limited to close friends within and without the profession. Of those outside the profession, the immediate family and loved ones are regularly mentioned as important sources of unqualified support and encouragement.

Role Models

A role model is a significant other whose style has been emulated or, more often, analyzed for desirable components that might be integrated into a personal approach to the work:

> **I have not had very many role models. [Present Vice-President, Nursing] is probably the best one. She allowed me a great deal of independence, and [was open about] the way she functions ... I got to see how she works in her own administrative capacity, and I learned from that. (#102)**

The decision to choose an administrative career, or to change settings once in it, does not hinge solely on the attractions of the job. More than half of the respondents mentioned that they were attracted to particular positions by the calibre of certain people (role models) with whom they would work in that job. However, respondents seemed more reluctant to acknowledge role models than

the other significant others in the typology. This may be because to do so would imply that their own values and approaches were second-hand. As influential as role models may have been, it may be unpalatable to some of the independent thinkers who become administrators, because they prefer to be considered as making their roles rather than adopting the roles of others.

Educators were most commonly cited by administrators as role models. This is perhaps explained by access to educators as models of non-clinical nursing work. In the early stages of progress toward an administrative career, respondents were in management positions closer to clinical than administrative areas of the hospital. In searching out role models for administrative work they had to look beyond the clinical arena, but could not, initially, get close enough to observe senior administrators in the detail of their work. They simply saw more of their educators during academic preparation for management work than they saw of senior administrators who, otherwise, would surely have been their principal role models:

> **As my professors now tell me, I was one angry person. One of my former advisors is now a great friend. She really encouraged me to go back after my Masters' to do my PhD. She has a fantastic concept of nursing. She's always known where nursing should be, and can operationalize it beautifully. She's completing a PhD in psychology. She was one of the most significant nursing people in my life. She taught me that the reason nurses are powerless is that they don't use knowledge well. They practise on the basis of procedure and policy, and they mindlessly believe that as long as their patient is safe their job is well done. The reality of collegiality and collaborative care was empty. We were still subservient. (#202)**

Such values imparted through the role (and values) modelling process were easily transferable to the administrative world when this respondent became an Assistant Director of Nursing. The role she created as an administrator was based on the values shared with, and learned from, this professor of nursing. Having clarified her own position on these professional issues while at university, she took an administrative position knowing what she would set out to change. She did not learn that pattern from role models in the actual administrative setting since she had limited access to the "backstage" areas of executive level administration.

Executive level administrators recognize the importance of selecting Head Nurses who are desirable role models for staff nurses and students:

> **I: You seem to place a heavy burden of responsibility on Head Nurses to generate that attitude in the ward.**
>
> **R: Yes. Head Nurses should be role models. That process [developing initiative and sense of professional responsibility] is assisted by education. It is not learned entirely at clinical level, but it certainly can't be learned in the absence of the clinical context, and of good role models. That's why the long process of building a good Head Nurse group is critical, and it means that upper levels of administration have to be supportive of the Head Nurses. That means giving them freedom to run their wards in their own different ways. (#103)**

Mentors

The mentor is a significant other in a superior position who has taken a particular interest in the fortunes and progress of an individual, creating opportunities to test, challenge, and develop the skills of their protégée. A critical

difference between this and the preceding category is that the role model is nominated by the respondent, often without the role model being aware of the influence they are having. The mentor, on the other hand, has a more direct relationship with the respondent and usually initiates the relationship through expressions of overt interest:

> **I was very close to my mentor who was a professor in the baccalaureate program [in which I taught]. She took me along with her as her own career [in nursing administration] blossomed. (#304)**

Thus, the mentor is someone whose professional and personal opinion is valued and sought:

> **Just as an organization needs periodic formal review, so does the career of the individual - just to see that the parts are all hanging together as we want them to. It is helpful to have a mentor of some kind to facilitate this. We are only beginning to recognise the importance of this person to our career development. (#209)**

In a nurse's career path to an administrative position, a mentor gives the opportunity needed to demonstrate outstanding skills in non-clinical nursing work. The person accorded mentor status was often referred to as allowing the respondent to do something; to introduce some new and daring scheme, or to play a hunch or take a long shot on some administrative matter; in short, to take a risk for which the institution rather than the individual would have to answer if it failed. This often enabled the respondent to capitalize on an attribute or interest they already had, rather than adopting an existing blueprint for solving the particular problem. Pursuing this line of enquiry revealed opportunity as an

important parameter in the formula for career success; and mentors as central figures in creating those opportunities:

> **I: Is it reasonable to suppose that some people at your own career stage don't need role models, but carve out their own role?**
>
> **R: Yes. Here in the [province] networking group we have all carved out our own roles. It's the opportunities that are the key. (#102)**

Networks are crucial to identifying opportunities. Davidson & Cooper (1984:248) link networking to mentoring as:

> ... the establishment of informal and formal contacts that can be of assistance in furthering one's career and in furthering the careers of others in the group.

Those people with potential in any system will only fulfil that potential when provided with opportunities they are able and willing to take. Beyond that, they also create their own opportunities, not being prepared to wait until asked, but volunteering opinions and comments, and generally engineering themselves into a position of being noticed so that when formal opportunities do arise, their name comes readily to mind. A broad conception of "opportunity" is also seen as important. The ambitious person will see as an opportunity something others regard as an imposition:

> **At times one might think that there is only a certain type of opportunity, and not see that there is a variety of opportunities, none of which may be the one you think to be important, but if you recognise it as an opportunity and work with it, then its outcome may well be that of an opportunity, even if it is not in the direction that you thought you needed. (#102)**

Clearly, the advice to the aspiring administrator is to take opportunities that come along and create your own as well. Mentors are instrumental in creating such opportunities.

Sponsors

The role of sponsor transcends that of mentor and supporter by being specifically goal-directed. The motive of a sponsor may lie more squarely with the organization they serve, than with the career success of the individual they seek to sponsor. While the mentor and supporter might both want the person to succeed, they are often unable to assist that in significant and direct way. The sponsor, on the other hand has very direct access to, and an interest in positions into which they hope to facilitate their protégée's entry.

Vice Presidents (Nursing) and Directors of Nursing sponsored their own staff into positions adjacent to them or beneath them on the organisational totem pole. They also sponsored them into positions in other, sometimes competing, hospitals and organizations. In addition, their self-appointed role as sponsor took the form of actively recruiting staff they knew to be good but who they saw as languishing in lesser institutions. This raises the possibility of a saviour component in the role. Those staff are in the category of being invited-to-apply for certain positions. Even if they do not ultimately get the position, the invitation represents an important vote of confidence by a significant other. This was mentioned by several respondents as significant to the development of their

confidence to apply for other jobs and to the development of their self-image as an administrator.

Sponsors also encourage their protégées to go to the best of the other institutions they know. The success of the individual seemed, to their sponsors, to be congruent with success of the institution to which they were appointed, and the development of nursing in the broadest sense. One Australian Director of Nursing made the proud boast, not without considerable foundation it would seem from a review of the success of her protégées in winning prestigious administrative appointments, that: "You see, we still train the best nursing administrators in the country." A similarly influential person in the Canadian context drew this remark:

> **[Vice President-Nursing] was a critical person in my career choices and opportunities. We had taught together before, and when she became V.P. at [this hospital] she invited me to a position here because she knew my approach to work. There were [pragmatic] difficulties associated with this job [e.g. travel-distance to work] ... but I saw the benefit of working with someone who was a leader in the field, and in a hospital recognized as having one of the most energetic and dynamic nursing departments in Canada. (#210)**

At the time of our discussion, this Director had already accepted the invitation to another position to work with what she described as "another dynamic and special person." She acknowledged my observation that she was now herself one of those critical people in nursing who attracted others to work with her. Other respondents had also cited her in this context.

This phenomenon of some hospitals and key people being able to attract and retain staff through reputations for excellence and innovation, rather than through active recruitment, has been recognized and studied by Kramer & Schmalenberg (1988 a, b) following the Peters and Waterman (1982) work on companies of excellence:

> **Yes. I am always recruiting people to improve the standard of nurse here. When they consult me on their career prospects, I am conscious of my needs for the best staff, but I guess they are evaluating whether or not they want to work in my sort of organization ... and whether I match what they might have heard about me. (#210)**

One Canadian respondent had neither seen herself as Director of Nursing material nor thought of it as a career option until a member of the search committee invited her to apply for the job. The respondent's reaction to this sponsorship was not exactly exuberant – "Well I suppose I could try it." Her skills were known by members of the search committee who believed she would suit the needs and philosophy of that hospital.

In Australia where patronage appointments to political, diplomatic and high-ranking civil service positions are a despised tradition of parliamentary and senior executive privilege referred to as "jobs for the boys," this sponsorship into important nursing positions is referred to bitterly by unsuccessful candidates as "jobs for the girls." In Canada, the network system and personal referral and recommendation are more widely accepted as a way of recruiting the best available candidates for key positions. This was the case only in a few Australian instances, though this factor is increasing in importance in Australia.

One notable way in which sponsorship occurs is through the demands made and the expectations held by the sponsor of the junior person. The Director of Nursing - Education, in the program in which one respondent (#102) taught, was referred to as an astute woman whose astuteness the respondent neither realized nor appreciated at the time. She put the respondent on every committee available. She took a troublesome, verbose staff member and put her in a position where that energy, creativity and knowledge could be used in a positive way. Only in retrospect was the role of that significant other (sponsor) recognized by the respondent as something other than persecutory. Her exposure to 'committee work as punishment' contributed to the restructuring of nurse education across Ontario. This sponsor was instrumental in creating opportunities that made the respondent what she subsequently became - a nationally influential nurse.

Another role of the sponsor is to encourage the flow of vibrant administrators to ensure a resource for the future:

I: How do you ensure that in twenty years time there will be sufficient nurses motivated, capable and articulate enough to do what you are now doing?

R: We have to identify them now, and I believe that people in senior positions have a responsibility to help them along. I don't believe we've been good at that. Then we have to encourage them to look at their careers in innovative ways, and provide them the opportunities that allow them to fulfil their ambitions.

I: How do you structure such opportunities for them?

> **R: There are a number of ways. For a start you put them on committees that give them hospital-wide exposure so they understand what is happening in the organization, they develop a keener perception of what their role is, and they develop contacts both in the formal and the informal sense...They recognize the importance of having contacts within the entire health care context...Those leaders can be found throughout the hospital and at any level including at the bedside since obviously leadership is not only a position [it is a quality of the person irrespective of the position]. Then you look at having nurses put on community health boards, task forces, and committees of the professional organization, giving them the opportunity to present to their colleagues and to the public so that they develop skills and a self-image of success which is reinforced, leading to their willingness to do a lot more. (#103)**

This comment suggests some blurring at the edges between the suggested ideal-types "role model," "mentor," "supporter" and "sponsor." Nevertheless the typology offers a useful starting point for further empirical work to extend the theoretical notion of "significant others" to executive level personnel and their occupational socialization and career path development. First, though, we will consider the role of education for the administrative role, a matter consistently drawn into interview responses by the respondents themselves.

EDUCATION FOR ADMINISTRATION

Formal education is critical to the development of an administrative ethos. Interviews revealed two strongly held beliefs about education. First, that administrators needed to be well and liberally educated in order to garner a vision for nursing in its societal context. Second, that the way to establish change in nursing was to educate nurses. Some respondents had had extensive experience in education and either maintained a teaching commitment or

fostered teaching-related activities. While this was generally true in both countries, it was less likely that Australian administrators had had direct teaching experience beyond isolated sessions. Though not having specific skills as educators, and while some found the idea of teaching to be intimidating, none sought to discredit the role of education in promoting good nursing.

The beliefs of administrators about their own education for the job are instructive:

> **I knew that since in our society education really speaks, I needed a master's degree in order to find a position [from which] ... to make a difference in nursing. (#202)**

In Canada, those who were secure in their positions, regardless of their level of education, were adamant that the appropriate level of education for appointment as a Director of Nursing was a doctorate. They are divided as to whether that should be explicitly in nursing, or in a related discipline:

> **I was advised by nurses not to take the non-nursing degree if I wanted to advance in nursing. But the issue is not so much which degree, but how much it broadens the horizons of the person taking it. (#304)**

A number of similar comments suggested that the real value in taking the degree, whether in nursing, administration, or another area altogether, was that it provided access to new interpretations of life and work, thus extending personal horizons and creating new opportunities. The university education helps to give people the opportunity to put their professional world into a new, broader perspective:

I have a concern for the way nurses are educated, the values they learn, because when it comes down to it, I have to buy the product of their education. That's why I want to have a hand in it by teaching. Administrators should take a more active interest in what happens in the schools of nursing. (#302)

There was marked uncertainty as to the best educational preparation for nursing administrators. The preferred combination seems to have been that available in Canada, and referred to in the next transcript: some administrators with post graduate qualifications in business or administration, others with postgraduate degrees in nursing:

R: I believe that nurses need university education because they need the breadth of thinking that goes with it. You can't negate the importance of experience by any stretch of the imagination, but I believe education to be of critical importance. We've proven it time and again ... I have made that very obvious here and it has filtered down to the staff nurses who now believe that you are not going to get anywhere in this organization if you don't get educated. Head Nurses know that none of them will ever become an Assistant Director here unless they can at least be doing their Master's degree. They know that there are no hiding places here, and they respond to that.

I: Are you looking for these people to be academically prepared in nursing, or are you wanting them specifically prepared as administrators?

R: Well you need both, but you can't always have it. Some [staff] have both, but it's a lot of work to get a graduate degree in nursing and one in administration. This person [referring to the organizational structure/ chart] with the M.B.A. feels the deficit in nursing in comparison to these others. Now ___ was an excellent clinical practitioner with good qualifications in nursing. She had been a Head Nurse around here for about ten years in three different places, and she had excellent [local] knowledge, which some other people didn't have, but she had no grasp of business and the broader context. (#101)

Yet, market phenomena in a rapidly developing profession largely dictate the graduate qualifications to which nurses have access (Price, 1984). In both countries, nurses seeking higher degrees (masters and doctoral) up to the 1960s and into the 1970s were obliged to take them in disciplines other than nursing simply because none were readily available in nursing. Even in the 1980s this was still largely true at doctoral level. Doctorally prepared nurses in Canada either had their degrees in nursing from the United States, or they had Canadian doctorates in other disciplines, often education. Asked her opinion on the most suitable qualification for a nursing administrator, one Canadian Vice President (Nursing) observed:

> **These things go in cycles. At the moment, the thing to be is doctorally qualified in nursing with a heavy research component. But in this vast country, there are no doctoral programs in nursing. We go to U.S. When the Dean addressed us on day one of the [U.S.] doctoral program I'm in, she said: 'You've come here to become nurse scientists'. I wasn't at all sure that was what I wanted, at least unless that definition adequately included the social sciences. In Canada, nurses who get doctoral preparation either go to U.S. in nursing, or they go for education, counselling, higher education, sociology, economics and so on, here. Mind you, at this stage in our development, having a Ph.D. in anything will get you a Dean of School position in nursing in Canada, all else being equal. (#205)**

In Australia, no doctorate in nursing was available at the time of the research, though such programs are now available in all states. No Australian administrator in the sample had, or was working toward, a doctoral degree. Three were enrolled in masters' degrees at the time. The W.K.Kellogg Foundation (Michigan) has made a vital contribution to Australian nursing

through the provision of Fellowships enabling Australian nurses to take masters and doctoral degrees at selected North American universities. This development program was phased out as masters and doctoral programs were set up in Australian universities to take over the role. University nursing departments are still the sole principal employer of Australian nurses with higher degrees, however this is changing rapidly as career clinical nurses take masters degrees, with some proceeding to doctorates.

SUMMARY

This chapter examined the processes and influences that contribute to the adoption of an administrative ethos in nursing. It identified a number of key changes that collectively yield an administrative ethos in nursing. Those changes include transformation of personal identity to achieve congruence with career identity, an accompanying re-working of professional beliefs and values (professional ideology) through the career stages leading to nursing administration, and role transition from clinical practitioner to administrator, representing a status passage in personal and professional identity.

In addition to these processes the chapter identified the role of significant others in the socialization of nurse administrators and proposes a typology of career-related significant others influential both in the shaping of career paths and the development of an administrative ethos. Formal education is also credited as a vital influence on the adoption of the values, beliefs and attitudes that make up the administrative ethos. Chapter 7 will consider the three variants

of administrative ethos, outlining a possible model for the interpretation of dominant ideological streams within nursing administration.

CHAPTER 7

VARIANTS OF THE ADMINISTRATIVE ETHOS

LOCUS OF PRIMARY OCCUPATIONAL CONCERN

Searching the interview data for patterns in the respondents' discussion of their dominant beliefs about nursing administration, it became evident that there was not one administrative ethos but several. In the spirit of grounded theory development (Glaser & Strauss, 1967), these themes became evident from the coding and classification of data relating to respondent beliefs about nurse administration. The categories have been garnered from interview data rather than being derived from highly focused questions based on *a priori* notions of what those belief systems should look like. They reflect differences between interview respondents in terms of their dominant beliefs about nursing administration and the type of administrative work they prefer to do. Hence, these themes, which I have designated "variants of the administrative ethos," represent a refinement of the concept of an administrative ethos. The variants proposed as comprising a generic administrative ethos are:

- clinical-nursing ethos,
- management-organizational ethos,
- corporate-executive ethos.

The elements of this typology of beliefs arise directly from respondent comments. Some administrators in the sample gave precedence in their remarks and examples, to clinical aspects of nursing. They seem to have retained the welfare of the patient/client as the locus of primary occupational concern. I have typified them as expressing an administrative ethos centred on clinical nursing.

Others in administrative positions manifest the fundamental concern with caring through a locus of primary occupational concern for managing the local organization and the nursing service. I have typified them as expressing an administrative ethos centred on management-organizational issues. The third group of administrators identified revealed the over-arching concern with caring, through a locus of primary occupational concern, for the institution and the profession. From their executive positions in community, organisational and political arenas they negotiate the role of nursing, promoting its image, standing and values. I have typified this group as expressing a corporate-executive ethos of administration. The locus of primary occupational concern identified for each of the three classifications of respondents, is illustrated in Figure 7.1.

TABLE 7.1 LOCUS OF PRIMARY OCCUPATIONAL CONCERN IN VARIANTS OF ADMINISTRATIVE ETHOS

Variant of administrative ethos	Locus of primary occupational concern
Clinincal-nursing	Patients / Clients
Management-organizational	Staff / functional unit
Corporate-executive	Institution / profession

THE CLINICAL NURSING ETHOS IN NURSING ADMINISTRATION

Clinical nursing is that area of nursing practice in which the nurse has direct, hands-on responsibilities for patients/clients in hospitals or other health agencies or in the community. There are many avenues of nursing practice in which nurses may be engaged - nursing administration, teaching, research, policy development and regulation - but only clinical nurses give direct hands on care. However, it is possible for a nurse to practice across more than one domain of nursing, for example a researcher engaged in clinical practice or a nursing service administrator engaged in part-time teaching. A number of the Canadian respondents, for instance, had such formal joint appointments during the 1980s, and this became more common in Australia from the 1990s.

The clinical nursing ethos is evident in the idealized statements of "philosophy of nursing" which almost all hospitals and nursing organizations have and show with some pride. The "Statement of Nursing" in the Registered Nurses' Association of British Columbia's (1984:6) "Standards for Nursing Practice" demonstrates the contemporary broad definition of nursing. It reflected the status of nursing at this time as a profession "in-transition" needing to "clarify its perspectives":

> **Nursing has a unique perspective, a distinct way of viewing health and its related phenomena. Nurses have a knowledge and understanding about the requirements of society for nursing and the nature of services necessary to meet those requirements. The profession has accepted the responsibility of clarifying this perspective and making it known to others through the development of conceptual models, which provide direction for**

> **nursing. Use of such models enhances the effectiveness of nursing and contributes to the development of nursing knowledge. (RNAO, 1984:6)**

The nursing ethos is clearly articulated at times of crisis in the profession and when nurses put their case in public and political fora. Examples include the political lobbying of nurses in response to the Sax Committee recommendations on nurse education in Australia; the public rally and deputations leading to reversal of a 1985 decision of the Wran government of New South Wales to move nurse education from colleges back to hospitals to ameliorate nursing staff shortages; the public debate sparked by a series of dismissals and resignations in the Nursing Department of Vancouver General Hospital in 1977-8 (Lovell, 1981); and the media time and space - not all of it bad - given to nursing at the time of criminal investigation (Bissland, 1984) and Ministerial (Dubin: 1983) and Royal Commission (Grange: 1984) hearings into *"Certain Deaths at the Hospital for Sick Children"* in Toronto.

Preparations for a nursing show of solidarity on the issue of the new Canada Health Act prompted this statement from the Canadian Nurses' Association representing the professional concerns of some 165,000 registered nurses in Canada:

> We [nurses] are the professionals with the most direct contact with those who use health services. In Canada's $30 billion-a-year health care expenditure, nurses account for more than 50 percent of the health care providers. Nurses provide much of the "care" in health care, and we feel a special responsibility to help determine the kind of health care we will have in the future. (Canada Health Act Bulletin V, Dec. 14, 1983)

Underlying such statements is a fundamental commitment to the role of the nurse as patient/client advocate. The phrase "... the kind of health care we will have..." suggests the embracing notion of "me and my patient", a common expression of partisan allegiance between nurse and patient.

Nurse administrators, such as those in the present study, are often the opinion leaders in nursing. They influence the ideas, policies, legislation, practice and structures of nursing and are at the forefront of the dramatic changes that have occurred in the last twenty years in nursing. The following quotations go part of the way toward explaining how this select body of nurses has established a values orientation and a sufficient power-base to make a significant difference to nursing and its place in the health care setting. One respondent described the professionalization process in terms of its effects on nursing work and structures:

> **The fact that nursing is evolving as a profession has made us behave in different ways ... In the past nursing fit very nicely into the bureaucratic structure because we had a lot of non-professional people who had to be supervised and told what to do. Bureaucratic ways of organizing nursing work are antithetical to the present development of nursing as a profession in which we are independently accountable for nursing practice. We have had to develop the role of the Head Nurse as a resource person rather than a controller and monitor and coordinator of nursing decisions. (#210)**

This has had implications for traditional nursing structures and in particular, for those appointed to supervise other nurses:

> **We don't need supervisors, we need people to solve administrative problems ... It is interesting that when we got rid of**

> **these very high-priced people [in a staff rationalization] the nurses often did not realize they were gone. That meant we had to ask some very serious questions about what we were using our supervisors for. (#210)**

Promoting change is the business of today's nurse administrator who is often selected with that in mind:

> **Promotion is based on a person's ability to spread the word and the enthusiasm and thus to create change. There are few [Clinical Nursing] Coordinators with that ability in this hospital ... they still see their role as a supervisory one. (#202)**

All administrators interviewed referred to the difficulty of getting nurses to change their approach to work and their ideas about how it should be done:

> **It's difficult to get nurses to claim ownership of new ideas, structures and techniques. You have to carefully stage the introduction of new things ... In time they will begin to see for themselves the motive behind things they otherwise will not tolerate. (#205)**

> **By giving more accountability at the staff nurse level, we hope staff will identify with and feel part of the changes to the system; that they are not just employees that come and work for eight or twelve hours; that they have a stake in what happens. (#102)**

Paradoxically, while they see themselves as leading a vanguard action for promoting change within the profession and for the welfare of staff and patients, the administrators are themselves regarded by many nurses as the impediment to changes clinical nurses want to see in place. A major difference is that clinical nurses see the needs at a ward level, management nurses see the world from the viewpoint of the whole hospital, while executive level administrators are motivated by a more global view of the organization in the context of health care

generally. This reflects the parameters identified for the three types of administrative ethos.

Many nurses find themselves so socialised to obey someone else's institutional rules that when they have the opportunity to change them, they still find it difficult:

> **When I arrived on the scene [1972], they were still wearing the traditional white uniform with a hat. They wanted to update things, but waited for my permission. I said 'Well changing things is really up to you people. There are established ways of doing it. There's no reason why we can't change whatever we need to, if it makes good sense.' So, we took a vote. They made the hat optional. They were still very conservative although I was effectively giving them *carte blanche* permission; it was only in 1985 - that the uniform changed from anything other than traditional white ... There was previously no committee structure, so, for instance, one person was writing all the procedures. That's unthinkable. Staff nurses need to have a say in what affects them most. But when you put these people on committees that have never had that sort of responsibility before, they flounder and keep looking for approval. (#301)**

Some expressed the view that nurses have changed for the worse; lost some of the commitment to caring that has always been a hallmark of nursing:

> **The basics of nursing have not changed. The people doing it have changed. Nurses, as representative of the society, care less for one another, for others, for things in general. They've lost the will for hard work and strong caring that characterized nursing a generation or so ago. (#612)**

The College of Nursing of Ontario is that province's statutory body responsible for registration of nurses to ensure safe and adequate care for the public. Their formal statement on the scope of nursing practice is similar to that expressed by

parallel bodies in the four other Canadian provinces and Australian states covered in the present research:

> The practice of nursing means acts performed for compensation, for or on behalf of persons (individuals, families, or groups), which are directed toward optimizing the functional competence of the individual and include promotion of health, the prevention of illness, treatment, or rehabilitation. The practice of nursing includes:
>
> a) Assessment of the health status and health needs of the individual, family or group,
>
> b) Application of nursing knowledge for the purpose of: planning the care provided, providing care, and evaluating the care provided, at any time during the life cycle;
>
> c) Management, education, and research to implement or complement the above.

THE MANAGEMENT-ORGANIZATIONAL ETHOS IN NURSING ADMINISTRATION

In the perception of some nurse administrators, the job centres on management and control of the organization or defined parts of it. They see effective administration in terms of structural and functional parameters, and engage in policy formulation and infrastructure building to ensure that the work is done according to clearly defined patterns. At one extreme, this group of nurse administrators represents the traditional style of nurse administration. A respondent in the upper age bracket of the sample and having trained in a more deferential and oppressive style of British nursing epitomized this extreme in her

description of administration as "making the rules and making sure they abide by them." Influences and developments over twenty years have changed that ethos. Nevertheless, the administrative ethos is now an amalgam of this traditional ethos and the influences of the diverse backgrounds and values new administrators bring to their positions.

One of the major structural changes in most nursing departments is the flattened hierarchy created by decentralization of management and decision-making. As a consequence, the supervisory roles and to a lesser extent the coordinating roles have diminished relevance within the social organization of nursing. With the transfer of nurse education to the higher education sector, hospitals have become less dependent upon the student labour force with its necessity for close supervision of students. They have eliminated the supervisory, assistant and deputy positions and created the corporate structure of a Vice-President (Nursing) for the organization and a series of Director's for major functional units. Head Nurses report direct to Directors of Nursing and clinical advice is available on a consultancy basis from Clinical Nurse Specialists. One effect of this restructuring of nursing administration has been the introduction of a corporate administrative structure remunerated at levels commensurate with management and executive functions, rather than as an extension of clinical nursing rates of pay (Bond & Bond, 1986). Concurrently, salary levels for clinical nurses have improved and new career structures have given nurses promotion and improved remuneration opportunities previously

accessible only by moving out of clinical positions and into administration or education.

THE CORPORATE-EXECUTIVE ETHOS IN NURSING ADMINISTRATION

The corporate-executive ethos refers to that set of beliefs guiding practice relating to the structural and political aspects of the nursing department, and in particular its role in the broader context of the hospital as a body corporate and an integral part of a health care system. Finance is a major component of administrative work in this domain with some hospitals in the study having annual operating budgets around $750 million.

Much of this corporate-executive work is interdisciplinary and finds the nurse-administrator in the role of advocate for nurses, patients, an organization or the profession. They may also be the designated representative or advisor to the nursing departments, hospitals, Ministries of Health/Health Commissions or government or funding bodies. In such capacities, these nurses serve on professional, community and political, executive and advisory boards and committees.

The increasing pressure on nursing administrators to function in an executive capacity at hospital, agency and ministerial level is creates a demand for a different type of administrator. At this level, they have transcended the principal responsibility to run their own department within budget and on the basis of a philosophy decided by the hospital or agency Board. As members of a

high-budget corporate elite, their work is increasingly business-related, and decreasingly clinically-related:

> **The administrative role is becoming very corporate. We are losing the clinical contact, and having to run the department as a business, competing with other interests who vie for the hospital's allocated dollar. (#301)**

Executive nurse administrators must compete, on behalf of the nursing department, for scarce resources and create policies to ensure the greatest yield of nursing care for the allocated dollar. This business ethos is contrary to the traditional service ethos of nurses. They have not generally been well prepared for assertive, entrepreneurial and business roles, though many argue, justifiably, that they have learned the skills along the way. Some described having an instinct for executive work, but some found the transition from clinical to administrative work much more difficult. A Canadian administrator with 20 years in a religious order described the difficulties of exchanging the entrenched service ethos for the requisite toughness of the corporate-executive ethos'.

> **I devoted my youth to missionary work and service to others ... Caring and prayer were my vocation. When I left the rigour and asceticism of The Order behind, what was left of my life was this desire to serve ... My big dream had always been to run a clinic/dispensary in Africa or China, but they had chosen me for administrative work at home. I became very well qualified and competent in administration, but it wasn't the sort of spiritual work I wanted to be doing. (#211)**

Stories such as this where nurses were plucked from a clinical nursing career and catapulted to power and glory, are scattered throughout the interview transcripts. Though of course, this will usually only occur if the individual is

amenable to the senior person's proposition that they may take on a new or expanded role or a greater degree of responsibility.

Promotion to executive status is now achieved through individual effort based on excellent practice, broad academic education, and demonstrated propensity for specific elements of the work. Two decades ago length of service in management roles was a key determinant of promotion. Today, propinquity for the role has greater currency. However, as we saw in previous transcripts, the appropriate balance between nursing experience, education and administrative skill is still at issue.

Those respondents in the group referred to in this study as representing a corporate-executive ethos have made their own careers secure by their highly visible trail-blazing activities directed at achieving professional status for nurses. They are tough-minded administrators who pursue their vision for the profession with relentless ardour:

> **I guess because I want to change everything I make the assumption that everyone else does, and that is quite wrong ... They were so distraught [at the idea of major changes] that they were becoming unable to function because of the uncertainty. So finally one day we tackled it head on. I sat down with two of the Assistant Directors and said 'What are all the crazy kinds of combinations of service that we could come up with?' We needed to break up this traditional demarcation between medical and surgical nursing. It's so constraining on the way nurses think about giving care. So, we came up with seven or eight positions that we were going to call Nurse Manager positions. We labelled them and went to the people who would conceivably fit into those roles and said 'How do you think these pieces fit together?' Then I said 'O.K., these are the positions that are available and you can each apply for them.' So, we went through that exercise and shuffled people around. They then realised that something was**

really going to happen and that we weren't just foolin' around ... so that was the beginning of major structural changes in this department. (#101)

The creation of such major structural changes in the nursing organization requires considerable push from the corporate entrepreneurs and occurs only at cost to those who cannot fit into the new plans. At the same time, it creates new opportunities for those bright, energetic young administrators who do fit the new vision. In most hospitals, it was possible to identify two distinct groups among the administrators, the progressives and the conservatives. In Australia, they were sometimes identified at the extreme of a continuum as "the young Turks" and the "old rear guard."

Nurse administrators in the corporate executive category appear to have a strong commitment to the notion of professionalization and a high level of involvement in attempts to secure professional status and recognition for nursing. The old management adage that if you want something done, ask a busy person to do it, is clearly borne out in the case of many senior nursing administrators in this category. They combine their experience in long hours of demanding work with the executive's penchant for high-level challenges.

One third of the sample of Directors and Assistant Directors at the head of large nursing organizations held concurrent executive positions in professional and community organizations. Some are reluctant conscripts, while others inject their enthusiasm into an organization or committee for a year or so and then move on to other challenges. One Director of Nursing nearing retirement

remarked on the importance of a high level of energy and a capacity for rapid replenishment in order to manage the tension, uncertainty and workload of the job. The source of such replenishment varied widely among women in the sample from mountain climbing in Nepal, to meditating in the hospital chapel, from weight lifting and windsurfing, to wallowing in a hot-tub.

Professional involvement has come to be seen as an integral part of the administrative role and thus constitutes a part of the ethos:

> **Some senior nurse administrators do not recognize that their responsibility and potential for influence go beyond their own organization. They cannot justify the luxury of being self-contained within their own comfortable work environment any more. They have a responsibility to the profession and the individuals associated with it, and they must be aware of the issues and prepared to speak out and to take the risks. To do so they must be able to draw on resources beyond their traditional nursing resources. (#102)**

Some people I interviewed at the Director and Assistant Director level appeared to spend the majority of their time working on behalf of the profession rather than the hospital. They are in positions in which it is seen as appropriate for them to have such involvement though it is not a requirement. I asked one Director:

> **I: What proportion of their time are you prepared to support senior nurses to be involved in activities of the profession beyond their regular hospital responsibilities? Much of that work needs to be done during the day - telephoning, consulting, attending meetings and making political representations, for instance.**
>
> **R: About 10-15% of their time. They more than make up this time in other ways, and their work doesn't suffer, on the contrary it benefits from their professional involvement. That is the mark of professionalism. (#201)**

To some extent, then, the hospital is subsidising the activities of the professional associations. But with what value or recompense to the hospital? The respondent explains:

> **Until a year ago, I was on an *ad hoc* committee of the College of Nursing of Canada - it happens to have lasted ten years - but at one point I might spend a week at a time away [from the hospital] and engaged on that business. But that week away causes you to miss a lot and put things on "hold" that should be going forward. It's not difficult to defend. There are other groups that people get involved in too - a research group, for instance - and some staff have joint appointments at [University] and may have some teaching commitments there. It's all defined as part of their job, though it is not required in their contract. (#201)**

The commitment of personal and work time to development of the profession can be considerable indeed. In this, a parallel exists between upper echelon nurses and the academic community where those who take the job seriously accept the responsibility for administration, program development, fostering learning and knowledge through research, or other involvement. They work long hours to achieve it. The institutional pay-off is relatively unquestioned protection of their right to involvement in matters of their own choosing. In the 1980s and 1990s, the involvement of senior nurses in non-institutional professional matters has progressed from being condoned as an indulgence, through being tolerated because someone has to do it, to its present widely accepted status of being expected as part of the representation of the institution in the community.

The following discussion on professionalizing the nursing staff of a hospital sheds some light on the perceived problem of staff that will not or cannot change with the times:

I: In some settings there is a clear demarcation between the young, enthusiastic professional nurses who are very good at carving out their own expanded roles and influencing others, and the older supervisors who fought a passive rear guard action against something they didn't really understand, but since it looked like changing their familiar worlds, they didn't want any part of it. How do you manage that problem?

R: Since they are at the same classification you have to either reclassify the positions and make new appointments, as we did, or you wait for natural attrition to solve your problem. But it often doesn't because it takes too long, and the new ethos of professionalism is watered down by those you are waiting on to retire. We grasped the nettle and went for a huge restructuring program. Everybody could apply for the new administrative jobs, but we [executive administrators] controlled the selection. It was costly, but we believe it paid off. Of those we didn't re-hire, some went to other jobs, but others went into "paid unemployment" status. [Under the provincial legislation] if they claim not to be able to find a suitable job, we have to pay them [at full salary] for up to two years after they become redundant. We didn't fire them, we just reorganized in such a way that their jobs no longer existed. It's difficult because a lot of these people have made big contributions to this organization and nursing over the years. We used to have places to put these people - in charge of Central Sterile Supply Departments, for instance - but we have trimmed away so much of the fat that we no longer have the luxury of these resting places for people to see out their careers in recognition of their service. Someday I'm going to be in that position. At the moment, I'm seen as very competent and useful, but what happens when I'm not? Will I get kicked out on me ear? That would kill me. (#210)

In business and private enterprise, the ethical, humanistic, interpersonal and industrial issues that worry the above respondent are not seen to be as problematic. When an organization changes so that it no longer needs their special skills, or when they are no longer performing at required levels and when there is no reasonable option for relocation, they may decide to take the redundancy package and try to go to an organization that better fits their style

and abilities. Nurses, whose vocation is to care about the welfare of others, find it difficult to make these tough staff management decisions. As the last respondent said:

> **It's on these issues that the nurse and the humanist in me interfere with the administrator in me. (#210)**

The fact that administrators do make those tough decisions reflects the changing necessity to run hospitals more like businesses, which must meet service demands within defined budgets and policy parameters. The recruitment of administrators today favours those who can make tough decisions with confidence.

THE RELATIONSHIP BETWEEN PARAMETERS AND VARIANTS OF THE ADMINISTRATIVE ETHOS

We can now summarize the nature and extent of any relationship between the parameters and the variants of the administrative ethos in nursing. Thus, we are in a position to comment on preferred type of administrative work from among the three variants identified, and the type of administrative work in which respondents were actually engaged, that is, whether clinically oriented, management oriented or corporately oriented. We have addressed a number of questions.

- Do the variants of the administrative ethos intersect?
- How can the points of intersection among them be represented?

- How does any such intersection accommodate caring as the dominant ideology we have portrayed as underpinning nursing?

Table 7.1 seeks to capture the relationships among these factors revealed through the interviews. Its principal features suggest that:

- Those whose belief orientation is corporate-executive in nature also express corporate executive work as their preferred work.
- Those whose belief orientation is corporate-executive work are also likely to have that as their actual kind of administrative work.
- Those whose preferred administrative work is corporate-executive work also are most likely to have that as their actual work.

Thus, Table 7.1 reveals a high degree of congruence between the beliefs nurse administrators have of appropriate values in nursing administration, the administrative setting in which they would prefer to work, and their actual work setting.

Having now established a profile of nurse administrators, it is instructive to ascertain differences between Canadian and Australian nurses in the research sample. Table 7.2 summarizes by country the categories to which respondents were assigned in analysing interview transcripts. It shows the distribution of the respondent classification by country and portrays the extent of such similarities and differences. It suggests congruence of experience and preference between administrators in the two countries. This is perhaps not surprising given the broad similarities identified between the two countries in earlier chapters.

Clearer delineation of the extent of such congruence would require more detailed study of specific elements. This is beyond the scope or mission of the present research, which has sought to identify parameters and variants in the ethos and to test qualitatively the veracity and utility of these broad conceptual delineations.

Table 7.2 RELATIONSHIP BETWEEN PARAMETERS OF THE ADMINISTRATIVE ETHOS AND ITS VARIANTS

	VARIANTS OF THE ADMINISTRATIVE ETHOS			
PARAMETERS OF ADMINISTRATIVE ETHOS	**CLINICAL**	**MANAGEMENT**	**CORPORATE**	**TOTAL**
Belief orientation	**Preferred Work**			
Clinical	4	2	1	7
Management	0	11	0	11
Corporate	0	1	21	22
Total	4	14	22	40
Belief orientation	**Actual Work**			
Clinical	6	1	0	7
Management	1	9	0	10
Corporate	1	6	15	22
Total	8	16	15	39
Preferred work	**Actual Work**			
Clinical	4	0	0	4
Management	2	11	0	13
Corporate	2	4	15	21
Total	8	15	15	38

Table 7.3 PARAMETERS AND VARIANTS OF THE ADMINISTRATIVE ETHOS: A SUMMARY BY COUNTRY

PARAMETERS OF ADMINISTRATIVE ETHOS	CLINICAL		MANAGEMENT		CORPORATE		COUNTRY TOTAL	
	Canada	Australia	Canada	Australia	Canada	Australia	Canada	Australia
Belief Orientation	4	3	4	7	10	14	18	24
Preferred Work	4	0	4	10	8	14	16	24
Actual Work	3	3	9	9	4	11	16	23
Total	**11**	**6**	**17**	**26**	**22**	**39**	**50**	**71**

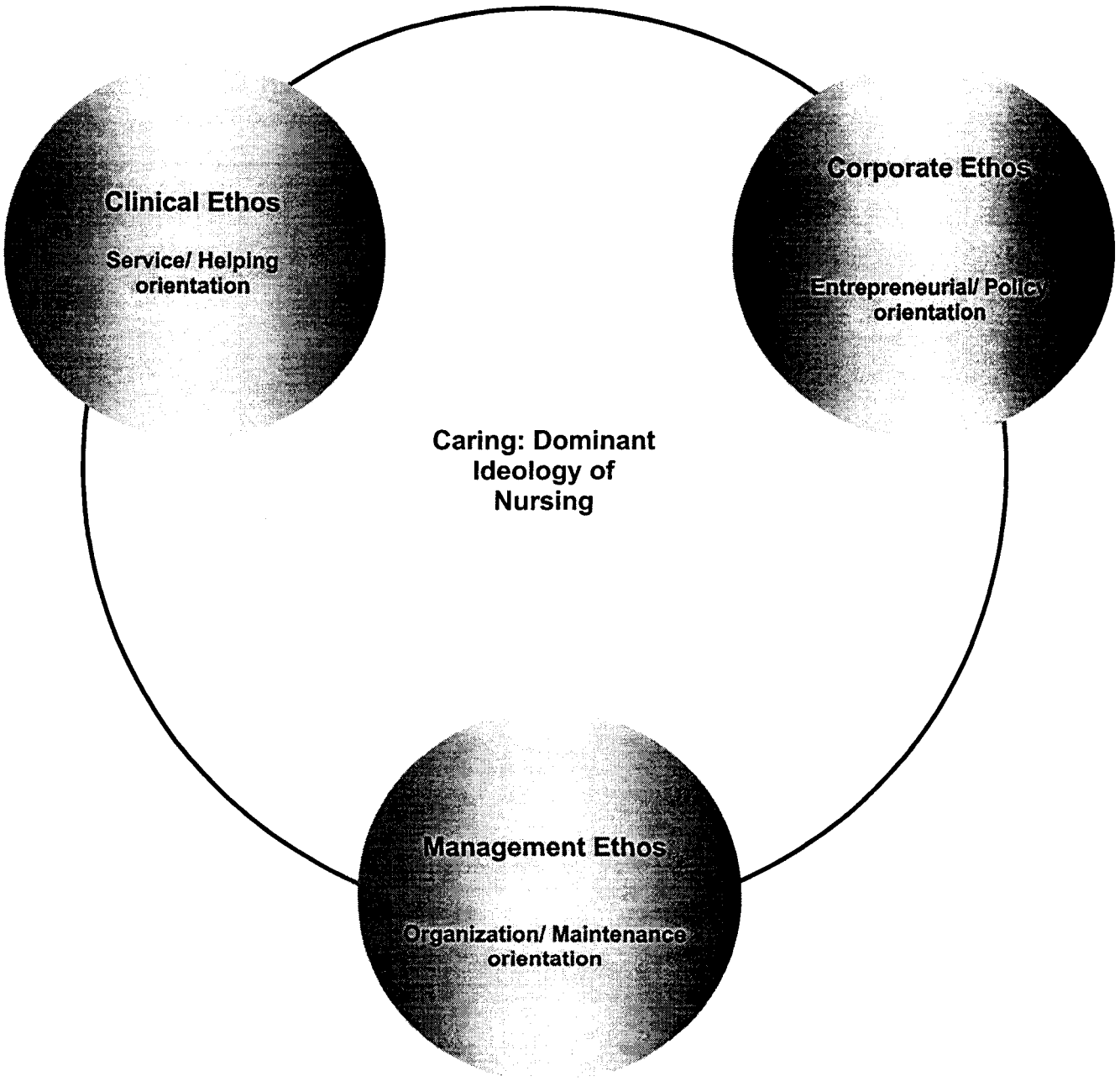
*Note: Minor discrepancies in totals arise from respondent summaries having not been allocated a category in every variable.

SUMMARY

This chapter summarized that interview evidence that revealed the existence of variants of the administrative ethos. It suggests that the administrative ethos in nursing is not a unitary entity, but that it can be identified according to three variants of that ethos: the clinical-nursing ethos, the management-organizational ethos and the corporate-executive ethos.

Having offered a representation of the relationships among pertinent factors in cross-national consideration of the administrative ethos in nursing, it is possible to represent these diagrammatically to suggest the nature of the relationship of variants of the administrative ethos to caring as the dominant ideology. Figure 7.1 portrays the relationship of the identified variants of the administrative ethos to caring as the dominant ideology underpinning nursing. It seeks to draw together diagrammatically the elements of this chapter.

Figure 7.1 THE RELATIONSHIP OF VARIANTS OF ADMINISTRATIVE ETHOS TO CARING AS THE DOMINANT IDEOLOGY OF NURSING



CHAPTER 8

CONCLUSION

REVISITING THE RESEARCH PROBLEM

This thesis presents a sociological portrait of the "typical" administrative career and a typology of the characteristics and beliefs of those who achieve the high status designation "nurse administrator". The thesis contributes to a sociological understanding of the preparation, recruitment, selection and appointment of senior administrators in nursing. This information is important to hospitals and health agencies requiring nursing leaders to shape and advance the objectives of the organization; and to prospective administrators who need to understand career routes to administrative positions, and to recognize attributes rewarded by promotion. The thesis draws on research experience in two countries, Canada and Australia, in order to:

- Contribute to the understanding of factors influencing practising nurses to consider a future in nursing administration
- Explain the range of motives practitioners have in seeking an administrative position.

- Bring evidence to bear on the problem of recognizing and selecting those aspirant administrators most suitable to the criteria of the organization and the nursing profession.

This final chapter draws together the themes explored in the course of identifying and defining an administrative ethos in nursing.

DRAWING THE THREADS TOGETHER

The first chapter outlined the genesis and evolution of the research project, defining nursing in terms of its professional socialization processes and outlining the influence of nurse administrators on that process. The chapter also outlined the emergence of caring as the dominant ideology of nursing and addressed the professionalization of nursing. Thus, the chapter served as the contextual background for the remainder of the thesis.

The theoretical framework for the study derives from social psychology as reflected in the symbolic interactionist perspective outlined in Chapter 2, and addressed the search for sociological patterns in interview data concerning the relationship between the belief systems and career paths of nurse administrators. The chapter outlined the key analytic constructs "career" and "administrative ethos" which underpin the thesis.

The life contingencies shaping the career path leading to nursing administration are identified as a major focus of the study. A range of factors, which can be broadly considered aspects of personal life, emerged as significant in the creation of career turning points and subsequent career decisions. Those

life contingencies critical to the shaping of an occupational career included marriage, parenthood, travel and residential mobility, primary family origins, individual ambition and perceived sources of personal reward. Life and organizational contingencies influencing career pathways were identified through semi-structured biographic interviews. These were used to demonstrate the dominant modes of entry to an administrative career in nursing.

This approach enabled the isolation and description of a set of beliefs influencing the career decisions of nurses who become administrators. This collective belief system is referred to as the administrative ethos in nursing. Through an exploration of this ethos from the perspective of the nurse administrators interviewed, three variants - the clinical ethos, the management/ organisation ethos, and corporate/ executive ethos – were revealed. The thesis concludes that recognition of these variants is important in understanding how the career and professional practice of an administrator were shaped.

In Chapter 3 the methodological foundations of the research were discussed. The significance of biography as a data source was placed in a sociological and theoretical context. The origins and sociological value of comparative research were also considered, whilst key features of the interview process and data management were outlined. This Chapter demonstrated how these career biographies circumscribed 'real life' contingencies that shaped the careers of an aspirant nurse administrator.

The life contingencies shaping the career path leading to nursing administration were elucidated on in Chapter 4. A range of factors, which can be broadly considered aspects of personal life, emerged as significant in the creation of career turning points and subsequent career decisions. Those life contingencies critical to occupational career include marriage, parenthood, travel and residential mobility, primary family origins, individual ambition and perceived sources of personal reward.

The thesis continued this examination of factors shaping the route to an administrative career in nursing in Chapter 5, this time focusing on aspects of the organization relevant to, but largely beyond the control of, the aspirant. The impacts of organizational contingencies on career paths were traced through a route of recruitment, selection and promotion processes. The final section of Chapter 5 dealt with the intersection of life and organizational contingencies to yield career turning points and career stages.

The interview data derived from interviews with sixty-two Executive Directors, Directors and Assistant Directors of Nursing, or their equivalents that generated a range of possibilities for predictive studies on typical career time-lines and the sequence of career stages for nurse administrators. These possibilities were not explored in this study, but presented opportunities for useful future analyses. The research sample was drawn from twenty-five large hospitals across seven major cities in three Canadian provinces and two Australian states. The cross-national comparative element of the study revealed

that nurse administrators in both Canada and Australia have comparable beliefs about nursing and administration. While their career paths to an administrative position do not differ greatly, the administrative position is more likely to be a final career position for Australians, while Canadians are more likely to move between senior appointments in clinical service, administration and education, or to have joint appointments.

Chapter 6 examined the processes and influences that contribute to the adoption of an administrative ethos in nursing. It identified a number of key changes that collectively yield an administrative ethos in nursing. Those changes include transformation of personal identity to achieve congruence with career identity, an accompanying re-working of professional beliefs and values (professional ideology) through the career stages leading to nursing administration, and role transition from clinical practitioner to administrator, representing a status passage in personal and professional identity.

In addition to these processes the chapter identified the role of significant others in the socialisation of nurse administrators and proposes a typology of career-related significant others influential both in the shaping of career paths and the development of an administrative ethos. Formal education is also credited as a vital influence on the adoption of the values, beliefs and attitudes that make up the administrative ethos.

Chapter 7 summarized interview evidence. It suggested that the administrative ethos in nursing is not a unitary entity, but that it can be identified

according to three variants of that ethos: the clinical/ nursing ethos, the management/ organisational ethos and the corporate/ executive ethos. This was shown in relation to nursing as the dominant ideology of caring.

Having offered a representation of the relationships among pertinent factors in cross-national consideration of the administrative ethos in nursing, it was possible to represent these diagrammatically to show the nature of the relationship of variants of the administrative ethos to caring as the dominant ideology. Figure 7.1 portrayed the relationship of the identified variants of the administrative ethos to caring as the dominant ideology underpinning nursing. It sought to draw together diagrammatically the elements of this chapter.

Informed by the theoretical perspective of symbolic interaction, this thesis began with the question "What do nurse administrators believe about nursing and administration?" and uncovered a diversity of expressed beliefs. However, these diverse beliefs are consistent within each of the three categories of administrative ethos identified in the research. Thus, the over-arching framework of beliefs and values about nursing administration, that is, the administrative ethos, has been described in terms of three variants:

- clinical-nursing ethos
- management-administrative ethos
- corporate-executive ethos

Recognition of these variants is important in understanding how the career path of an administrator is shaped. The selected interview responses of nurse

administrators shed light on the extent of concurrence between what they believe in abstract terms about their work, and how they actually do that work. We found that the key elements of the administrative ethos were faithfully reproduced in the real world of administrative work. The social organization of nursing is such that ambitious nurses were able to choose a particular stream of administrative work that aligned with their personal values framework.

Among those interviewed, there was congruence between the administrative ethos revealed in their expressed beliefs and the type of administrative work they did, whether emphasizing clinical, management or executive aspects of the administrative role. It should also be noted that this sample is limited to administrators in large teaching hospitals where the existence of complex administrative structures creates the opportunities for people to find their niche in administration. This cannot be expected in smaller organizations where a small number of administrators - often only one - must meld the requirements of each of the administrative roles I have identified.

In a way, what we found in the hospitals studied is round pegs in round holes; square pegs in square holes. The shape and dimensions of those holes can be changed through restructuring; the pegs can be changed by buying in new ones from elsewhere to establish a better fit. Those pegs that atrophy fall through the sieve coming to rest on another board in which the size and shape of holes may allow a comfortable fit. These people become uncomfortable in one hospital and move to another setting. Extending the analogy just a little, we can

see that some pegs develop and become too big for their holes, or they take on a different shape, requiring a new position to make for a snug fit in an organization in which they can do their best work. These people construct their own passage to a bigger board with bigger holes of different shapes, and when there, they carve out new niches for themselves.

Hence, the organizational and professional context of the nurse administrator is best conceived as a dynamic one in which people largely create their own futures, often assisted, inspired or encouraged by significant others in their personal and professional settings. It is an occupational world in which opportunity does exist to create roles that match skills, inclinations and aspirations of individuals. This is an optimistic note on which to end the study. Nurse administrators do not need to be confined to areas they have outgrown. The profession, and many of the institutional and non-institutional settings in which nursing is practised and administered, offers ample opportunity for the mobility which will give nurses the job satisfaction and level of achievement to which they aspire. There are sufficient opportunities for innovative work in nursing that ambitious and innovative nurses should not have to find themselves career-blocked and ultimately, bitter, negative and counter-productive. It is thus incumbent upon the leaders in nursing to ensure that this does not happen; that they identify people with potential, understand and help shape the specific direction of that potential, and help find the most suitable way to use it. This frequently implies the lateral thinking that facilitates organizational opportunities

in which such people can do their best work. In relation to the administrative ethos identified in this study - clinical, managerial and corporate orientations - this means not merely rewarding the best people by making them administrators, but choosing for particular types of administrative work the nurses most suited to it and most likely to do the best job because of their individual administrative ethos, perspective and preference.

Implicit in the foregoing discussion is a rejection of the widely held notion that an administrator is an administrator, is an administrator. They are not all alike in their attitude toward nursing and nursing administration, any more than they can be expected to be alike in the measures they bring to their work of openness, flexibility, control, aggressiveness, compassion, professional involvement, cross-disciplinary credibility, and so on.

PORTRAIT OF A NURSE ADMINISTRATOR

This conclusion briefly outlines the characteristics most consistently revealed through the interviews. Analyzing the career routes, beliefs, values and administrative style of nurse administrators, enabled the identification of characteristics of successful nurse administrators. Together they offer a portrait of the nurse administrator, which can be summarized thus:

- Nurse administrators seek challenges. The most ambitious seek difficult positions in which there are few precedents. They like to break new ground, as in the commissioning of new areas or hospitals. Some accept positions in which the challenge is to turn around the fortunes of an institution that has run into bad administrative repair. They are the crusaders who resurrect organizations in decline and seek to breath new life into them.

- Nurse administrators delegate. This frees them from routine work enabling them to engage in professional activities; it develops their staff by giving them opportunities; it leaves primary responsibility for patient care and ward management with the Head Nurses, which, administrators argue, is where it should be.

- Nurse administrators are ambitious, but they often define that ambition as being for the advancement of the profession, rather than for the advancement of self.

- Nurse administrators share a concern for the development of the nursing profession but they express this through different but overlapping forms of administrative ethos. The profession of nursing is a central life concern for many nurse administrators. They articulate a clear personal vision of what they want to achieve and to contribute, especially through encouraging others to promote those objectives and put them into effect.

  The best nurse administrators surround themselves with competent, strong people whose opinions are not necessarily congruent with their own. They would be comfortable with the assertions of corporate chief executive officer Booth (1985:54) that:

  "A lot of people tend to hire in their own image. There is nothing worse. They all go off the cliff together because there's no counterbalance."

- Nurse administrators tend to be better at the big picture than the fine detail. They delegate daily management to good people and actively recruit such support, recognizing that there is no single ladder to the top but that:

  "There is no single ladder to the top of the nursing hierarchy, but one thing is certain; on arrival, it is no easy life, whatever the view from the lower ranks may be." (Booth, 1985: 46)

- Nurse administrators establish a five year vision, a one year plan and monthly progress reviews, usually on the basis of a belief that:

  "Progressive improvement is better than postponed perfection." (Booth 1985:55)

Upward mobility on a rung-less ladder is futile. Aspiring administrators seek to align themselves with an organization on the move, partly on the basis of a belief that "As in all things in life, the cream always rises to the top." (Reimax Realty, advertisement, Canada)

- Nurse administrators have outside interests, activities and friends. This encourages a broader perspective and insight into the socio-political context in which their organizations serve the community. They love their work, which is just as well because they give a lot of themselves to it. Work often becomes also leisure, pleasure and hobby.

- Nurse administrators choose friends and business associates carefully, but have strong personal and professional networks that may influence their career paths and professional objectives.

- Nurse administrators involve themselves in the early stages of policy development, setting it on the right track early and then backing off to let others put in the detail. Importantly, they are able to let go, believing that "If you hire a watchdog, there's no point in doing your own barking."

- Nurse Administrators with the strongest commitment to clinical nursing, or the most recent active experience of it, are most likely to engage in day-to-day ward management.

- Nurse administrators have a strong commitment to education and a broad base of knowledge. They encourage the educational aspirations of their staff.

- Nurse administrators are self confident and frank. They display an open management style, though few can afford the luxury of an open door policy and a majority see it as fostering dependence among staff.

In the final analysis, nurse administrators are inextricably tied to a caring ethos as their reason for being in nursing. They have an over-arching conviction that to make a difference to nursing care, they must be in a structural position of power and influence to achieve change. This conviction is at the core of an administrative ethos in nursing; an ethos that is learned and adopted as nurses

travel their career paths to arrive, ultimately perhaps, at the doorway to senior nursing administration. Once there, they are able to give form and function, for the benefit of their community and their profession, to "The administrative ethos in nursing."

REFERENCES

Abel - Smith, B. *A History of the Nursing Profession.* London: Heinemann 1977.

Abercrombie, Nicholas; S. Hill and B. S. Turner. *The Dominant Ideology Thesis.* London: Allen & Unwin. 1980.

Abrahamson, M. *The Professional in the Organisation.* Chicago: Rand McNally. 1967.

Aiken, L. and D. Mechanic, eds. Applications of Social Science to Clinical Medicine and Health Policy. New Brunswick, N.J.: Rutgers University Press, 1986

Allen, D. W. "How Nurses Become Leaders: Perceptions and Beliefs about Leadership Development." *Journal of Nursing Administration, no. 28* (September 1998): 15-20.

American Sociological Association. "Cross-National Research in Sociology." *Footnotes,* no. 13, November. New York: American Sociological Association 1987.

Argyle, Michael. *The Social Psychology of Work*, 2nd ed. London: Penguin, 1989

Barnes, J.A. "Some Ethical Problems in Modern Fieldwork." In *Qualitative Methodology: Firsthand Involvement with the Social World,* ed. W.J. Filstead, Ch. 21. Chicago: Rand McNally, 1970

Becker, Howard S. "Personal Change in Adult Life." *Sociometry* 27, March 1972: 40 – 53.

Becker, Howard S. "The Nature of a Profession." *Sociological Work: Method and Substance.* New Brunswick, New Jersey: Transaction, 1970.

Becker, Howard S. *Outsiders: Studies in the Sociology of Deviance.* New York: Free Press, 1963.

Becker, Howard S., B. Geer, E. Hughes, and A. Strauss. *Boys in White: Student Culture in Medical School.* Chicago: University Of Chicago Press, 1961.

Becker, Howard S. and A. L. Strauss. "Careers, Personality and Adult Socialization." *American Journal of Sociology* 62, (November 1956) : 253 – 263.

Benner, Patricia, and Judith Wrubel. *The Primacy of Caring: Stress and Coping In Health and Illness.* Menlo Park, California: Addison-Wesley, 1989.

Benner, Patricia. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Menlo Park, California: Addison-Wesley, 1984.

Benner, Patricia and R.V. Benner. *The New Nurse's Work Entry: A Troubled Sponsorship.* New York: Tiresias Press, 1979.

Berger, Peter and Brigitte Berger. *Sociology: A Biographical Approach.* New York: Basic Books, 1975.

Berger, Peter and Thomas Luckmann. *The Social Construction of Reality.* New York: Doubleday, 1971.

Bertaux, D, ed. Biography and Society: The Life History Approach to the Social Sciences. Beverley Hills: Sage, 1981.

Bissland, Ted. *Death Shift: The Dioxin Murders at "Sick Kids."* Toronto: Methuen, 1984.

Blumer, Herbert. *Symbolic Interactionism: Perspective and Method.* Englewood Cliffs, New Jersey: Prentice Hall, 1969.

Blumer, Herbert. "Society as Symbolic Interaction." In *Human Behaviour and Social Process: Sociological Perspective,* ed. Arnold Rose. Boston: Houghton Mifflin, 1962.

Bogdan, Robert and S. J. Taylor. *Introduction to Qualitative Research Methods: A Phenomenological Approach to the Social Sciences.* New York: Wiley, 1975.

Bolles, Richard N. *What Colour Is Your Parachute? A Practical Manual for Job-Hunters and Career-Changers.* Berkley, California: Ten Speed Press, 1996.

Booth, Amy. "Managing In Style: Views From the Boardroom - Ten Top Executives Tell Their Story." *The Financial Post*, Summer, 1985.

Boreham, Paul, A. Pemberton and P. Wilson, eds. , *The Professions in Australia: A Critical Appraisal.* St. Lucia: University Of Queensland Press, 1976.

Bottomore, Thomas, B. *Elites and Society.* Harmondsworth: Penguin, 1964.

Brenner, Phyllis S. *Temporal Perspective, Professional Identity and Perceived Well-being.* Ph.D. diss., Wayne State University, Detroit, Michigan, 1986.

Bucher, Rue and Joan Stelling. *Becoming Professional.* Beverley Hills: Sage, 1977.

Bucher, Rue and Joan Stelling. "Characteristics of Professional Organizations." *Journal of Health and Social Behaviour 10,* (1969) : 3 – 15.

Bucher, Rue and Anselm L. Strauss. "Professions in Process." *American Journal of Sociology,* no. *66.* (1966) : 325 – 334.

Buckenham June and Gerard McGrath. *The Social Reality of Nursing.* Sydney: Aids Health Science Press, 1983.

Bush, Dianne M. and Roberta Simmons. "Socialization Processes over the Life Course." In *Social Psychology: Social Perspectives,* eds. Rosenberg and Turner. New York: Basic Books, 1981.

Canadian Nurses' Association. *Canadian Health Act Bulletin V.* Ottawa: Canadian Nurses' Association, December 1983.

Caplow, Theodore. "The Dynamics of Information Interviewing." *American Journal of Sociology,* no. 62 (1965) : 169

Carr-Saunders, A. M. and P. A. Wilson. *The Professions.* Oxford: Clarendon Press, 1933.

Castles, Ian. *Career Paths of Qualified Nurses, Australia 1989.* Canberra: Australian Bureau of Statistics, 1990.

Chanka, L. B. "Work Vs. Family." *Healthcare Executive,* no.14 (January 1999) : 45 – 46.

Charon, J. M. *Symbolic Interactionism: An Introduction, An Interpretation, An Integration,* 5th ed. Englewood Cliffs, New Jersey: Prentice Hall, 1995.

Chaska, Norma L. *The Nursing Profession: Turning Point.* St Louis: Mosby, 1990.

Chaska, Norma L. ed. The Nursing Profession: Views through the Mist. New York: McGraw Hill, 1978.

Cohen, H. A. *The Nurse's Quest for a Professional Identity.* Menlo Park: Addison Wesley, 1981.

Commonwealth of Australia, Australian Bureau of Statistics, *Yearbook of Australia.* Canberra: Australian Bureau of Statistics, 1994.

Commonwealth of Australia, Australian Bureau of Statistics, *Yearbook of Australia.* Canberra: Australian Bureau of Statistics, 1985.

Cooley, Charles H. *Two Major Works: Social Organization, Human Nature and the Social Order.* Glencoe, Illinois: Free Press, 1956.

Coser, Robert L. *Life in the Ward.* East Lansig: Michigan State University Press, 1962.

Cox, Caroline and Adrianne Mead, eds. *The Sociology of Medical Practice.* London: Collier-Macmillan, 1975.

Davies, Celia. "Professionals in Bureaucracies: The Conflict Thesis Revisited." In *The Sociology of the Professions: Lawyers, Doctors and Others,* eds. R. Dingwall and P. Lewis, London: Macmillan Press, 1983.

Davis, A.J. "The Phenomenological Approach in Nursing Research." In *The Nursing Profession: Views through the Mist,* ed. Norma L. Chaska, 186 – 197. New York: McGraw Hill, 1978.

Davis, M. Z., M. Kramer and A. Strauss, eds. Nurses in Practice: A Perspective on Work Environments. Saint Louis: C. V. Mosby, 1975.

Davidson, Marilyn J. and C. L. Cooper, eds. Working Women: An International Survey. Chichester: John Wiley, 1984.

Davidson, Marilyn J. and C. L. Cooper. "Attitudes of European Women." *Leadership and Organizational Development Journal* 3, no.5 (May 1982) : 30 – 32.

Deal, Terrence E. and Allen A. Kennedy. *Corporate Cultures: The Rites and Rituals of Corporate Life.* Reading, MA: Addison-Wesley, 1982.

Dean, J. P. "Participant Observation and Interviewing." In *Introduction to Social Research,* ed. J. T. Doby. Harrisburg, PA: Stackpole, 1954.

Deatrick, Janet A and Sandra A. Faux. "Conducting Qualitative Studies with Children and Adolescents." In *Qualitative Nursing Research: A Contemporary Dialogue,* ed. Janice M. Morse. Newbury Park, California: Sage Publications, 1991.

Denzin, Norman K. *Sociological Methods: A Sourcebook,* 2nd ed. New York: McGraw Hill, 1978.

Denzin, Norman K. *The Research Act: The Theoretical Introduction to Sociological Methods.* New York: Aldine, 1973.

Dingwall, Robert and Philip Lewis. *Sociology of the Professions: Lawyers, Doctors and Others.* London: Macmillan, 1983.

Douglas, J. D. *Investigative Social Research: Individual and Team Field Research.* Beverley Hills: Sage Publications, 1976.

Drucker, Peter. *The Changing World of the Executive.* New York: Truman Tally, 1982.

Dunphy, Dexter. *Cliques, Crowds and Gangs: Group Life of Sydney Adolescents.* Melbourne: Cheshire, 1969.

Durkheim, Emile. *The Rules of Sociological Method,* 8th ed. Glencoe, Illinois: Free Press, 1964.

Durkheim, Emile. *The Division of Labour in Society.* 1893. New York: Macmillan Reprint, 1933.

Ericson, Richard. *Making Crime: A Study of Detective Work.* Toronto: Butterworths, 1981.

Ertl, N. "Choosing Successful Managers: Participative Selection Can Help." *Journal of Nursing Administration* 14, no. 4 (1984) : 27 – 33.

Etzioni, Amitai. *A Comparative Analysis of Complex Organizations: On Power, Involvement and their Correlates,* 2nd ed. New York: Free Press, 1975.

Etzioni, Amitai, ed. The Semi-Professions and Their Organizations: Teachers, Nurses and Social Workers. New York: Free Press, 1969.

Field, Peggy A. and Janice M. Morse. *Nursing Research: The Application of Qualitative Approaches.* London: Croom Helm, 1985. Reprint, London: Croom Helm, 1990.

Filstead, William J. *Qualitative Methodology: Firsthand Involvement with the Social World.* Chicago: Rand McNally, 1970.

Foote, Nelson. "Identification as the Basis for a Theory of Motivation." *American Sociological Review* 16, no.1. (1981): 14 – 21.

Freidson, Eliot. *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Dodd Mead, 1970.

Gerber, Lane A. *Married to Their Career: Career and Family Dilemmas in Doctor's Lives.* New York: Tavistock, 1983.

Gerson, Kathleen. *Hard Choices: How Women Decide About Work, Career, and Motherhood.* Berkley: University of California Press, 1985.

Giddens, Anthony. *Central Problems in Social Theory: Actions, Structure and Contradictions in Social Analysis.* Berkley: University of California Press, 1979.

Glaser, Barney G. *Theoretical Sensitivity: Advances In the Methodology of Grounded Theory.* Mill Valley, California: Sociology Press, 1978.

Glaser, Barney G. and Anselm L. Strauss. *Status Passages.* Chicago: Aldine Atherton, 1971.

Glaser, Barney G. and Anselm L. Strauss. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine, 1967.

Glaser, Barney G. and Anselm L. Strauss. *Awareness of Dying.* Chicago: Aldine, 1965.

Goffman, Erving. *Behaviour in Public Places.* Glencoe, Illinois: Free Press, 1963a.

Goffman, Erving. *Stigma.* Englewood Cliffs, New Jersey: Prentice Hall, 1963b.

Goffman, Erving. *Asylums.* Harmondsworth: Penguin, 1961.

Goffman, Erving. *The Presentation of Self in Everyday Life*. New York: Anchor Books, 1959.

Gold, R. L. "Roles in Sociological Field Observation." *Social Forces* 36, no. 3 (1958) : 217 – 223.

Goodman, Ellen. *Turning Points.* New York: Fawcett Crest, 1979.

Gove, Walter, 2nd ed. *The Labelling of Deviance.* Beverley Hills, California: Sage Publications, 1980.

Gray, Genevieve and Rosalie Pratt, eds. *Towards A Discipline of Nursing.* Melbourne: Churchill Livingstone, 1991.

Greenwood, E. "Attributes of a Profession." *Social Work* 2, no.3. (1957) : 44 – 55. Also in *Man Work and Society,* eds. Nosow and Form, New York: Basic Books, 1962. Also in *Sociology of Occupations and Professions,* R Pavalko. Itasca, Illinois: Peacock Publishers, 1971.

Gubrium, Jaber F. "Biographical Work: The Descriptive Organization of Life History." Proceedings, *Qualitative Research: An Ethnographic/ Interactionist Perspective.* University of Waterloo, Canada, 1985.

Haas, Jack and William Shaffir. "The Professionalization of Medical Students: Developing Competence and a Cloak of Competence." *Symbolic Interaction 1.* (1977) : 71 – 78.

Hall, Richard. *Dimensions of Work.* Beverley Hills: Sage, 1986.

Hardy, Margaret E. "Strategy for Theory Development: Stages of Theory Development." Proceedings: The Second Annual Nursing Science Colloquium - *Strategies for Theory Development in Nursing.* Boston University, MA. (March 21 – 22, 1985).

Hardy, Margaret E. and Mary E. Conway. *Role Theory: Perspectives for Health Professionals.* Norwalk, Connecticut: Appleton-Century-Crofts, 1978.

Henry, Beverly & Richard Heyden eds. "CGEAN Instructional Resource Survey Data Report." *Council on Graduate Education for Administration in Nursing,* 1990.

Heraud, Brian. *Sociology in the Professions.* London: Open Books Publishing Ltd., 1979.

Herman, Nancy. "Crazies in the Community: An Ethnographic Study of Ex-Psychiatric Patients in Canadian Society: Stigma, Management Strategies, and Identity." Ph.D. diss., McMaster University, Ontario, Canada, 1985.

_____. "High Hospital CEO Turnover Trend Continues." *Healthcare Executive* No.14 (1999) : 34-35

Higsley, John, D. Deacon and D. Smart. *Elites in Australia.* London: Routledge and Kegan Paul, 1979.

Hoffman, Joan H. "Problems of Access in the Study of Social Elites and Boards of Directors." In *Fieldwork Experience: Qualitative Approaches to Social Research,* eds. William B., Shaffir, R. A. Stebbins, and A. Turowetz. New York: St. Martins, 1973.

Hogan, D. P. "The Variable Order of Events in the Life Course." *American Sociological Review* 43, (1978) : 573 – 87.

Huber, Joan. "Symbolic Interaction as a Pragmatic Perspective: The Basis of Emergent Theory." *American Sociological Review* 38, (1973) : 274 – 284.

Hughes, Linda. "Professionalizing Domesticity: A Synthesis of Selected Nursing Historiography." *Advances In Nursing Science* 12, no. 4 (1990) : 25 – 31.

Hughes, Everett. *Men and Their Work.* Glencoe, Illinois: Free Press, 1958.

Hughes, Everett, Hughes, H. and Deutscher, I. *Twenty Thousand Nurses Tell Their Story.* Philadelphia, PA: J. B. Lippincott, 1958.

Humphreys, R. A. Laud. *Tearoom Trade.* Chicago: Aldine, 1970.

Irish, Richard. *Go Hire Yourself An Employer.* New York: Anchor Press/ Doubleday, 1978.

James, William. *Principles of Psychology, Vol. 1.* New York: Henry Holt, 1893.

Johnson, John M. *Doing Field Research.* New York: Free Press, 1975.

Johnson, Terrence J. *Professions and Power.* London: Macmillan, 1972.

Jones, R. Kenneth and Patricia Jones. *Sociology in Medicine.* London: English Universities Press, 1975.

Kanter, Rosabeth M. *The Change Masters: Innovation and Entrepreneurship in the American Corporation.* New York: Simon and Schuster, 1983.

Kerr, Janet R. "Political Awareness in Nursing." In *Canadian Nursing: Issues and Perspectives,* Kerr, J. and J. MacPhail. Toronto: McGraw-Hill Ryerson Ltd., 1988.

Kiam, Victor. *Going For It: How To Succeed As An Entrepreneur.* London: Collins, 1986.

Klegon, D. "The Sociology of Professions: An Emerging Perspective" *Sociology of Work and Occupations 5*, no. 3 (1978) : 259 – 284.

Kramer, Marlene. *Reality Shock: Why Nurses Leave Nursing.* St. Louis: C. V. Mosby, 1974.

Kramer, Marlene and C. Schmalenberg. "Magnet Hospitals: Part I - Institutions of Excellence." *Journal of Nursing Administration* 18, no. 1 (1988a) : 15 – 24.

Kramer, Marlene and C. Schmalenberg. "Magnet Hospitals: Part II - Institutions of Excellence." *Journal of Nursing Administration* 18, no. 2 (1988b) : 11 – 18.

Krejci, J.W. "Changing Roles in Nursing: Perceptions of Nurse Administrators." *Journal of Nursing Administration* 29, no. 3 (1999) : 21 – 29.

Krugman, Mary E. "Nurse Executive Role Socialization and Occupational Image." *Nursing and Health Care 11*, no. 10 (1990) : 526 – 530.

Kuhn, Thomas S. *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press, 1962.

Languess, L. C. *The Life History in Anthropological Science.* New York: Holt, Rinehart and Winston, 1965.

Lawler, Jocalyn. *Behind the Screens: Nursing, Somology and the Problem of the Body.* Melbourne: Churchill Livingstone, 1991.

Leatt, Peggy. "Education for Nursing Administration in Canada: A Discussion Paper." *Canadian Nurses' Association*, 1981.

Leininger, Madeline, ed. Qualitative Research Methods in Nursing. Orlando: Grune Stratton, 1985.

Leininger, Madeline. *Caring: An Essential Human Need.* New Jersey: Charles B. Slack, 1981.

Leininger, Madeline. *Transcultural Nursing: Concepts, Theories, Research and Practices.* New York: McGraw Hill, 1995.

Letkemann, Peter. *Crime as Work.* Englewood Cliffs, New Jersey: Prentice Hall, 1973.

Lofland, John. *Doing Social Life.* Toronto: Wiley, 1976.

Lofland, John. *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis.* California: Wadsworth, 1971.

Lovell, Verna. *'I Care That VGH Nurses Care!' A Case Study and Sociological Analysis of Nursing's Influence on the Health Care System.* Vancouver: In Touch Publications, 1981.

McCall, G. J. and J. L. Simmons. *Identities and Interactions.* New York: Free Press, 1978.

McCall, G. J. and J. L. Simmons eds. Issues in Participant Observation. Reading, Massachusetts: Addison-Wesley, 1969.

McCloskey, Joanne C., D. Gardner, M. Johnson and Meridean Maas. "What Is the Study of Nursing Service Administration?" *Journal of Professional Nursing 4*, no. 2, (1988) : 92 – 98.

McClure, Margaret L. "The Nurse Executive Role: A Leadership Opportunity." *Nursing Administration Quarterly 13,* no. 3 (1989) : 1 – 8.

McHugh, Peter. "The Social Ascription of Motives." *American Sociological Review* 26, (1975) : 98 – 109.

McHugh, Peter. *Defining the Situation.* Indianapolis: Bobbs-Merrill, 1968.

McLees, Mary Ann. "The Career Patterns and Orientations of Nurses." Ph.D. diss., The University Of Alberta, Edmonton, Canada, 1988.

McPhail, Clark and Cynthia Rexroat. "Mead vs. Blumer: The Divergent Methodological Perspectives of Social Behaviourism and Symbolic Interaction." *American Sociological Review 4*, no. 33, 449 – 467.

Manis, Jerome G. and Bernard N. Meltzer, eds. Symbolic Interaction: A Reader in Social Psychology, 3rd ed. Boston: Allyn and Bacon, 1978.

Marchak, Patricia M. *Ideological Perspectives on Canada,* 2nd ed. Toronto: McGraw Hill Ryerson, 1981.

Martindale, Don. *Nature and Types of Sociological Theory.* Boston: Houghton Mifflin, 1963.

Marx, Karl and F. Engels. *The German Ideology.* London: Lawrence and Wishart, 1965.

Mead, George H. *Mind, Self and Society: From the Standpoint of a Social Behaviourist.* Chicago: University Of Chicago Press, 1934.

Medley, H. A. *Sweaty Palms: The Neglected Art of Being Interviewed.* Belmont, California: Lifetime Learning Publications, 1978.

Melia, Kathleen M. "Student Nurses' Construction of Occupational Socialization" *Sociology of Health and Illness 6,* no. 2 (1984) : 132 – 151.

Melia, Kathleen M. " 'Tell It As It Is' - Qualitative Methodology and Nursing Research: Understanding the Nurse's World." *Journal of Advanced Nursing 7,* no. 4 (1982) : 327 – 336.

Meleis, Afaf. *Theoretical Nursing: Development and Progress.* Philadelphia: Lippincott, 1985.

Mellish, Joyce M. *An Introduction to the Ethos of Nursing.* Durban: Butterworths, 1988.

Meltzer, Bernard N., J. W. Petras, and L. T. Reynolds. *Symbolic Interactionism: Genesis, Varieties and Criticism.* London: Routledge and Kegan Paul, 1975.

Merton, Robert K., G. C. Reader and P. L. Kendall, eds. The Student Physician. Cambridge, Massachusetts: Harvard University Press, 1957.

Merton, Robert K. *Social Theory and Social Structure.* Glencoe, Illinois: Free Press, 1949.

Miller, Karen L. "Keeping the Care in Nursing Care: Our Biggest Challenge." *Journal of Nursing Administration 25,* no. 11 (1995) : 29 – 32.

Mills, C. Wright. "Situated Action and Vocabularies of Motive." *American Sociological Review* V, (October 1940) : 904 – 913. Also In Stone and Faberman, Ch. 28, 1970.

Mills, C. Wright. *The Power Elite.* New York: Oxford University Press, 1956.

Moore, Wilbert E. and G. W. Rosenblum. *The Professions: Roles and Rules.* New York: Sage, 1970.

Moore, Wilbert E. and G. W. Rosenblum. *The Professionalization of Occupations.* New York: Sage, 1970.

Moorhouse, Christopher P. *Registered Nurse: The First Year of Professional Practice.* Melbourne: La Trobe University Press, 1992a.

Moorhouse, Christopher P. "Adopting New Definitions of Work: When Nurses Become Academics." Proceedings: *12th International Seminar for Teacher Education,* University Of New England, Armidale (April 1992b)

Moorhouse, Christopher P. "Occupational Socialization of the New Graduate in Nursing and Adaptation to the Professional Role." M.Ed. thesis, University of New England, Armidale, Australia, 1983a.

Moorhouse, Christopher P. "New Graduates: The Preceptorship Plan." *The Australian Nurses' Journal 12*, no. 9 (1983b) : 44 – 46.

Moorhouse, Christopher P. "The Role of Values in the Nursing Curriculum." *The Australian Nurses' Journal 10*, no. 8 (1981) : 43 – 44.

Morse, Janice, M. ed. Qualitative Nursing Research: A Contemporary Dialogue. Newbury Park, California: Sage Publications, 1991.

Munro, J., R. Fitzsimons, D., O. Hennessy and C. Moorhouse. *Promotion and Promotion Appeals in Australian Policing - Toward a Model for Standardisation.* Adelaide: Department of the Special Minister of State, 1985.

Nosaw, S. and William Form, eds. Man, Work and Society. New York: Basic Books, 1962.

Olesen, Virginia and Elvi Whittaker. *The Silent Dialogue: A Study in the Social Psychology of Professional Socialization.* San Francisco: Jossey Bass, 1968.

Omery, A. "Phenomenology: A Method for Nursing Research." *Advances in Nursing Science 5,* no. 2 (1983) : 49 – 63.

Ontario Ministry of the Attorney General. *Report of the Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children and Related Matters.* Chair: The Honourable Mr. Justice Samuel G. M. Grange, Commissioner, Supreme Court of Ontario, Canada, 1984.

Ontario Ministry of Health. *Report of the Hospital for Sick Children Review Committee.* Chair: The Honourable Mr. Justice Charles L. Dubin, Ontario, Canada, 1983.

O'Rand, A. M. and J. C. Henretta. "Delayed Career Entry, Industrial Pension Structure and Early Retirement in a Cohort of Unmarried Women." *American Sociological Review 47,* no. 3 (1982) : 365 – 373.

Parker, H. J. *View from the Boys: A Sociology of Downtown Adolescents.* London: David and Charles, 1974.

Parsons, R. J., G. Gustafson, B. P. Murray, R. B. Dwore, P. M. Smith, and L. B. Vorderer. "Hospital Administrators' Career Paths: Which Way to the Top?" *Health Care Management Review 22*, no. 4 (1997) : 82 – 96.

Pavalko, Ronald. *Sociology of Occupations and Professions.* Itasca, Illinois: Peacock Publishers, 1971.

Pawluch, Dorothy. *The New Paediatrics: A Profession in Transition.* New York: Aldine De Gruyter, 1996.

Pearson, Alan and Barbara Vaughan. *Nursing Models for Practice.* London: Heinemann, 1986.

Pelletier, D., J. Donoghue, C. Duffield and A. Adams. The Impact of Graduate Education on the Career Paths of Nurses." *Australian Journal of Advanced Nursing 13*, no. 3, (1998) : 23 – 30.

Peters, Thomas J. and Robert H. Waterman. *In Search Of Excellence: Lessons from America's Best-Run Companies.* New York: Warner Books, 1982.

Phillips, L. "Women Executives Say Their Time Is Near – If Not Already Here." *Healthcare Executive 8*, no. 6 (1993) : 12 – 16.

Price, S. A. "Master's Programmes Preparing Nursing Administrators: What Are the Essential Components?" *Journal of Nursing Administration 14,* no. 1 (1984) : 11 – 17.

Price, S. A., L. M. Simms and S. K. Pfoutz. "Career Development of Nurse Executives: Planned or Accidental?" *Nursing Outlook 35*, no. 5 (1987) : 236 – 239.

Prus, Robert and Styllianoss Irini. *Hookers, Rounders and Desk Clerks: The Underlife of the Hotel Community.* Toronto: Gage, 1980.

Psathas, George. *Phenomenological Sociology: Issues and Applications.* New York: Wiley, 1978.

Quist, B. D. "The Nursing Career Tree." *Nursing Management 20*, no.9 (1989) : 61 – 63.

Registered Nurses' Association of British Columbia. "Standards for Nursing Practice." RNABC, Vancouver, Canada, 1984.

Report of the National Review of Nurse Education in the Higher Education - 1994 and Beyond. *Nurse Education in Australian Universities.* Chair: J. Reid Canberra: Australian Government Publishing Service, 1994.

Report of the Committee of Inquiry into Nurse Education and Training to the Tertiary Education Commission, Nurse *Education and Training.* Chair: S. Sax. Canberra: Australian Government Publishing Service, 1978.

Rice, David G. *Dual-Career Marriage: Conflict and Treatment.* New York: Free Press, 1979.

Richman, Joel. *Medicine and Health.* London: Longman, 1987.

Ritti, Richard and Ray Funkhouser. *The Ropes to Skip, And the Ropes to Know: Studies in Organisational Behaviour.* New York: John Wiley, 1982.

Rooney, M. "Advancing Your Career." *Healthcare Executive 15*, no.3 (2000) : 69 – 70.

Rose, Arnold, ed. *Human Behaviour and Social Process: An Interactionist Approach.* Boston: Houghton Mifflin, 1962.

Rosenberg, M. and R. Turner, eds. *Social Psychology: Sociological Perspectives.* New York: Basic Books, 1981.

Rosenthal, C. J., R. W. Marshall, A. S. MacPherson and S. E. French. *Nurses, Patients and Families.* London: Croom Helm, 1980.

Rossi, Alice S. *Gender and the Life Course.* New York: Aldine, 1985.

Roth, Julius A. "Professionalism: The Sociologist's Decoy." *Sociology of Work and Occupations 1,* no.1 (1974) : 6 – 23.

Roth, Julius S. *Timetables.* Indianapolis: Bobbs-Merrill, 1963.

Rozier, C. K. "Nurse Executive Characteristics: General Differences." *Nursing Management 27*, no.12 (1996) : 33 – 37.

Rubington, Earl and Martin S. Weinberg. *Deviance: The Interactionist Perspective*, 2nd ed. New York: Macmillan, 1973.

Ryff, Carol D. "The Subjective Experience of Life-Span Transitions." In *Gender and the Life Course,* Alice S. Rossi. New York: Aldine, 1985

Schatzman, Leonard and Anselm L. Strauss. *Field Research: Strategies for a Natural Sociology.* Englewood Cliffs, New Jersey: Prentice Hall, 1973.

Schein, E. H. *Career Dynamics: Matching Individual and Organisational Needs.* Reading, MA: Addison-Wesley, 1978.

Schein, E. H. "The Individual, The Organisation, And The Career: A Conceptual Scheme," In *Adult Career Transitions,* R. E. Hill, E. L. Miller and M. A. Lowther, 17 – 38. Graduate School of Business: University of Michigan, 1971.

Schorr, Thelma M. and Anne Zimmerman, eds. Making Choices, Taking Chances: Nurse Leaders Tell Their Stories. St. Louis: W. Mosby,1988.

Schutz, Alfred. *Collected Papers II: Studies in Social Theory*, ed. Arvid Broderson. The Hague: Martinus Nijhoff, 1964.

Schutz, Alfred. *Collected Papers I: The Problem of Social Reality,* ed. Maurice Natanson. The Hague: Martinus Nijhoff, 1961.

Scott and Lyman. "Accounts." In *Symbolic Interaction: A Reader in Social Psychology,* 3rd ed. Manis and Meltzer. Boston: Allyn and Bacon, 1978.

Seliger, Martin. *Ideology and Politics.* London: Allen and Unwin, 1976.

Shaffir, William B., Robert A. Stebbins and Alan Turowetz, eds. *Fieldwork Experience: Qualitative Approaches to Social Research.* New York: St. Martin's, 1980.

Shaffir, William B. and Jack Haas. "Fieldworkers' Mistakes at Work: Problems in Maintaining Research and Researcher Bargains." In *Fieldwork Experience: Qualitative Approaches to Social Research,* eds. W. Shaffir, R. Stebbins and A. Turowetz, 1980.

Sharpe, Sue. *Double Identity: The Lives of Working Mothers.* Harmondsworth: Penguin, 1984.

Shibutani, Tomatsu. "Reference Groups and Perspectives." In *Symbolic Interaction: A Reader in Social Psychology,* 3rd ed., eds. Manis and Meltzer, Boston: Allyn and Bacon. 1981.

Shibutani, Tomatsu. "Reference Groups as Social Control." In *Human Behaviour and Social Process: An Interactionist Approach,* ed. Arnold Rose, 128 – 147. Boston: Houghton Mifflin, 1962.

Simpson, Ida H. *From Student to Nurse: A Longitudinal Study of Socialization.* Cambridge: Cambridge University Press, 1979.

Smelser, Neil J. *Comparative Methods in the Social Sciences.* Englewood Cliffs, New Jersey: Prentice Hall, 1976.

Sorrentino, E. A. "Profiling a Chief Nursing Officer." *Nursing Management 23,* no.1 (1992) : 32 – 34.

South Australian Health Commission. *Trends in Nursing Employment (A Study of 1972 Graduates).* Nursing Section, SAHC. Adelaide: SAHC. November 1978

Spector, Malcolm. "Learning to Study Public Figures." In *Fieldwork Experience: Qualitative Approaches to Social Research,* eds. W. Shaffir, R. Stebbins and A. Turowetz, 1980.

Spilerman, S. "Careers, Labour Market Structure and Socio-Economic Achievement." *American Journal of Sociology 83*, (1977) : 551 – 593.

Starr, Paul. *The Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry.* New York: Basic, 1982.

Stebbins, Robert A. "Careers in Professional Football: Maintenance and Decline." In *Work in the Canadian Context,* eds. K. L. P. Lundy and B. D. Warme, 2nd ed. Toronto: Butterworths, 1985.

Stebbins, Robert A. "Career: The Subjective Approach." *Sociological Quarterly* 11, (Winter 1970) : 32 – 49.

Stevens, Barbara J. "The Role of the Nurse Executive." *Journal of Nursing Administration 11,* no. 2 (1981) :19 – 23.

Stevens, Barbara J. *The Nurse as Executive,* 3rd ed. Rockville, MD: Aspen Publishers, 1985.

Stevens, Paul. *Career Transitions: The Australian Experience.* Sydney: The Centre for Worklife Counselling, 1990.

Stone, Gregory P. and Harvey A. Farberman, eds. *Social Psychology through Symbolic Interaction.* New York: Wiley, 1981.

Stroud, C. *The Blue Wall: Street Cops in Canada.* Toronto: Seal Books/ McClelland and Stewart, 1984.

Strauss, Anselm L. *Qualitative Analysis for Social Scientists.* (First published 1959) Cambridge: Cambridge University Press, 1987.

Stryker, Sheldon. *Symbolic Interactionism: A Social-Structural Version.* Don Mills: Benjamin/ Cummings Publishing, 1980.

Styles, Margaretta. *On Nursing: Toward a New Endowment.* St. Louis: Mosby, 1982.

Sutherland, Edwin H. *On Analyzing Crime.* First published 1949. Chicago: University of Chicago Press, 1973.

Sutherland, Edwin H. and Donald S. Cressey. *Criminology.* New York: J. B. Lippincott, 1967.

Swanson, J. M. and W. C. Chenitz. "Why Qualitative Research in Nursing?" *Nursing Outlook 30,* (1982) : 241 – 245.

Terkel, Studs. *People Talk about What They Do All Day and How They Feel about What They Do.* New York: Avon Books, 1974.

Terkel, Studs. *Hard Times: An Oral History of the Great Depression.* New York: Washington Square Press, 1970.

Thomas, W. I. *The Unadjusted Girl.* Boston: Little, Brown, 1931.

Toffler, Alvin. *The Adaptive Corporation.* New York: Bantam/McGraw Hill, 1985.

Turner, Ralph. (1962) "Role-Taking: Process versus Conformity." In *Human Behaviour and Social Process: An Interactionist Approach,* Ch. 2, ed. Arnold Rose. Boston: Houghton Mifflin, 1962.

Tuckett David and Joseph Kaufert, eds. *Basic Readings in Medical Sociology.* London: Tavistock, 1978.

Van Maanen, Hanneke M. Th. "Nursing In Transition: An Analysis of the State of the Art in Relation to the Conditions of Practice and Society's Expectations." *Journal of Advanced Nursing* 15, (1990) : 914 – 924.

Van Maanen, Hanneke M. Th. *Organisational Careers: Some New Perspectives.* New York: Wiley, 1977.

Viney, Linda L. *Transitions.* Sydney: Cassell, 1980.

Vollmer, H. W. and D. J. Mills. *Professionalization.* Engelwood Cliffs, New Jersey: Prentice Hall, 1966.

Ward, M. J. and S. A. Price. *Issues in Nursing Administration: Selected Readings.* Mosby, St. Louis, 1991.

Watson, James D. *The Double Helix.* New York: Mentor, 1968.

Watson, Jean. *Nursing - Human Science and Health Care.* Norwalk: Appleton, Century, Crofts, 1985.

Watson, Jean. "Professional Identity Crisis - Is Nursing Finally Growing Up?" *American Journal of Nursing 81,* no. 8 (1981).

Watson, Jean. *Nursing: The Philosophy and Science of Caring.* Boston: Little Brown, 1979.

Wax, Rosalie "Reciprocity as a Field Technique." *Human Organization* 11, (1952) : 34 – 37.

Webb, C. "Caring, Curing, Coping: Towards an Integrated Model." In *Contemporary Leadership Behaviour: Selected Readings,* 5th ed., Hein, E C. ed. 1998

Weil, P. A., S. A. Wesbury, A. H. Williams and M. D. Carver. "Hospital CEO Turnover Phase 11: A Longitudinal Study Comparing Leavers and Stayers (1979-90)." *Healthcare Executive 6*, no. 3 (1991) : 30 – 35.

Whyte, William F. *Street Corner Society: The Social Structure of an Italian Slum.* Chicago: University of Chicago Press, 1955.

Wieder, D. L. *Language and Social Reality: The Case of Telling the Convict Code.* The Hague: Mouton, 1974.

Wilensky, Harold L. "The Professionalization of Everyone?" *American Journal of Sociology 70,* no. 2 (1964) : 137 – 158.

Willis, Evan. *Illness and Social Relations: Issues in the Sociology of Health Care.* Sydney: Allen and Unwin, 1994.

Willis, Evan. *The Sociological Quest: An Introduction to the Study of Social Life.* Sydney: Allen and Unwin, 1993.

Willis, Evan. *Medical Dominance: The Division of Labour in Australian Health Care.* Sydney: Allen and Unwin, 1989.

Willis, Evan. *Technology and the Labour Process: Australasian Case Studies.* Sydney: Allen and Unwin, 1988.

Zola, Irving. "Medicine as an Institution of Social Control: The Medicalizing of Society." In *Basic Readings in Medical Sociology,* eds. David Tuckett and Joseph Kaufert. London: Tavistock, 1978.

APPENDICES

APPENDIX 1: INTERVIEW SCHEDULE

Reference Code:_____ Time Completed: _____

Time Commenced: _____

Time Elapsed: _____

Date: _____

CAREER CONTINGENCY AND AMBITION AMONG NURSING SERVICES ADMINISTRATORS IN CANADA AND AUSTRALIA

Interview Schedule

Note: This schedule is intended only as a guide for the interviewer. Additional areas of relevance should be explored as appropriate. Sections I-III may be completed by the respondent to save time.

A RESEARCH STUDY SPONSORED BY THE W.K. KELLOG FOUNDATION, MICHIGAN, AND CONDUCTED UNDER THE AUSPICES OF McMASTER UNIVERSITY, ONTARIO.

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CAREER CONTINGENCY AND AMBITION AMONG NURSING SERVICE ADMINISTRATORS IN CANADA AND AUSTRALIA

Consent Statement

1. The purpose of this study is to collect data on the careers of successful nurses who have reached executive level administrative positions in nursing service institutions. The study investigates the relationship between ambition and ultimate success in nursing. It will contribute to the nursing profession's understanding of the contingencies and career decisions which lead to appointment to these hierarchically senior nursing ranks.

2. Since you are an influential and important figure in the nursing profession, many of your views and attitudes are likely to be well known through media, journals and professional involvement. Protecting your identity will be a major consideration in this study, one which, in view of your professional affiliations, prominence and possible outspokenness on certain professional issues, will require extraordinary measures to uphold. On the other hand, there may be nothing here, which you would not be prepared to "go on record as having said." People will feel comfortable and "safe" with different levels of exposure, and those differences will be respected in this study. You may choose the level to which you are prepared to be identified in this research report and any professional papers arising from it.

____ I consent to the use of this material for research purposes on condition that my comments remain anonymous.

OR

____ I consent to be identified in my capacity as ..... and to have my comments attributed to me in that capacity EXCEPT where I ask for certain comments to be "off the record", in which case those comments, if used, will be free from identifying marks.

OR

____ I consent to the use of interview material for research purposes only if the following conditions are met:

Respondent Signature: _____ Interviewer Signature: _____ Date: _____

Note: For reasons of confidentiality and security, the interview schedule and this consent form, will be filed separately.

SECTION I. PERSONAL BACKGROUND

1. *Curriculum vitae* provided Yes/No

   If Yes, complete only parts of section I – III not included in CV.

2. Year of birth: 19 ____

3. Country of birth: _____

4. Languages spoken:
   English _____
   French _____
   Other (list)_____

5. Marital status:
   Single, never married _____
   Widowed (how many years _____) _____
   Separated (how many years _____) _____
   Divorced (how many years _____) _____

6. Describe the occupation / profession of your spouse / cohabitant.

7. Highest level of education of spouse / cohabitant: _____

8. In what environment did you spend most of your life before commencing nursing?
   a) urban _____
   b) suburban _____
   c) small town _____
   d) rural _____

9. What was your father's occupation or profession?_____

10. What was your mother's occupation or profession? _____
    (Before marriage or while married)

11. List the occupation / profession of each of your siblings stating their age relating to you (i.e. 2 years older, 5 years younger)

Age Relative to You	Sex	Occupation / Profession

SECTION II DETAILS OF PRESENT APPOINTMENT

1. Present position: _____

2. Month and year of appointment: _____

3. Bed capacity of present hospital: _____
(Or other measure of responsibility if not hospital)

4. Number of nursing staff for whom you have administrative responsibility:

SUPERVISORS	_____
CONSULTANTS / SPECIALISTS	_____
NURSES	_____
BScN.	_____
DIPLOMATES	_____
RN	_____
RNA / EN	_____

5. Present annual salary range:

Less than 20,000	_____
20,000 to 24,999	_____
25,000 to 29,999	_____
30,000 to 34,999	_____
35,000 to 39,999	_____
40,000 to 44,999	_____
50,000 to 54,999	_____
55,000 to 59,999	_____
60,000 to 64,999	_____
65,000 to 69,999	_____
Over 70,000	_____
Plus Benefits Package	$_____

SECTION III CAREER HISTORY

1.	Nursing qualifications	Year		Institution
2.	Academic qualifications	Year		Institution
3.	Other qualifications, awards, memberships	Year		Institution
4.	Clinical nursing appointments	Year Comm.	Duration (Months)	Institution
5.	Administrative nursing appointments	Year Comm.	Duration (Months)	Institution
6.	Other appointments	Year Comm.	Duration (Months)	Institution

7. Major professional contributions, activities, publications etc.

SECTION IV CAREER PLANNING

1. After how many years of nursing did you first realise that you may ultimately attain an administrative nursing position?

   a) Above Head Nurse? _____

   b) At your present level? _____

2. Who or what led to your decision to apply for your present position?

3. How did that job vacancy come to your attention?

4. What is your short-term career goal (within, say, five years)?

5. What is your long-term career goal? How many years hence? _____

6. What will result in the termination of your appointment?

7. When might that be? _____

8. What will you do then?

SECTION V ROLE TRANSITION

1. How were you prepared for your present role in ways other than through formal education?

2. What personal steps did you take in preparation for your present role?

3. What were the major features of your first three months in your present role?

4. What two things eased your transition into the executive role?

5. What two factors made your transition most difficult?

6. Comment on each of the following forms of educational preparation for new nursing administrators. Circle the one (a, b or c) you believe most appropriate.

a) Formal academic qualification
Degree and specialization: _____

b) In-service Education

c) Continuing Nursing Education

SECTION VI ASPIRATION AND AMBITION

1. List in order of your preference at the time, the jobs you had seriously considered on completion of secondary school.

2. Do you now describe yourself as ambitious YES/NO

3. At what stage of your career (if at any) did you recognise that you were ambitious?

4. What does the term ambition mean to you?

5. What is your highest aspiration in each category?

   a) Personal:

   b) Professional:

6. Are you presently studying? YES/NO

   If YES: For what degree / qualification: _____

   In what program and institution: _____

   With what expectation / for what reason: _____

SECTION VII ADMINISTRATIVE ROLE

1. List up to ten major elements of your present job in order of the time you commit to them (most time-consuming first).

Time		Reward	Import.
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	7.		
	8.		
	9.		
	10.		

2. Rank the above job elements according to their personal reward value for you (most rewarding first). Use the column labelled "Reward."

3. Rank the above job elements according to your evaluation of their importance to nursing (most important first). Use the column labelled "Import."

4. In what ways do you regard yourself as:

   a) Typical as a nurse?

   b) Unique as a nurse?

   c) Typical as a senior nursing administrator?

   d) Unique as a senior nursing administrator?

SECTION VIII ADMINISTRATIVE ETHOS

1. In what ways must a service administrator think differently from a clinical nurse?

2. How has your own conception of nursing work changed since you became an administrator?

3. What do clinical nurses understand least well about the work of the executive nursing administrator?

4. What do you understand least well about the work of the clinical nurse today?

5. What are the most distinctive personal features / qualities you bring to your work?

SECTION IX CHANGING CONCEPTIONS OF ROLE

1. How, in your opinion, has nursing changed for the better in, say, the last ten years?

2. What changes have taken place in nursing for the worse?

3. How has the nursing service administrator's role changed for the better in that time?

4. How has the nursing service administrator's role changed for the worse in that time?

5. Who, and / or what are responsible for these changes?

6. What changes do you anticipate in nursing in the next ten years?

7. How will they be affected?

8. By whom?

SECTION X INFLUENCE

1. In what spheres of nursing do you have the greatest influence?

2. What form does that influence take?

3. What has been your most important contributions to nursing?

4. How would you <u>like to be remembered</u> on your retirement from nursing?

5. How are you most likely to <u>actually be remembered</u>?

SECTION XI CONCLUSION

1. In your view, how important are the issues raised in this questionnaire to an understanding of the nursing service administrator's world?

   a) Not at all important _____ c) Somewhat important ____

   b) Very important _____ d) Extremely important ____

   Any additional comments?

2. What additional issues should have been raised, in your opinion?

3. Is there something about your role as an administrator, your attitude toward that role, or toward nursing generally, or about your preparation for the role, which is noteworthy?

   For example, did you have another career before commencing nursing? Have you had a long frustration with nursing and wished for another career option? Did you never want anything other than a job such as your present one?

SECTION XII PERSONAL REFLECTION

1. Comment on administration as a career option in nursing.

2. Reflect on your own career as a nursing administrator.

3. Reflect on the nature of ambition among nurses