THE EXPERIENCE OF MANAGING FROM THE PERSPECTIVE OF
FIRST-LINE NURSE MANAGERS WORKING IN PROGRAM MANAGEMENT

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science
Graduate Department of Nursing Science, University of Toronto

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ABSTRACT

The Experience of Managing from the Perspective of First-Line Nurse Managers

Working in Program Management

Master of Science in Nursing 2001

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The purpose of this study was to describe the experience of managing from the perspective of first-line nurse managers working in program management. The descriptive qualitative study involved 6 managers. It took place in a Canadian hospital in which there was an absence of traditional professional departments, (b) first-line managers reported to non-nursing or nursing supervisors, (c) authority was decentralized to the first-line manager for human and financial resources, and (d) first-line managers supervised nursing and non-nursing professionals. Mintzberg's model of managing (1994a, 1994b) was used as the conceptual framework.

Interview data indicated that managing in program management was about (a) taking on more and more in a lean management structure, (b) maintaining a commitment to patient care in light of urgent resource issues, and (c) carrying on despite patchy success. Furthermore, the managers' in-depth descriptions of what managing was like illustrated the impact of program management on managers' leadership.
ACKNOWLEDGEMENTS

Many people assisted and supported me during the process of completing this study. I would like to express my appreciation to Dr. Gail Donner, my thesis supervisor, for believing in the importance of giving voice to first-line nurse managers. I am grateful for her encouragement, warmth, and understanding of the complexities of life. I also appreciated the guidance and support provided by my thesis committee members, Dr. Donna Wells and Dr. Diane Doran. Furthermore I would like to thank Barbara Bauer for her invaluable editorial assistance and interest.

I am indebted to the nurse managers who participated in this study for their willingness to tell their stories and personally reflect on their experience. I also wish to acknowledge the vital contribution that first-line nurse managers make every day to the care of society’s sickest members by facilitating the provision of compassionate care under increasingly challenging circumstances.

I owe a very special thank you to my friends and colleagues for their continual support, for their asking/not asking, and their belief that I would eventually succeed.

Most importantly, I would like to thank my husband John, for his love, calming influence, and patience. I would not have been successful if it had not been for the many ways he supported me, our children, and family. A heartfelt thanks to my sons Tom and Brad who I am so proud of, for putting up with the times that I wasn’t as available to them as I would have liked. Thanks also to my mother Goldie and Aunt Jessie, for their prayers and understanding.
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CHAPTER 1: BACKGROUND

Hospitals in Ontario are experiencing profound change. Reduction in health care spending, technological changes, the government's desire for measurable outcomes of care and increased operational efficiency, and consumer demand for more responsive, high quality care are some of the factors driving change. Hospitals attempt to adapt to fiscal constraints and to improve quality by refining existing designs or by creating new hospital structures.

Program management is one of the organizational designs introduced to Ontario hospitals in the 1980s (Leatt, Lemieux-Charles, & Aird, 1994). Clinical, technical, and decision making functions are integrated under one manager or management committee for a program of care. The underlying assumption of program management is that by decentralizing decision making to the program level, opportunities to reduce costs and to improve the outcomes of care would be identified more readily. Innovation would be encouraged "by forcing more staff to pay attention to finances, team work and other organizational issues" (Miller & Miller, 1997, p. 49).

In a program management design (a) programs are designed around patients' needs, (b) decision making for fiscal and human resources is decentralized to the program manager, (c) the focus is on outcomes in terms of health of patients and the community, and (d) decision making is driven with information provided in a timely fashion (Leatt et al., 1994). The term program refers to "an integrated set of patient care services delivered to a targeted... set of clients" (Charns & Smith Tewksbury, 1993, p. 27). Programs can represent groups of patients such as children, older adults, and women or can be structured according to patient conditions, problems, or diagnoses, such as heart, cancer,
or mental health. In pure program management, "program divisions operate as autonomous businesses, each containing all of the functions it needs" (Charns & Smith Tewksbury, p. 29).

Program management is different from the traditional hospital structure. Program management emphasizes integration of those professional services and other functions necessary to provide care to a group of patients with similar needs. In a functional organization, responsibilities are divided by function rather than by program. The major organizational units of a hospital are departments that represent the different professional and non-professional functions such as nursing, dietary, and housekeeping. "The functional organization maximizes differentiation and emphasizes management of, and professional focus on each function or profession independently. The structure itself provides for no integration of functions to achieve coordinated, comprehensive care, and it affords no managerial focus on programs or other outputs of the hospital that require combined efforts of functions" (Charns & Smith Tewksbury, 1993, p. 29).

Implementing program management in the midst of a turbulent health care environment has a significant impact on both the organization of hospitals and their employees. Program management directly affects people in the first-line manager role since they supervise care providers at the point of care, where much of the impact of organizational change such as program management emerges (Porter-O'Grady, 1995; Sullivan & Decker, 1992). More specifically, first-line nurse managers are affected because their role includes responsibility for integrating and managing change at the point of care, for turning organizational goals into reality, and for buffering direct care providers from the turbulent environment. At the same time, they are challenged to
assume additional responsibilities and unclear roles while personally experiencing the impact of change.

The first-line nurse manager role has been described as the pivotal leadership position in the traditional hospital organization (Byers & Klink, 1978; Stahl, Querin, Rudy, & Crawford, 1983; Stevens, 1974). The first-line nurse manager serves as a major linking pin within the hospital organization and is critical to (a) developing quality patient care (Eubanks, 1992); (b) increasing productivity, building worker morale, and reducing costs (Metzger, 1991); (c) enhancing staff nurse job satisfaction and performance (Sorrentino, 1992); and (d) improving clinical outcomes (Sovie, 1994).

Given the importance of the first-line manager's role, more in-depth knowledge about the impact program management is having on the role is essential. In their study of 468 health managers in British Columbia, Kazanjian and Pagliccia (1993) emphasized the need for understanding the role of the first-line manager from the perspective of those experiencing it. Since managers in their study reached a high degree of agreement about the aspects of managing they deemed most important, it seems worthwhile to seek managers' perspectives. Therefore, the current study examined the first-line manager in Ontario hospitals to further our understanding of the impact of program management on these individuals.

Although program management affects first-line managers from all disciplines and functions, those in nursing represent the largest group. Because integration of work activities occurs at the clinical level first, nurses are often the first group to be assigned to programs (Leatt et al., 1994). In some hospitals, first-line nurse managers continue to hold patient care manager positions and supervise staff from other disciplines as well as
nursing. Therefore, only first-line nurse managers were sought for their experiences in program management. But the findings of this study may have implications for other managers as well.
CHAPTER 2: REVIEW OF THE RELATED LITERATURE

A comprehensive literature review was undertaken in order to determine the state of knowledge on the topic of first-line nurse managers' experience of program management in hospitals and to identify research gaps. The literature reviewed pertained to program management, first-line nurse managers, first-line nurse managers' perception of their role, first-line nurse managers' experiences in the role, trends in the role, and strategies for success in the role. After the method used to conduct the review is described, the review findings will be presented. Then conclusions about the literature as a whole, as well as the purpose of the present study, will be articulated.

Identification of Studies

The CINAHL, Health, and Medline databases were searched, as well as the business databases. Studies identified through this strategy were included in the review if they were (a) research-based and concerned perceptions of people in the first-line nurse manager role, (b) about managing in program management, and (c) published in English. Eighteen citations met these inclusion criteria.

Systematic Review of Studies

A coding form was used to collect information from 12 of the 18 studies identified. Six of the studies reviewed could not be coded as the information of interest was not noted. The form reported the following information: (a) author(s), (b) publication date, (c) design, (d) purpose and theoretical perspective, (e) site and sample, (f) procedure(s), (g) analysis, and (h) findings related to the role (see Appendix A).

A systematic review of the 18 research-based studies revealed that the findings related to the role could be grouped according to the following categories: (a) the first-
line nurse manager role, (b) program management as a context for managing, and (c) strategies for success in the role. The substantive findings of the studies will be described in terms of these categories.

Findings of the Review

Overview of the Studies

Eleven of the 18 studies took place in Canada, 6 were situated in the United States, and 1 was situated in Australia. Six of the 18 studies used a qualitative design. An exploratory design was used in those 6 studies, 4 of which more specifically used an exploratory descriptive design. Five of the other studies used a survey design, one study was an ethnography, and six were case studies. Seven studies noted the use of a theoretical perspective or conceptual model. These included management models (3), work role inventories (2), quality of worklife framework (1), and symbolic interactionism (1). Where hospitals were chosen as sites, all 10 were acute care sites. Although 3 studies described details pertaining to organizational context, such as "decentralized nursing departments" (Everson-Bates, 1992), "over 100 beds" (Duffield et al., 1993), and "public, private or federal" (Miller & Heine, 1988), these descriptions did not define the type of organizational design or the degree of integration of responsibilities.

Substantive Findings of the Studies

Role of First-Line Nurse Manager

First-line nurse managers described multiple and overlapping roles rather than one single role (Baxter, 1993; Coulson & Cragg, 1995; Duffield et al., 1993). The description was similar to those used to describe the roles of managers both in Mintzberg's (1994b) and Quinn's models of managing (Quinn et al., 1990). Nurse managers described their work within the context of all 10 managerial roles in Mintzberg's model (Baxter; Coulson
The 7 roles that were most familiar to the managers included monitor, disseminator, entrepreneur, disturbance handler, resource allocator, leader, and liaison (Baxter). Laschinger and Shamian (1994) used Quinn's managerial model (Quinn et al., 1990) to measure nurse managers' perceptions of self-efficacy. Nurse managers scored high on all the roles, which indicated congruence between managing in general and managing in health care.

The key management roles that appeared most frequently in 6 of the 12 research studies reviewed were managing fiscal and human resources and leadership (Baxter, 1993; Coulson & Cragg, 1995; Duffield et al., 1993; Mark, 1994; Miller & Heine, 1988; Westmoreland, 1990). Duffield et al. emphasized the importance of the staff management role.

The leader role influenced the relationship between the nurse manager and staff more than any other role (Baxter, 1993; Coulson & Cragg, 1995; Duffield et al., 1993). Major components of the leader role were staffing, coaching, facilitating, directing, developing, setting directions for the unit through role modelling, establishing the philosophy, objectives, and standards of practice for the unit, and creating an environment in which people were motivated (Baxter; Coulson & Cragg). Leadership required skills in communication, research, and decision making.

Nurse managers also assumed the position of nerve centre for information moving in and out of the unit (Coulson & Cragg, 1995), and for deciding what information was passed on, and in what form (Baxter, 1993; Duffield et al., 1993). The informational role also required skill in communication as well as interpersonal relations (Coulson & Cragg; Duffield et al.). Development of the interpersonal component of the role was considered
essential, since the first-line manager role was performed within a web of formal and informal relationships (Baxter; Coulson & Cragg). Conflict manager, disturbance handler, contingency manager, and problem solver were all described as important roles (Baxter; Coulson & Cragg; Duffield et al.).

The following factors influenced the roles in which first-line nurse managers chose to engage: (a) situational requirements, such as whether an issue affected the unit internally or whether it influenced the external environment, and whether the situation demanded flexibility or control (Laschinger & Shamian, 1994); (b) the skills and education of the manager (Baxter, 1993; Coulson & Cragg, 1995); (c) organizational characteristics such as organizational culture and the degree of standardization and formalization and the number of levels of nursing administration (Laschinger & Shamian; Miller & Heine, 1988); (d) the chief nursing executives' opinion of the importance of the first-line manager role (Mark, 1994); and (e) the expectations of superiors, subordinates, and managers themselves, as well as the influence of managers' past, current, and anticipated experiences (Westmoreland, 1990).

Dual accountability, Miller and Heine (1988) reported that first-line nurse managers have a dual accountability for both the professional dimension, which included the quality of nursing care, and the corporate dimension, which included responsibility for fostering the philosophy, goals, and policies of the organization at the staff level. Mark (1994) reported a number of trends in nurse managers' dual accountability in her analysis of several national U.S. surveys of nurse managers and chief nurse executives. Chief nurse executives viewed the nurse manager role as being of increasing importance in achieving organizational goals. Five administrative activities that contributed to the
corporate dimension of the role were (a) making final decisions about staff hiring, firing, and promotion; (b) making final salary decisions; (c) determining staffing standards; (d) adjusting staffing levels; and (e) being accountable for unit budget deficits. However, despite the increasing importance of the corporate dimension of the role, Weaver, Byrne, Dibella, and Hughes (1991) reported that first-line nurse managers found it difficult to actively engage in operational and human resource management activities, although they believed in the value of doing so. In the researchers’ 1986-1987 survey of 13 first-line nurse managers in an acute care hospital in New Jersey, they discovered that with regard to managing operations and human resources, what the manager actually was doing fell short of what that person believed should be done. Regarding those activities that contributed to quality patient care, managers actively performed the skills they believed in performing.

Scope of responsibility. Although no research studies were identified that focused on the role of first-line nurse managers working in program management, one empirical study described an expanded role for first-line managers. Everson-Bates' (1992) qualitative study was an ethnographic analysis of semistructured, 1-2 hour interviews with 16 managers, 4 directors of nursing, and 2 vice presidents for patient services from two acute care hospitals in the United States. Everson-Bates defined the expanded role to include "24-hour accountability for one or more clinical areas or programs and decisional authority concerning budgetary and personnel issues, standards of practice, and development of the unit(s) to support working relationships. Each manager had line authority for all unit/program professional and support staff, and reported to a director of
nursing" (Everson-Bates, p.32). This description is similar to how the role of the manager is described in the program management literature.

In addition to the Everson-Bates study, six case studies were reviewed that described program management implementation in six hospitals (Bain et al., 1994; Bruner & Barker, 1994; Harber, 1994; MacLeod, 1994; Monaghan, Alton, & Wojtak, 1994; Pond & Herne, 1994). These studies included anecdotal data as well as data about the first-line manager role drawn from program management implementation evaluation processes that included surveys, interviews, and focus groups. Findings of the program management case studies and the Everson and Bates’ study about managers’ expanded role were integrated in the following discussion of the five-part managerial role described by Everson-Bates.

Everson-Bates (1992) described the expanded role of first-line nurse managers in terms of five parts, one part task and four parts process, the latter of which was further specified as social control, resourcing, coordination of work, and managing change. The task part of the role consisted of tracking information (Harber, 1994) to monitor the program’s strategic and operational performance (Everson-Bates; Hutchison, 1994). The information tracked included budget sheets, personnel forms, workload measurement, and staff schedules (Harber, 1994). Also included under tasks were preparing and typing minutes.

Social control, the first of four management processes, pertained to establishing, monitoring, and maintaining standards and service needs including clinical, fiscal, or personnel policies (Everson-Bates, 1992; Harber, 1994). Staff compliance with standards
was managed by coaching, counselling, supporting, evaluating, and appraising performance (Everson-Bates; Harber; Pond & Herne, 1994).

**Resourcing**, the second process, was broadly defined as the "process of providing emotional support, goods, and services for staff" (Everson-Bates, 1992, p. 33) that were essential for providing patient care. Staff placed the highest value on managers' resourcing role. Being visible was an important part of resourcing because managers needed to be available to offer support to staff and to respond to issues. Managers reported experiencing conflict when trying to be visible to both staff and administration.

The third identified process consisted of coordinating the work of all team members and stakeholders across functional lines, across the program, and between programs to ensure team effectiveness and continuity of care (Everson-Bates, 1992; Harber, 1994; Harber & Eni, 1989; Hutchison, 1994; Monaghan et al., 1994). First-line managers needed to be competent in translating, interpreting, and negotiating so that they could communicate effectively to coordinate work. Managers in program management required a broader perspective than those working in functional structures. Sensitivity to other realities developed through acquiring new values and priorities that were not limited to nursing (Everson-Bates).

Facilitating change was considered to be the fourth managing process even though it involved activities included in the three previously described processes. Managers prepared staff for change and helped them through difficult change by engaging people in talking about all aspects of the change and through developing trusting relationships with staff (Everson-Bates, 1992). In light of the link between trusting relationships and effective managing, the scope of responsibility, namely, the number of staff one manager
is responsible for relating with, becomes critical to a manager's success. The evidence supporting the importance of this relationship helps us understand calls in the literature to be cautious about increasing managers' scope of responsibility for more than one nursing unit (Baxter, 1993; Miller & Heine, 1988; Nadeau, 1991). The manager's role in advocating for staff and patients may be undermined without further study of how a greater scope of responsibility would influence managers' effectiveness (Baxter).

However, first-line managers continue to assume a greater role scope. Everson-Bates (1992) and Harber (1994) describe assuming a greater role scope as a critical process of becoming enculturated. Cultural change is particularly important when staff reporting relationships change to another discipline (Harber). More detailed descriptions of the enculturation process include a change in frame of mind that requires managers to accept a flexible perspective, flexible relationships, and the flexibility to approach problems multidimensionally (Harber). They must also learn to accept trade-offs rather than expect perfect solutions, as well as learn to be comfortable with ambiguity. The process entails a change in values and beliefs that lead managers to become sensitive to new realities (Leatt et al., 1994) and a change in the ways managers view themselves, for example, as program directors rather than nurses, in order to foster a concern for broader issues (Bain et al., 1994).

The enculturation process cited in the literature may indicate that program management leads to a new way of being a nurse manager. Being different requires nurse managers to make fundamental changes in their values, beliefs, and assumptions about the role. To perform the role in program management may require more than doing more things or different things. It may require a new way of looking at the role. Harber (1994)
went as far as suggesting that program management may not be about trying to achieve
the perfect structure but rather about hiring or developing the perfect manager.

**Program Management as a Context for Managing**

For the purposes of this review, the literature pertaining to program management
was considered to reflect two phases of program management’s history. An early group
of case studies published between 1980 and 1995 described the restructuring process that
culminated in the implementation of program management
(Harber, 1994; Harber & Eni, 1989; Hutchison, 1994; Leatt et al., 1994; Monaghan et al.,
1994). These studies examined the reasons for change and the change process hospitals
engaged in, early trends concerning the influence of program management characteristics
on managers, the impact of program management implementation on cost savings and on
sharpening the organizations’ focus on the needs of patients. Studies published since
1995 analyzed the impact of ongoing changes on program management (Acorn &
Crawford, 1996; Baumann et al., 1996; Gelinas & Manthey, 1997; Keith, 1996) and
evaluations of the long-term impact of program management on the quality of patient
care (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovanetti, Hunt, Rafferty &
Shamian, 2001; Britain & Langill, 1997; Leatt, Baker, Halverson, & Aird, 1997; Miller &
Miller, 1997). Literature from both time frames described program management as a
context for managing.

The nature of managing is one of the aspects of organizational functioning that is
altered as a result of the process of redesign. Organizational design is defined as
"the manner in which authority, accountability, information, and rewards are distributed
to improve the efficiency and effectiveness of the organization" (Leatt et al., 1994, p. 1).
Hospitals undertake redesign when performance no longer meets accreditation or peer standards, when funding is cut, when leadership changes, or when service needs evolve (Leatt et al.).

In Canada, program management design is a popular model as a "long-term efficiency and cost-saving strategy. ....It was usually coupled with a reduction of middle management" (Baumann et al., 1996, p.9). It was implemented to encourage greater creativity in organizational planning by helping people "to step out of traditional thinking patterns in order to find better and more affordable ways to serve customers" (Miller & Miller, 1997, p. 47).

Program management is at one end of the continuum of organizational configurations, and the traditional hospital structure is at the opposite end (see Figure 1). In traditionally structured hospitals, responsibilities are differentiated by function "with the major organizational units being departments that represent the different professional and non-professional functions" (Chams & Smith Tewksbury, 1993, p. 29). Examples of professional functions are nursing and physiotherapy, and examples of non-professional functions are housekeeping and maintenance. Functional structures such as these work best in small hospitals that operate in a relatively simple environment. Program management, at the opposite end of the continuum, "emphasizes integration of function within program divisions" (Chams & Smith Tewksbury, 1993, p. 28).
Isaak and McCutcheon’s 1997 evaluation of program management implementation confirmed Kanter’s 1983 analysis that internal structure had an important influence on people working in an organization, especially on their performance:

“Structure can influence the information people receive and their perspective on it, ultimately influencing their priorities and approach to change” (p. 34). Charns & Smith Tewksbury (1993) recommended that people holding leadership roles in program management needed, “specific skills, abilities and orientations, along with the appropriate systems and organizational support” (p. 44). Therefore, it is important to match the individual and the organizational structure.

The case studies published between 1980 and 1995 cited different reasons for implementing change to program management. It is assumed that these reasons became managers’ goals in the process of implementing program management. Reasons included
“operating deficits, breakdown in relationships with medical staff and/or the desire to include medical staff in management decisions; the desire to increase accountability for decision making related to the delivery of patient care services; new C.E.O.s [Chief Executive Officer] with a mandate to restructure” (Leatt et al., 1994, p. 85). Leaders also chose program management to promote decentralized decision making (Leatt et al., 1994).

The case studies also highlighted challenges facing people in leadership roles that contributed to the context in which managers found themselves. At the onset, new information and human resources systems, as well as professional governance structures needed to be developed in such a way that the programs could call on the systems to help meet program goals. (Harber, 1994).

Organizations counted on managers to play a key role in promoting decentralized decision making by helping staff develop the necessary skills and by creating an environment in which decision making was rewarded (Bruner & Barker, 1994; Leatt et al., 1994). To enhance the speed of decision making, some organizations created a very flat program structure that had implications for managers’ workload and the availability of support and coaching (Bruner & Barker). The effort to flatten the organization led to the elimination of professional departments, and, thus department heads. The nature of the relationships between members of the senior management team and program managers needed to be well established in order to ensure a balance between corporate and organizational goals (Britain & Langill, 1997; Harber, 1994).
Strategies for Success

The literature identified strategies and factors that enhance the success of first-line nurse managers. No strategies for success were linked to different organizational structures. Strategies were grouped according to the following topics: a) understanding the nature of the role, b) being appropriately prepared for the role, and c) understanding the organizational factors that contribute to first-line managers' success and effectiveness in the role.

Understanding the nature of the role. Baxter (1993), Coulson and Cragg (1995), and Duffield et al. (1993) recommended that managers understand the components of this multidimensional role in order to integrate the roles successfully. Moreover, Baxter suggested that if managers understood the true nature of managing, namely, that management work was less systematic, reflective, or organized, and more informal and reactive than previously thought they would be able to adjust to the unpredictability of the role more readily. It was thought, that if managers understood the nature of the role in greater depth, their evaluation of success would be based on realistic criteria that stem from the true nature of the role.

Westmoreland (1993) reported that when first-line nurse managers shared their experiences with each other, it helped them realize that certain problems were not unique to them or a result of personal inadequacies. Consequently, this realization contributed to their feelings of success: "Sharing stories is also empowering because shared practices and common meanings are revealed that make visible nursing expertise" (Westmoreland, p.64). It was assumed that if managers could clearly articulate their contribution to the effectiveness of the organization, they would feel a greater sense of personal success.
Donner and Wylie (1995), Duffield et al. (1993), Mark (1994), Miller and Heine (1988), and Nadeau (1991) identified the following interventions that would enhance role clarity and reduce role conflict and ambiguity, which in turn would contribute to greater feelings of success for managers: (a) ensuring that managers' role descriptions reflected the role accurately and were revised frequently enough to reflect the evolutionary nature of the role, (b) holding discussions with superiors to clarify expectations and discuss differing expectations, and (c) clearly communicating standardization (regularly patterned rules and routines, e.g., norms) and formalization (written policies and procedures).

Coulson and Cragg (1995) and Duffield et al. (1993) reported managers' confusion related to the extent and nature of their involvement in patient care and patient care decision making. Managers believed credibility as a nurse was required to succeed in the manager role. However, the dilemma emerged as greater emphasis was placed on the administrative focus of day-to-day operations, leaving them with less time for clinical involvement of any kind. This shift toward an increasing emphasis on the corporate dimension of the role created a situation in which managers needed more help interpreting two competing paradigms: patient/caring and administrator/economic (Westmoreland, 1993).

Researchers supported inconsistent views related to the advantages and disadvantages of this shift. Coulson and Cragg (1995) viewed the shift toward an administrative focus positively. They believed that progress toward the shift came from further education and growth within the role. Baxter (1993) anticipated that the administrative focus would make up a greater portion of the manager role in the future.
Alternatively, Westmoreland (1993) discovered that being a nurse was an integral part of being a nurse manager. Managers described giving any degree of patient care as self-affirming. Nursing practice contributed to personal learning and development, and to a sense of competency, adequacy, and wholeness. This finding has not been explicated in previous research. Giving patient care was also a strategy for connecting with oneself and others. It helped managers become focused and grounded, established rapport with challenging patients, helped managers to be role models for staff and helped them show caring when staff were overloaded, and maintained empathy with staff nurses. Baxter, Coulson and Cragg, Donner and Wylie (1995), and Duffield et al. (1993) agreed that if first-line managers and their supervisors clarified and agreed on the nature of managers' involvement in the clinical aspect of their role, managers' job satisfaction would increase, and managers could measure their success in this area more easily against clear performance criteria. Since first-line managers report to people who hold many different titles, for the purposes of this study, the word supervisor will be used to indicate those people to whom managers report directly.

Supportive relationships with supervisors, colleagues, and staff contributed to managers' success in the role (Coulson & Cragg, 1995; Donner & Wylie, 1995). Westmoreland (1993) illuminated the pattern of connectedness, relatedness, and networking in descriptions of the relationship-oriented aspect of the role. Managers depended on their interpersonal skills for success in their informational, decisional, interpersonal, and professional roles, since, for most managers, these roles were performed within a web of relationships (Westmoreland). Relationships also provided the context for managers' personal development in the role.
Being prepared for the role. Managers and others identified that attending to knowledge and skill development, in addition to clinical expertise, resulted in greater success in the role (Baxter, 1993; Coulson & Cragg, 1995; Mark, 1994; Nadeau, 1991). They noted that key areas for knowledge and skill development were budgeting and financial management, human resource management and staff development, problem solving, power sharing and participative management, and computer skills. Management education directed explicitly to nurse managers was required to orient managers to new roles and to provide continuous updating (Donner & Wylie, 1995; Miller & Heine, 1988). Managers in Coulson and Cragg's study perceived that success would be enhanced with greater assertiveness, conflict resolution and negotiation expertise, as well as political skills.

First-line nurse managers' success within an ever-increasing scope of responsibility was facilitated by strong interpersonal and communications skills (Donner & Wylie, 1995; Everson-Bates, 1992). Factors that contributed to managers' success included being flexible, acquiring clinical knowledge and mastering necessary skills, being prepared at the master's level, having political savvy, having access to mentoring relationships early in the role, having ongoing peer preceptors and opportunities to watch others engage in effective problem solving, developing a strong ego, having a desire for power, and having enough control to make change (Donner & Wylie).

Organizational factors that contribute to managers' success. Baxter (1993), Coulson and Cragg (1995), Donner and Wylie (1995), Duffield et al. (1993), Miller and Heine (1988), and Nadeau (1991) identified the following organizational factors that contributed to people's success in the role: reasonable workloads; adequate clerical
support; computerization of routine functions; adequate and reliable information systems; decentralized decision making to the first-line manager level, including organizational support for staff decision making; matching managers' accountability with greater authority; authority to employ and terminate staff at the unit level; senior management's valuing of the role of first-line managers; fair compensation; recognition, as well as encouragement and support, from supervisors; opportunities for networking and research activities; and access to an updated library of managerial resources. Based on the findings of their study, Donner and Wylie recommended redesigning the organizational climate to enhance manager success. Specifically, they recommended "making it more supportive through improved two-way communication, positive feedback and reinforcement, and the creation of an atmosphere that fosters trust, value and self-esteem.... Greater peer collegiality and cohesiveness would help nurse managers gather support, be more proactive in the organization, assume more control and be a positive influence" (pp. 42-43).

Organizational change affected managers' attitude toward their role and feelings of success. Donner and Wylie's (1995) findings indicated that managers experienced stress and anxiety during organizational change as a result of a number of factors: altered reporting relationships; frequent changes in reporting relationships in a short period of time; job insecurity, especially when reporting to a non-nurse who may not understand or value the manager role; dramatic and rapid change and anticipation of even greater change in the future; role conflict and ambiguity related to increased administrative activities; the pressure to be more educated; greater span of control; lack of time to facilitate staff development; loss of friends through downsizing; and loss of personal and
family time. Managers also struggled with concerns over quality of care, an organizational emphasis on economics perceived to be greater than that focused on patient care, how to be accountable without adequate authority, how to be visible to both staff and management, and whether to stress management or leadership in role activities.

Summary

The literature described the role of first-line nurse managers as one consisting of multiple and overlapping sub-roles (Baxter, 1993; Coulson & Cragg, 1995; Duffield et al., 1993) and were congruent with managing in general (Baxter; Coulson & Cragg). The key management roles that appeared most frequently were managing fiscal and human resources and leadership. The leader role was considered essential because it influenced the many relationships first-line managers had, in particular the relationship between the nurse manager and staff (Baxter, 1993; Coulson & Cragg; Duffield et al.). The following factors influenced the roles in which first-line nurse managers chose to engage: (a) situational requirements (Laschinger & Shamian, 1994); (b) the skills and education of the manager (Baxter, 1993; Coulson & Cragg, 1995); (c) organizational characteristics (Laschinger & Shamian; Miller & Heine, 1988); (d) the chief nursing executives' opinion of the importance of the first-line manager role (Mark, 1994); and (e) the expectations of superiors, subordinates, and managers themselves, as well as the influence of managers' past, current, and anticipated experiences (Westmoreland, 1990).

Miller and Heine (1988) reported that first-line nurse managers have a dual accountability for both the professional dimension of the role, which included the quality of nursing care, and the corporate dimension, which included increasing responsibility for fostering the philosophy, goals, and policies of the organization at the staff level.
However, despite the increasing importance of the corporate dimension of the role, Weaver, Byrne, Dibella, and Hughes (1991) reported that first-line nurse managers found it easier to engage in those activities that contributed to quality patient care than to actively engage in operational and human resource management activities.

No research studies were identified that focused on the role of first-line nurse managers working in program management. Several related studies described the role in terms of 5 processes, including social control, resourcing, coordinating work, managing change, and doing tasks. As a context for managing, program management was usually implemented at the same time middle management positions were eliminated and the expectation that managers view the role in a new way was introduced. To encourage a change in perspective, the design usually meant that all professional and support staff were integrated into the programs and reported to first-line managers directly. The realignment of staff and other changes were intended to encourage first-line managers to promote decentralized decision making.

The literature indicated several strategies for success in the role, however, no strategies were linked to different organizational structures. The following strategies appeared in the literature; understanding the nature of the role, being appropriately prepared for the role, and having certain organizational supports available.
Purpose of the Study

The purpose of this study was to describe the experience of managing from the perspective of first-line nurse managers working in program management.
CHAPTER 3: CONCEPTUAL FRAMEWORK

The conceptual framework chosen for the study was Mintzberg's model of managing (Mintzberg, 1994a, 1994b). This model, which blends what we already know about what managers do into one framework, was chosen because with respect to managing, the whole is greater than the sum of the parts. Although the literature revealed studies that looked at certain components of the role, Mintzberg's model addresses the relationship between the components. Two assumptions underpin the model. First, for the job to be understood properly, the integrated job of managing must be described as a whole. It cannot be viewed simply as a set of independent parts, because the roles cannot be separated behaviourally (Mintzberg, 1994b). Second, despite the propensity of individual managers to favour a certain dimension of the role, success in the role depends on managers' engaging in all the interactive aspects of the role.

The model creates an image of the manager's job from the inside out, beginning at the centre with the person, namely, with his or her set of values, experiences, knowledge, competencies, and the preferred style that he or she brings to the job (see Figure 2). The frame represents the perspective that the manager assumes to perform the job (see Figure 3). The components of the frame are purpose, perspective, and positions. Purpose is what the manager is seeking to do with the unit. The purpose might include creating a unit, maintaining it, or adapting or recreating it in response to some new condition. Perspective is the overall approach to management and includes vision and culture. Positions, which are more concrete than purpose and perspective, include strategy, or structures, or specific ways of doing work. The conceiving role emerges from the frame. Conceiving
incorporates "thinking through the purpose, perspective, and positions of a particular unit to be managed over a particular period of time" (Mintzberg, 1994b, p. 13).

Figure 2. The Person in the Job (Mintzberg, 1994b, p. 12)

The person in a particular job with a particular frame manifests the agenda of the job by addressing specific issues and scheduling the allocation of managerial time on a daily basis (see Figure 4). The agenda is also manifested in the prioritization of issues. The sharper the frame, namely, the more explicit the purpose, perspective and positions, the more integrated the issues, and the clearer the priorities. The next three concentric circles in the model that surround the frame represent the three levels of management (see Figure 4). Mintzberg contends that managers need to participate in all three levels to be well rounded. The levels begin with the information level, which is the least tangible level, then proceed to the people level and finally to the outside or action level. These three levels reflect the actual behaviours managers engage in to do their jobs. The ultimate
objective of managerial work and of the functioning of any organizational unit is taking action. Managers can take action themselves directly, or indirectly through other people, or even more indirectly through information that will influence other people to take the necessary actions.

Conceiving

Figure 3. The Frame of the Job
(Mintzberg, 1994b. p. 13)

The informational behaviours, which are the most indirect ways to manage action, can be grouped into two broad types, communicating and controlling. Communicating refers to the collecting and disseminating of information. Mintzberg's research has shown that oral and informal information play a more critical role in managing than formal communicating, that is, information generated by computerized reports. Managers' communicating role leads them to be described as the "nerve centre" of the unit. The controlling role describes manager's efforts to use information in a directive way to influence other people's actions. Controlling is carried out in three ways: developing systems, designing structures, and imposing directives.
Managing through people brings managers one step closer to action. Other people become the means to get things done. Managers are described as the “energy centre” at this level. People-level roles such as leading occur internally, within the unit being managed. Linking occurs with people outside the unit being managed. Managers lead at the individual, group, and unit levels. The manager is both an advocate of the unit’s influence outside itself, and in turn, a recipient of much of the influence exerted on it from the outside. Managers must regulate the external influence to protect their units. The process of regulating the external influence on the unit is described as buffering.

Managers also manage actively through their own direct involvement in action. Managerial “doing” is getting closer to the action their employees engage in. Ultimately managers are always at least one step removed from employee action that constitutes the business of the unit. “Doing inside” involves projects and problems. “Doing outside” refers to deals and negotiations.

The job of managing cannot be practised as a set of independent roles. Managers are the ones who have the authority to commit the resources of their unit. They are the nerve centres of its information processing as well as the energy centres of its activity, not to mention the conceptual centres of its strategy. All around the circles, therefore, action connects to people, who connect to information, which connects to the frame. These components form one job and cannot be separated, because they are complementary.

According to Mintzberg (1994a, 1994b) when the components of managing are well integrated, the job is well rounded. However, managers do not participate in all of the components of managing with equal emphasis. Managerial work varies, according to
the needs of a particular job and the approach of its particular incumbent. Managers in different contexts have to emphasize different roles. Style is considered to affect managerial work in three ways: which roles a particular manager favours, how he or she performs these roles, and what kind of relationship exists among the roles. Examples include a conceptual style of management, which focuses on development of the frame, an administrative style, which concerns itself primarily with controlling, an interpersonal style, which favours leading on the inside of the unit or linking on the outside, and an action style, which is concerned mostly with participating directly. In short, context and personal predisposition interact with the various components of the job to create the way managing is practised.

Figure 4. A Model of Managerial Work Rounded Out
(Mintzberg, 1994b, p.23)
CHAPTER 4: METHODS

Design

A descriptive qualitative approach was used in this study of first-line nurse managers in program management. In such a design, specific questions for data gathering are determined by the gaps in knowledge that need to be filled and, by the investigator's conceptual framework (Parse, Coyne, & Smith, 1985). A qualitative design was chosen to capture the complexity of the first-line nurse manager's role because this approach provides rich descriptions. Without an understanding of how managers experience their role, we can know only about separate dimensions of the job. An understanding of the gestalt of the roles would fill in the detail missing in the literature related to the integration of values, experiences, knowledge, activities, and situations that comprise managing as a whole. Although there is a substantial body of knowledge about first-line nurse managers, no systematic study of the specific population of first-line managers who work in program management was found in the literature. A descriptive study of known variables in unknown populations provides descriptions of the phenomenon to answer the research question (Brink & Wood, 1994). In this study, in-depth descriptions were obtained regarding first-line nurse managers' perspective about (a) the nature of the role, (b) how success is defined and achieved, and (c) the day-to-day experiences of managers.

Mintzberg's model of managing (1994a, 1994b) was chosen as the framework for this study because it allowed for a description of the nature of managing in program management, and for some understanding of people in the job from their own point of view. The descriptive method is consistent with Mintzberg's model
because it allows for an elaboration of the context of the phenomenon being studied. Context is considered an important factor in Mintzberg's model.

The main data collection approach used in this descriptive study was the long interview as described by McCracken (1988). It is a focused method of inquiry that takes place between researcher and participant, and is appropriate for this study because it provides in-depth dialogue with individuals. McCracken's method was also chosen because it is consistent with the descriptive method that yields findings based upon conversations and observations (Parse, Coyne, and Smith, 1985). It also provides opportunities to "glimpse the categories and logic by which the individual sees the world and ...to see the content and pattern of daily experience" (McCracken, p. 9), namely, "to see and experience the world as they do themselves" (McCracken, p. 9). Moreover, McCracken sees the long interview as a method in which individuals' experiences are examined in order to generate a clear understanding of the experiences of a population. It promotes the goal of qualitative research to isolate and define categories so that "patterns of interrelationship between many categories emerge rather than the sharply delineated relationship between a limited set of them" (McCracken, p.16).

Site, Sample, and Sampling Procedure

Site

This study took place in an acute care hospital in the greater Toronto area. Program management was introduced at this site in order to promote significant integration of both patient care services and support services to the programs. This site met the criteria for program management identified for the purposes of this study: (a) There was an absence of traditional professional departments, (b) first-line managers
reported to non-nursing or nursing supervisors, (c) authority was decentralized to the first-line manager for human and financial resources, and (d) first-line managers supervised nursing and non-nursing professionals. Although the general climate during the interviewing process was affected by the considerable disruption that other health care institutions in the city faced, the study site was not experiencing a merger with another hospital nor expecting a closure. However, the effect of system disruption and fear of the future may have contributed to the overall environment at the time of the study. A change in hospital executives' management philosophy was another factor that came to light during the interviews, and may have affected the nature of the organizational climate. The new philosophy embraced a greater degree of centralized decision making, and valued interdependence of programs instead of the original intent to create independent programs.

Sample

A small sample of subjects was deemed appropriate in order to study managers' experiences in detail (McCracken, 1988; Sandelowski, 1995). To ensure that the subjects were unknown to the researcher and had the experience of interest, purposive sampling was used (Bernard, 1994). A purposive sample of 6 first-line nurse managers was thought to be sufficient to describe what managing in program management was like for first-line nurse managers (McCracken). This number allowed the researcher to gather enough experiences or incidents to recognize "what is there and what can be made out of the data" (Sandelowski, p. 180). Inclusion criteria were:

1. The manager was a registered nurse and currently worked full-time in the position of first-line manager in program management.
2. The nurse manager had 24-hour responsibility for more than one patient care unit or area.

3. The nurse manager has acted in the role for at least one year. Managers who had not yet experienced a year of working in program management may not have had sufficient time to reflect on their experiences.

4. The nurse manager had to volunteer willingly to participate in the study.

The demographic profile completed at the end of each interview provided a description of participants’ responsibilities. The number of units or areas managers were responsible for ranged from 2 to 11 with the average number being 5. The number of staff reporting directly to the managers ranged from 18 to 190 with an average of 87. The number of positions or full time equivalents (FTE) ranged from between 17 and 135, with an average of 50 FTE’s. Participants managed a budget that ranged from less than a million to between 6 and 10 million dollars.

Sampling Procedure

After the University of Toronto Office of Research Services and the hospital ethics committee granted approval to conduct the study, the researcher explained the purpose of the study to the Vice President in a letter of introduction (see Appendix B) that included the criteria for potential participants and a request that the VP ask the managers if they would be willing to participate in the study. A 2nd letter of explanation was sent to a total of 13 managers (see Appendix C). Those willing to participate were asked to call the researcher directly to arrange an interview at their convenience. Six managers volunteered. While the scope of 2 of the managers was broader than the other 4 who reported to them, together their roles had evolved so that they shared the first-line
manager responsibilities. Both categories of manager were included to provide a complete picture of first-line managing at the study facility. Titles of all hospital personnel mentioned in the study were changed to ensure anonymity.

Data Collection Procedures

The primary data collection strategy was the long interview outlined by McCracken (1988). According to McCracken, the long interview is designed to allow participants to tell their own story in their own words. The long interview is useful because it provides a clear understanding of the beliefs and experience of the participants and helps situate participants' descriptions in their context. To elicit the participants' own point of view, the opening questions are phrased in a general and non-directive manner. These general questions are what McCracken calls "grand-tour questions" (p.35). These questions are designed to elicit responses from the participants that take the researcher on a tour of the world from their perspective (see Appendix D).

In the current study, the long interview involved one session with each participant that lasted approximately 1-1 1/2 hours. The participants were asked to suggest a convenient time (either during or after business hours) and their preferred location for the interview. All participants chose to meet with the investigator during business hours in their own office, to ensure privacy. The other form of data collection used was a demographic profile (see Appendix E). The demographic data were collected at the end of the interview so as not to interfere with the openness of the managers' responses at the beginning of the interview. Demographic information was gathered regarding the responsibility of the manager so that readers could compare their own situations to the context of the study participants.
Before asking any questions at the interview the researcher reviewed the nature of the study, the interview process, and the estimated length of the interview with the participants by using the letter of explanation (see Appendix C). The researcher asked if the participants had any questions. Informed consent, including consent to audiotape record was obtained from all subjects (see Appendix F). A copy of the signed consent was given to each participant. The participants were reassured that the researcher was interested in their own perspectives and that the information they provided would be kept strictly confidential.

The interviews were audiotape recorded to facilitate the flow of the interview. In case anything should happen to the tape recorder, the researcher took notes so that the interview could be reconstructed afterwards. Also the researcher noted any points that were to be revisited at the end of the interview for further exploration.

The interview began with the grand-tour question, "Tell me what managing is like in program management". Throughout the interview, the researcher used floating prompts to sustain dialogue and to encourage the subject to elaborate. In this study floating prompts included (a) gestures such as nodding and raising one's eyebrows to show interest, (b) repeating one or more of the participant's key words in a questioning way, and (c) using the phrase, "Can you tell me more?" to prompt the participant to expand upon key words and utterances.

The researcher also used planned prompts but only when conversation stemming from the grand-tour questions ended, and when further information about the categories identified in the literature and conceptual framework did not emerge spontaneously in the course of the interview. Planned prompts took the form of contrast and category
questions. According to McCracken contrast questions are designed to give participants a point from which to begin discussion of something that has not already been discussed (1988). They give participants something to compare or contrast in their minds that should generate further thinking about their own situations. Examples of contrast questions used in the current study were, "What is it like now?", "How is it different?" and, "Do you think it's different because of program management?". Category questions refer to categories or relationships stemming from the literature review and conceptual framework that the researcher wants to investigate. They were used in this study only after subjects finished responding to the grand-tour and contrast questions to ensure that all areas of interest were discussed during the interview. They were not used if all areas of interest were addressed spontaneously during the interview. Examples of category questions in the current study included "What is succeeding as a manager like in program management?", "What issues are you engaged in now?", and "What is your life as a manager in program management like?" (see Appendix D).

The researcher concluded each interview by asking the question, "Is there anything else you would like to tell me?" All participants were given a contact number for the researcher, should they have any further questions stemming from the interview. The researcher obtained permission to call the participants should clarification of data be required.

Two pilot interviews were conducted before the study began to determine the type of data that might be generated by the interview questions. These interviews were conducted at a different site. Consequently, some minor wording changes were made to the interview questions to more accurately reflect participants' previous management
experience. The data from the two pilot interviews were not incorporated into the data analysis.

**Researcher's Perspective**

From her position in a clinical nursing role, the researcher observed managers during the implementation of program management at an acute care hospital. While the impact of the changes brought about by program management implementation affected all staff in the organization, people in the first-line nurse manager role and the role itself, seemed to the researcher to be significantly affected. In turn, the staff felt unsettled and this appeared to affect the quality of care. It was concerning to observe managers struggling with the impact of change, which had not been predicted by others in the organization.

**Informed Consent**

The Vice President of Professional Affairs shared the letter of explanation with the managers and invited them to participate. When those interested called the researcher, she (a) explained the study using a letter of explanation (see Appendix C) which outlined what managers were consenting to, (b) allowed them to ask questions about the study and their participation, (c) obtained their verbal permission to participate, and (d) arranged an interview. Before asking any questions at the interview, the researcher (a) reviewed the details of the study with the potential participants using the letter of explanation again (see Appendix C), (b) provided the potential participants with a written copy of the letter, (c) informed the potential participants of the risks and benefits of participating in the study, (d) informed the potential participants that their decision to participate in the study was their own, (e) informed the potential participants that they could refuse to answer
questions or withdraw from the interview at any time, (f) explained to potential participants that the information provided was confidential and would not be shared with senior management at the study site, with the exception of information suggesting that the safety of the individual or others was threatened, (g) allowed the potential participants to ask questions, (h) had the potential participants sign two copies of the consent (see Appendix F), and (i) provided the participants with one copy of the signed consent while keeping the other in a secure location separate from the data.

**Risks and Benefits**

The greatest risk to the participant was considered to be in the area of confidentiality. Steps taken to ensure confidentiality will be discussed in the next section. It also was anticipated that participants might become emotionally upset while talking about their experiences as a manager. An emotional response did occur during one interview. At the time, the interview was stopped temporarily. After a few minutes the participant indicated that the interview could continue, and the interview was completed.

Participants did not benefit directly from participating in this study. However, they may have benefited from sharing their experiences. Moreover, the study may contribute to senior executives' and managers' understanding of managers' experiences in program management and thus, improve the quality of worklife and effectiveness of people in the manager's role.

**Confidentiality**

Participants' rights to privacy and confidentiality were upheld throughout the study process. Steps taken to ensure confidentiality included (a) conducting interviews in a private location, (b) ensuring that all records were kept in a secure location, (c) not
identifying the site of the study or any specific detail about the facility that might identify
the site, (d) not identifying participants by name anywhere except on the master list (see
Appendix G), (e) altering job titles to prevent identification of individuals, (f) aggregating
the demographic information managers provided about their programs, (g) not sharing
results with senior executives at the study site, and (h) planning to destroy all records 7
years after the study was completed. Quotations from participants that appeared in
written reports about the study, did not indicate who said them or the area of hospital to
which they referred. Thus, the participants may be able to identify their own quotations in
the reports, but no one else should.

Data Analysis Plan

Data analysis serves to "determine the categories, relationships, and
assumptions that inform the respondent's view of the world in general and the topic
in particular" (McCracken, 1988, p. 42). The researcher used material from the
literature, conceptual model, and experiences with the topic as a guide to what
existed in the interview transcripts. At the same time, the researcher was alert to what
McCracken called surprises in the material, that is, unanticipated discoveries. The
data analysis plan (Tesch, 1990) included the steps of data organization and data
interpretation.

Data Organization

Data were organized through the following steps, as outlined by Tesch (1990):

1. The researcher completed the post-interview summary (see Appendix H)
immediately after the interview. A list of the main points that struck the
researcher from the interview was created without listening to the tape.

Adjustments were made to the interview process based on this review in
preparation for the next interview. Examples included adjustments to anything
the researcher felt was not congruent with the process outlined in the
interview guide.

2. Later, the audio taped interview data were transcribed and entered in The
Ethnograph software program (Seidel, Kjolseth, & Seymour, 1988).

3. A numbered copy of the transcribed data was printed.

4. As a preliminary step the researcher read the numbered copy closely to
identify key utterances without concern for their significance. Then she wrote
down comments and questions that the transcript raised for her. This step of
writing down comments and questions was taken as an attempt to articulate
the researcher's thoughts and biases so they could be taken into account by her
and the committee members during the analysis process.

5. The researcher printed a second copy of the numbered transcript and again
reviewed it for key utterances or segments of data that provided information
about the phenomenon under study.

6. Key utterances were marked with a code. The research questions and
categories from the literature review and conceptual model were kept close at
hand to help with coding.

7. A master list of codes and a description of the coded topics were kept. To
ensure the reliability of the coded data, two members of the committee read
the transcripts and reviewed the codes that the researcher had created. Codes
were redefined and the transcripts were coded a second time.
8. No utterances were identified for some codes in some transcripts. Therefore these transcripts were reviewed a third time.

**Data Interpretation**

The data were interpreted through the following steps, as outlined by McCracken (1988). First, the researcher worked with the coded utterances to describe the meaning or content of the utterances and to examine how the content across utterances was related. This step was accomplished by summarizing each code across transcripts. The researcher also looked for both similarities and contradictions in the data.

Then the researcher used her judgement to formulate the general themes from each transcript and to identify interrelationships between the themes across transcripts. Three major themes were identified. Explanations for outlying or contradictory themes were sought. The coded data and preliminary themes were reviewed by the thesis committee members to ensure that the interpretations were clear and valid.

**Methodological Rigor**

This study was judged by the criteria Sandelowski (1986) set out for qualitative research - credibility, fittingness, auditability, and confirmability.

**Credibility**

Credibility refers to the truth value of the findings or the "discovery of human phenomena or experiences as they are lived and perceived by subjects" (Sandelowski, 1986, p. 30). Credibility is evident when descriptions of findings are faithful to the participants' experiences and recognizable by participants as their own (Sandelowski, 1986). Several steps were taken in this study to enhance its credibility. The researcher stated her experiences and beliefs related to managers' experiences in program management so they could be distinguished from those of the participants. Interviews
took place in a private place chosen by the manager being interviewed to facilitate the participant's comfort. Moreover, the interview questions were open-ended and non-directive, which encouraged participants to describe their experiences in their own words. Both the researcher and the thesis supervisor reviewed the coded data to ensure that the themes represented the data. Furthermore, some of the initial data also were analyzed by the thesis committee to ensure that the themes represented the data. Finally, contradictory data and alternative explanations for the conclusions were sought to ensure the accuracy of the conclusions.

**Fittingness**

Fittingness is achieved when the study "findings can fit into contexts outside the study situation, when its audience views its findings as meaningful and applicable in terms of their own experiences...and findings are well-grounded in the life experiences studied, and reflect their typical and atypical elements" (Sandelowski, 1986, p. 32).

Several precautions were taken in this study to enhance its fittingness. First, a literature review was conducted, which suggested how this study may contribute to the literature and to management practice (Hammersley, 1992). Then, demographic data about the sample and details about the hospital site were included in the final report to allow readers to determine if the findings would be applicable to their situations.

**Auditability**

Auditability refers to consistency of findings (Sandelowski, 1986). "A study and its findings are auditable when another researcher can clearly follow the decision trail used by the investigator in the study...and arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective and situation"
(Sandelowski, 1986, p. 33). In order to enhance the auditability of this study, Sandelowski's suggested steps were followed. These steps included a full description of (a) how the researcher became interested in the subject matter, (b) how the researcher viewed the thing being studied, (c) the specific purpose of the study, (d) how subjects came to be included in the study, (e) how the data were collected, (f) how the data were reduced or transformed for analysis, interpretation, and presentation, (g) the inclusiveness and exclusiveness of the categories developed, and (h) the techniques used to determine the truth value and applicability of the data. The researcher kept a journal that included a record of the research process, the impressions of the researcher, and notes about any problems that were encountered and how they were resolved. All research materials will be kept for 7 years and will be available for review.

**Confirmability**

Confirmability is assured when the findings reflect the implementation of credibility, auditability, and fittingness standards (LoBiondo-Wood & Haber, 1994), and when the research process and findings are free of researcher bias (Sandelowski, 1986). The findings should truly represent the "subjective reality or meanings participants give to, and derive from their life experiences" (Sandelowski, 1986, p. 34). This research was guided by several steps that Miles and Huberman (1994) outlined to avoid biases resulting from the researcher's effect on the research and the effect of the research process on the researcher; to reduce the effect of the researcher on the research, the researcher used an interview, an unobtrusive measure. Data collection took place in a location chosen by the manager, not by the researcher. In addition, the researcher made her intentions and plans clear through the use of a letter and verbal explanations. The
researcher thought conceptually about the interview data by putting personal thoughts into more theoretical ideas in the post-interview summary (see Appendix H) and reading the transcripts the first time noting issues and questions raised by the researcher. In addition, the researcher used a predetermined interview guide (see Appendix D) and data analysis plan, which kept the research process focused. Finally, the conclusions of the study were supported by examples from the data.
CHAPTER 5: STUDY FINDINGS

Three main intertwined themes emerged from the interview data when the managers responded to the question, "What is the nature of managing from the perspective of first-line nurse managers working in program management?" They included (a) taking on more and more in a lean management structure, (b) maintaining a commitment to patient care in light of urgent resource issues, and (c) carrying on despite patchy success. Furthermore, the managers' in-depth descriptions of what managing was like illustrated the influence of organizational characteristics on the execution of their role.

Organizational Context

All participants responded to the initial interview question, "What is managing in program management like?" by describing their organization's model of program management and offering their opinion of it. Their comments revealed three main points. First, they identified that programs at this site were originally conceived as if they were independent businesses "out there on a street corner". Managers understood that hospital leaders chose this model of program management to encourage managers to think and act independently. Managers were expected to focus primarily on what was best for the population served by the program and to develop services that met their needs. As managers assumed this intraprogram perspective, they were rewarded for focusing on their own program and being independent in order to facilitate innovation and creativity at the program level. However, managers discovered that an intraprogram focus meant that they did not communicate frequently with managers in other programs. With few opportunities to formally share activities, managers reported feeling isolated from their
peers, unaware of activities of other programs, confused about where to seek approval for new policy, and lacking each others’ support. “A lot of things slipped through the cracks. I think program management contributed to that” [M1]. This situation prompted managers to initiate processes and activities to reconnect so that they could benefit from and build on the work of others.

Second, participants identified several attributes of program management that helped them be more effective managers. Managers could adjust resources more easily in response to the impact of budget cuts when they were accountable for the program budget and had authority over all the players. Managers could solve problems in one part of the service that affected care in another, and maneuver money, staff, and support services to get the most from available resources when all the services patients needed during their hospitalization were under the authority of one person:

Firstly, for me it’s a logical fit, as a manager because I see the whole continuum of care, and you don’t get into the same kind of battles you did in previous structures where, say for instance, I would manage the operating room and I’d have problems with the pre-admission thing, and I couldn’t change it because it was another manager. … For me it makes logical sense. I can’t imagine why we were set up in any other structure, now once I’ve worked in this. [M4]

When staff from different disciplines reported to the same person, managers realized that they could no longer assume that past experiences in their own discipline would lead them to make sound decisions. Therefore, managers sought input more readily from a broad range of staff. Managers believed that this process of seeking broad
input resulted in better decisions being made, because they reflected a variety of perspectives:

When I was the manager of a nursing unit and I was the nursing manager and I'd been a nurse – I kind of knew what decisions to make, right? Now that I have every member of the disciplinary health care team reporting to me, when I'm dealing with a social work issue or a pharmacy issue, whatever, I'm not the expert anymore. And so ... it really does force you to go out there and ask questions and you know, seek the advice from the staff... And I guess the same thing happens now that I'm a manager of a huge area, where I'm accountable for everything, I have legal issues come up now, that I never really dealt with before, because a lot has been pushed down. So I go to talk to the director that would be involved, that has that little bit of ... that might be in her portfolio. So you tend to use each other more than before. [M5]

I think the ability to renew our resources is much more... there's more opportunities for doing that, than there were. And you get it without the boundaries. There's a lot of artificial, if you will, territorial boundaries that everyone has. Now you have kind of the whole area to maneuver, it's amazing. Suddenly what you couldn't do in the past, [now] you can maneuver anything. [M5]

Lastly, at the time of the interviews, managers were experiencing a transition to a new senior executive team who viewed program management from a different perspective and led with a different management philosophy from that of the original executives who implemented program management. The new team viewed the programs
as interdependent versus independent, and had begun removing resources from individual programs to support corporate activities that crossed all programs. Before the new senior team’s arrival, managers felt motivated by their autonomy. At the time of the study, some managers perceived that they had less autonomy and less involvement in program decisions as they experienced a shift to more “top down” or centralized decision making:

What I’m seeing now with new eyes here, is everything’s being centralized ... or what’s coming across is you [the managers] don’t make decisions unless they’re approved. And I’m now starting to see the difference again. ...and it’s a bit sad because we were really... I had a real strong sense of ownership and feel very loyal to the organization and my system and my people that I work with, and feeling very frustrated at their being pulled in again. And I think the worst you can do to people who are very self-motivated and wanting to do a very good job.... It hurts. It’s very de-motivating. [M5]

Taking on More and More in a Lean Management Structure

The theme taking on more and more in a lean management structure elucidates the managers’ experience of assuming responsibility for more and more management activities. They described working at a higher management level than their job title indicated because there was a lean management structure with fewer managers to share the work and fewer centralized support systems.

One of the key factors that led to increased responsibility for the first-line managers was the degree of decentralization of activities to the first-line managers that program management at this site was originally intended to provide:
I think the unique thing about here is we’ve flattened the organization. So, I’ve seen program management where you still have lots of players, and so, perhaps in that environment you’re not as … you don’t have as much scope within your job to deal with. Maybe you still have layers of management, and more hierarchical still, whereas here, we’re pretty lean. [M5]

Indeed, managers reported that the management structure was too lean. One manager said:

I think program management is really good, and I like it. I think the only problem is when you de-layer departments and you de-layer and take away, you have to be very conscious of the fact that you may take away too much, and you may have to reinvest, that you may have to go back and put in systems because you really don’t know what you’re taking away until you take it all away and strip it all down. And then you have to build pieces back up. And I really feel that that hasn’t been done here. [M1]

Flatter management structures increased the workload of managers’ supervisors too, leading them to delegate more to first-line managers. In addition to officially delegated responsibilities, all the managers spoke about also taking on work that their supervisors could not get to, or helping out when their supervisors became overwhelmed with their own workload. Managers also reported that their supervisors had less time to support and coach them because they were pulled in many different directions.

I think in a flat structure like this, there is a significant amount of pressure. And in the previous structures, VP levels did that work. Now we’re expected to. And you’re expected to be able to write a proposal at the same level that the VPs
would have with minimal support. From my supervisor, for one thing, he’s pulled in all kinds of directions too. ... And you’re pushed into a level that is beyond where the previous structure’s level was, without a lot of support. [M4]

The second factor that affected the nature of managing was the elimination of many policies and procedures when program management was implemented. The intention in starting with a skeletal framework was to promote the development of specific processes and structures needed by programs in the new organizational design:

The leader at the time felt that policies and procedures really inhibited rather than supported. And if you want people to use their good judgement within their scope of practice....If you have so many policies and procedures then they *think* policies and procedures. So we really cut back our policies and procedures and, in fact, if you look at our manuals they’re really deplorable. [M5]

Since then managers have been challenged to create guiding processes suited to their specific programs to replace those that were eliminated when program management was implemented. Assuming responsibility for, and creating and refining, policies and procedure manuals was a new addition to the front-line manager’s role. One manager described what it was like to be creating new manuals for upcoming accreditation in conjunction with her other responsibilities:

This program has gone through tremendous change in the last year and a half.
There are no things like departmental manuals.... And there’s nobody else to do that except myself. So this is haunting me now and, in fact, it sort of almost made me freeze. The manuals are such a huge problem that you just keep putting it off. ... I’ve taken the first few steps, touching people for their table of contents from
other facilities. …Practice issues have changed and on and on. …Ultimately I’m responsible for making sure the actual thing gets written…. The other thing is that my clinical counterpart left about a month ago so I’ve taken [her unit] on…. And they don’t have a department manual. [M3]

Along with the elimination of many policies and procedures, managers identified other activities that used to be coordinated centrally for the entire organization that were gradually integrated into the program structure. Front-line managers had to assume responsibility for such decentralized functions as fire training, safety training, revising manuals, preparing for accreditation, and orienting new staff. Purchasing, payroll, and staff hiring were also decentralized to the programs. Self-scheduling became the responsibility of the front-line staff with coaching and support provided by the manager. Over the past few years as resources were taken out of the management structure, more responsibilities landed at the first-line managers’ feet:

Global issues that hit all areas of the hospital have been pushed down to the manager level, because, I think, for a lack of - who else is going to do it? Because it has to be operationalized at a clinical level. And so what has happened is things like WHMIS [Workplace Hazardous Material Information System], [emergency] codes, any of the codes that need to be in a hospital have been pushed down to the manager level, who are required to make sure everybody’s educated, make sure that they’re up to date, …on top of whatever else the manager also has to do. And what became clear was that the hospital was not meeting standards or certain codes. And so, [at a meeting with the senior team] it was very clearly articulated
by the manager group: this is unrealistic to expect that we take these global issues, push it down to a clinical, without any corporate support. [M3]

Managers also reported the absence of a hospital-wide system to identify trends across all programs. They felt that the lack of horizontal communication added to their workload since they found themselves duplicating work done by other managers:

What is happening in surgery in the physio department gee whiz, is happening in maternal and. . . . But who’s catching the trends? Very, very difficult. . . . There are potential inefficiencies in the system because there’s nobody sort of taking a [bird’s] eye [view] over it and saying, “Oh, look at that, everybody’s doing the same thing and gee, one person could be doing this”, and so on. And I think the manager role is being able to take, you know the bird’s eye view of what the trends are. . . . Unless one of us says, “Are you doing this? Are you doing that?”, a lot of balls get dropped. [M3]

Participants also noted that when hospital-wide projects were identified, there were few people available in the organization to take on additional responsibility, for example, changing the documentation system.

Another move that thinned out the management structure was the disappearance of disciplinary leaders when professional departments were eliminated. One professional person became the leader for all the disciplines. The workload of managers grew as a result of their increased involvement in the committees that were created to replace some of the work formerly handled by the nursing leader position. In these forums, participants could also observe the confusing consequence of unclear structures and approval processes:
Nursing, unfortunately being the largest body, in some ways has suffered the most, with the loss of the department of nursing. Basically the chief nursing officer suddenly became the director of professional practice and had to meet the needs of all the professional groups. She could no longer devote herself [just] to nursing. ...We do have a professional nursing practice committee which is supposed to basically become the director of nursing—the committee does; it's made up of volunteers. ...What's happened is, the reason those people are coming to us with agenda items [that aren't appropriate] is they don't know where to go. And that’s been the biggest problem with program management, sometimes there's a real loss of direction, especially in approval processes of important policies and procedures that may have an effect hospital wide, but one little system approved it, it did not get shared because there's no central core, kind of person, body monitoring that. [M1]

As a result of taking on more and more within their roles, managers reported dissatisfaction with their ability to complete activities. They believed this lack of closure was a result of doing too many different things: "I feel like I’m always juggling 6 balls" [M1]. "The biggest frustration is never closing the loop" [M1]. "We’ve been asked to cut, cut, cut, and we’ve done it and I’m sitting here an emotional mess and my staff are in the same position" [M2]. "My quality of life is not great and that’s because the scope is too big. It is beyond what one person can do. I don’t have a family, I don’t, thank God. My cat’s pretty understanding. I don’t know how people do this job with kids. I guess they get better at just leaving....I think program management and the lack of structure has produced more stress in this role" [M4].
Maintaining a Commitment to Patient Care in Light of Urgent Resource Issues

Although all participants agreed that their primary responsibility was to ensure quality patient care, managers reported being increasingly challenged by a lack of resources as they endeavored to provide the best possible care to patients who were sicker and, therefore, have more intense care needs.

Putting Patients First

First-line managers in this study reported doing whatever was necessary to make patient contact with the hospital a positive experience:

And I have to keep reminding myself I’m here for the patient care in this system. That’s where my focus has to be. Yes I know the restructuring commission want us to have a partnership outside, however, inside has to be working well too. And if that takes 90% of my time, then I’ve only got 10% left. It’s very hard. [M4]

We don’t want surgery to be cancelled. That’s the last resort. We want to make sure that patients in the community are cared for as best they can be. [M2]

What happens is, if the clinical area needs you, everything else drops. And usually the clinical area needs you more than you anticipate. [M1]

Increased Intensity of Care and Diminished Resources

Managers felt that they needed to support front-line staff more than ever to maintain their commitment to quality patient care. Staff were being challenged by increased occupancy rates, increased patient turnover and acuity, and more complex clinical scenarios: “I’m seeing a huge increase in my volumes in [my area] with a high, high acuity increase in bed days and procedure days, which is just an indication of what
we’re objectively seeing in the data around relative intensity weights. The staff are saying boy-oh-boy these patients are sicker” [M5].

At the same time managers stated that available resources to care for patients were not adequate for the intensity of care that the staff need to provide:

They [my staff] are being asked to take care of these patients, that we already discussed as being sicker, with the same resources we had 5 years ago, or longer, and without me there as much as I could be sometimes in the previous role. [M2]

This organization has been in program management since I’ve started. Things were different 3 years ago, 4 years ago. I think it’s health care in general. The resources are stretched and cut and pushed, and you’re constantly questioned to support why you need this, and provide data. [M4]

Not only were managers faced with dwindling resources, they also noted that those resources were always changing. Fluctuating resources made planning for the future challenging because managers could not predict which resources would be available:

I think our director right now is so burdened with so many things. She had a clinical resource, you know, they did a lot of your financial trending they did a lot of your workload trending, they did requests for proposals for the Ministry [of Health]. And they were dedicated to each system, and they were a great help to the directors. …They don’t have those anymore. They’ve taken them out and put them back into the senior management team. And, again, so it’s resources they’ve taken out. [M3]
The managers were also contending with a lack of resources to orient new staff and with the reluctance of current staff to continue to volunteer their own time for committee work or projects. But the looming nursing shortage was the resource issue that most concerned them. Managers were already experiencing an increased turnover and a scarcity of experienced staff to fill vacancies. This concern was noted especially in critical care where the shortage of skilled nursing staff was already being felt:

Recruitment is a big issue in [my area]... so I'm looking at: How can I position myself, ...sourcing out a...program that meets our qualifications that would give enough clinical and a theoretical base, so that the person could actually come out and function? Budget wise, I need to say: How much do I need? How many people do I think I'm going to send a year? And then I have to lobby that. [M6]

In some areas of the hospital, new graduates were being hired for the first time in 5-7 years. In light of managers' commitment to patient care, they were concerned about the lack of resources to orient new graduates and to support their professional as well as clinical development. Time available for staff orientation had been cut to a minimum over the past few years because of low staff turnover. Another factor that managers said was coming back to haunt them was the reduced availability of unit-based educators:

I need help. I'd really like an educator...especially when we see such a drastic turnover. [M6]

[We] coordinate the orientation of all new staff, because we no longer have what we used to have. We no longer have that role [educators] available to do that. [M2]
Managers also reported that the organization had relied on staff to volunteer their off-duty time for committee and project work following the implementation of program management. But recently, staff were less willing to “go the extra mile” without being compensated in some way:

All of these committees, hordes of them - and I mean, we’re not talking a big facility - tended to be, you know, a lot of the same people sitting on a lot of these committees,... And so I think what happened is that, you know, everybody is very excited at the very beginning. Things happened very quickly when they went from the traditional model to the program management. But I think now people are tapped out....so what we find now is that it’s really, really difficult to get people to engage in new things. [M3]

Since a nursing perspective is often required for effective decision making, front-line managers felt pressured to participate in committees to bring forward the clinical perspective when front-line nurses no longer participated. “They ask you to go on every committee. Every committee in the hospital they want the managers, every new initiative.... I mean, people say delegate it, but the people [front-line staff] are working.... I respect the work that they’re doing, and I’m not going to delegate that to someone, unless I’m going to provide back-up, or a 4-hour relief person” [M1].

**Increased Tension Between Two Dimensions of the Managing Role**

Maintaining a commitment to patient care in light of urgent resource issues means that managers must engage effectively in both the quality and the corporate dimensions of their role. The quality dimension refers to their responsibility for ensuring quality care, while the corporate dimension refers to managers’ responsibility to meet corporate objectives such as adjusting to budget cuts. Therefore, managers must be involved in day-
to-day care issues and visible to front-line staff, while also being involved in corporate activities, obtaining resources, and being visible to senior executives. The act of maintaining visibility with both staff and senior management has become more difficult to accomplish since the demands in both dimensions have increased. The struggle to maintain visibility has created tension for managers as they tried to fulfil their responsibilities in both areas.

Participants reported that front-line staff did not have the skills to independently handle some of the responsibilities that were pushed down to them. These added responsibilities included involvement in creating policies for the programs, orientation packages, and interdisciplinary care maps, staff self-scheduling, and addressing interpersonal conflicts and professional practice issues. As one participant explained:

self-scheduling is a way of empowerment but it can also be very frustrating if the team is not very well developed. Self-scheduling involves negotiation, collaboration, recognition of the program needs and professional responsibility. And the team that I.. the group that I’m with have worked very well with their self-scheduling and the pitfalls that we’ve had, and so, you know, mistakes that have been made in the schedule, and clearing them up. But other groups, if they’re not feeling really good, and the morale’s really low, it’s disastrous. Self-scheduling isn’t really disastrous, but that’s part of the premises of program management, is people are empowered. [M1]

Aspects of Managing Important to Ensuring Quality with Fewer Resources

Managers in this study identified four strategies that helped them to maintain quality care with scarce resources. They (a) developed staff to be more independent and skilled at making good decisions, (b) created and sustained trusting relationships, (c)
fostered flexibility, and (d) they focused on communicating effectively to identify issues, manage change and gather information required for decision making.

Developing Staffs' Decision Making Skills

At the same time that resources were reduced and clinical demands were greater, managers had less time to supervise staff directly or to coach them. Managers, therefore, tried to focus on developing staff to be self-directed and on empowering staff to make independent decisions. In light of their various role demands, managers struggled to find time to devote to staffs' development.

In fact, senior management thought staff were performing at a much higher level than managers did. Senior management's expectations were expressed in statements such as, "Now, in this particular facility...one VP...said 'We were empowering our staff to do it all, so you didn't have to do this all'...So I don't think they clearly understood what that meant" [M3]. Managers believed such statements demonstrated senior management's lack of understanding of the clinical demands on staff that resulted from increased occupancy rates and intensity of care needs, the actual resources that empowering the staff required, and the consequential inability of staff to support unit management projects.

The gap between what the senior management team envisioned for the units and the unit reality that managers experienced impacted on the managers' role because staff assumed only part of the responsibility for the increased volume of managers' work that senior management assumed they would. While managers felt capable of doing most of the work, it was impossible to attend to the volume of work without more resources and support. As one manager said, "I know that the intention of empowering staff was to take
some of the pressure off the managers for some things. But they did not give the tools staff needed. So I don't think they understood what empowerment meant". [M3]

All in all, managers felt that developing staff was one of the most important aspects of their role because of the impact staff have on patient outcomes. The dilemma for managers continued to be finding time to devote to this activity. Managers observed that staff needed certain types of resources since more was expected of them in terms of clinical care and team responsibilities, but fewer of the traditional supports such as manager’s time and unit-based educators were available:

I think you have to have a huge amount of educational support, and not the typical kind of educational support that you would think of in a health care environment, like someone to insert ideas, and all that stuff. You just have to start talking leadership skills, cause you start working as a team: conflict management, delegation skills, how to give feedback. Because the whole concept is that if something happens amongst the team members, they need to be able to talk about it right than and there. [M5]

Managers stressed the need for resources such as educators to be accessible to staff. Staff used resource people more readily when they knew them, when they were seen to be credible, and when they were able to respond to requests when staff needed them. Yet in this facility, most educators were not unit-based. The education department had been decreased and there were no criteria put in place to determine the allocation of available educational resources. Managers observed that when educators were not unit-based, they seemed to become oriented toward projects for senior management.
Creating Trusting Relationships

In addition to helping staff develop the skills they needed to function autonomously, managers identified that establishing trusting relationships was another important aspect of managing when staff were trying to do more with less. Feeling trusted is essential for staff empowerment. Staff take risks and try innovative things when they know they will be supported no matter what the outcome. Managers, too, did not feel as able to challenge the status quo or discover more efficient and effective ways of serving patients without having a trusting relationship with their own supervisor:

The whole concept at the time was to flatten the organization and push decision-making down to the level where staff makes the decisions. And I think that’s better. The success of it is, you have to have a philosophy where you trust your staff. You give them the opportunity to make decisions. It has to be a safe environment, where they know that if they make a mistake, they’re not going to get, you know, shipped out. And if they make a mistake you look at it as a learning opportunity, and working together in resolving that. And it goes along with that whole concept of the learning organization, that bringing us to explore and trial and take risk. I think the key in that is you have to make the environment safe. [M5]

Fostering Flexibility

Once trust is established, all participants identified flexibility as one of the keys to managers’ effectiveness in maintaining a commitment to patient care when resources are an issue. Experience had taught them that flexibility was an ideal quality in any
management structure or style, not just in program management. More important, participants said that everyone who works in program management needs to be flexible:

There is definitely a type of person who does very well in program management. It is a more self-directed style, and...you have to have a good work ethic to make it work, cause you could really slide and whatever you want....And the people who do well in program management have to be able to see other people’s point of view...You really have to start selecting the people that fit the culture. [M1]

Managers valued flexibility to allow them to respond to changing situations, changing expectations, and other points of view with ease: “If they want me to move, then that’s what I have to do” [M6]. “We’ve changed the operating schedule so patients will be ready for discharge by the end of the week” [M2]. Inherent in being flexible is the attitude that “if it looks one way today, it will look different tomorrow, and that’s okay because it may be better” [M6].

Participants described organization-specific factors that contributed to their ability to be flexible. These factors included (a) having the authority to make decisions autonomously without going through a lot of other people, (b) a non-unionized environment, (c) a higher ratio of professional staff, and (d) comfort with continuously challenging the status quo: “We try things here, we just do it, we’re so used to change” [M4]. Another factor that contributed to their ability to be flexible was the linking of different levels of care under one manager, for example, ICU, medicine, and sub-acute medicine. Managers acknowledged that they also needed to view their own role as flexible and spoke of accepting its fluid nature: “My role is an evolutionary role. I’ve had to keep redefining what I do. I keep this list of what I do, because people ask me all the
time. My role changes” [M6]. The increased role scope of their supervisors has led them to delegate more to managers.

**Communicating Effectively**

Finally, managers viewed effective communication as a key aspect of their role in light of the need for front-line staff to make their own decisions related to quality care but still be guided by the norms of the system. Managers found they were always communicating their vision, values, and goals through other people. Since staff serve as managers’ ambassadors and communication occurs in many directions, managers reported that managing is more effective when everyone is a good communicator: “You have to be a really good communicator...because the people who don’t communicate, you have a lot of problems with. It seems they get lost in the shuffle, they work in their own insular world and so they get frustrated because they can’t get anything done” [M6]. Managers reported that when they worked with the right people, that is, people who are comfortable challenging each other and supporting each other, communication flowed more smoothly. The ability to both challenge and support each other created an environment that helped managers through rocky times.

Managers spoke of how important informal lines of communication were in program management. One manager went as far a saying she did not think there were any formal systems for communicating in the facility. Managers identified the advantages of hallway conversations and of bumping into people to effective communication with staff, patients, and families: “There’s a huge value to what you learn and do when you’re out and about” [M4]. Several managers talked about the necessary role the automated internal email system played in effective communication. Getting to know staff
personally, getting a sense of who they are as people was satisfying to both staff and manager. Others spoke of communication as a way of preventing isolation in the manager’s role.

Managers valued effective communication for its impact on successfully initiating and managing change. In keeping with the organization’s goal of decentralized decision making, front-line staff expected that they would be involved in change early on in the process, not after the fact. Managers spoke of “touching” staff to identify issues, explore solutions, or “feel them out” regarding their readiness for change or their reactions to tentative plans the manager was contemplating. They noted that a participative way of managing change was different and more time consuming than the traditional way of managing in which the manager would inform staff of most changes. However, it led to internalization of values and better “buy-in” from the staff. As a result, change was integrated into day-to-day practice and was more lasting.

Carrying on Despite Patchy Success

The theme, carrying on despite patchy success, describes the paradoxical relationship managers seem to have with success. They described feeling successful yet at other times unsuccessful. They identified that they were successful in specific elements of managing, however, a general and sustained experience of success eluded them. The reasons they cited for carrying on despite feeling generally unsuccessful were varied and personal.

Defining Success: Quality of Patient Care and Personal Priorities

All participants discussed success in managing in terms of high quality patient outcomes and satisfied patients. They acknowledged that ensuring quality patient
outcomes was their priority or the essence of their role. Therefore, participants measured their ultimate success in terms of smooth patient processes and satisfied patients:

I would say [success] is the smooth coordination of patient care for the patient. It’s getting the right people there at the right time. It’s responding to the patient’s needs, making changes in your processes....To me, it’s responsiveness to the front-line people’s concerns and issues...it is important to me that they get the service that they need for patients. [M1]

And seeing that what you’re doing makes a difference to people.... I know you can in this role, but you don’t always see the outcome of it face to face. [M4]

Personal priorities also contributed to the meaning of success for each manager. One said her staff were desperate for leadership when she arrived and she valued the ability to help staff lead themselves. She also prided herself in being able to engage in the get down and get dirty kind of management and she felt successful when staff were able to disagree or be honest with her. Openness was important because she identified that she could accomplish very little through her efforts alone and that in her position, most outcomes were achieved through collaboration [M3]. Another manager prided herself in making accurate predictions about future trends in care funding and responding proactively. She had also been successful in reducing length of stay in her system, a tangible accomplishment that she valued because it was appreciated by both administrators and physicians alike [M5]. To another manager, success meant getting below the surface, understanding the issues and possible solutions, and finding responses that were successful. She felt great when she could see a project through to the end [M4].
Success-Oriented Activities

Participants highlighted the following activities they engaged in to help them manage successfully: (a) supporting the staff’s professional development, (b) challenging themselves to learn and grow, and (c) providing leadership in key areas.

Supporting staffs’ professional development. Managers measured their ability to support staffs’ professional development in terms of having good relationships with them, being able to support them, and seeing them develop. Therefore, they felt that they were succeeding as managers when they were able to influence the staff’s critical thinking skills and increase their confidence in making decisions independently, and when they saw that the staff were integrating the organization’s values into their decision making. These results were particularly important in light of the need for staff to become more autonomous and self-managing. “...that feels good. When you feel like you’ve put a plan in place that works, that will, maybe relieve some of their stress” [M2]. “To have a nurse who has been identified with some difficulties - to be able to work with them...and see positive change” [M4]. Managers also feel successful when staff work well together: “The team works so cohesively now and it’s almost trans-discipline, where they know their scope, but they know where their scope overlaps and they help each other. And so, the patient isn’t left sitting” [M5]. Managers have also begun to see the staff as more autonomous and are proud of the shift in management philosophy.

Managers’ personal growth. Managers’ perceptions of success depended on their own willingness to challenge themselves by taking on work they had not engaged in before, by learning new skills, and by developing personal strengths in response to job demands: “My eyes have opened up to senior management’s role, the governance role the
board plays. I mean I never had an opportunity to work with the foundation. But here I do...things are much different” [M6]. “My director asked me to take over the hiring process. And so we had a little bit of a workshop with one of the HR [Human Resource] people about interviewing, coaching and developing questions. And I guess it's really been a growing experience for me” [M1].

Managers identified that enhancing certain abilities contributed to successful managing. These included knowing which battles to pick, being comfortable with ambiguity, feeling confident in your own abilities to do the job, being able both to view things globally and being able to attend to details, having a sense of humour, and having insight into your own strengths and weaknesses. Participants also spoke about the benefits of understanding the larger context of health care. Knowing trends in the health care world-at-large helped them to understand shifts in their own areas and to explain trends to staff. Most spoke about seeking a broader perspective through reading professional journals.

Managers thought that they were expected to connect with their counterparts from other facilities in their region to share information and successes. They believed that connecting with others would enhance their personal growth and improve their effectiveness. However, all parties were so busy that connecting with others was difficult to arrange and maintain. They also felt their growth was limited by a lack of mentoring relationships within their own organization:

There’s no mentoring relationship in the program management because people are so busy with their programs...And the business of each program is so different, that even if you have a mentor, they may not completely understand all the
issues...I tried to access the other two hospitals for the similar position in our region, and they’ve been great when they can, but it’s the same....The time crunch....It would be nice to have a formalized time to do that, and support from senior administration to do it. [M4]

**Providing leadership in key areas.** Participants observed that providing leadership in the following key areas contributed to their success: (a) responding to issues staff raised by removing barriers to effective practice; (b) creating new systems, policies, and care delivery models; and (c) anticipating trends and positioning their program for the future. Knowing what issues were current was the first step:

And so that was a very good feeling for me that, gee, I am connected and I am aware of the issues. And when most people ask me about something, I know the background to it, so I’m able to manage that. [M5]

Once issues were identified, managers felt successful when they were able to remove barriers to effective practice:

There was a little waiting room for the whole patient area. There was no quiet room, ..and people would literally move in and lie on the couches and whatever. So I said, this doesn’t work . Deliveries would come through the waiting room, garbage would go through too....We did a major renovation. ...There’s now a quiet room so the team can talk to family members. There’s a phone in there so family don’t have to pay for local calls. That’s really worked well. [M6]

We’ve changed our whole model of care. Before, RNs alone cared for patients. They had no other support . And we moved to an RN-PCA (patient care assistant) partnership model. ...And they have found that to be very beneficial. [M5]
I was working on creating a new policy. It took me six months, 3 advisory meetings and I finally got it approved. And now I feel like I deserve a million dollars. [M1]

**Success and Organizational Attributes**

The critical factors that managers thought were necessary for success within the context of a delayered, decentralized program management organization included (a) recognition, (b) the trust of their supervisor and others, and (c) the effectiveness of the change process.

Recognition came from various sources. Some managers sought internal recognition by reviewing their accomplishments and individual successes. Others acknowledged that most people around them did not understand the role and found it difficult to provide recognition: “But you know what? There’s not a heck of a lot of people that can evaluate your work. I mean there is no tangible evaluation.” [M3], “My supervisor tried very hard to be supportive....but you know, they don’t really know what this job is like either” [M4]. Despite the lack of understanding of the role, when senior executives tried to provide recognition, it was appreciated.

Gaining other people’s trust, specifically their supervisors’ trust, went a long way towards helping managers feel successful. Developing a relationship with their supervisor also built trust and made recognition easier to give and receive:

It was a time she could get to know me and I could get to know her. I really valued that time because she got to know me and maybe some of my strengths or my creative ability, because the next week she called me and she opened herself up. She said “I'm having a problem in this area. Can you help me with it?” [M6]
Participants observed that the effectiveness of the change process in this facility contributed to their success as managers. They identified that because of the nature of program management, change was implemented in a more timely fashion: “In a program management style, the distance between a decision maker [and a decision to be made] is very small. There is just your director. Change is much quicker. Now the degree of autonomy your director gives you as a manager has a direct impact on how quickly and effectively you can work” [M3]. Managers viewed change to be more lasting in program management because of its participative nature: “You must do a lot more seeking out of people to articulate a change... There’s a lot more consultation at the decision making stage and subsequently a lot better buy-in for any change” [M3].

Elusive Overall Success

While managers articulated feelings of success when they spoke about specific parts of their role, such as removing barriers to practice, and developing individuals, all participants were frustrated and tentative regarding their ability to feel successful about the job of managing. Although these modest successes felt good, most managers reported at the time of the interview that a feeling of overall success still eluded them: “I think I’m at a very frustrating point in this role, so I’m not sounding positive” [M4]. Participants reported that the following conditions hindered their overall success: (a) being spread so thin that you could not do anything well, (b) wondering what doing a good job would look like, and (c) not having clear role expectations.

All participants felt overextended. “Personally, I’m feeling that I’m being pulled in so many different areas that I’m not doing a good job at anything right now” [M2]. “What’s my life like? Very stressful, very... It has a lot of moments of satisfaction, but
because you're stretched in so many directions” [M1]. What's my life like? Well, not
great, and that's because my scope is too big. ...It's beyond what one person can do.... I
don't know, the hours of work. I cannot continue to do this long-term. I know I can't.
That's part of the reason I chose to leave middle management when I did [before]” [M4].
“It's a sense of never being finished, I guess, is that true some of – But that's, I think,
inherent in management” [M3]. “Program management, though, I think again it goes
back to the leanness of the environment that if you don't do it, no one else will. And so,
subsequently, what you can do is end up with a lot of holes in the fabric” [M3].

One manager wondered what a good job would look like and decided she did not
know and did not know who could tell her. Most managers seemed to be working hard
just to keep their heads above water because of the scope of their responsibilities or
because of the increased effort they were expending to protect current program resources:
"What's my life like?”... Never knowing if you actually did a good job. And never
knowing if you've actually accomplished what you thought you were supposed to
accomplish.... But you know what, there's not a heck of a lot of people that can evaluate
your work....And my [supervisor] does not directly monitor me. I get sort of off the cuff
feedback...But they [my peers] can't tell me what they do in their job because what we
have found, very, very, clearly is that it is different from system to system. And it
probably differs within the system too. And so whether she knows whether I’m doing a
good job or not, is impossible” [M3].

The lack of clear role expectations also prevented managers from feeling
successful. All of them spoke about the incongruence between their written role
description and the way the role was actually practised. Managers wanted to more clearly
understand the expectations senior management had of their role. They said that when their role was unclear to themselves and others, problems remained unresolved longer than necessary, service from other departments was accessed more slowly, and support was sometimes unavailable in crises or when issues escalated. Unclear expectations also led some managers to take everything to their supervisor, in order to protect themselves from repercussions. They reported that when they acted to "cover themselves", decision making was slowed down. Managers needed a sense that their supervisors understood their abilities so they would support them when they took on big hospital-wide projects that did not fall within their written job description.

One participant spoke about doing all the same things she had always done, which were viewed as successful by one senior team. When the team members changed, her activities were perceived in a less favourable light. Participants observed that managers enjoyed varying amounts of autonomy in their relationships with their supervisors that affected their view of themselves and, in turn, how their staff viewed them. When their supervisor respected them less so did their staff. They believed that a lack of respect compromised their effectiveness as a manager. Participants viewed relationships as being more important in program management because many of the decisions currently made by managers had never been made at that level before and they needed more support.

**Carrying On**

Managers said that the different resources and strategies they used to carry on despite their patchy success included acknowledging small accomplishments, reviewing past successes, facing the possibility that they might be laid off, putting on a false front,
continuing to set daily goals, seeking support from their family and friends, venting their frustrations to colleagues, remembering better times, and hoping for an improved future:

I’ve managed to keep a sense of humour. This week it’s a little tougher, and so I’m using other coping mechanisms….I’m basically putting on somewhat of a false front right now, because that’s the only way I can cope out there, and not break down…. I can go home and talk and have someone listen, and sometimes things look better the next day....So each day, even though it’s sometimes hard to get here, you try and start fresh, and try and think, okay, well I’m going to try and accomplish this or something else today. [M2]

During the interviews, all managers spoke about visualizing themselves in positions other than their current one. They were either in the process of reviewing their options, remembering what it was like in other positions, or reviewing why they had left management positions in the past. One manager had decided to apply for another position. Another contemplated doing the job as if it were a temporary or time-limited role. She also wondered what it would be like to go back to a position that involved a more clinical focus rather than the dual responsibility of ensuring corporate and quality outcomes. Another commented that although she was paralyzed at times by the volume of work, the role met her need to be the leader, and she acknowledged she was not a good follower. One manager speculate what it would be like to leave health care and noted that she had planned her graduate education to make a management career in another industry possible. Two other participants spoke about deciding to leave a management position in the past because of lack of recognition and burnout, but returning to management again in their current positions.
Summary

Participants reported that when they were accountable for the program budget and had authority over all the players they could adjust resources more easily and involve others more in decision making. They reported that this practice resulted in better decisions that were more broadly supported. However, they also indicated that they did not communicate frequently with managers in other programs, therefore, had few opportunities to formally share activities, felt isolated from their peers and the support they offered, were unaware of activities of other programs, and unclear about where to seek approval for new policy.

Participants reported assuming responsibility for more and more management activities and of working at a higher management level than their job title indicated because there was a lean management structure with fewer managers to share the work and fewer support systems. The combination of more work with less support has affected both the nature of managing for first-line managers and the quality of their worklife.

Participants all reported that their primary responsibility was to ensure quality patient care to patients who are sicker, but they were increasingly challenged by a lack of resources. Participants identified four strategies that helped them to maintain quality care with scarce resources. They (a) developed staff to be more independent and skilled at making good decisions, (b) created and sustained trusting relationships, (c) fostered flexibility, and (d) they focused on communicating effectively to identify issues, manage change and gather information required for decision making.

The theme, carrying on despite patchy success describes managers' descriptions of feeling successful yet at other times, unsuccessful. They all defined success in terms of
quality patient care and personal priorities. Participants highlighted specific activities they engaged in to help them manage successfully: (a) supporting the staff’s professional development, (b) challenging themselves to learn and grow, and (c) providing leadership in key areas. The critical factors that managers thought were necessary for success within the context of a delayed, decentralized program management organization included (a) recognition, (b) the trust of their supervisor and others, and (c) the effectiveness of the change process.
CHAPTER 6: DISCUSSION OF THE FINDINGS

This study sought to add to the body of knowledge related to managing in health care by asking the research question, "What is the nature of managing from the perspective of first-line nurse managers working in program management?" The discussion will focus on program management's impact on leadership and on the three themes that emerged from the findings, (a) taking on more and more in a lean management structure, (b) maintaining a commitment to patient care in light of urgent resource issues, and (c) carrying on despite patchy success. Program management's impact on leadership will be discussed in relation to the literature, whereas the themes will be discussed in relation to the conceptual model as well as to the literature.

Program Management's Impact on Leadership

Participants reported that the degree of integration of people and services to the programs, a key feature of program management, meant that managers had authority over all the players and, therefore, could solve problems more easily. It also meant that they could get the most out of resources by being able to allocate them without restriction within the program. They claimed that their ability to get the most from resources was improved by the significant degree of integration of support functions and professional activities at this site. This finding confirms that the integration of services in program management, which was cited as a benefit in the organizational design literature, is indeed helpful to managers in their efforts to manage resources effectively (Charns & Smith-Tewksbury, 1993).

Study participants also identified that having authority over most professional services associated with the program was advantageous. Integrated services encouraged
them to develop a broader leadership perspective and an approach to decision making that relied less on their own discipline-specific expertise and more on the various expertises of the people involved. Consequently, they believed they led with a more participative style and they made better decisions that were more broadly supported. The program management literature suggested that the design’s ability to capitalize on new sources of cost savings is achieved through managers’ ability to encourage front-line staff’s involvement in decision making. Managers in this study reported the need to acquire a broader knowledge base related to the professional standards of a range of disciplines (Harber, 1994).

However, participants also experienced the disadvantages associated with significant integration of people and services to the programs. Participants reported that while programs were encouraged to demonstrate independence and to focus inward to enhance outcomes, they also reported being compromised by a lack of knowledge about issues and trends that were common to more than one program. They shared their belief that gaps in service and other problems that arose as a result of program autonomy would be resolved more effectively with a collaborative approach and the use of shared resources.

Furthermore, managers are often described as the nerve centre of the unit or program because of their connection to a wide variety of information. Mintzberg, for example, observed that most of the managers’ sources of information are informal (1994b). In light of their role as nerve centre, managers understandably sought to create connections and structures that would promote coordination across the organization and create greater access to the information they needed to lead effectively. This finding was
to be expected since coordination was noted in the organizational design literature to be
one of the characteristics that suffers when organizations emphasize integration, for
example, in the program management design, versus differentiation of functions (Charns
& Smith-Tewksbury, 1993). Although both the nature of support that arises from
managers' connections with others and its impact on the effectiveness of front-line
leaders has not been explored extensively in the literature, it is apparent that collegial
relationships and affiliation with a group who have like needs are important contributors
to quality of worklife for managers (Westmoreland, 1993).

Participants also reported that they developed an entrepreneurial leadership style
because programs at this site were originally conceived of as stand-alone businesses. This
leadership approach focused on determining the needs of a specific population, predicting
trends in care, finding ways to provide high quality care with fewer resources, and
creating an environment that encouraged risk-taking behaviour when it came to satisfying
patients and identifying sources for cost savings, etc. Taking an entrepreneurial approach
to managing has been cited as critical to management success in today's environment
(Roemer, 1996). Managers in program management have been described as the
champions of the program and considered as “intrapreneurs” (Leatt et al., 1994, p. 6).

At the time of the study, participants felt unsettled in their role and unsure of
themselves as the result of a recent change in the senior management team. This included
a change in the C.E.O., which is one of the factors noted in the literature that could
trigger redesign (Leatt et al., 1994). Managers scrutinized their new supervisors’
decisions for clues that would help them to understand their leadership philosophy and
their view of program functioning.
Donner and Wylie (1995) also reported that changes in managers’ reporting relationships can be a source of stress for managers. In this study, as time past, some managers were beginning to feel less vulnerable and more open to their supervisors’ changing views of the way programs might work better after they engaged in dialogues and developed relationships with members of the new executive team. The literature also referred to the need for this relationship to be well developed so that managers could be more effective in ambiguous environments and adjust their priorities more easily. Westmoreland found that “newer nurse managers (3 years or less) had considerable difficulty setting priorities because they were unsure what was and was not important to their bosses.” (Westmoreland, 1990, p. 62). This finding supports the need managers expressed to meet regularly with their supervisors to continually clarify what is important. It appeared to the researcher that participants reports of the senior management teams’ decision to move some resources from the larger programs to the centralized functions of the hospital and of the senior team’s description of programs as interdependent rather than independent, indicated a different conceptualization of program management from the view operationalized by the original implementation team. These reports may have indicated a decision to create more coordinating mechanisms that would ultimately connect the programs more closely to the goals of the organization as a whole. However, in the absence of dialogue, some managers interpreted the changes to mean a loss of autonomy and a return to centralized decision making.

Taking on More and More in a Lean Management Structure

Participants reported taking on more and more activities, often of a diverse nature, as a result of a number of shifts in the organization. The increased volume of work they
juggled made them feel scattered in their efforts, as though they had barely scratched the
surface of the work they needed to do. Mintzberg’s early research which supports the
finding, indicated that managerial activities are characterized by brevity, variety, and
discontinuity, which in turn cause managers to overwork and to perform tasks
superficially (Mintzberg, 1989). Of the three levels of activities in Mintzberg’s model of
managing (a) managing by information, (b) managing through people, and (c) managing
action, the level that sheds most light on this finding is managing action. Mintzberg
described the managing action level of managing as the “doing” role, namely, “managers
must be the focal point for action in and by their units” (Mintzberg, 1994b, p. 20). This
belief may also explain managers’ reported experience that people in the organization
want them involved in everything, and the resulting increase in the volume of their work.

In addition to being involved in a greater volume of activities, participants
reported being pushed to what they described as a higher level of management. A higher
level of management meant that along with involvement in day-to-day unit activities,
they also were involved with groups and projects that took them beyond the unit.
Managers’ experience of greater involvement with external links such as hospital
lawyers, Ministry of Health officials, and outside vendors is supported by Mintzberg’s
description of managers’ performing activities inside and outside the unit. “Doing inside”
(Mintzberg, 1994b, p.21) involves the usual project management approach to solving
problems and creating change. “Doing outside” (Mintzberg, 1994b, p.21) involves
making deals and negotiating on behalf of the unit. The current study’s findings indicated
that managing in today’s environment means greater involvement outside the unit. These
findings also promoted a horizontal view of managers’ scope of responsibility that is in
contrast to the traditional or vertical view of managing whereby doing outside the organization was reserved for those working at higher levels of management.

Participants’ experience of the managing role’s complexity and the resulting feelings of being burdened by taking on more and more may not be explained simply by counting the number of their management activities. Mintzberg’s model explains, in part, the impact when managers initiate a project or problem at one of the levels of managing, either action, people, or information, “but once done, must then work through the remaining ones” (b, 1994b, p.15). Consider, for example, the activity of updating manuals. In order to seek ideas for content, first-line managers begin at the people level. They link with people outside the organization, in other programs within the hospital, and with staff inside the unit or program. Still operating at the people level, they create and lead a work group to write the manual. At the information level, they communicate the job to be done and control the evolving content by reviewing sections the staff completed and by giving feedback. They engage in the action level by writing some of the sections themselves and by making sure other staff complete their work within the time lines set. Once the manual is created, the same process of working through the three managing levels begins again as the manager initiates the process of ensuring that all staff become familiar with the new content and integrate it into their practice. The process begins again when the manager leads the work group in evaluating and revising the manual.

Therefore, Mintzberg’s model is useful in describing the impact of simply adding one new responsibility to the manager’s role, and in leading to the question, “How much can first-line managers handle and still be effective?”
Moreover, participants stated that while they can learn new things and enjoy new challenges, they cannot do everything. At the time of the study, participants lacked clear priorities as a consequence of a new executive team. While managers agreed that ensuring quality patient care was their priority this was such a broad goal that it did not appear to help them in the many decision points they encountered about what they should or should not engage in. One of the paradoxes of managing seems to emerge from the very nature of the role. Although research shows that managerial work is by its very nature fragmented and superficial, resulting in managers’ involvement in many different things (Mintzberg, 1989), Drucker (1993) suggests that managers are not effective enough because they try to do too many things. He advises that managers need to focus for effectiveness:

Managers should spend a little time thinking through what their company should hold them accountable for by way of contribution and results. “What is the one thing that I, and only I, can do that if done well will make a difference?” A clear priority is essential. Do not diversify, do not splinter, do not try to do too many things at once. Without priorities, managers will be pulled in 5,000 directions at the same time (p. 348)

Mintzberg agreed that purpose and vision, components of the model’s frame, must be clear to the person in the role. In the model, the task of conceiving the frame is the role that arises from the person in the role, working in a specific context. At the time of the study, participants were beginning to engage in dialogue with the senior team to establish priorities and clarify their roles, thereby engaging in conceiving the role.
The elimination of policies and procedures led managers to feel unsure about the hospital’s values and direction and added to their workload, because it fell to them to replace them. Miller and Heine (1988) found that the activities managers engage in are influenced by the degree of standardization, namely, the culture or norms of the institution, as well as the degree of normalization, that is, its policies and procedures. Mintzberg’s model of managing supports the notion that managers are responsible for conceiving the frame which involves clarifying the vision and culture and structures such as policies and procedures. Therefore, changes in policies and procedures may affect the nature of managing, by altering the frame of the job.

Mintzberg’s model’s level of managing through information further explains the impact on managers of reducing policies, procedures, and coordinating processes. The information level involves two roles, controlling and communicating. Managers’ ability to control the way care is given is weakened when formal policies and procedures are eliminated. Also, as managers’ scope of responsibility gradually increased, they found that they became less visible and available to caregivers and, therefore, less able to monitor care directly. The shift to being less able to monitor care directly led them to rely more on communicating values and standards to indirectly influence quality. Mintzberg placed the information level the farthest away from the centre of the model to recognize its distance from managing action directly. Current management literature stresses the importance of creating values-based organizations to replace organizations in which direct control was possible before management levels were delayered (Crowel, 1996). However, managers reported conflict when they tried to be visible to both staff and
administration, a finding that has appeared consistently in the literature (Everson-Bates, 1992; Harber, 1994, Hutchison, 1994).

Maintaining a Commitment to Patient Care in Light of Urgent Resource Issues

Participants spent more and more of their time trying to ensure that necessary resources were available. In order to do this, managers strove to be visible to both front-line staff, so that they could fill some of the gaps in support left by vacant and eliminated positions, and to senior management, so that they could represent the program to them and lobby effectively for additional resources. This finding that managers strive to be visible to both supervisors and staff links most directly to the managing through people level that Mintzberg described in his model. The level of managing through people involves the roles of leading and linking, where leading occurs inside the unit at the individual, group, and unit level, and linking occurs with people both within and outside the unit being managed. Clearly, both roles are important to ensuring that the necessary resources are available, since the manager’s role is to negotiate for resources while making sure that resources are being conserved and used most effectively at the bedside. Additionally, resources are required to develop staff so that they may serve most effectively in an environment in which direct supervision is difficult to provide. Participants regretted that they were not able to spend as much time on staff development as they would have liked. Although this finding has been explicited in the literature before, one suspects the impact is greater in the current environment where managers depend more on front-line staff to make good decisions in keeping with the organization’s values to ensure satisfied patients while using fewer resources.
Study participants employed a number of management strategies to help them maintain quality care with fewer resources. They included (a) developing staff's decision making skills, (b) creating and sustaining trusting relationships, (c) fostering flexibility, and (d) focusing on communicating effectively. These strategies continue to reflect leading and linking activities that managers engage in through the people level of Mintzberg's model as well as the communicating roles of the information level.

Human resource issues affected managers' ability to maintain a high standard of patient care. Study participants identified the most critical human resource issue to be the nursing shortage. Managers were spending their time anticipating future needs for staff, recruiting and orienting new staff, supporting new graduates in practice, and making decisions, in some cases to close beds, because of nursing shortages. Mintzberg described managers process of engaging with these issues, as a means they have of operationalizing the frame of the job, "as well as changing it, by feeding in new concerns" (Mintzberg, 1994b, p.14). Study findings indicated that another issue managers were grappling with was the increased time they were spending inside the unit supporting staff and helping them provide care to increasingly sick patients with fewer available resources such as educators, peer support, and time to devote to learning and development. According to Mintzberg, the schedule, or how managers spend their time on a day-by-day basis, reflects both the issues, in this case a nursing shortage, and the frame, namely, providing the best care possible to people being served by the hospital with the most efficient use of resources.

Study participants found it difficult to set priorities when they viewed so many of their activities as being essential to ensuring quality care. They felt pressure to link with
external contacts, but at the same time they felt it necessary to provide daily support to
front-line staff. Mintzberg included setting priorities as a part of the role of scheduling.
The literature also reported that managers engage in time management or scheduling as a
way of being more effective (Mintzberg, 1994a).

Although managers spoke of their pride in their staff’s ability to take on more and
more responsibility, they also reported that the staff lacked the full complement of skills
to be able to independently handle all the decisions delegated to them as a result of
decentralization. Hospital executives had indicated to study participants that they had
empowered staff to take on more to ease the burden of managers in a lean management
structure, but managers felt executives did not appreciate the resources required to
empower staff and develop them in ways that would actually relieve managers of some of
their responsibilities. It was a catch-22 situation for managers in that they wanted to be
able to delegate more to front-line staff, and they believed staff could contribute in
meaningful ways if given the chance. However, they did not have the money to replace
the time they spent on projects away from bedside care. Little in the literature described
the impact that the societal mandate of front-line staff to minister to the very sick has on
the nature of managing in hospitals. Nor did the literature discuss the wisdom of attempts
to import ideas from business to health care organizations.

Another finding related to the people level of managing is front-line staff’s
withdrawal from volunteering to participate on committees and other decision making
bodies because of the demands of bedside care and the resulting stress that affects the
quality of their worklife. Nurses across Ontario are making similar choices in response to
the nursing shortage (Aiken et al., 2001).
Mintzberg proposed that managers manage the taking of action without being involved in the action directly but, instead, remain one step removed from action. This study’s findings indicated that managers in health care are also actively engaged in activities such as creating manuals and orientation packages, developing care maps, policies, and procedures, managing interpersonal conflict directly, and seeing patients. Managers felt that it was left to them to be involved in some of these activities because front-line staff were unable to participate, and therefore, unable to incorporate clinical knowledge into decision making. Although managers are known to participate in these activities for management reasons, when they are called upon to participate in order to replace other clinical resources, their workload grows for reasons unessential to the role.

Carrying on Despite Patchy Success

All participants measured their ultimate success in terms of quality patient outcomes and satisfied patients. For the most part, managers felt that they were continuing to have a positive effect on the quality of care. According to Mintzberg’s model this view may reflect the influence of a clear organizational vision that acts as a magnet, holding managers’ activities together. Participants did not always feel as successful in other aspects of their role that had a more administrative focus. This finding is consistent with Weaver, Byrne, Dibella, & Hughes’s 1991 study. They found that, with regard to patient care, managers actively performed the skills they believed in performing. But managers found it difficult to actively engage in operational and human resource management activities as consistently, even though they believed in the value of doing so. The finding that managers could not engage in activities indirectly related to
patient care when those activities directly related to patient care were urgently required, may also reflect nurse managers’ ethical standards.

The current study’s findings also made it abundantly evident that personal priorities contributed to the meaning of success for individual managers. According to Mintzberg and others, the way a role is performed can vary considerably among managers and is influenced by the needs of a particular job and the approach of its incumbent (Coulson & Cragg, 1995; Mintzberg, 1994b). “Style is considered to impact on managerial work in three ways: which roles a particular manager favors, how he or she performs these roles, and what kind of relationship exists among these roles” (Mintzberg, 1994b, p. 23). Success criteria in the findings represented examples of all three of Mintzberg’s levels of managing, that is action, people, and information. At the information level for instance, participants experienced success if they accurately predicted trends in demographics and their impact on program configuration. Some participants valued their ability to provide leadership, an aspect of the people level of activities. Others favoured getting “down and getting dirty” and fixing things, which represented the action level. These findings provide useful information about the influence of personal priorities and preferences on managers’ experience of success even when managers share the same commitment to quality care. These results are to be expected in light of Mintzberg’s belief that managers often prefer one level of managerial activity above the others. One suspects that managers may also prefer orienting their activities either inside or outside the program. Such a preference would also affect their definition of success.
Participants expressed confidence in their abilities to perform individual aspects of their role. However, they did not feel they could engage effectively in all aspects of the role. No direct link could be made between the findings and Mintzberg’s contention that to be successful, managers need to be well rounded, that is, managers need to balance the roles of thinking, communicating and controlling, linking and leading, and doing. But having said that, when participants’ responses were considered, evidence emerged that participants who emphasized one aspect of managing over the other two demonstrated some of the problems Mintzberg predicted. Those participants who focused on the action level by doing and responding to problems at the unit level felt somewhat powerless and burnt out. Those who focused on the information level by mapping trends in health care and dealing with raw data felt disconnected from the people who worked for them. Those who focused on the people level concentrated on team building and conflict management on a daily basis. They felt they lacked the opportunity to connect with senior management; as a result, they were unsure of their direction and did not have the opportunity to advocate for the staff and the unit. If managers conceived of their role in terms of a management model or theory, they might be more aware of the need to balance their activities among the various parts of the role and be better able to articulate the role to others. Using a framework to understand the complexity of the role may also help managers to judge their success more realistically.

Participants identified factors that contributed to their success. Activities they chose to engage in included (a) supporting the staff’s professional development, (b) providing leadership, and (c) challenging themselves to learn and grow. Providing leadership and contributing to the growth of others are aspects of the role the literature
cited as most important because they have a powerful and direct influence on the productivity of unit personnel. (Baxter, 1993; Fox, Fox, & Wells, 1999; Laschinger & Shamian, 1994). The literature also lent support to the participants' belief that transformational leadership is essential in a decentralized organizational environment that is continuously changing and demanding different things of people, and that relies on staff to make independent decisions that reflect organizational values (Laschinger, Wong, McMahon, & Kaufmann 1999).

Moreover, participants believed that their success depended on their ability to challenge themselves and learn from experience. Their belief is supported by Noer (1997), who proposed that learners are the people who contribute to the success of organizations by holding them together. Learners are different from those who are not comfortable with change or do not know how to make change happen. As he defined them, learners have a high capacity for change and a high level of comfort with that change. They respond actively to transitions by engaging the issues and growing as people: “In an existential sense, they are the adhesive, they hold organizations together. Learners are what separate organizations that will grow and thrive from those that will wither and die.” (Noer, 1997, p. 89).

Participants acknowledged that organizational factors such as being recognized, supported, and trusted, as well as being served by an effective organizational change process helped them manage successfully. Although Mintzberg’s model does not specifically address what supports managers need to flourish in today’s environment, Donner and Wylie (1995) noted in a survey of Ontario nursing managers that receiving
adequate recognition and support and being trusted by others are critical to managers’ success and quality of worklife.

Although participants were able to discuss successful aspects of their role, a sustained overall experience of being successful eluded them. They attributed the feeling of unsustainable success primarily to being spread so thin that they did not feel they could do anything well. Other first-line managers in Ontario have reported role conflict as a result of having large numbers of staff reporting to them while they tried to spend the time necessary to develop staff, ensure quality care at the unit level, and address program and organizational needs related to fiscal restraint and a rapidly changing environment (Donner & Wylie, 1995). Porter O'Grady (1995) noted that as a result of new organizational designs, "managers are now responsible for broader areas of function as integration expands their locus of control and challenges them to assume more of the activities of the organization that have impact on the viability and success of the services they are providing" (p. 2). The finding that managers experience role conflict may suggest that organizations should systematically review the span of control, or the number of people reporting to a manager. For example, although managers’ span of control was usually increased as the staff’s level of education and expertise increased, managers reported that staff still required a significant amount of support.

Although the study of span of control in nursing has been largely neglected, Alidina and Funke-Furber (1988) identified a set of principles to guide the process of determining span of control based on findings from the management literature and from interviewing staff in a Canadian hospital who supported reviewing span of control at the study site. For example, the researchers proposed:
that while the assumption has been made by many that employee education allows a greater number of staff to be supervised [by one manager]... another group of researchers caution that as subordinates ... become more expert, a manager's span of control could become narrower. A narrower span of control may be necessary because more educated and expert people are usually employed in more complex tasks. Also when a complex task is of an innovative or developmental nature, closer collaboration and interaction may be required between the manager and nursing staff which necessitates a narrower span of control (Alidina & Funke-Furber, 1988, p. 37).

The findings of the current study suggested that managers are struggling with the increased need to support staff who are caring for sicker patients while at the same time staff are learning to be more involved in their own governance through responsibilities such as self-scheduling.

Other factors related to span of control also emerged from the findings. For example, differences in the people being supervised narrows the span of control. In this study, participants indicated that they were challenged to learn about various sets of professional standards so that they could evaluate individuals' performance.

Managers reported that different strategies helped them carry on despite being able to achieve only patchy success. Some of these strategies reflect what Tonges (1997) described as finding fundamental solutions to fundamental problems: “Given the fundamental problem is that she [the manager] is overworked, the fundamental solution must entail finding a way to reduce her workload. She could delegate more to her subordinates, renegotiate responsibilities with a supervisor, appoint an assistant, or find
another job” (p. 66). Participants in this study were pursuing all these possible solutions. They were engaging in discussions to clarify organizational values and renegotiate their responsibilities. Some were putting assistants like a self-scheduling facilitator in place, and some were contemplating changing jobs.

In this study, managers found it difficult to use delegation as a strategy because those available to accept delegated work were few and far between. The role of delegation in health care requires more discussion; however, and no studies were found that addressed options for delegation by first-line managers working in acute care hospitals. The issue seems to be that given the essential nature of the work society expects of hospitals, namely, the involvement of front-line staff in the moment-to-moment caring of very needy people in a context of progressively inadequate staffing, the ability of front-line managers to delegate responsibilities to others is limited. Adding to managers’ dilemma is the decrease and even elimination of support staff such as clerical staff, educators, and data managers, which leaves few if any staff to whom the first-line manager may delegate. This delegation dilemma was highlighted by reports of senior management’s expectation that unit staff would automatically assume some of managers’ responsibilities as their scope broadened. But managers felt senior management did not understand the resource requirements to enable staff to assume added responsibilities.

Many of the strategies participants used were personal and, therefore, valuable in light of the belief that as a manager, the most valuable tool you bring to the job is yourself. Some of the strategies they employed were noted to help leaders through the “white water of change”-trying to maintain their perspective by taking breaks, realizing it was impossible to do everything at once and prioritizing as best they could, and
thinking about work as a journey rather than a destination (Tonges, 1997). Donner & Wylie (1995) also supported the need for managers to define their success over time in terms of career accomplishments.

Summary of Discussion

In summary the finding that the nature of leadership is affected by organizational design characteristics was consistent with the management literature (Charms & Smith Tewksbury, 1992; Leatt, Lemieux-Charles, & Aird, 1994; Porter-O’Grady, 1995). When different professions reported to them, managers were better able to manage resources effectively and were influenced to develop a more participative style of management. Furthermore, the study finding that the organizational advantages of design characteristics were fully realized when a trusting relationship existed between managers and their supervisors supported findings of Westmoreland (1990) and Donner & Wylie (1995). These studies demonstrated that a trusting relationship affected manager’s stress, their ability to choose priorities, and their willingness to take risks. The finding that programs and managers become isolated from each other as a result of integrating activities and people to the programs supported the organizational design literature (Charms & Smith Tewksbury, 1992). When the flow of information among programs and between programs and the hospital executives is hindered, managers’ role of nerve centre was compromised.

The finding that the nature of managing is about taking on more and more in a lean management structure, supported Mintzberg’s (1989) accepted view of managing as a complex role involving a diverse set of activities that are characterized by brevity, variety and discontinuity. The findings that managers are engaged in all areas of
managing, namely, inside the unit, within the organization and outside the organization, and at all levels of managing, namely, at the action, people and information levels, supported Mintzberg’s model. Since the complex nature of the managing was illuminated by Mintzberg’s model of managing, the model may help managers articulate their role to others and help them judge their own success more realistically.

When considering the theme, maintaining a commitment to patient care in light of urgent resource issues, the finding that the roles of linking with others outside the unit and of leading staff within the unit are critical roles when managers are trying to manage resources wisely was consistent with Mintzberg’s model. The roles of linking and leading became especially important when managers are focusing on developing their staff and trying to manage decreasing resources. The literature offered no solutions to managers’ dilemma of being expected to delegate to front-line staff when staff can’t leave bedside care because of the high level of patient acuity. The finding that managers regretted not being able to spend more time on staff development was noted in the literature (Coulson & Cragg, 1995).

The finding that participants felt successful in ensuring quality of care but did not feel as successful in other areas of managing was documented previously (Weaver, Byrne, Dibella, & Hughes, 1991). The finding that providing leadership and promoting staff development contributed directly to managers’ success was supported by a 1999 study that found that leadership has the most effect on unit productivity (Fox, Fox, & Wells). It was evident from the data that personal priorities and preferences also contributed to the meaning of success for individual managers. The study provided some evidence to support Mintzberg’s belief that if managers focused primarily on the
activities of one of the levels of managing at the expense of the other 2 levels, then their ability to be successful was compromised, adding credibility to Mintzberg’s assertion that managing needs to be well rounded. The experience of patchy success was attributed to being spread too thin, an experience shared by other managers (Donner & Wylie, 1995).
CHAPTER 7: IMPLICATIONS, LIMITATIONS, CONCLUSIONS

Implications

This study explored the nature of managing from the perspective of first-line nurse managers working in program management. The findings suggest that characteristics of program management influence managing and that the nature of managing is about taking on more and more in a lean management structure, maintaining a commitment to patient care in light of urgent resource issues, and carrying on despite patchy success. Implications for management theory, research, education, and practice are discussed in the following section.

Implications for Theory

Findings of this study indicated that Mintzberg’s model of managing helps to explain the complexity of the role of first-line managing in health care and the relationship of individual activities to managing as a whole. Therefore, further testing of the model’s usefulness in other settings and in different organizational designs would both develop the model and add to our understanding of the nature of managing in health care facilities.

Study findings indicated that participants were keenly aware of their obligation to continue to provide the best care possible to the sickest people of their community even though the necessary resources were not always available. Further testing of the model’s ability to enhance understanding of the professional and personal impact of this responsibility on first-line managers is recommended.

Specific testing of Mintzberg’s model of managing is indicated, in particular, testing the model’s relevance to first-line managers working in program management is
recommended. Further research is needed to add credibility to Mintzberg's contention that managing needs to be well rounded, that is, each management activity should be worked through each of the three levels of managing, namely, the action, people and information levels.

**Implications for Research**

Study findings indicated that the integration of activities and people to programs influences the way first-line nurse managers lead. Since the program management design at the study site represented a highly integrated form of program management in which most professional and support services were combined under the programs, further research is recommended to explore the nature of managing in forms of program management that emphasize different degrees of integration of services. It would be helpful for managers and others to understand in more depth the factors that maximize the benefits of the program management design.

The finding that managers are taking on more and more responsibilities as a result of a trend toward decentralized decision making, integration of functions into programs, and the elimination of management positions, focuses the need for research into what constitutes an appropriate scope of responsibility for first-line managers. How much is too much, or, at what point does the continuous increase in role responsibilities of first-line managers negatively affect quality outcomes? Research is required to measure the impact of first-line managers on patient outcomes and organizational success. Research may shed light on the question of just how many layers of management can be removed and still provide the necessary support to front-line staff. As one participant indicated, "...I think the only problem is when you de-layer departments and you de-layer and take
away, you have to be very conscious of the fact that you may take away too much, and you may have to reinvest, that you may have to go back and put in systems because you really don’t know what you’re taking away until you take it all away and strip it all down it’s not always clear…” [M1].

It appears that part of the solution to this dilemma is to investigate the nature of delegation and empowerment in hospital settings in which front-line staff, those people most available to assume some of managers’ work, are experiencing a growing workload because patients are sicker and fewer nurses are available. Furthermore, an estimation of the costs of empowering staff in the ways hospital executives in this study envision will be required.

This study focused on nurses in the role of first-line managers because nurse managers were often the first to assume program management positions (Leatt et al., 1994). However, research is required to determine whether managers from other disciplines have the same experience of program management and face the same challenges.

Education, Preparation & Selection

Since study findings were consistent with components of Mintzberg’s model of managing, then the model has been helpful in explaining the nature of managing. Therefore, people who are currently in the manager role may benefit from using the model to articulate their role to others, to understand the relationship between the separate activities of managing and to help them judge their own success more realistically.

Managers found it impossible to use work time for their own development, because of the demands of the role. Strategies to help managers learn the skills and
develop the perspectives they need to manage in today’s health care environment include (a) assisting managers to return to school full-time with financial support provided in part or in whole by the organization, (b) providing opportunities for first-line managers to take a break from the demands of a first-line position by encouraging them to take advantage of secondments to the government or different organizations, and (c) making on-going career planning available to managers.

Participants measured their success in terms of their ability to learn on the run as they do and to promote front-line staff’s development. These abilities are important because, to a large extent, organizational goals are met and the advantages of integrated organizational designs such as program management are realized when front-line staff perform autonomously and make sound decisions. What does the knowledge of managers’ importance to front-line staffs’ performance mean for those who hire managers? It means that when considering people for management positions executives need to evaluate applicants’ specific achievements in developing and promoting staff.

The success of hospitals in the current resource-poor environment depends to a large extent on the ability of managers to be innovative, to see old problems in new ways, to be flexible, to establish trusting relationships, and to take risks in order to find new solutions. These skills are required if managers are to take an entrepreneurial approach to managing. The trend toward creating new graduate education programs that combine nursing and management degrees provides opportunities to appropriately develop future managers.

**Practice**

The integration of professional and support activities to the programs was reported to make managers more effective resource managers. In light of what appears to
be a trend to limited health care resource in Ontario, opportunities to promote integration of activities in acute care hospitals should be sought. Participants discovered that integration of a diverse set of professionals and support staff also encouraged them to engage in participative approaches to decision making that resulted in better decisions than they could have made themselves and decisions that were more broadly supported. This finding should motivate managers to encourage participation of staff as part of their management practice so that innovative ways of responding to the current health care challenges such as the nursing shortage can be found. As indicated in the findings, managers are responding to the resource issue of the nursing crisis by spending more time recruiting, interviewing, and orienting nurses, and supporting new graduates in the development of their clinical and professional competencies. At the same time, experienced staff are less able to contribute to the development of new staff because of the demands of sicker patients whose care is more complex and the decrease in support from clinical educators among others.

The finding that the advantages of program management, namely effective resource management and improved decision making were fully realized when a trusting relationship existed between managers and their supervisors, has implications for practice. In light of the finding that both managers and their staff are beginning to feel the consequences of taking on more and more responsibilities, and findings in the literature that nurses in Canada and abroad are concerned about declining quality of care (Aiken et al., 2001), managers need support to address these concerns. While it is clear that freeing the time for regular contact and dialogue is challenging given the demands on their time, both managers and their supervisors would benefit from the support and direction a
trusting relationship would provide in the currently unsettled health care environment. In this study, managers felt confident in their ability to take on new challenges and to learn new skills. However, the complexity of the situations they found themselves dealing with often requires support gained through mentoring. Managers need to learn the nuances of navigating in situations that may be ethically or politically charged and have no clear or obvious solutions. Westmoreland (1993) reports that managers find it helpful to be able to watch more experienced people engage in problem solving, therefore, if managers work closely with their supervisors, opportunities to learn on the job will present themselves.

Managers’ reports of feeling isolated from other programs and the activities of the organization as a whole are to be expected given the lack of coordination among programs that can exist in program management designs. Managers, their supervisors, and other hospital executives need to collaborate to create effective communication systems among programs to ensure that people in one program benefit from the work of those in other programs. When managers, the nerve centres of their units, are cut off from information about organization-wide trends then the identification of gaps in service and practice issues that affects the quality of patient care does not take place.

The finding that leading is a critical role when managers are trying to manage resources wisely is consistent with the findings of a 1999 study that leadership has the most impact on the productivity of unit staff (Fox, Fox, & Wells). However, the dilemma of how to free managers from focusing on the immediate concerns of the day with regard to patient care activities in light of the current nursing shortage and to focus instead on
activities with long term benefits such as developing the self managing skills of staff such as autonomous decision making, conflict management and team building still exists.

Managers are challenged to choose between conflicting priorities. As a result, a sense of overall job success eludes them. Since lack of job satisfaction and role clarity are important contributors to job burnout and poor performance, (Mirvis, Graney & Kilpatrick, 1999) efforts to improve managers’ satisfaction with the role need to be found. As Drucker has suggested (1993) individual managers need to identify with their supervisors, what they and they alone can do, that if done well, will make a difference to the success of organization. Managers in this study identified their belief that they can do almost anything but they can’t do everything at the same time. If they negotiated the focus of their role, and thought of themselves as consultants there to meet explicit goals and make a difference in a specific area, their success rate and job satisfaction might improve, making them more effective.

Limitations

The sample size of only 6 nurse-manager participants limits the transferability of findings to other settings. As well, the study was limited to one site, therefore, future studies could include other sites to determine the applicability of the findings to different settings.

Participants from two different roles were included in the sample to capture the perspective of the whole of first-line managing since their roles had evolved in such a way that they both shared responsibility for front-line staff. While both roles met the selection criteria, in retrospect this sample may not have been as homogeneous as first
thought. A lack of sample homogeneity may have decreased the ability of readers to determine the transferability of the findings to their own situations.

An unstable organizational climate existed during the interviewing process that the researcher did not become aware of until after data collection had begun. A change in the members of the hospital’s executive team with an accompanying change in management philosophy and a different way of viewing program management came to light during the interviews. The change in the executive team membership undoubtedly influenced the perspective of the participants and ultimately the findings, but there is no way of knowing in what way or to what extent. Because today’s health care organizations are so complex and influenced by so many societal factors it is difficult to predict what the influences will be during the study period.

Conclusion

In the current environment, forms of program management continue to be developed and implemented for various reasons, including the need to get the most from decreasing resources and to ensure accountability for outcomes. The nursing shortage is now a critical human resource issue that was only beginning to affect managers when this study was conducted. Furthermore, new evidence continues to support the importance of the role of first-line managers to organizational success. Therefore, the role of managing in health care facilities is an important area for further study.
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Roemer, L. (1996). Hospital middle managers' perceptions of their work and competence. *Hospital & Health Services Administration, 41*(2), 210-235.


APPENDICES
# Appendix A Methodological Characteristics of the Reviewed Studies

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<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Purpose &amp; theoretical perspective</th>
<th>Site/sample</th>
<th>Procedure</th>
<th>Analysis</th>
<th>Findings</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Mintzberg's Model of Management</td>
<td>20 FLNMgr</td>
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<td>Leader and resource allocator most important roles</td>
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<td></td>
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<td></td>
<td>Convenience sample</td>
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<td>Many manager activities unstructured/informal,</td>
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<td></td>
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<td>Emphasis on individual roles varies with situational requirements and managers' skills</td>
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<td>The ability to see whole picture may be unrealistic for a first-line manager</td>
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<td>Participative management &amp; power sharing are important to staff development and job satisfaction of the manager</td>
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</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Purpose &amp; theoretical perspective</th>
<th>Site/sample</th>
<th>Procedure</th>
<th>Analysis</th>
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<tbody>
<tr>
<td>Coulson &amp; Cragg (1995)</td>
<td>Exploratory Descriptive</td>
<td>To learn perceptions &amp; problems of nurse managers</td>
<td>1 acute hosp in Ontario</td>
<td>Semistructured interviews related to position, problems, and priorities</td>
<td>Constant Comparative analysis using Miles, Huberman &amp; Strauss approach</td>
<td>Two major themes were (a) conflict within &amp; among roles, and (b) strong need for support</td>
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<td></td>
<td></td>
<td>Mintzberg's Model of Management (adapted)</td>
<td>10 FLNMgr purposive sample</td>
<td></td>
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<td>All managers fulfilled the roles outlined in the adapted Mintzberg model; however, their approaches to the position and their emphases differed widely</td>
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<tr>
<td>Donner &amp; Wylie (1995)</td>
<td>Population survey and Focus groups</td>
<td>To describe current role of nurse mgs in Ontario hospitals, To identify indicators of success as perceived by these nurse mgs &amp; strategies to increase the success &amp; job satisfaction of nurse mgs</td>
<td>Nurse managers in Ontario hospitals N=1352 (65% response rate).</td>
<td>Mailed survey Questionnaire based on Miller Carey Work Role Inventory</td>
<td>Mean &amp; standard deviation of each Indicator</td>
<td>Nurse mgs are: age = 48.3 years mean education = 45% BSc experience = 67%, &gt; 6 yrs mgr # of reports = 58.8% have 40 or fewer, 14.5% have &gt;60 people reporting to them</td>
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<td></td>
<td></td>
<td>Miller-Carey Model of Work Role Expectations</td>
<td></td>
<td>Investigator developed demographic questionnaire Focus groups</td>
<td>Descriptive statistics &amp; tests of differences</td>
<td>Role traits are split 50/50 between mgt focus traits/interpersonal focus traits</td>
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<td>Study</td>
<td>Design</td>
<td>Purpose &amp; theoretical perspective</td>
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<tr>
<td>Duffield, Donaghue, Pelletier, &amp; Adam</td>
<td>Exploratory</td>
<td>To determine respondents' perception of importance &amp; relationship between 156 competencies in the FLNMgr role</td>
<td>34 hospitals with &gt;100 beds in Australia</td>
<td>Questionnaire with 156 competencies divided into 4 parts: functional mgmt, pt. care mgmt, staff mgmt &amp; leadership</td>
<td>Factor Analysis of ratings</td>
<td>3 main categories of competencies concerning (a) economic mgmt, (b) staffing, &amp; (c) personal/professional development of FLNMgr were deemed most important by managers</td>
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<td>(1993)</td>
<td></td>
<td>None reported</td>
<td>N= 318 FLNMgr (77% response rate)</td>
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<tr>
<td>Everson-Bates (1992)</td>
<td>Ethnography</td>
<td>To examine beliefs, values, behaviours of FLNMgrs considered to be effective and successful in their practice</td>
<td>2 voluntary acute multiservice hospitals with decentralized departments of nursing in California</td>
<td>2 months intense observation of 1 mgr to develop semi-structured interview guide</td>
<td>Ethnographic Methodology</td>
<td>Essence of role is managing reality &amp; managing people</td>
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<tr>
<td></td>
<td></td>
<td>None reported</td>
<td>N=15 nurse mgrs</td>
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<td>The role can be described as 1 part task (paper work) and 4 parts process (social control, resourceing, translating/interpreting/ negotiating &amp; facilitating change)</td>
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<td>=2 DONs</td>
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<td>Profile created including characteristics and essential skills</td>
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<td></td>
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<td>=2 VPs</td>
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<td>Striking parallels within nursing, management, and lay literature</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Purpose &amp; theoretical perspective</td>
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<td>Laschinger &amp; Shamian (1994)</td>
<td>Descriptive survey</td>
<td>To explore link between empowerment concepts described by Kanter and the self-efficacy of mgers for executing leadership role competencies described in Quinn's Competing Values Model. Kanter's Structural Theory of Organizational Power &amp; Quinn's Competing Values Model of Management.</td>
<td>1 teaching acute hospital in Ontario. Proportionate random sample. staff N=112. FLNMgrs N=27.</td>
<td>Descriptive statistics Inferential statistics</td>
<td>Managers perceived themselves to have greater access to empowering structures such as information, support, supplies, opportunities. Most self-efficacy as facilitator/mentor role &amp; least in broker role. Monitor role associated least with overall manager empowerment. Managers empowered others through association.</td>
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<tr>
<td>Mark (1994)</td>
<td>Comparative</td>
<td>To discover trends in FLNMgr role &amp; explore implications for development of graduate programs for nurse managers. None reported.</td>
<td>Compared 5 surveys. Hodges 1987. 299 CNE/AONE members in U.S. Subset in SW U.S. N=44. 1988 survey of CNEs N=88 in Virginia.</td>
<td>not reported</td>
<td>not reported</td>
<td>Managerial activities will eventually make up the majority of FLNMgr work. Increased willingness of CNEs to hire master’s prepared managers. 83% of CNEs indicate nurse managers are most important in achieving organizational goals. 5 admin. activities fundamental.</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
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<tr>
<td>Miller &amp; Heine (1988)</td>
<td>Exploratory</td>
<td>To determine difference in role perceptions of FLNMgrs in various types of hospital settings</td>
<td>7 acute hospitals in SE U.S. 2 private 4 public 1 federal Convenience sample FLNMgr N=43 (47% response rate)</td>
<td>Standardized questionnaire based on Van de Van &amp; Ferry's Job Design Module</td>
<td>Not reported</td>
<td>to role of FLNMgr in a decentralized setting: final decision re. Firing/hiring, final decision re. Salaries/hiring/promotion, determining staffing standards, adjusting staffing levels &amp; being accountable for unit budgets Increase in involvement in these 5 key activities from 88% to 92% Conflicting opinions whether admin. or clinical knowledge more important for success</td>
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</tbody>
</table>

- **Study**: To determine difference in role perceptions of FLNMgrs in various types of hospital settings
- **Purpose & theoretical perspective**: To determine difference in role perceptions of FLNMgrs in various types of hospital settings
- **Site/sample**: 7 acute hospitals in SE U.S. 2 private 4 public 1 federal Convenience sample FLNMgr N=43 (47% response rate)
- **Procedure**: Standardized questionnaire based on Van de Van & Ferry's Job Design Module
- **Analysis**: Not reported
- **Findings**: To role of FLNMgr in a decentralized setting: final decision re. Firing/hiring, final decision re. Salaries/hiring/promotion, determining staffing standards, adjusting staffing levels & being accountable for unit budgets. Increase in involvement in these 5 key activities from 88% to 92%. Conflicting opinions whether admin. or clinical knowledge more important for success.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Purpose &amp; theoretical perspective</th>
<th>Site/sample</th>
<th>Procedure</th>
<th>Analysis</th>
<th>Findings</th>
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</thead>
</table>
| Nadeau (1991)         | Exploratory Descriptive | To identify & rank job satisfiers & dissatisfiers experienced by FLNMgrs  
To identify strategies to improve quality of manager worklife  
Walton's Quality of Worklife (QWL) Framework | 1 acute hospital in Ontario  
FLNMgrs N=36 | Open-ended questionnaire using Walton's QWL framework | Not reported | Ten top satisfiers were autonomy, challenge, positive staff attitude, adequate supervision, contact with patients/families, working relationships with medical staff, professional growth in nsg. staff, clinical speciality, support for education & control over work hours  
Ten dissatisfiers were workload, lack of payment for overtime, lack of job security, inadequate supports/resources, role ambiguity, budget pressures, rate and volume of organizational change, salary, lack of recognition, & paperwork |
| Weaver, Byrnes, Dibella, & Hughes (1991) | Survey | To investigate congruity between FLNMgr role expectation & actual competencies for enacting the role  
None reported | 11 acute hospitals in New Jersey in 1986-1987  
N=113  
FLNMgrs 61% | Skills questionnaire adapted from Stahl et al.  
Demographics questionnaire | Not reported | Actively perform skills they believe in performing related to the patient care aspect of their role |
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Purpose &amp; theoretical perspective</th>
<th>Site/sample</th>
<th>Procedure</th>
<th>Analysis</th>
<th>Findings</th>
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<tr>
<td>Wells (1990)</td>
<td>Descriptive survey</td>
<td>To examine the effect of organizational structure on the job satisfaction of FLNMgrs.</td>
<td>8 acute hospitals in Houston, TX</td>
<td>Demographic profile, Staff Satisfaction Scale</td>
<td>Not reported</td>
<td>In operations and human resourcing what the manager is actually doing is significantly different from what the FLNMgr believes he/she should be doing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None reported</td>
<td>4 teaching for profit and 4 corporate for profit</td>
<td></td>
<td></td>
<td>No significant differences between job satisfaction scores of nurse managers in decentralized and those in centralized acute settings</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Purpose &amp; theoretical perspective</td>
<td>Site/sample</td>
<td>Procedure</td>
<td>Analysis</td>
<td>Findings</td>
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<tr>
<td>Westmoreland (1993)</td>
<td>Exploratory</td>
<td>To describe what nurse managers experience and interpret as meaningful in their role</td>
<td>4 acute hospitals in Texas</td>
<td>Semistructured</td>
<td>Constant comparative analysis &amp; dialectic</td>
<td>Three categories of experience inform the participants’ role perspective: being a nurse, being a nurse manager, and being a person in various work situations over time</td>
</tr>
<tr>
<td></td>
<td>Descriptive</td>
<td>Symbolic Interactionism Belenky's Women's Way of Knowing Model</td>
<td>Purposive-diverse sample FLNMgrs N=9</td>
<td>interviews</td>
<td>processes</td>
<td>Superior, subordinates, &amp; self inform the role definition of study participants</td>
</tr>
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<td></td>
<td>Role conception formed through association with their relationships with self &amp; others, their definitions of nursing, their definition of problematic situations and coping behaviours &amp; perceived costs of stress</td>
</tr>
</tbody>
</table>
Appendix B Letter of Introduction to the VP

My name is Jane Hollett and I am a registered nurse working in clinical practice. I am also a Master of Science student in the Department of Nursing Science at the University of Toronto. As part of my program, I am doing a study under the supervision of Dr. Gail Donner who is a professor in the Department of Nursing Science of the University of Toronto. The purpose of my study is to learn about the experiences of first-line nurse managers who are working in program management. I hope that knowledge about their experiences will help prepare other first-line managers for the role and contribute to their success in program management. I am writing to seek permission to speak with the first-line managers’ supervisor so that I may ask him or her to explain the purpose of my research study and invite managers to participate. Ethical approval for the study has been obtained from the Office of Research Services, University of Toronto (see attached).

The study will involve a private interview of approximately 1-1 1/2 hours with each manager who agrees to participate. The interview will be conducted at a time and place chosen by the manager. I would like to interview 6-10 first-line managers in total. I will ask first-line managers to describe what it is like to be a manager in program management. I will also ask some specific questions about the role and managers’ experiences.

The criteria for potential subjects to be included in the study are:
1. The manager is a registered nurse and currently working full-time in the position of first-line manager in program management.
2. The manager has 24-hour responsibility for more than one patient care unit or area.
3. The manager has acted in the role for at least one year.
4. The manager must volunteer willingly to participate.

The name of the hospital and names of managers will not be printed in any reports of the study. Study findings will not be shared with senior management at the hospital.

Being in the study may not help first-line managers directly, but they may benefit from talking about their experiences. Their participation in the study may help other first-line managers working in program management in the future.

I am available to answer any questions about the study and can be reached at 416-782-1016. Dr. Gail Donner can be reached at 416-978-2861.

Sincerely,
Jane Hollett, RN, BScN, MSc(Student)
Appendix C Letter of Explanation about the Study

My name is Jane Hollett and I am a registered nurse working in clinical practice. I am also a Master of Science student in the Department of Nursing Science at the University of Toronto. As part of my program, I am doing a study with Dr. Gail Donner who is a professor in the Department of Nursing Science of the University of Toronto. The purpose of my study is to learn about the experiences of first-line nurse managers who are working in program management.

If you agree to be in the study, I will interview you for about one to one and a half hours. We will meet at a place and time that is convenient for you. I will ask you to describe what it is like to be a manager in program management. I will also ask you some specific questions about your role and your experiences. At the end of the interview I will ask you some specific questions related to your span of responsibility.

Your name and the name of the hospital will not be printed in any reports of the study. Nothing you say will be shared with senior management.

Being in the study may not help you directly, but you may benefit from talking about your experiences. The results of the study may help managers in the future.

To allow me to focus on the interview process, I will audio-tape-record the interview. Your name will not be recorded on the tape. You may review the audio-tape if you wish. The audio-tape recordings will be kept in a safe place by me and will be destroyed when the study is complete.

Sincerely,
Jane Hollett, RN, BScN, MSc(Student)

You may choose to be in the study if:
1. You are a registered nurse and currently working full-time in the position of first-line manager in program management.
2. You have 24-hour responsibility for more than one patient care unit or area.
3. You have acted in the role for at least one year.

If you have any questions about the study please call me at 416-782-1016 or Dr. Gail Donner at 416-978-2861.
Appendix D Interview Guide

1. Introduction

I would like to thank you for volunteering to participate in this study. At this time I would ask you to review the letter of explanation about the study. (allow time for reading)

Do you have any questions about the study? (allow time for questions)

I would like you to read and sign the consent form at this time. (Have the participant sign two copies and give one to him/her).

2. Interview Questions

Now I am going to ask you about your experiences.

Grand-tour question:

1. Tell me what managing is like in program management?

**Use floating prompts to sustain dialogue such as nodding, saying yes/uh-huh, repeating single words with inflection.

**Make notes of words, phrases, or ideas that should be returned to later in the interview.

Contrast questions:

1. Is managing different than it was before program management was introduced?
   a) How is it different?
   b) What is it like now?
   c) How do you feel about that?
   d) Why do you think it's different?
   e) Do you think it's different because of program management?

2. Is your life different than it was before program management?
a) How is it different?

b) What is it like now?

c) How do you feel about that?

d) Why do you think it's different?

e) Do you think it's different because of program management?

**Category questions:**

1. Do you think succeeding in the role of manager is different in program management?

   a) How is it different?

   b) What is succeeding in the role like now?

   c) How do you feel about that?

2. Do you think your relationships at work have changed because of program management?

   a) How have they changed?

   b) What are they like now?

   c) How do you feel about your relationships at work now?

   d) What about with the staff? Have your relationships with staff changed?

   e) Why do you think they are different?

   f) Do you think it is because of program management?

3. What issues are you engaged in now?

   a) Are they different than they were before program management?

   b) What are they like now?

   c) How do you feel about that?
d) Why do you think they are different?

3. Summary

Is there anything else you would like to tell me? Anything you think might be important for me to know about your experiences.
Appendix E Demographic Profile

Now I am going to ask you some questions about the scope of your responsibility.

Manager's Code #________ mgt focus

No. of service units or program units responsible for:_____

Description of units:

<table>
<thead>
<tr>
<th>Service/Program Unit Name</th>
<th>Description: services etc.</th>
<th># of beds or visits/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</table>

Description of total nursing and non-nursing staff:

<table>
<thead>
<tr>
<th>Category</th>
<th>#FTE</th>
<th>#Staff (head count)</th>
</tr>
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<tbody>
<tr>
<td>RN</td>
<td></td>
<td></td>
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<tr>
<td>RPN</td>
<td></td>
<td></td>
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<tr>
<td>CNS/Educ</td>
<td></td>
<td></td>
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<tr>
<td>Clerk</td>
<td></td>
<td></td>
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<tr>
<td>Multiskilled Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</table>

Total size of budget (check one):

<table>
<thead>
<tr>
<th>Size of budget</th>
<th>&lt; $1 million</th>
<th>$1-3 million</th>
<th>$3-5 million</th>
</tr>
</thead>
</table>
Reporting relationship:

| Position | Professional Designation |

Thank you very much

Do you have any questions you want to ask before I go?

May I call you if I need to clarify anything you have told me?

Thank you very much for being in the study.
Appendix F Consent Form for all Managers

I, __________________________ agree to take part in Jane Hollett's study of first-line nurse managers' experiences in program management.

I have read and understood the letter of explanation about the study. I understand that the purpose of the study is to learn about the experiences of managers who work in program management.

I understand that I will be interviewed for about one to one and a half hours. I do not have to answer any questions I don't want to. I can stop the interview at any time.

I understand that I may not benefit directly from being in the study. Other managers may benefit in the future.

I understand that what I say will be audio-tape-recorded but that my name will not be recorded on the tape. I understand that I can review the audio-tape if I wish. I understand that Jane Hollett will keep the audio-recordings in a safe place. I understand the audio-recordings will be destroyed when the study is complete. My name and the name of the hospital will not be printed in any reports of the study. Nothing I say will be shared with senior management at the hospital.

______________________________   ______________________________
(Date)                          (signature of manager)

I have explained the nature of the study to the manager and I believe that he/she has understood it.

______________________________   ______________________________
(Date)                          (signature of researcher)
Appendix G Master List

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Participant Code</th>
<th>Letter of Explanation Given</th>
<th>Consent Signed</th>
<th>Interview completed</th>
<th>Interview transcribed</th>
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Appendix H Post-Interview Summary

**The researcher will ask herself the following questions immediately after the interview.

1. What were the main issues or points that struck me in this interview?

2. Summarize the information received form each interview question.

3. What changes should I consider for the next interview?

4. Do I need to add other terms to the Definition of terms? Were should it go? Appendix or body of text?
Appendix I Definition of Terms

Program Management

Program Management is an organizational design that facilitates integration of clinical functional and medical activities and coordination of work among departments or units. Programs may be defined by population group (ageing), disease (heart), patient need (rehabilitation), type of service (ambulatory) and by medical speciality (surgery) (Leatt et al., 1994).

First-Line Management

First-line management is the first level of management with responsibility for directly supervising non managerial care providers (Sullivan & Decker, 1992).

Expanded Role of First-line Managers

The expanded role is defined to include 24-hour responsibility for one or more clinical areas or programs and decisional authority concerning budgetary and personnel issues, standards of practice, and development of the unit(s) to support working relationships. Managers in the expanded role have line authority for all unit/program professional and support staff, and report to a person at the director level (Everson-Bates 1992).

Perspective

The underlying beliefs, values and assumptions which forms the paradigm or lens through which people view the world. Perspective shapes the way people perceive, understand and make sense of the their experiences. Perspective determines behaviour or the way people act and interact with the world (Rogers, 1991).