Qualifications and experience: how well prepared are nurse managers compared to health service executives?

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Abstract

The purpose of the paper was to compare the demographic details, educational qualifications, professional support and career guidance experiences of two groups of health managers as reported in previous research. One group comprised nurse managers (Duffield et al 2001) and the other comprised senior health administrators (Harris, Maddern & Pegg 1998).

Employment and education data from self-administered questionnaires were compared. Nurse managers were predominantly female (88%), while the administrators were 50% female. The nurse managers, although with a relatively equal rate of managerial qualifications as their health service counterparts, had not attained as many senior positions in health care administration. Over half had not had a mentor.

Nurse managers have skills attained through their academic studies and experience that cause them to be as capable as (if not in some cases better than) health service administrators. Increased use of mentoring may provide opportunities for professional advancement in wider administrative areas.

Purpose of the study

The most senior responsibility for the management of health care institutions has in Australia largely been the domain of generalist managers or members of the medical profession. It has very rarely involved members of the nursing profession. Reasons for this could include the lack of academic qualifications held by nurses, or perhaps to a much lesser extent a lack of experience deemed to be appropriate. The transfer of responsibility for nursing education to the university sector in the mid-1980s had a 'flow-on' effect in that nurses are now enrolled in higher degrees in bigger numbers than ever before (Pelletier, Donoghue et al 1998). While this may not necessarily translate to enhanced qualifications for nurses in management positions, there is every reason to believe that this should occur.

If nurses are to continue to contribute, as they surely must, to health care administration at all levels, it is essential that they are able to compete with others on a level playing field. This paper will provide a comparison between nurse managers and health services managers in terms of qualifications and years of experience. This will be important if nurses want to be marketable and fit the profile required of health care administrators in the 21st century.

This article will use two sources of primary data to compare the demographic details, educational attainment, and professional support and career guidance experiences from two groups of health managers. The first group comprises all nurse managers in one of the largest area health services in Australia (Duffield et al 2001), while

the second comprises a sample of senior health administrators from across Australia and New Zealand (Harris, Maddern & Pegg 1998).

Nurses in health care management

Mintzberg (1994) called nurse managers '*natural managers*', applauding their ability to juggle the many priorities and their ability to mix managerial characteristics and activities into a *'craft style*' of management practice. Dean (1990) similarly pointed out that what distinguishes nurses in health services management from their non-nurse counterparts is their unique understanding of the art and science of nursing and an acute appreciation of the many aspects of clinical care.

Nurse managers are frequently described as being central to health care organisation and the delivery of efficient, effective, high quality health services (AONE, 1992; Mark, 1994; Herrin & Prince, 1994; Corser, 1995). There are three main reasons for this. The first is that nurses working as managers (by way of their background in the clinical area) have a clear appreciation of the day-to-day workings of clinical practice including the tensions and competing priorities that can occur. They have a good understanding of how the system works in a practical sense and can visualise the impact of policies more readily. This gives nurses in management the ability to translate and operationalise policies more effectively into clinical areas. Secondly, their clinical knowledge and experience, coupled with their management expertise, enable nurses in management to contribute at higher organisational decision making levels. Finally, they are also perceived to be credible to their staff. Brewer & Lok (1995) for example, in an Australian study of management strategy and nursing commitment, found a high degree of mistrust between senior management and nurses. Their findings suggested that nurse managers (particularly middle nurse managers) played a major role in generating commitment to the health care organisation because the nurses both trusted and identified with them.

How well are nurse managers prepared for their role?

Although it is acknowledged widely in the literature that nurses have the potential to make excellent health service managers, there is little consensus regarding how they should be prepared for the task. Nurse managers have thus far been remarkably adaptable, increasingly taking on non-traditional roles within health service organisations – for example, as business or human resource managers, facility planners or policy analysts.

They are also increasingly taking positions at more senior levels of health care organisations, signalling their own confidence and a perception by those who employ them that they not only have the ability to perform but are also able to fulfil competencies expected of modern day health service senior administrators. However, in an ever-changing management workforce profile, it is unwise for nurses in health care management to rest on their laurels. Indeed they must strive to become even more competitive.

Nurses in management positions need to possess many skills and attributes. For example, Dubnicki & Sloan (1991) studied nurse manager competencies and identified five key skills required of successful nurse managers as being able to get the job done, work through others, work with others, problem solve, and manage oneself.

A primary way of achieving these competencies is through academic preparation. The literature provides many examples of the global shift towards the academic preparation of nurses and health service administrators (Smith & Friedland 1998; Krejci 1999; Ingersoll et al 2000; Aiken, Havens & Sloan 2000). This includes developing a range of skills such as critical thinking through participation in academic assessment and development of theoretical perspectives. Academic preparation builds on existing experience and also gives students the requisite knowledge to perform proficiently in other key managerial areas such as being able to lead, organise complex tasks, manage their time, process change, have clear and concise writing skills, and be able to synthesise information quickly and effectively.

The 1999 study (Duffield et al, 2001) and other studies from the US give clear evidence that nurse managers (in common with other health service employees) are becoming increasingly more highly qualified. Krejci (1999), in a US survey of nurse administrators, found that 68.3 percent of respondents had masters degrees and

10 percent held doctoral degrees. Ingersoll et al (2000), in a survey of all hospital staff at a hospital in America's Mid West, found that 61.9 percent of the respondents (13.7 percent of whom were unit or department managers) had qualifications at bachelor level and 20.9 percent had either masters or doctoral qualifications. Smith and Friedland (1998), in a US study, highlighted the benefits of higher education for professional autonomy, which they linked to increased job performance in terms of nurse managers being able to take appropriate and necessary risks. Finally, Aiken, Havens & Sloane (2000), in a study of Magnet hospitals in the US, found that such institutions had significantly higher levels of bachelor-prepared nurses, also suggestive of the link between quality and level of qualification.

This is in marked contrast to Australian studies in the 1980s. They showed a low level of academic attainment amongst directors of nursing, with only 30 percent holding a college diploma or degree (Rawson 1998) and approximately 15.5 percent of first-line nurse managers at diploma or bachelor degree level (Duffield 1992). More recently, Courtney, Yacopetti, James and Walsh (2001) found that, at the nurse executive level in Queensland, at least 75% of nurse managers had a bachelor's degree, and 18% of directors of nursing had a master's degree while 34.5% of assistant directors of nursing did so.

Educational attainment alone does not provide a complete picture as to how nurse managers should be prepared. For instance, there is a strong consensus in the literature that a judicious mixture of mentorship and nurturing, as would occur in a managed succession program, might also be critical in the development of effective nurse managers. But just how does succession management planning and mentorship help to prepare nurses to manage in the health care sector?

Little formal research has been done into the impact of succession planning and mentorship on the career outcomes and performance of nurse managers. However, several examples of effective succession management are available in the literature and both strategies are generally considered valuable (Wiersema 1992; Andrica 1994; Feist-Price 1994; Hensler 1994; Johnson, Costa, Marshall, Moran & Henderson 1994; McConnell 1996, Cope 1998; Walker 1998; Garret & Orr 1999; Walsh & Borkowski 2000). Succession management has been described as an organised way of identifying and developing talented individuals within organisations and giving them the opportunity to advance and achieve promotion (Johnson, Costa et al 1994). McConnell (1996) argues that in today's environment of rapid change in health care, no organisation that hopes to keep up with the competition can afford a leaderless period while replacements for outgoing managers are recruited.

Succession management has a long track record in industry and has been successful in lowering staff turnover rates, improving staff morale and placing those most able in key positions within the organisation (Johnson et al 1994). A survey of 305 hospitals in the US indicated that 74 percent of chief executive officers were preparing their successor from within their senior management team (Hudson 1993). Andrica (1994) also points to the fact that succession management can be used to retain talented employees, maintain organisational vision, heighten morale and provide a return on investment by organisation on employees. Succession management can take several forms and occurs at all administrative layers within health care organisations. If done well, it can substantially enhance the quality of leadership and the pool of talent that are needed to meet present and future business requirements (Walker 1998).

There is clearly much scope for professional support and development within health care organisations. Mahaffey, Kaplan & Triolo (1998) point out that fellowship, although widely used within medical circles, is seldom used by nurses as a way of achieving professional development. They suggest that postgraduate nursing fellowships may be a way of developing skills such as change management, goal directed behaviours and strategic planning in future leaders.

Garrett & Orr (1992) argue that the nurturing of fledgling leaders must not be left to chance, suggesting that the many competing demands of the workforce prevent voluntary professional developmental support from occurring as a matter of course. They describe a fellowship program in New York State, USA, which was set up to foster leadership development amongst advanced nurse practitioners and nurse managers.

Mentoring is also frequently referred to in the literature as a way to foster professional development. Mentoring has been variously defined but is generally understood to mean the fostering of the professional development of protégés (Stewart & Krueger 1996). Mentoring therefore can include coaching; providing training; stimulating knowledge attainment; giving organisationally based information about available programs; being supportive;

encouraging and facilitating the development of coping mechanisms; providing role socialisation in regard to organisational imperatives and requirements; fostering an appreciation of organisational systems; being a role model; being a motivator; nurturing the protégé's self confidence and esteem; and protecting the protégé from potential mistakes and problems (Blackwell, 1989 cited by Feist-Price, 1994).

Mentoring ranges from the informal to the formal, may take on several forms (Feist-Price 1994) and has been cited as a contemporary skill of nurse executives (Vestal 1995). However, it is not clear to what extent mentorship can or does exist in reality. Pannowitz (1999), for example, argues that little is known about what mentoring, if any, exists in hospital settings, arguing that it is unusual for new nurse managers to experience a work culture conducive to open disclosure of work related problems, and that owning up to a lack of expertise can be perceived as being risky.

A further factor of note is that the majority of nurses are women and therefore not automatically associated with attaining positions in high-level management (Sebrant, 1999). This author also argues that a flexible and anti-authoritarian approach to work organisation gives women better opportunities to develop in their roles and accept positions of leadership (Sebrant, 1999). There is also some evidence that points to the fact that mentoring might be beneficial to women in health care management. For example, a study by Walsh & Borkowski (2000) found that mentoring relationships positively influence the career development of female managers in the health care industry particularly in terms of promotion and remuneration.

Background to the two comparative studies

In 1998, Harris, Maddern & Pegg published the results of a study that examined the impact of change (over a six year period) on the roles and careers of a group of health service managers in Australia and New Zealand and the influence of professional and education programs on their career prospects. They used a randomised postal survey and structured interview, stratified by level of College membership, and 135 people responded (a rate of approximately 31%). A survey of non-respondents (n=45) confirmed the validity of these initial respondents as representative of the whole group in terms of demographic characteristics. Nurses were surveyed, but they comprised only a small sub-sample of respondents.

In 1999 a team of managers based in one of the largest area health services in Australia (Duffield et al 2001) repeated a study similar to one first undertaken in 1989 (Duffield 1992), to determine a demographic profile of nurse managers with whom comparisons with other available data could be made. All nurse managers were invited to complete a 28-item questionnaire in which a combination of dichotomous, multiple choice and open response questions were asked concerning the respondent's employment characteristics, education history and career future career plans. For this article two categories of the data were analysed: employment data; and education data. Following ethics approval and piloting, questionnaires were distributed by the research team to each site following a presentation about the research purpose. 269 questionnaires were disseminated of which 205 were returned, giving a response rate of 77 percent. The data from these two studies will be compared.

Findings and discussion

It is important to note that the samples were taken at different times and in different places. However, in acknowledging this, it is still possible to draw some conclusions about how nurse managers are developing within existing health care organisations, particularly in comparison with managers in the health service overall.

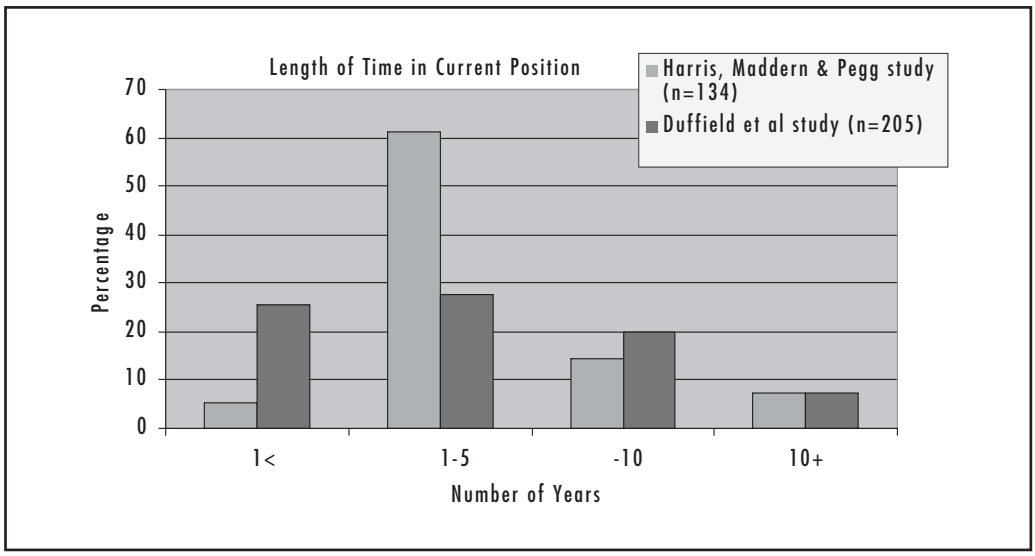
Table 1 indicates that, compared to the Harris, Maddern & Pegg (1998) findings, the nurse managers in the 1999 study (Duffield et al 2001) represented a distinctly younger group which was also predominantly female. This is not surprising considering nurses are predominantly female. Table 2 indicates difference between the two studies' respondents in length of time in their current position.

Table 1: Comparison of key data

Data shown in percentages	Harris et al.	Duffield et al.
Age		
<50 years	68.1 (n=94)	81.9 (n=167)
>50 years	31.9 (n=38)	18.1 (n=37)
Gender		
Male	50.4 (n=67)	11.7 (n=24)
Female	49.6 (n=66)	88.3 (n=181)
Percentage with a management qualification	51 (n=135)	49 (n=205)
Indicators of professional support and guidance		
No mentoring during career		51.5 (n=105)
Dissatisfied with quality of supervision	55 (n=N/A)	

Sources: Harris, Maddern & Pegg 1998, Duffield et al 2001

Table 2: Comparison of length of time in current position by respondents in the two studies



From Table 2 60 percent of respondents in the Harris, Maddern & Pegg (1998) study, compared to over 20 percent in the 1999 study (Duffield et al, 2001) have been in their position for 1-5 years which, perhaps reflects some stasis for senior managers or alternatively, lack of retention of nurse managers. Interestingly, for the managers in the Duffield et al (2001) study the modal number of years in their current position was one year. This was thought to be due to temporary cover for leave, for example maternity leave (of up to one year) and secondment of more junior managers to more senior positions elsewhere in the organisation.

Table 3: Comparison of qualifications held by respondents in the two studies

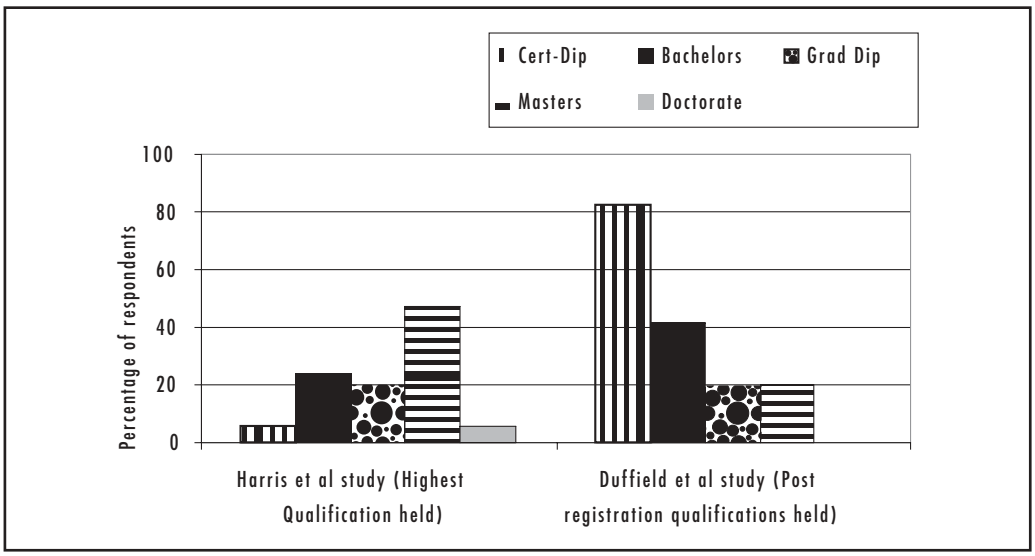


Table 3 shows that, when compared to the larger health service management group (Harris et al 1998), the nurse managers (Duffield et al, 2001) showed relatively equal rates of attainment of managerial qualifications. For nurse managers (Duffield et al, 2001), 40 percent had a bachelor's degree whilst less than 20 percent held a master's degree, a lower proportion than that found for health services managers where, over 40 percent of (Harris et al 1998) held masters level qualifications. Over 50 percent of the nurse managers who were currently studying were doing so at masters level and significantly fewer (less than 10 percent) were studying at bachelor level (Duffield et al, 2001). This indicates that the nurse managers (Duffield et al, 2001) are as competitive in terms of academic qualifications and achievement.

Nurse managers (Duffield et al, 2001) were asked if they had ever had a mentor. Table 1 indicates that just over half said that they had not. This is significant when linked to the findings of Harris, Maddern & Pegg (1998) who reported that 55 percent of respondents were dissatisfied with the quality of supervision they received. This is also borne out in the findings of Walsh & Borkowski (1999) in the US, who found that whilst 54 percent of females in their study had had a mentor, 46 percent did not have a mentor in the health care industry. Of the male managers in their study, 68 percent did not have a mentor and only 32 percent were currently involved in a mentoring relationship. In view of the fact that the literature clearly supports the notion of mentoring and professional support being linked to effective and efficient succession management, particularly in the case of women (Walsh & Borkowski, 1999), there is clearly a missed opportunity to nurture the leadership development of nurses in management and indeed all managers.

Nurse managers in the Duffield et al (2001) study were asked to indicate factors that influenced their leadership development. Several respondents indicated that role models (both good and bad), learning by experience and support, and encouragement from peers and more senior management were influential. Other more senior managers appeared to be important personal influences on their role development (Duffield et al, 2001).

Conclusions

Girvin (1998) has suggested that leaders in clinical areas need to be educational, political and managerial leaders. Thus, a portfolio of both clinical and managerial skills is necessary. If, it is argued, nurses are equipped with the requisite knowledge, skills and ability then they will be well placed to lead in management at any level.

The literature points strongly to the fact that all staff in health care organisations are becoming increasingly more highly qualified. However, without professional support and development, the potential benefits of a highly skilled workforce are likely to be lost. Those at the helm of health care organisations must develop and nurture those who will follow them up the career ladder. Similarly, it is the business of academic institutions to work closely with health care managers to ensure that the skill pool is readily available (Rudan & Frederickson 2000; Silvetti 2000).

The research presented in this article clearly demonstrates that, when compared to their health service counterparts, nurses are both qualified and ready to rise to these demands and that being both clinically competent and academically prepared gives them a clear advantage in the health care market. However, on a more cautionary note, some US commentators have expressed concern that nurses are no longer drawn to management roles (Rudan & Frederickson 2000, Silvetti 2000, Sullivan, 2000). Perhaps this is because what appears to be lacking is a clear career path and structured professional support and supervision strategies to encourage the development of talented individuals identified in health care organisations.

Several authors point to the critical nature of nurture within the nursing profession (Joel, 1997, Wright, 1997). Stewart & Kreuger (1996) argue that, whilst mentors and protégés are not born in classrooms, they are cultivated by academic settings. Mentoring therefore is a unique relationship born from the mutual need for professional connectedness, interpersonal development, scientific inquiry and theory-based clinical practice which benefits both mentor and protégé as well as the wider health care organisation in which it takes place. Education consequently has a large part to play and must be integrated into nurse manager development at an early stage.

Comparison of the two studies discussed in this article (Harris, Maddern & Pegg 1998; Duffield et al 2001) shows clearly that nurses choosing health care management are holding their own in terms of academic preparation. However, this is not reflected in their levels of professional attainment of higher health care administration positions in Australia. Perhaps this is because nursing as a profession fails to push those with most talent forward or possibly it is due to a lack of confidence amongst nurse managers or within the nursing profession of their ability to succeed at higher administrative levels. An alternative cause might be a lack of vision regarding the opportunities for nurses in management positions outside those that are traditional for nurses.

Gender role differences might also be a barrier to the progression of nurses in health care management. For example, women frequently have career breaks to have children or care for family members and are often either not able or unwilling to return to return to the workforce. If nursing, which remains a predominantly female occupation, is to compete for key positions at all levels of health care organisations, it must act strategically to support and encourage women to lobby for a work environment that is conducive to women. If this does not happen, then female nurse managers, in particular, are less likely to progress up the career ladder and some may move out of health service management altogether. These factors, coupled with organisational change and a climate of uncertainty in health care management circles, make entering management a less attractive proposition than it once was. Indeed there has recently been some concern expressed in the US that there are vacancies in nursing administration that cannot be easily filled (Rudan & Frederickson 2000; Silvetti 2000; Sullivan 2000).

There is a case for saying that nurses should not worry about moving outside of the nursing domain because they are needed to lead nurses of the future and there are already many opportunities for nurses in nursing positions. Equally, it could be argued that nurses looking for managerial positions are more likely to succeed outside health care organisations, where their transferable skills might be more readily appreciated. If this is the case, then to lose such expertise and enthusiasm must surely be a poor use of resources, particularly when we consider the important insights that nurses have regarding patient care and the transferable expertise which they bring to management. Perhaps an even more compelling reason to ensure that our best nurses attain key management positions is that we must aggressively continue to market nursing as a profession.

Health care organisations are competitive enterprises with key stakeholders. In order to maintain the profile of nursing it is essential that nurses have a strong voice. This cannot be achieved unless there are those in senior positions who can maintain that voice of nursing within health care organisations and ensure that patient care issues are recognised and remain the focus of health care institutions.

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