

**Certified Registered Nurse Anesthetists' Transition to Manager of an  
Anesthesia Department**

By Jennifer Martens, MSN, CRNA

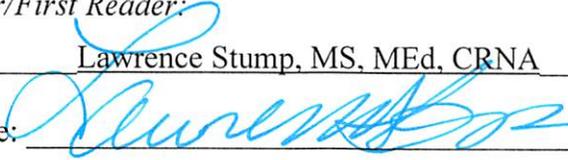
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*Primary Advisor/First Reader:*

Name: Lawrence Stump, MS, MEd, CRNA

Signature:  Date: 1

*Second Reader:*

Name: Jane Motz, DNAP, CRNA

Signature:  Date: 12/19/17

## **DEDICATION**

To my mother, Muntaha and my father, Najib. Both of you have sacrificed the most for me to get here. You have given me the genes to keep going, and the love to make me want to.

Thank you.

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### Abstract

**Purpose:** The purpose of this exploratory qualitative study is twofold. The first is to identify common experiences or barriers that arise during the first year as Certified Registered Nurse Anesthetists (CRNAs) transition into management. The second purpose of this study is to identify if these shared experiences can prepare future CRNA managers by providing insight into what knowledge, skills, and abilities are necessary to ensure a smooth and successful career transition.

**Methods:** A representative sample by email and Facebook (FB) elicited 18 phone interviews of current and past Certified Registered Nurse Anesthetist (CRNA) managers. One interviewer asked 16 questions: seven demographic and nine open-ended. Survey information was (1) transcribed, (2) reviewed and de-identified, and (3) coded for content and classical analysis by two experienced independent coders. A coding tree was developed by coders after independent and random assessment of codes with an IRR (0.93). NVivo 11 software was used to assist with analysis of codes.

**Results:** CRNA participants (66%) had less than five years of CRNA management experience and 61% had no previous management experience or education before accepting their first role as a CRNA manager. Of the participants that did have previous management experience, 50% either had a doctorate, MBA, or MHA degree or took formal business courses or management training. An incidental finding, 83% of participants were reluctant managers and 76% of CRNA managers devoted greater than 50% of their time to performing clinical duties. Two resources that CRNA participants agreed were helpful resources during transition included: mentors (83%) and previous education or experiences (44%), especially in business, finance, or management. The skills CRNA participants believed were important during transition included people skills (56%), financial knowledge (33%), and communication (28%).

**Conclusion:** This study found incidentally that CRNAs were reluctant managers that spent greater than 50% of their time performing clinical duties in addition to managerial duties. CRNA managers may be relatively new in the role, with less than five years of clinical experience, and no previous management experience or education. The most important resources identified in this study that assisted new CRNA managers through transition included mentors and business, finance, or management education. Mastering “people skills,” either through relationship management or communication skills, was perceived to be important during a transition. Derailment may be avoided if new managers consider the results of this investigation.

**Data Sources:** Medscape, PubMed, CINAHL, and EBSCOhost

**Keywords:** health care managers, nurse managers, physician managers, transition, hybrid managers.

## Introduction

Many first-time managers in health care were successful in their roles as individual practitioners;<sup>1,2</sup> however, success as an individual practitioner may not translate into success as a new manager. Many professionals, including Certified Registered Nurse Anesthetists (CRNAs), enter into management positions through nomination by supervisors or colleagues, or by applying for the job when a position becomes available. The practitioner's level of management knowledge may not be a consideration when first hired into the role. Instead, these first-time managers may be chosen based on individual clinical abilities and leadership potential. Nurse anesthetists may enter management positions with a lack of managerial experience and business knowledge. Novice managers should be aware of job expectations and how to be better prepared for a new role.

The transition for a new nurse anesthesia manager is more challenging than ever before due to the changing political and financial landscape in healthcare.<sup>3-6</sup> Management positions require a type of knowledge that deviates from physiology and pharmacology in clinical anesthesia practice. Psychology, organizational behavior, finance, the business of healthcare, and human resource tenets become the focus of the practitioner. The ability to quickly adapt to new day-to-day job responsibilities, acquisition of new knowledge, and the change in focus required for managerial roles becomes imperative for a new manager.<sup>7</sup>

Recently, many healthcare organization hierarchies have been "flattened" by removing middle management positions.<sup>7-10</sup> For new managers, this can mean an increased workload and subsequent feelings of being overwhelmed. Organizational flattening can establish greater influence for managers within an organization due to enhanced collaboration with decision-makers.<sup>7</sup> This "flattening" may lead to both greater influence within an organization and an increased workload.

New managers are expected to lead a department, adapt to new responsibilities, and be effective in the dynamic healthcare business.<sup>7,8</sup> The perceptions of managerial duties of a practitioner CRNA may not be in alignment with the actual complexities of the manager's job duties. The weight of representing a department and interacting as one contributor in a complex organization, coupled with the need to acquire a vast amount of new management knowledge, may cause a new manager to have feelings of inadequacy and disappointment in the new role.<sup>1,2</sup>

Identifying evidence-based management practices can help new managers distinguish the misconceptions of the role of a manager.<sup>9,11</sup> Practitioners considering management should investigate the myths associated with management.<sup>1,12</sup> Some examples include: management as a skill innate in natural born leaders, only novices make mistakes, and extroverts make better managers. These misconceptions may prevent qualified potential candidates from maintaining or pursuing managerial roles. The effectiveness of current managers may be reduced if staff believe in these misconceptions. The need for managerial support from clinical CRNA staff is critical to a manager's success.<sup>9,11</sup>

To be included in administrative decisions, new CRNA managers must have an understanding of management tenets while producing departmental results. A gap in literature currently exists regarding the transition of CRNA practitioners to management. Research suggests that nurse and physician transitions to management differ based on their previous clinical identity.<sup>13</sup> Nursing research focuses on the need for additional transitional support and education, while physician research focuses on obtaining managerial education to ensure a smoother transition to management.<sup>14-16</sup> An examination of the nurse anesthetist's managerial transition is lacking in the literature.

Lorraine Jordan once wrote that CRNA managers obtain the skills needed for management over "the lifetime of a nurse anesthetist."<sup>17(p3)</sup> While experience is a great teacher, the type of knowledge needed to assume a leadership role is constantly changing. Following the

implementation of evidence-based practices in healthcare, development of evidence-based management has grown significantly in the past two decades, guiding managers to specific, researched techniques.<sup>18</sup> Interviewing current managers may offer insight into which evidence-based knowledge should initially be presented to the first-time manager to ensure a smooth transition.

Navigating a new role as a manager during a tumultuous time in healthcare may be intimidating to practitioners entering healthcare management. The primary aim of this project was to explore shared experiences and barriers encountered by current CRNA managers as they transitioned into management. The secondary aim of this project was to identify knowledge, skills, and abilities that aid new managers for successful career transition. This project aims to answer these research questions:

1. Are there common barriers or experiences that CRNA practitioners encounter when transitioning into new roles as managers?
2. What knowledge, skills, and abilities are most important in the first year of transitioning to a CRNA manager?
3. What do CRNA managers recommend transitioning CRNA managers utilize as resources, and what are recommendations for education and training?

### **Literature Review**

A new manager may misperceive the complexity or depth of the new role. As such, candidates should explore the potentially drastic changes associated with moving into management before taking a new position.<sup>19</sup> The practitioner must decide whether their motivation is clinical burnout or the need to fulfill a vision that is worth changing career paths to achieve. The transformation from being a part of the healthcare system to working *for* the

healthcare system can be a small leap or a big jump, depending on motivation and understanding of what the position truly entails.

The transition into management is a critical time and is perhaps one of the biggest challenges the manager will face.<sup>20</sup> A new manager is in the vulnerable position of learning the expectations of people both horizontally and vertically (above and below), without making any missteps that could derail their career.<sup>20</sup> Regardless of what a new manager brings to the position, many will find they have to practice management skills while learning to manage on the job. Acceptance of a managerial role should be grounded in the actual realities of what that role is within the organization. However, defining the job duties of a manager is a challenging and elusive task: Management scholars are still attempting to correct the “folklore” surrounding what managers truly do.<sup>21</sup> Correcting the myths to align with the reality could help to improve the practice of management and could help future CRNAs determine if they are up to the task.

### Managerial Myths

Vince Lombardi is frequently quoted as saying “a leader is made, not born.”<sup>22</sup> Despite this favorite quote, the managerial myth of “born leaders” continues to permeate some areas, including the field of anesthesia. Many also believe that charisma equates to leadership abilities.<sup>1,12</sup> Management scholars, hoping to debunk this myth, instead found that charismatic characteristics such as extroversion, positivity, and higher emotional intelligence (EI) were indeed initially predictive of effective leadership.<sup>23-25</sup> Concern over these results led management scholars to investigate introverts as leaders. Recent findings have revealed that introverted leaders, who lack the charisma of their extroverted peers, instead have abilities that are just as important in great leaders, such as the capacity to listen to staff, self-reflect, and innovate.<sup>26-28</sup>

Introverted managers can be effective in managerial positions, and EI can increase with awareness and practice.<sup>30</sup> People such as Warren Buffet, Abraham Lincoln, and Mark Zuckerberg are successful introverted leaders who serve as evidence that extroversion and

charisma are not necessarily traits required of successful leaders.<sup>29</sup> The myth that a manager must have charisma or be an extrovert may inhibit qualified individuals who are introverts, yet have the requisite talent and veracity. Nurse anesthetists who are introverts or who have low EI can practice skills to ease the transition, just as extroverts need to practice the contributive skills of introverts.

Another common managerial myth that permeates many disciplines is the idea that managers are experts at everything, and hence managers are rewarded for their expertise. As an individual contributor providing anesthesia, the CRNA is rewarded by the patient who wakes with relief and surprise that “the surgery is over,” or a patient who wakes with little pain, or who can wake at all. As a manager of an anesthesia department, the reward is based on the performance of other CRNAs.<sup>1,2,12</sup> Their collective performance is measured by tracking the number of reintubations, compliance of documentation, and hitting benchmarks required for Medicare/Medicaid, to name only a few. New managers who are experts in their fields frequently have difficulty reconciling the reality that their previous expertise may not help them perform many functions as a manager of their field.<sup>1,12,31</sup> The difficulty here may be due to the common myth that power and control are only assumed with the acquisition of the position.

Understanding the difference between two types of power—authority and influence—can help a manager adapt during a transition. The myth that the position itself holds power can deceive a new manager into believing their agendas must be followed, or that an initial use of power should be used to establish their new presence. Power is often confused with authority, which is “the type of power a person possesses due to his or her position.”<sup>12</sup> The type of power managers frequently rely on is influence, or “power in action.”<sup>12</sup> However, those with influence who wield power may have unimportant titles. For example, a secretary to the CEO has influence over that CEO’s schedule or time. Conversely, those with power may have little authority, such as the Royal Queen of England, who has power with no authority (albeit some

influence) on the British Parliament. First-time managers are cautioned to avoid exercising power during transition periods.<sup>2,12,20</sup> A new manager should try to build influence before asserting authority.

### Expectations for the Managerial Role

The mismatched expectations of what a manager's role entails can cause undesired consequences for both the new manager and the employees. Clarifying those expectations can help both the new manager and the staff to adapt to the transition more efficiently and quickly. Everyday thoughts or comments to new managers from their former peers include everything from, "You've gone to the dark side. You're one of them. What a waste of training," to "Great. Now we can get all our problems fixed," which describes the dichotomy of expectations for any new manager.<sup>19</sup> Often, this dichotomy is one that the new manager already feels. Traditional negative stereotypes of a middle manager as being "a barrier to change" or "an addition to bureaucracy" can prevent good CRNA managerial candidates from considering management as a career path.<sup>19,32</sup>

The stressful first years embed many habits that new managers may carry with them throughout their careers.<sup>1,2,33,34</sup> Making poor decisions initially can undermine a new manager's credibility, alienate potential supporters, and prevent those who have valuable information from sharing it, which can lead to making more poor decisions.<sup>20</sup> Knowing what it means to manage (such as relying on others to get work done, adapting to the feeling of constrained decision-making versus having a relative freedom, and accepting changing peer relationships) can help those who are considering or transitioning into management to adjust to their new role quicker.

Learning management skills differs from learning clinical skills. Management addresses the psychology and sociology of people and organizations, while clinical skills address physiology and pharmacology. The role of management is about how the department performs overall. The individual practitioner manages tasks associated with the administration of

anesthesia, while the manager manages people associated with anesthesia. The focus on “me,” or “my duties” in the clinical role changes to “us,” and “our outcomes” in a managerial role, which has resonated throughout the literature in many professions.<sup>1,8,11,12,34</sup> The shifted focus from clinician to manager requires a technical expert to become a novice student in management.

The clinical CRNA may underestimate the difficulties associated with this change of focus upon first entry to the practice of management. Insights from interviews with current CRNA managers may give those questioning their desire to enter management the opportunity to assess their real motivations and perceptions before making that decision.

#### New Managers’ Motivation, Support, and Pitfalls

A clinical CRNA may choose to pursue a managerial position for many reasons, although it is common for an anesthesia department to elect the managerial candidate. The selected person may lack desire for the position but may fill it out of a sense of obligation. Managers are frequently chosen because of their previous success in a non-management role,<sup>1,2</sup> yet not all clinical staff aspire to managerial roles. If the nominee is content in their current clinical role, the work role of a manager may be unsatisfying.<sup>35</sup> The position requires learning on the job, in a stressful environment, with higher stakes for the new manager including a lack of job security. To ensure success, the CRNA should have a desire to enter the field of management.

Those in upper management may feel that they are “rewarding” clinicians when giving them management opportunities; however, many clinicians may not desire a management position. Of those who may desire a management position, 20% decline a management position if given an actual understanding of the control of a manager and the duties required to be a good manager.<sup>35</sup> Management is not about exhibiting expertise in clinical matters or simply balancing a budget, but expertise in organizational behavior, conflict management, communication, and relationship management. This research suggests that building relationships and mastering communication or people skills should be a priority in a new CRNA during a transition phase.

Other external motivators to encourage the pursuit of management may include the perceived “bankers’ hours” (less afternoon, midnight, or holiday hours), less work, and a modest increase in pay. Zidel has cautioned those who are entering into management that the “control of one’s time is not as great when in a management position.”<sup>19</sup> A clinical CRNA finishes an assigned shift once the surgical cases are completed. As a manager, work is frequently brought home from the hospital, e.g., financial reports, scheduling, et cetera. Work hours are not just those spent in the hospital. Subsequently, many new CRNA managers find that the hours required of them to complete all tasks are not proportional to the pay raise. The new manager may quickly become disillusioned and ineffective if the motives for taking a management position were only for the perceived “perks” of the job.

Clinical CRNAs who have chosen the management pathway must realize the challenges within management. First-time managers, who represent the largest population of supervisors, are frequently responsible for managing more employees than their supervisors who have greater managerial experience.<sup>34</sup> Some research has revealed that up to 62% of nurse executives planned to leave their positions within the next five years, which has also been reported in other countries.<sup>10,36-39</sup> Recent studies have suggested that reasons for this mass exodus include the need for work/life balance, job change, and retirement.<sup>38</sup> Fewer people are interested in management positions (compared to remaining in clinical positions) due to fewer perks, lack of organizational support, and the greater workload required due to organizational flattening.<sup>1,8,38</sup>

### Nursing Managerial Support

Turnover for first-time nursing managers is higher than that among more senior-level nursing administrators.<sup>37-38</sup> First-time or front-line nursing managers are frequently required to balance patient-care duties and new management duties with more direct reports and fewer resources than senior-level administrators.<sup>8,40,41</sup> Turnover of nursing managers is double that of clinical nurses, which has been attributed to expectation mismatch and lack of organizational and

psychological resources.<sup>42</sup> These managers are at greater risk for experiencing depression and lack of engagement within an organization, which leads to job burnout.<sup>8,40,43,44</sup> As a new CRNA manager, the source of stress changes from accountability to one anesthetized patient to instead being accountable for all direct reports under and above this new manager. This change in accountability and the learning of management principles require a period of adaptation that may take years, even with administrative support.

Support from hospital administrators, such as leadership education with mentored, monitored, accurate, and timely feedback, has been slow to arrive for many emerging nurse managers. Lack of support, coupled with the lack of succession planning within hospital organizations concerning the leadership gap within nursing, will catch up to nurse anesthesia leadership in the form of a crisis.<sup>38,39,45</sup> A lack of desire from clinicians to enter front-line managerial positions, lack of succession planning, and nursing shortages within healthcare has created discussion in the literature about engaging staff within hospitals to enter into management positions.<sup>8,10,36,46</sup>

Hospital organizations suffering from lack of discretionary funds may still have difficulty providing programs to develop nursing managers. Those who do enter management positions may need to be self-motivated to seek learning opportunities that their hospital organization may be unable or unwilling to support. Encouraging and preparing CRNAs to tackle entry-level CRNA manager positions is needed now more than ever to prevent leadership gaps within the CRNA profession and healthcare institutions.

Despite administrative budget controls and a lack of resources and authority, front-line nurse managers are required to be effective leaders, financial managers, and expert clinicians. The same front-line nursing managers have been notably devoid of organizational support and resources, despite research attesting to an effective nurse manager's role in reduced absenteeism

and improved patient outcomes.<sup>47-49</sup> First-time managers in any profession need supports, either by mentoring or education, to ensure personal, departmental, and organizational success.

#### State of CRNA Manager Support

New CRNA managers do have some supports, such as access to certain basic management resources within the nurse anesthesia community. Nurse anesthesia doctorate programs currently include managerial courses in the curriculum; however, CRNAs who were not required to take management courses in their master's programs are now finding themselves in management positions. CRNAs lacking management knowledge from previous academic courses need to fill this gap. Transition to management requires learning the basic management tenets and skills.

Access to available resources for new CRNA managers can be found at the American Association of Nurse Anesthetists (AANA) leadership conferences, by accessing the AANA Learn website (continuing online education), and more recently, by obtaining information through the AANA Practice Management Initiative.<sup>50</sup> These courses are introductory and focused, and for a new CRNA manager navigating a rapidly changing healthcare world, the modules are yet to be comprehensive.

The AANA leadership meetings, which are held twice a year, are appropriate for updating leadership skills, yet lack as a resource for day-to-day practice issues. The new AANA Practice Management Initiative, still in its initial stages, provides a forum for CRNA managers with different experiences from all over the United States.<sup>50</sup> The ability of managers to ask and answer questions in the online forum has the potential to be useful as long as this resource is used by both the experienced manager and the novice seeking help. Leadership development for front-line CRNA managers must be recognized as a critical need in the profession.

Other resources for the new CRNA manager include private courses given by consultants and management experts. Prioritizing courses for management topics in evidence-based management can be difficult and time-consuming for new CRNA managers. Likewise, popular management books and professional papers have different foci concerning management techniques. The success of one popular management technique does not ensure the same management technique will provide success in a different setting for a different person.<sup>21,51</sup> New CRNA managers coming from diverse academic or management backgrounds may benefit from the unique perspective of the experienced CRNA manager's past experiences. Understanding these experiences, the hardships and the benefits, may guide future managers to master specific knowledge, skills, and abilities (KSAs) during the transition period.

Many leadership courses provided by the new manager's hospital or organization via "learning institutes" are beneficial for understanding the mission and values of that particular organization. The purpose of these learning institute courses is to ensure that those missions and values are transmitted to the employees through manager reinforcement or example. Unfortunately, many of these hospital-based organizational classes do not provide a satisfactory ongoing learning process for a new CRNA manager.

Currently, leadership preparation for education or political nurse anesthesia roles dominates the AANA landscape. New front-line managers seeking information may find few support or resources to assist them in their managerial career. Providing support and developing leadership and managerial skills of these new front-line managers will ultimately shape healthcare at the grassroots level.

### Healthcare Organizations' Roles

Healthcare organizations are starting to create methods to develop executives, which could eventually carry over onto new first-time managers.<sup>16,52-55</sup> Beginning in the early 2000s, one such method, the "Dyad Model," was used in large hospital organizations such as the Mayo

Clinic.<sup>52,56</sup> The Dyad Model engages physician practitioners by pairing them with non-physician administrators, which has been shown to enhance teamwork between the two collaborators by sharing common organizational goals. The Dyad Model forces administrators and physician clinicians to make joint decisions with the aim of engaging and developing leaders; however, the Dyad Model requires continued commitment from staff and has high costs, including time and resources.<sup>52,57</sup> Executive coaching companies have recently suggested changing from the Dyad Model to the “Triad Model,” which adds a nursing component to the decision-making process within hospital organizations.<sup>56</sup> The Dyad Model as a resource for first-time nursing managers is only relevant if the effectiveness of this model creates momentum for hospital organizations to pursue the Triad Model.

### Managerial Development

Navigating the complexity of the healthcare system and managing other CRNAs may be a daunting task in the absence of guidance. Linda Hill, a professor at Harvard Business School, described her academic experience in teaching managers leadership skills: “We took seriously the notion that we could not teach our students to manage—they had to teach themselves,”<sup>1(XI)</sup> which suggested that there can be a place between formal schooling and just experience. Leadership development research has suggested the efficacy of “Experience-Driven Leader Development,” or the 70-20-10 principal of leadership development where 70% is learning on the job, 20% is learning relationship management, and 10% is academic training.<sup>58</sup> This type of leadership training is still in its infancy in implementation for many organizations.<sup>59,60</sup>

Management relies on getting things done through others.<sup>1,2,16,19,34</sup> Nurse anesthetists are determined, highly skilled, and independent, so relying on others for success may be difficult to embrace upon first becoming a manager—it may even be the greatest difficulty a new CRNA manager encounters, because it contradicts how CRNAs function in a clinical setting. Hill describes why management may be challenging for independent CRNAs:

Management has just as much, if not more, to do with negotiating interdependencies as it does with exercising formal authority...being a manager means not merely assuming a position of authority but becoming more dependent on others both inside and outside the organization. In fact, the higher your position in an organization, the more dependent you become on others to get things done.<sup>1(p262)</sup>

Clarifying definitions and providing insight into what “relying on others” means in day-to-day practice may provide a new CRNA manager with a more effective transition into management.

### The Characteristics and Statistics of a Manager in Healthcare

Abraham Zaleznik, a psychoanalyst and Harvard professor, published a Harvard Business Review article in 1977 that suggested a difference between “managers” and “leaders.”<sup>61</sup> Leaders create and inspire vision, thereby creating chaos, and managers organize this chaos. This difference has led to a heated debate within the management community and has since established an understanding of the complementary yet distinct aspects of management and leadership within an organization. John Kotter, a Harvard professor and established author within management, compared leadership and management:

Management is about coping with complexity...Good management brings a degree of order and consistency to key dimensions like the quality and profitability of products.

Leadership, by contrast, is about coping with change...developing a vision of the future (often the distant future) along with strategies for producing the changes needed to achieve that vision.<sup>62(pp26-27)</sup>

Leaders set a vision according to the changes occurring within healthcare and inspire the organization’s direction. Managers organize, staff, budget, and ensure consistency according to the leader’s vision. Leaders can be poor managers, and managers can be poor leaders. A first-time CRNA manager must quickly learn to manage by following the administration’s vision to control the chaos of a busy anesthesia department. The expectation is that both managers and

leaders will work together within an organization, with leaders developing their managers to the point that they can successfully lead.<sup>62-64</sup> In reality, these two positions are intertwined. As Mintzberg, an author and researcher of management, stated:<sup>21</sup> “We are now over-led and undermanaged...we should be seeing managers as leaders, and leadership as management practiced well.”<sup>21(p7-8)</sup>

Peter Drucker, a famed management expert, noted that “healthcare is the most difficult, chaotic, and complex industry to manage today.”<sup>65</sup> Understanding healthcare, including finance, strategies, and operational issues, can help a new CRNA manager navigate the most complex idiosyncrasies of management. While senior healthcare executives rarely expect new front-line managers to be adept at these issues from the beginning of their tenure, knowing the expectation of a new manager is vital to a seamless transition into the new role. Expectations of new managers, such as prioritizing and getting the resources to navigate through this new position, are usually difficult for any new manager to verbalize or define.<sup>66</sup> One aim of this project is to help identify, through the interviews of current CRNA managers, if any resources or abilities can help ease the transition for managers entering the role for the first time.

Middle managers are commonly defined as any manager at least two levels below the CEO and only one level above a practitioner.<sup>9</sup> Middle managers, previously perceived as agents for the status quo or an addition to bureaucracy, have recently been recognized as agents of change and communication within the healthcare system.<sup>9,12</sup> Research has revealed that companies with good managers outperform other companies by decreasing absenteeism and turnover and by increasing employee satisfaction, productivity, and net profits.<sup>12,67</sup> Effective managers are credited with improving patient safety, developing relationships based on fairness and empathy, and making employees feel valued and respected.<sup>55,68</sup> Alternatively, bad managers can cost an organization anywhere from \$500,000 to \$2.7 million dollars depending on the level of the manager within the organization.<sup>69</sup>

Effective managers can reduce the costs for organizations, and yet these same organizations do little to nurture new managers. Many professions promote exemplary employees to management positions to increase employee wages or give trusted employees greater autonomy.<sup>70</sup> However, the skills needed to be a star employee are rarely ever the same skills required to become an effective manager. In fact, some researchers have suggested that, contrary to popular opinion, focus on a new manager's "strengths" as a method of building management skills can be the start of that new manager's downfall.<sup>69,71</sup>

### Learning from Derailed Managers

Recent leadership research has focused on how best to teach managers to become good leaders. Mostly ignored over the past decade, well-documented research on identifying what makes a poor manager is currently resurfacing.<sup>66,71</sup> This research has suggested a consensus on what makes a bad manager; therefore, it may be more important to understand why failure occurs.<sup>66,69,71</sup>

Failure or derailment in management positions occurs at a rate of over 50%, which has been true since the 1980s, and the numbers of derailed managers have remained constant.<sup>69</sup> Derailed managers (or those unsuccessful in their management position resulting in voluntary or involuntary resignation) were shown to have certain personality defects or behaviors that contributed to their derailment.<sup>69</sup> The research on behaviors arising from these character deficiencies can be sorted into three broad categories: problems with interpersonal relationships, leadership problems, and the inability to adapt.

Problems with interpersonal relationships prevent managers from building relationships with bosses, peers, and people who report directly to them. A failure to attain interpersonal relationships is the most cited cause of manager derailment.<sup>66,69</sup> An inability to attain interpersonal relationships goes against the most important management tenet, which is to get things accomplished through others. Perceived or behavioral issues causing a lack of

interpersonal relationships include betrayed trust, insensitivity, aloofness, being arrogant, being overly ambitious, and the inability to deal with conflict.<sup>66,69,71</sup>

The second most cited cause of manager derailment is leadership problems that stem from the inability to perform the functions of a leader, such as thinking strategically, building or managing teams, acting with decisiveness, and finding the appropriate level of managing.<sup>66,69,71</sup> Lastly, adaptation problems (such as an inability to adapt to the transition or stressful situations, overdependence on new bosses or mentors, and lack of flexibility in assessing different opinions) has recently surfaced within the research as another cause of derailment.<sup>66,69</sup> This confirms the need for a new CRNA manager to have flexibility and the ability to adapt to new situations.

The mistakes of a new manager do not preclude a successful career. Mistakes can, however, slow a new manager's effective transition.<sup>1,2,20,34</sup> An inherent difficulty in management is that, once certain errors (perceived or real) to relationships occur, reversing errors may be difficult to correct, if not entirely irreversible. Leaving a position may seem harsh for a new manager who is more than competent to function in that role. With a high failure rate of 50%, it may be that a previously failed manager is successful in subsequent management positions after (hopefully) having learned from their mistakes. To avoid having to cut their losses as a derailed manager and start over in a new position, certain behaviors that lead to derailment can be managed before the derailment occurs.<sup>66,72</sup>

### Strength-Based Management

The consensus on what makes a bad manager is well documented within the management literature.<sup>66,69,71</sup> The alternative—knowing what makes a good manager—is more ethereal and vague in the literature. Strength-based articles urging managers to focus on the qualities that made them successful as a clinician have been contradicted in recent years.<sup>71</sup> The strengths that have allowed the successes of an individual clinician can be viewed as weaknesses when applied to a management role.<sup>1,70</sup> For example, a confident, competent clinician that takes initiative,

works independently, and is decisive may be perceived as a micromanager who directs other clinicians to their way of thinking and doing (because their methods did make them a star employee)—which may be perceived as arrogant—and refusing input from their subordinates (being decisive and independent).

The first year as a manager can shape a career either by setting up good foundational habits or by starting with poor practices that create cyclical events that are difficult to undo, thus having a greater potential to derail a promising management career.<sup>1,2,20,34</sup> Most management derailments have occurred after a transition to a higher level in management.<sup>68</sup> The initial year as a manager demands quick adjustments, with sound guidance, as a springboard for a good start to being an effective manager.

#### Organizational Climates for New Managers

Upper management plays a key role in preventing derailment by maintaining good communications with the new manager and ensuring feedback that includes the manager's supervisor and the new manager's peers and subordinates.<sup>66,72</sup> Providing honest feedback can promote self-awareness, which is a learned skill. A common flaw of derailed managers is the lack of self-awareness.<sup>66,69,72</sup> Likewise, certain skill sets at the beginning of a manager's career were found to prevent career derailment.<sup>72</sup> Some of these skills included the ability to communicate what needs to be accomplished and why, to get others to make suggestions and to use those ideas, to organize the workflow, to work effectively within the organization, and to coach, train, and ensure that others have the support to get the job done.<sup>72</sup>

In a 2016 report from Deloitte, organizations surveyed reported a concern with the inability to find leaders with talent.<sup>73</sup> This problem is not a lack of commitment or talent among employees, but a lack of leadership development within their organizations. Despite the need to identify and build leaders, many organizations, in a tight economic market, delay or reduce the

added expense of such development<sup>8,9</sup>—those high-performing organizations surveyed that did spend money on leadership development spent up to four times more than other companies.<sup>73</sup>

Managers need a commitment from their organizations to develop leaders, such as continued communication through accurate feedback and the provision of resources or education for leadership opportunities. In anticipation of strict governmental payment structures, hospitals are continuing to tighten budgets and rearrange organizational structures. In this climate, despite its fundamental necessity, hospital organizations will treat leadership development as a luxury on the budget sheets.<sup>47,53</sup> In the meantime, the burden and commitment of becoming an effective manager and acquiring management KSAs will be left to the new CRNA manager.

Nurse anesthesia managers within hospital organizations can have varied roles. Some managers in clinical settings may act more as a practitioner than other managers. The flattening of the organizational hierarchy may propel some new managers to interact with executives or to perform occasional executive duties. Nursing and physician managerial transition research combined with manager and executive roles are explored. Similarities exist among first-time healthcare practitioners who transition into managers and managers who transition into executives.

#### Physician Versus Nursing Leadership Support

Physician executives in many institutions are being encouraged to seek an MBA after acquiring a management position.<sup>15,19,74</sup> In fact, over 60% of hospital systems or CEOs have offered to pay for the advanced education of physician executives, or have produced their own educational programs to assist in the transition to physician manager.<sup>74,75</sup> On the other hand, nurse executives have stated personal finances and the time necessary to get an education as the two biggest challenges to seeking managerial training.<sup>36,45</sup> Hospitals' lack of nursing support may be due to tight budget restraints.<sup>8,10</sup> The supposition that leadership development of physicians in hospital organizations is valued more than that of nurses is clear. The documented lack of

support currently experienced by many nurse leaders must be addressed in the nurse anesthesia profession. Support needs to start at the beginning of a new CRNA manager transition to ensure these new managers become our leading decision-makers within the healthcare system.

Despite statistics that have extrapolated a nursing leadership gap by 2033,<sup>76</sup> many hospital organizations continue to provide little support for advancing nursing leadership. In a 1992 article about the need for organizations to reconsider the relationship of the employee to the employer, Peter Drucker, described as the founder of modern management, wrote:

Many organizations may tout that “People are our greatest asset.” Few organizations nurture this resource as if they were indeed their greatest asset. Most still believe, though perhaps not consciously, what nineteenth-century employers thought: People need us more than we need them. But, in fact, organizations have to market membership as much as they market products and services—and perhaps more. They have to attract people, hold people, recognize and reward people, motivate people, and serve and satisfy people.<sup>77(p8)</sup>

Unfortunately, this thought process has yet to permeate many healthcare organizations.

The good news is that, while slow to build momentum, hospital organizations are now starting to develop programs within their institutions for leadership programs.<sup>8</sup> Magnet recognition is given to hospitals who prove investment in their nurses. This investment, from Magnet hospitals, is credited with starting the movement to include education, training, and empowering nurses, especially in leadership roles.<sup>78-80</sup> The validity of Magnet hospital accreditation and the commitment of hospitals to support Magnet values are also finally gaining ground, despite initial criticism that early research proving Magnet designation improved patient outcomes was weak.<sup>78-81</sup> The since recognized outcomes of Magnet designation, such as increased patient quality, decreased absenteeism, and increased nursing retention, have

confirmed organizational behaviorists' research indicating that investment in people can improve a company's bottom line.<sup>36-38,82</sup>

The professional background of clinicians has been found to affect how their transition into management is developed, such as physicians resisting management roles more than nurses.<sup>13,83</sup> Until hospital organizations build momentum to develop nursing leaders, new CRNA leaders must be proactive in avoiding the pitfalls of derailed managers, seeking accurate feedback, and obtaining access to related business and healthcare resources. The paucity of research dedicated to ensuring a successful transition of CRNA practitioners into management requires further exploration.

#### Prioritizing Competencies for First-Year Managers

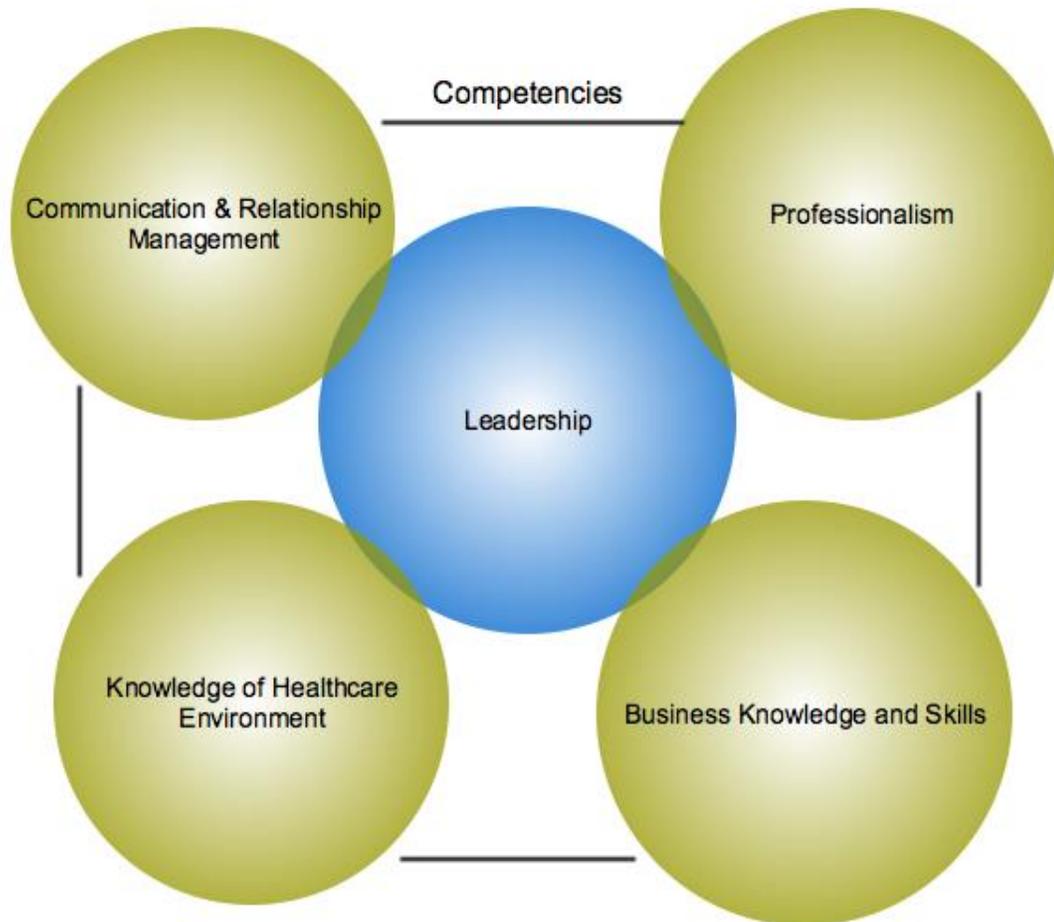
The Healthcare Leadership Alliance model was formed from six healthcare specialties, including the American College of Healthcare Executives (ACHE), American College of Physician Executives (ACPE), American Organization of Nurse Executives (AONE), Healthcare Financial Management Association (HFMA), Healthcare Information and Management Systems Society (HIMSS), and Medical Group Management Association (MGMA), to develop a competency list for healthcare managers.<sup>84</sup> The format for the knowledge, skills, and abilities (KSA) needed for first-time managers is based on this multidisciplinary Health Care Leadership Alliance model. The list, divided into three subgroups, delineates skills required for first-time, mid-level, and highest-level managers. This competency list is for healthcare managers to use as a resource for prioritizing the skills needed to be effective in their roles throughout their management careers.

The Healthcare Leadership Alliance Model (Figure 1) identifies five core competencies of management. Leadership competency, central to all levels of management, is a value acquired over time and practiced alongside other competencies. Mastering the other four competencies

ensures the likelihood of maintaining effectiveness in management. An examination of these five competencies will both validate and categorize CRNA shared experiences within the interviews.

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**Figure 1.** Four Core Competencies, with the “Leadership” Competency Developing Alongside Others.




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From American College of Healthcare Executives (ACHE). 2016. “ACHE Healthcare Executive 2017 Competencies Assessment Tool.” Accessed July 31, 2017.

[https://www.ache.org/pdf/nonsecure/careers/competencies\\_booklet.pdf](https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf).  
[https://www.ache.org/pdf/nonsecure/careers/competencies\\_booklet.pdf](https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf). Page 1

### *Communication*

Essential functions of a manager—communication and relationship management—are listed first in the ACHE competencies. Research has suggested that new managers focus on acquiring skills in this competency to ensure success or effectiveness within the first year of management.<sup>72,85</sup> Expressing why and what needs to be done, ensuring that members of the

department feel included, and networking effectively within the organization are just a few examples of communication within a management role. Each skill, communication, and relationship management will ultimately affect the others. The competency of communication and relationship management encompasses many scenarios that a new manager will encounter in their first year. Many new managers may not anticipate certain delicate situations that will inevitably occur. The unanticipated nature and urgency of these situations may catch a new manager off-guard and prevent a planned course of action.

One such example of communication and relationship management includes new managers interacting with peers as these same peers become subordinates. Managers hired from within an organization may already have healthy relationships with peers and supervisors; however, these interpersonal relationships will inevitably shift and change. Communication is an important tool when navigating this delicate balance. It is important to identify situations or experiences that may affect interpersonal relationships within the department, since these relationships have been identified as a primary cause of derailment.

### *Leadership*

The second competency, leadership, includes having the skills needed to inspire individuals and groups and the ability to perform organizational changes to ensure success in performance measures of an organization. The most important aspect of this competency within the first year is the ability to “lead through others.”<sup>84</sup> The Center for Creative Leadership described the mindset of first-time managers as needing to shift from “Me and my abilities” to “It’s not about me; it’s me and you.”<sup>70</sup> The majority of barriers that first-time managers struggle through relate to the inability to adapt to this concept. It is not expected that new managers will become fully actualized as leaders in their first year. It is, however, important for a new manager to begin to immerse themselves in the learning of leadership concepts. Some evidence-based resources can give new managers an underlying platform for sound leadership practices.

*Professionalism*

The third competency, professionalism, as described by the American College of Healthcare Executives, is “the ability to align personal and organizational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement.”<sup>84</sup> The new manager must hold themselves and others accountable for professional expectations and outcomes. The ethics of power within a managerial position, ethical patient and staff dilemmas, and the continued solicitation of feedback about personal strengths and weaknesses are just a few examples of the professionalism competency.<sup>85</sup> Researchers who studied whether derailment is avoidable have suggested that the one consistent trait distinguishing between a successful manager and a derailed manager is self-awareness or the lack thereof.<sup>66,69,71,72</sup> In other words, one trait a new manager can modify to prevent failure is to practice seeking feedback, which requires discipline and accountability, both of which are part of the professional competency.

*Healthcare knowledge*

The fourth competency is having knowledge of the healthcare environment. The American Organization of Nurse Executives (AONE) has described this competency as having knowledge of the roles and functions of patient care team members, standards of accreditation, regulatory and quality agencies, patient care delivery models, healthcare economics and policy, organizational finances, evidence-based practice outcomes, and risk management issues, to name a few.<sup>86,87</sup> Many new CRNA managers may enter into a management position suspecting that this type of knowledge is the only knowledge required to be successful or effective as a manager. However, this competency, while required of a hospital department, is not an immediate priority as a transitioning manager.

*Business/finance knowledge*

The fifth competency is business skills and knowledge. This type of knowledge or skill can be acquired by seeking an MBA or Master's in Health Administration (MHA) degree. The United States (US) Department of Health and Human Services has estimated that the number of nurses obtaining Master's and Doctoral degrees increased by 67% between 2007 and 2011.<sup>76</sup> This increased demand may have been due to hospital organizations seeking practitioners with business skills.

An alternative to the MBA is the Master's in Health Administration (MHA) degree, which differs from the MBA by focusing on the uniqueness of the healthcare business.<sup>88</sup> Healthcare administration education's debate regarding which degree provides more value to the field continues, and the choice should be made based on the individual practitioner's knowledge gap.<sup>89</sup> Regardless of which degree is chosen, management experts who advocate for obtaining a business degree also agree that academics alone do not ensure success in a management position.<sup>1,75,90</sup>

The aim of this exploratory study is to identify shared experiences that arose during the first years as CRNAs transitioned into management, and to identify if these common experiences can prepare future CRNA managers by giving us insight into what knowledge, skills, and abilities (KSAs) are needed for an effective career transition. Ensuring that new CRNA managers have a firm picture of the pitfalls and practices of management may decrease their odds of a derailment. The opportunity of CRNAs to be successful through management is essential for ensuring departmental success within an organization as well as for advocating for the Nurse Anesthesia profession. CRNAs advocate for our patients and our profession in political, educational, and clinical settings. The success of new managerial CRNAs as they advocate for our patients and profession through anesthesia meetings, boardrooms, and departmental success is just as valuable.

## Methodology

An extensive literature review performed for this project examined the experiences of CRNAs transitioning into management. Literature was obtained using Medscape, PubMed, CINAHL, and EBSCOhost data sources. The search parameters for the literature review included peer-reviewed research produced after 2010 that focused on healthcare practitioners' transitions into managerial roles, including the transition of managers into executive roles. All types of managerial references were used to assess statistical data on derailment and myths of management. Permission to implement this study for HUM00113078 was obtained from the Institutional Review Board of the University of Michigan–Flint.

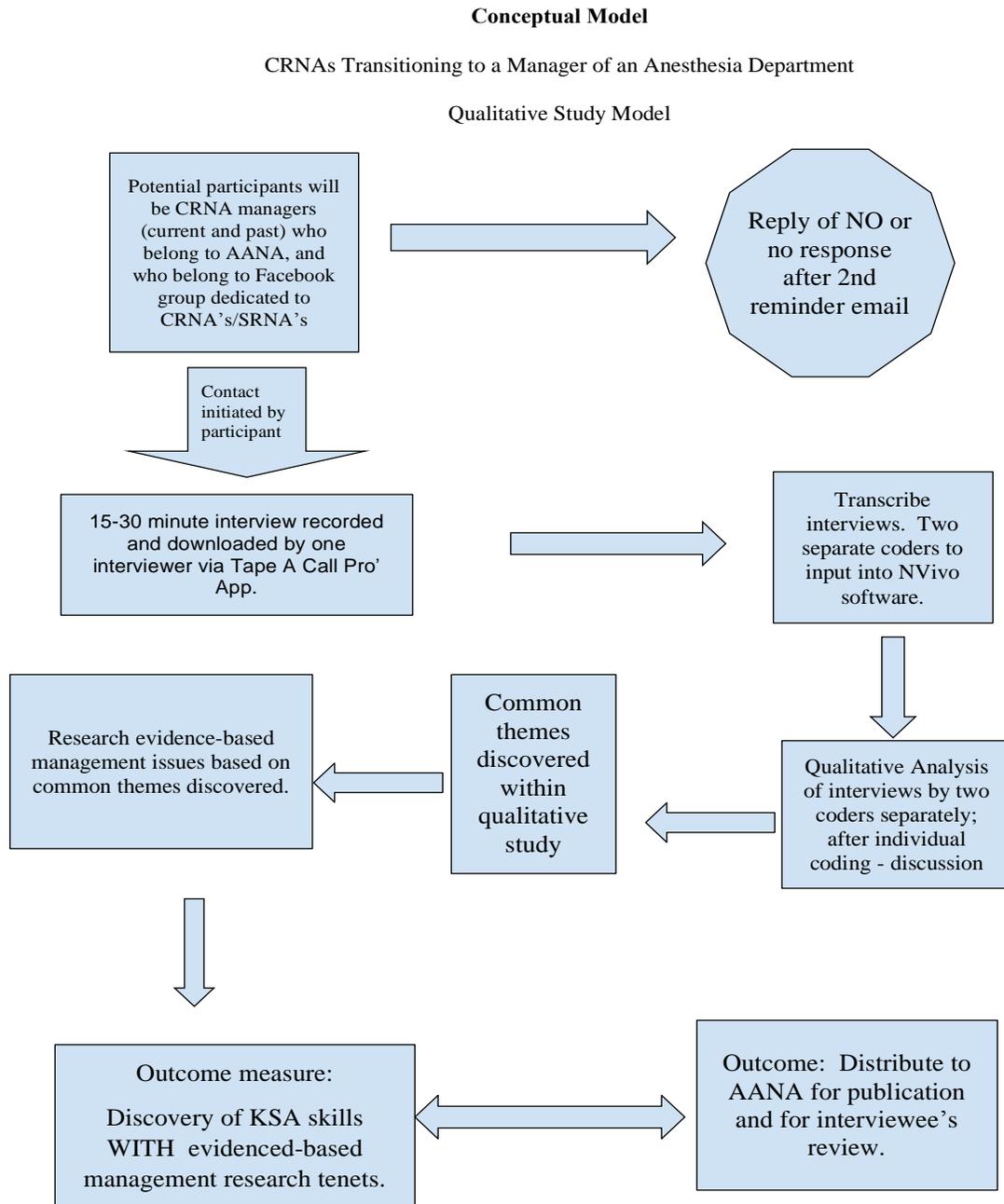
### Study Design

This exploratory qualitative study was designed based on the research question to identify and investigate relevant themes among the participant interview data. A phenomenological qualitative design was used to develop an understanding of phenomena that may occur for CRNA managers.<sup>91</sup> Qualitative studies of CRNA managers evaluating their transition into management may offer many insights into possible trends that are unique to the nurse anesthesia profession. Data for this exploratory study were gathered using only detailed participant interviews by telephone. A conceptual model was created to describe the implementation of this project (Figure 2).

The narrative data from the participating managers were analyzed by constant comparison analysis, word count, and classical content analysis. These three methods were used to ensure triangulation of data for descriptive and interpretive validity.<sup>92</sup> Constant comparison analysis was selected for this project because it enables data to be labeled (or coded) by words or phrases to be indexed, searched, and analyzed to expose common threads or themes.<sup>92</sup> Classical content analysis was used to assess the frequency of coded words or phrases, thereby adding a

layer of analysis. In this study, the purpose of the classical content analysis was to determine prominent themes among the participants.

**Figure 2.** Conceptual Model Illustrating the Flow of the Qualitative Study Design.



### Sample

This study attempted to recruit a representative sample of CRNAs with all levels of managerial experience to include various levels of transition and expertise. It is typical in qualitative research to select a small sample because the ability to provide an in-depth picture can diminish as the sample size increases, depending on the amount of data collected or the type of study.<sup>92,93</sup>

Six to ten participants were chosen as the minimum target sample. Data saturation was used to determine sample size, thereby enhancing the validity of the research. Data saturation is achieved once existing themes become exposed and further data input does not reveal new information or new themes.<sup>94</sup> Triangulation of data analysis and ensuring the consistency of questions (by having one interviewer) assisted in determining data saturation. The process of data analysis can become biased when collecting and coding data. To improve the reliability of this qualitative study, the triangulation of data analysis included one interviewer to maintain the consistency of the interview protocol (by use of the data collection tool), detailed documentation of coding procedures to ensure replication of the study, and data coding by multiple investigators.<sup>94</sup> Data triangulation increases the likelihood of data saturation.<sup>94</sup> Data saturation was confirmed by the Principal Investigator (PI) and two independent coders.

### Interview Data Collection Tool

A 16-question interview protocol (Appendix A) was designed for this study. Questions were developed to elicit information necessary to answer the three research questions proposed for this project. Of the 16, ten qualitative questions were designed to elicit open-ended responses to ensure rich data compilation; the remaining six quantitative questions were intended to assess a representative sample of CRNA managers and to associate specific phenomena with age, gender, and experience. For example, Questions 2 and 3 evaluated the participants' years of experience as both a clinician and a manager. The responses were then used to assess if certain

managerial scenarios were more familiar with less experienced clinical CRNAs or managers, as compared to those with more experience. Questions 12 and 15 were intended to elicit responses associated with preparing for transition: “Is there anything you would have done differently if you could go back and do it again?” and “What abilities or skills do you perceive would have initially assisted you when transitioning into a managerial position?” To ensure rich data and to maintain consistency in the interview protocol, the same questions were asked in different ways, and follow-up questions were used to elicit greater detail if needed.

### Study Population

Participants were asked to contact the interviewer if they were previously or currently a CRNA manager or chief. Participants were obtained from two sources, first by email to AANA members and second by a Facebook (FB) post to a group titled “CRNAs & SRNAs.” After applying through the AANA research committee for “E-mail solicitation for research participants via Telecommunications Software,” 3000 emails (Appendix B) were sent to random CRNAs who were identified as AANA members. It was not possible to recruit participants by emailing only managers, as many members do not include that type of data in the information they provide to the AANA. The second method of obtaining participants (after ensuring the group administrators’ approval) included posting to the FB group “CRNAs & SRNAs”; the informed consent for this post can be viewed in Appendix C. A screenshot of the FB post is located in Appendix D. The author is a member of this 22,614-person group, where admittance to the group requires confirmation or proof of CRNA status.

Potential participants received an initial email or FB post describing the study, with an assurance of anonymity. Two attempts were made over the course of a three-week period, by email or FB post, asking for voluntary participation. No compensation was offered to participants. Subjects interested in participating were instructed to reply to the email or FB post with a phone number and available times for initial contact. Participants recruited via FB were

asked to private message the author with their phone number and a time to call. Their responses were considered initial consent.

To prevent interviewer bias, managers or chiefs known to the interviewer were excluded. Participants were included in the study if they were previously or currently a CRNA manager or chief of an anesthesia department, and if they were unknown to the author. Twenty participants responded to the email and FB post, and 18 were interviewed. Respondents were interviewed only after they provided verbal informed consent and agreed to be recorded. Two of the twenty participants were not included in the findings; one participant's data was lost due to the recording app disconnecting, providing an incomplete interview recording, and the other participant could not be reached after two unsuccessful telephone attempts.

During the initial phone contact, participants were notified that the interview would last approximately 15 to 20 minutes, they could disengage at any time, and any information would be confidential, anonymous, and recorded. The participants were notified that once the interview data were coded and evaluated, they would receive copies of any written materials derived from the study by email.

#### Data Protection

The data were obtained by phone interview from one interviewer throughout the study to ensure consistency of the interview process. The interviewer allowed each participant to expound on situations to glean detailed meaning from the information. Interviews differed in flow or pattern during questioning. Depending on the participant, different probing questions or processes were needed to explore situations for understanding. The phone interviews were 1) conducted and recorded by the interviewer, 2) transcribed by a professional transcriber party, and 3) reviewed and de-identified by the interviewer for content accuracy and participant protection. Any identifying information within the interviews was deleted. The taped recordings are being held in a computer file under each participant's assigned pseudonym and will be kept for three

years, at which time the data will be erased. Only the interviewer was aware of the identity of the participants.

### Resources

The resources used for this project include one computer software program capable of recording phone interviews and another that was used to code research data. A phone recording mechanism application (Tape A Call™) was used to record phone interviews, and NVivo 11 was used for data analysis. The author's private funds subsidized the cost of the study. Institutional Review Board (IRB) approval for HUM00113078 was granted by the University of Michigan–Flint review board. Ethical considerations, including maintaining anonymity, privacy, informed consent, and confidentiality, were described to the participants in an email or web posting. Impact on the participants was minimized by eliciting only phone interviews and by educating the participants as to the time allowances needed for the study before obtaining consent.

### Coding Methodology

The interview protocol guided data analysis for this research study. Interviews were coded using NVivo 11 data analysis software. Two independent qualitative analysts with extensive experience in NVivo data analysis coded the data in waves. The primary independent coder was provided with interviews 1-3, and the secondary coder was provided with only interview 1. Each coder established a single coding tree using an iterative method by independently coding interview 1 in NVivo software. A mixed-methods approach employing both etic and emic techniques was used to create themes, codes, and sub-codes, both from the demand characteristics of the survey protocol as well as from the emerging thematic trends within the data.

The primary coder also coded the interview data from participants 2 and 3. Coders then compared, reviewed, and edited coding discrepancies (including reviewing research questions, interview protocol, and coding techniques) to create a mutually informed coding schema. The

coding method allowed co-coders to detect sources of disagreement and correct bias, thereby training one another to code independently, reducing subjectivity and increasing validity.

Both coders then coded (or recoded, in the case of the primary coder) interview 3 based on the agreed coding schema to ensure completeness of said coding schema, and to ensure the schema met the needs and characteristics of the interview protocol. After coding interview 3, the coders once again reviewed their levels of agreement, discussed differences in code assignment, and modified the coding tree for improved reliability. Then a detailed codebook was constructed based on the unified coding tree. Interviews 1-12 were then independently (re)coded by the primary coder using the agreed upon coding tree. The second coder coded half of these (approximately 35% of the total number of interviews) to establish reliability. Using a random number generator, interviews 1, 2, 5, 7, 9, and 11 were selected for the reliability process and were coded by the second coder. Once the coding mechanism was shown to have a high rate of reliability, the primary coder completed coding the full data set, which included 22 codes and 108 sub-codes (Appendix E)

The primary coder used a four-wave process when coding the data. During the first wave of coding, interviewees' responses were coded according to the individual interview questions of the study. The second wave of coding consisted of looking at each interview question individually, across the interview participants, and coding for either emergent themes or sub-questions within the specific question. The third wave involved rereading each of the interviews to refine the coding scheme, either by editing the existing coding scheme (merging and combining like themes into larger categories or deleting themes that were not relevant to the focus of the question) or by finding subthemes for the larger themes in the research participant's responses. The fourth wave of coding consisted of reading the codes to ensure each theme was an accurate representation of the research participants' words. This coding procedure was preferred because it provided a way of looking at the data from various points of view.

### Reliability Measures

Inter-Rater Reliability (IRR) or inter-rater agreement is used to measure the extent of agreement between coders.<sup>95</sup> Cohen's kappa was used to measure IRR because this kappa offers a statistical measurement of the agreement between two coders that also accounts for the likelihood of unintentional agreement.<sup>96</sup> An NVivo analysis (Coding Comparison Query) was used to determine that the inter-rater reliability kappa between the two coders was 0.93186 after the initial randomly assigned overlap of coding between the two coders. A value above 0.90 is considered to be very high coder agreement (see Table 1). Further, the same NVivo analysis was used to demonstrate that the coders had an Inter-Rater Agreement (IRA) of 99.1219%, which is exceptionally high considering the large number of codes utilized in the analysis.

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**Table 1.** Interpretation of Cohen's Kappa.<sup>a</sup>

<b>Value of Kappa</b>	<b>Level of Agreement</b>	<b>% of Data that are Reliable</b>
0–.20	None	0–4%
.21–.39	Minimal	4–15%
.40–.59	Weak	15–35%
.60–.79	Moderate	35–63%
.80–.90	Strong	64–81%
Above .90	Almost Perfect	82–100%

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<sup>a</sup>. From McHugh ML. Interrater reliability: The kappa statistic. *Biochemia Medica*. 2012;22(3), 276-282. At: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3900052/>

## Results

### Response Rate

The Response Rate (RR) to the email solicitation and FB post was 0.4% and 0.07% respectively, which is similar for research that uses email or FB methods to recruit participants.<sup>97</sup> Eleven participants responded by random email, and the final nine responded by FB post. The low RR in this study may be due to the following factors: CRNA managers were not targeted in the recruitment; study participation required the participant to reach out to the interviewer; a relationship with potential respondents was not established prior to interview requests; the study required a greater amount of time and commitment from participants than other online survey studies; the timing of the FB post may have resulted in limited viewers, thereby decreasing the number of potential respondents; and general study fatigue of potential participants.<sup>98,99</sup>

High nonresponse may create bias that affects how applicable the findings of the study are to the general body of knowledge in the field.<sup>99</sup> However, many qualitative studies have not assessed RR. Instead, triangulation of data and comparison methods have assessed the trustworthiness of qualitative studies. Triangulation in this study included multiple data sources (random email and FB post) and convergence of data by multiple independent coders and investigators (IRR). The investigation of phenomena with transitioning CRNAs was compared to other groups during transition, such as nursing and physician groups, for enhanced validity.<sup>100</sup>

### Demographics

The representative sample of 18 participants were interviewed and recorded through phone conversation following email and Facebook solicitation. Three participants (17%) interviewed were less than 40 years of age, 17% were 61 years and over, with the majority of participants (67%) being between the ages of 41 and 60 years. Of the 18 interviewed, 17 (94%) were Caucasian and 10 (56%) were male (Table 2).

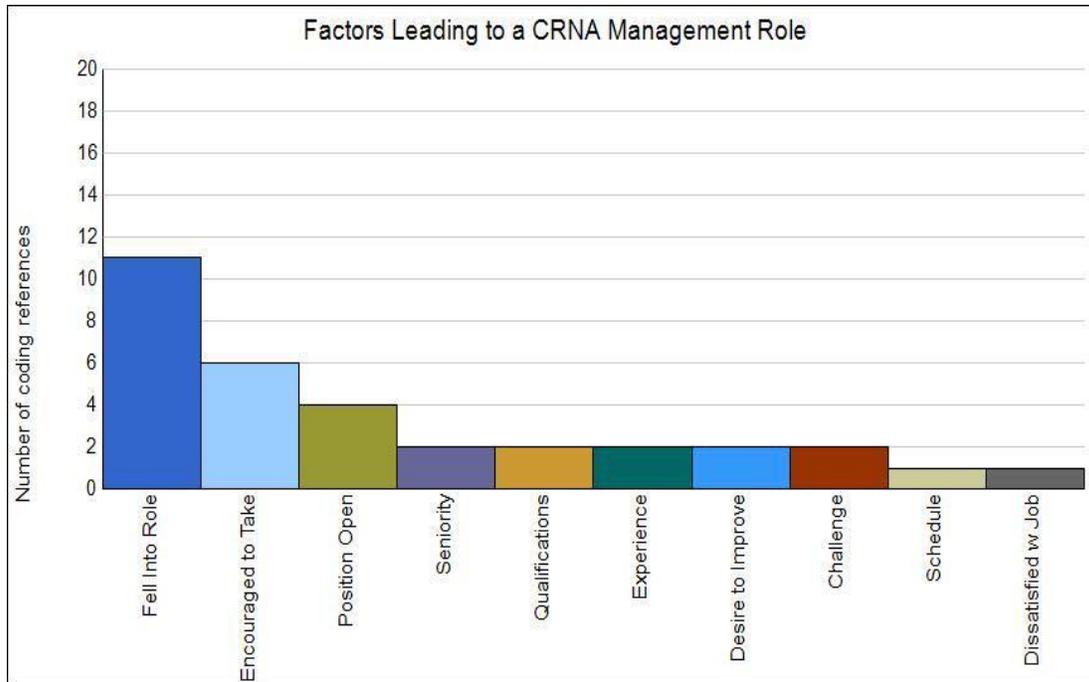
As clinician CRNAs, only two (11%) had less than five years of experience (Table 3). Six participants (33%) had 6-10 years, three (17%) had 11-20 years, and seven (39%) had 21 years or more of clinical experience as a CRNA (Table 3). As manager CRNAs, the majority of participants (44%) had less than two years of CRNA management experience, four (22%) had 3-5 years, and six participants (33%) had 6-30 years. For 75% of participants, their managerial role required more clinical than managerial duties; 50% or more of their time was spent performing clinical duties versus managerial duties

<b>Table 2. Demographics of Participants (n = 18)</b>		
	<b>Number of Participants</b>	<b>%</b>
<b>GENDER</b>		
Female	8	44
Male	10	56
<b>AGE</b>		
31-40	3	17
41-50	7	39
51-60	5	28
61-70	3	17
<b>Table 3. Characteristics of Participants (n = 18)</b>		
<b>Characteristic</b>	<b>Number of Participants</b>	<b>%</b>
<b>Previous Management Experience/Education before becoming a CRNA Manager?</b>		
Yes	7	39
No	11	61
<b>First Position in Management?</b>		
Yes	5	28
No	13	72
<b>Years' Experience as a Clinical CRNA</b>		
3-5	2	11
6-10	6	33
11-20	3	17
>21	7	39
<b>Years' Experience as a Manager CRNA</b>		
0-2	8	44
3-5	4	22
6-10	2	11
11-20	2	11
>21	2	11

Seven (38%) participants described previous military or law enforcement experience. The question of previous training prompted three of the seven participants to declare military training as previous management experience, while others mentioned it as a theme involved in their responses. Thirteen of the 18 participants (72%) had experience as a managerial CRNA prior to their current role. Eleven (61%) participants had no previous management experience or education before accepting their first role as a CRNA manager. During time of interview, participants with management experience, nine (50%) either had a doctorate, MBA, or MHA degree, or had taken formal business courses or management training.

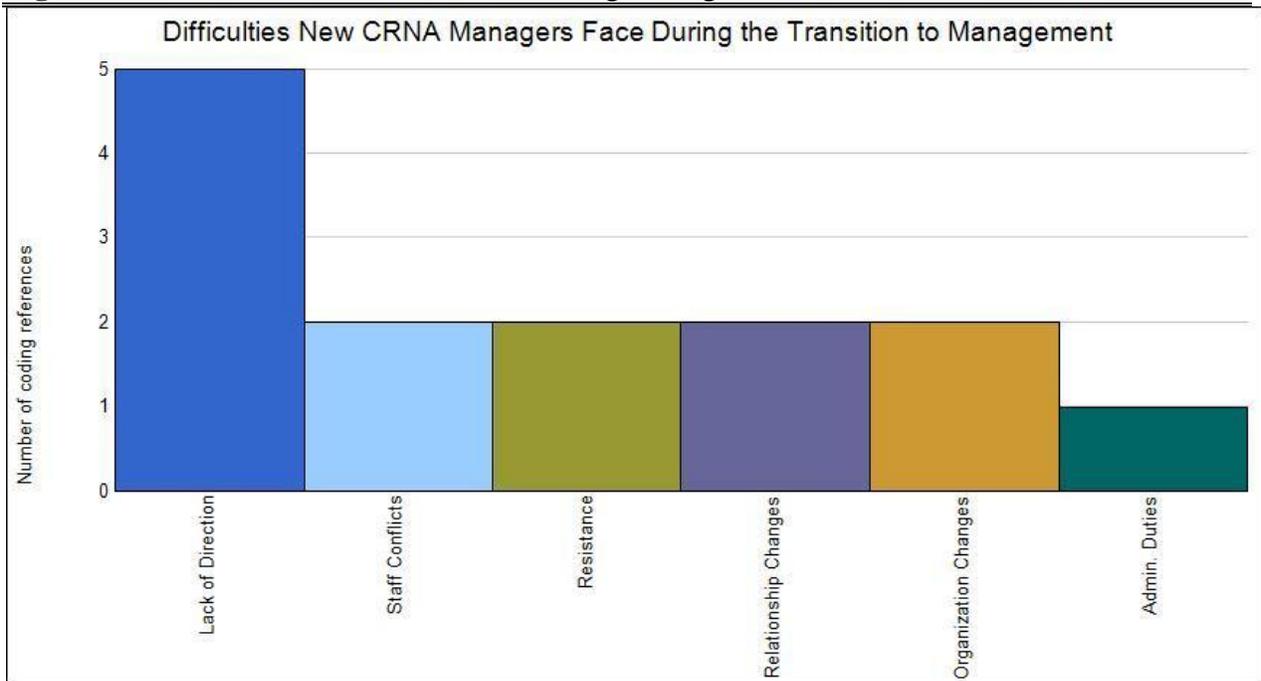
### Leading Factors

In addition to being asked about their demographic characteristics, research participants were asked about the factors that lead them to a CRNA management role (Figure 3). Eleven of the 18 (61%) research participants indicated that they simply fell into the role. Falling into the role of a CRNA manager was both explicitly and implicitly expressed by these participants.

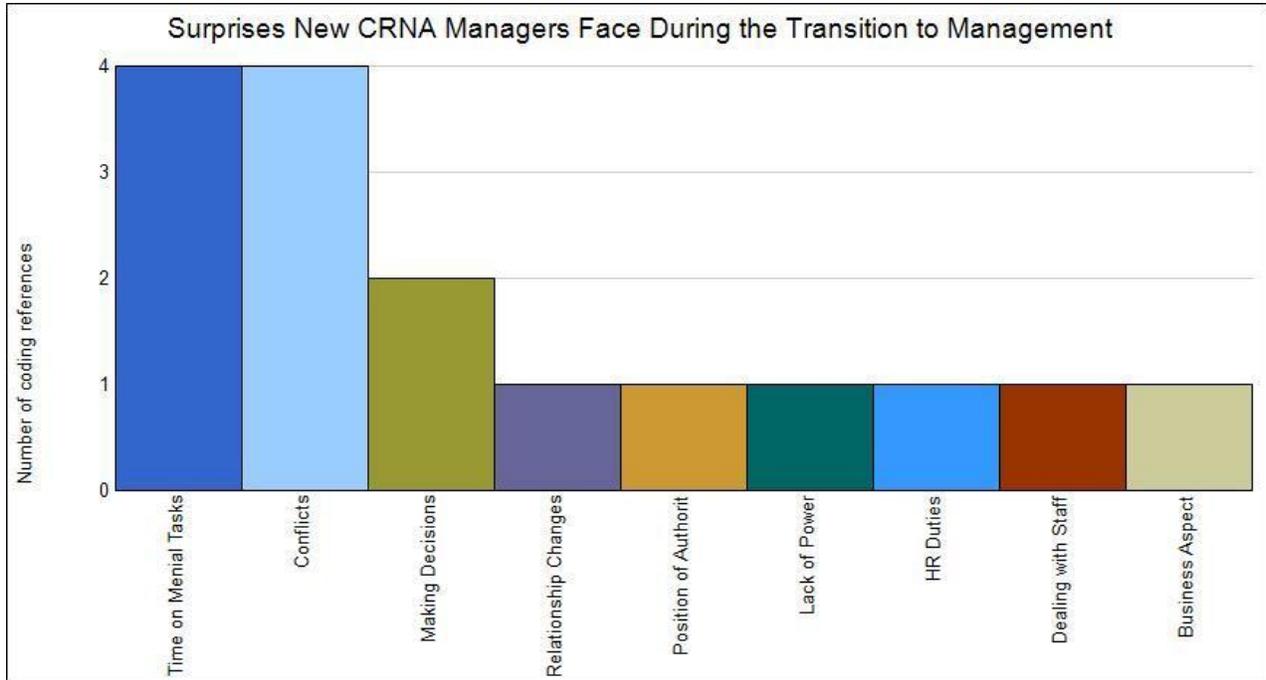
**Figure 3.** Factors That Led to Participants Entering Management.

### Common Difficulties Experienced During Transition

When participants were asked to describe their transition, including any tribulations, triumphs, or successes, the majority of participants expressed difficulties (Figure 4). Five (28%) cited lack of direction or training as a problem. Staff conflicts, resistance, relationship changes, and organizational changes were equally cited as the next most common problem (11%) for each.

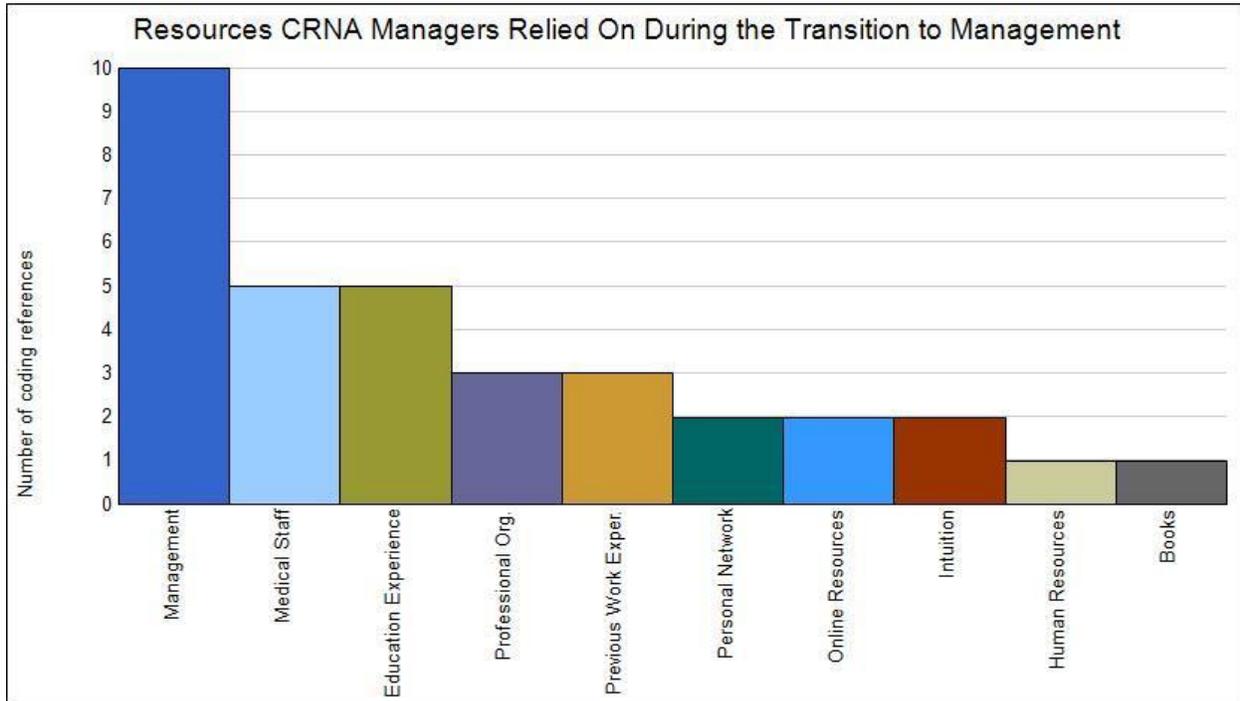
**Figure 4.** Common Difficulties of Transitioning Managers.

Participants were asked the follow-up question, “What surprised you as a new manager that you did not know as a clinician, e.g., difficulties with peers, MDAs, or management” only if they had difficulty answering the question. The answers yielded more details or code nodes (Figure 5). Time spent on menial tasks (22%) and conflicts (22%) had four participant responses each, making them the two most cited surprises for a transitioning CRNA manager. Staff personalities, making decisions, or dealing with new authority (or lack thereof) were the next most commonly cited surprises of new managers.

**Figure 5.** Unanticipated Barriers During Transition.

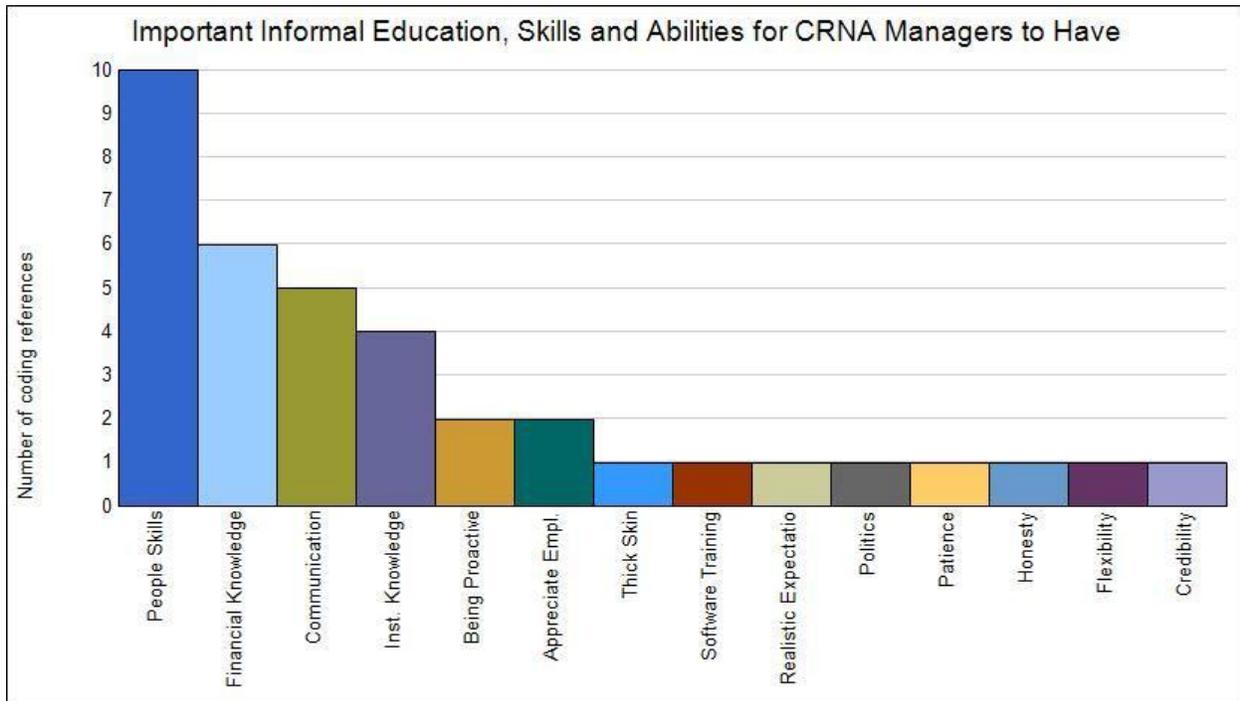
### Resources for Transitioning CRNAs

Transitioning CRNA managers perceived the most valuable resource during their transition period to be mentors such as current or past managers, medical colleagues, and lateral managers—this answer was given by 15 of the 18 participants (83%) (Figure 6). Eight participants (44%) listed previous education or experiences as a resource during transition, and 3 participants (17%) cited the AANA as the third most common resource used by new transitioning managers.

**Figure 6.** Resources Used During Transition That Were Considered Helpful.

### Knowledge, Skills, and Abilities (KSAs)

Participants were asked what KSAs they perceived were (or would have been) helpful when first transitioning into a manager role (Figure 7). Ten of the 18 participants (56%) cited people skills as the most important skill to acquire when transitioning into management. The next most cited KSAs included: financial knowledge (6 of the 18 [33%]), communication skills (5 of the 18 [28%]), and institutional knowledge (4 of the 18 [22%]).

**Figure 7.** Knowledge, Skills, and Abilities.

Most participants (12 of the 18 [67%]) believed formal education was important for transitioning managers. Six of the 18 participants (33%) stated MBA courses specifically as being helpful for new managers, while 4 of the 18 (22%) described management courses formally provided by their organizations. Two participants described having a Doctrate of Nursing Practice (DNP) as vital to their managerial duties, while another two participants viewed a DNP as not useful to themselves or someone else in a management position. Previous experience as a manager (either in the military or another profession) was cited by 5 of the 18 participants (28%) as being helpful during their transition into management.

## Discussion

### Characteristics of CRNA Managers

The lack of cultural diversity within the study—17 of the 18 respondents (94%) were Caucasian and 10 (56%) were male—may be due to a documented lack of diversity in management positions in general, including in hospital organizations.<sup>101-104</sup> Lack of diversity is an issue that many organizations are challenged to address, especially in an unprecedented era of demographic change within the United States: The population of the United States is expected to be mostly nonwhite within the next 30 years, and diverse cultural and ethnic leadership teams have been credited with increased performance.<sup>101-103</sup>

The question of military duty was not asked of the respondents, yet 38% did include military training in their responses. An incidental finding, this number might have been larger had the interview protocol included a direct question about military experience. The study required self-volunteerism, which has been shown to be higher in military veterans, likely due to an increased sense of duty and citizenship.<sup>105</sup> This may enhance a military-trained CRNA's willingness to accept greater responsibility out of duty (managerial duties) than their nonmilitary CRNA peers. Military leadership may skew results as to how these managers transitioned into their CRNA position.

“... it also gave me kind of a skewed idea of the role, I'll say (this of) the employees in the air force: give an order and it's followed... So, the (civilian) workforce has been much more lax.” (Participant 2, male, age 58)

Military training focuses on enforcing rank, trust in leaders, and the duties required of a leader. As a transitioning manager of a civilian workforce, the veteran CRNA may have different experiences than the nonmilitary CRNA. The veteran CRNA could have greater or less difficulty during transition. This variable requires more in-depth evaluation, recommended for future studies.

Commonly held perceptions of managers as being the most knowledgeable or having the most experience of the group pervades many professions. CRNAs in this study had many clinical years of experience, with 33% having 6-10 years and 39% having greater than 21 years. Clinicians may feel that they need to have “the answers” before accepting a management position for the first time.

Managers in our study had many years of clinical experience and yet (72%) were in their first management position. Sixty-one percent had no previous management experience or management education before accepting their first role as manager, and 66% had less than five years of experience as a manager. High turnover in healthcare management may have created positions for these new managers.<sup>41,42</sup> Many first-time managers are promoted based on clinical and/or professional abilities, and this study has confirmed that CRNA participants are no exception. Decision-makers hire CRNA managers based on clinical abilities, skills, or personalities, not necessarily management skills or experience.

#### Clinical or Managerial Skew—The Hybrid Manager: Phenomenon 1

The expectations of managers vary depending on the size of the hospital and scope of anesthesia services throughout the hospital. To help clarify the scope of the CRNAs' managerial duties, Question 5 was added, which is why only 17 of the 18 participants were asked this question: “What percentage of the time do you perform clinical duties versus management duties?” Thirteen (76%) spent 50% or more time providing clinical anesthesia services. The smaller the hospital, the less opportunity a manager had to perform managerial duties. This creates a manager who functions both clinically and managerially: a hybrid manager.

“You did your management things by hook or by crook when you were on call or any other way (that) you got it done...for many years I had no dedicated administrative time. But I used to kind of accomplish a lot when I was on call...My staff could go to bed if they

wanted to, if they weren't busy, but I always had something to do.” (Participant 3, female, age 68)

“We are not big enough for me just to do management.” (Participant 1, male, age 44)

The reasons CRNAs devote more time to clinical duties than to management duties may vary. CRNAs may devote more time to clinical duties to avoid the stigma associated with management. Other healthcare management professionals, physicians, and nursing colleagues recognize that management is viewed as an added layer of bureaucracy that some clinicians may consider a hindrance to their practices.<sup>106-108</sup> To prevent the perception that managers lack an understanding of clinical staff issues and to present themselves as team players, managers perform clinical duties to show solidarity.<sup>41</sup>

“I was always clinical as well. That sort serves you well. If you're locked in an office and nobody sees you doing anything, that breeds contempt.” (Participant 3, female, age 68)

Support (or lack of) to nursing managers may also transcend to CRNA managers.

“They want you to do the work, but you cost them money when you're not sitting on a stool. So, you have to have dual roles, and it's the dual roles that put the stress on the job because you have to be, you have to talk to pharmacy, talk to maintenance, talk to the OR, you know, you're multitasking tremendously because at 7:30 in the morning you got to be doing a case.” (Participant 5, female, age 55)

The hybrid manager provides an individual *and* departmental contribution that increases workload, and may increase errors.<sup>41</sup> Healthcare managers with less patient contact were more likely to stay in their position as a manager.<sup>41</sup> Balancing clinical and managerial duties may create high turnover and lack of desire for CRNAs to enter (or reenter) into management. Lack of support or resources such as education, mentors, compensation, and time to perform administrative functions can create added stress on the CRNA, which may increase their chances of derailment or decrease their desire to enter into management.

Some CRNA managers may want to keep clinical skills sharp to avoid losing their honed abilities. A managerial career may not be as daunting if clinical skills remain sharp. Due to high demand for clinical CRNAs, managerial derailment may be less of a concern for a CRNA. The ability to readily restore a clinical career may mitigate the risks of derailment from a management position. Many physician and nursing colleagues experience the same phenomenon.<sup>19,52,106,107</sup>

Promotions to management may be given as a “reward” by well-meaning supervisors or administrators; however, not all clinicians desire a management position. One participant manager was happy to perform clinical skills above his managerial duties.

“... like I said, I would never want to be 100% manager; it would be awful to me. I love doing anesthesia because—I just do it really well.” (Participant 7, male, age 45)

A manager’s role is less about the individual contribution (clinical skills) and more about the departmental contribution (managerial skills). To require some managers to contribute more than 50% of their time to providing individual contributions may stunt their ability to learn a new type of contribution (departmental) that may be required to manage a department.

A manager maintaining the mindset of the individual contributor increases the chances of derailment.<sup>66,70</sup> The ability to be effective during their transitional period is dependent on their quickly becoming a departmental contributor. Maintaining a balance of hybrid duties can create stress not experienced by other clinicians or non-hybrid managers.

“...I spend a lot of my free time doing admin stuff. When I’m, you know, working at my facility as chief and I’m clinical eight hours during that day, I still have all of those stresses, people coming to me with complaints, concerns—not just the CRNAs, other administrators in the hospital with issues...My level of stress is way higher than it should be...” (Participant 13, female, age 41)

Some CRNA managers saw their clinician-first status as helpful to their managerial position.

“If anything, it gives me a lot of leeway; I think everybody recognizes that, as I come running and I’m five minutes late with a set of scrubs on, that nobody really gives me any flak for it...like I said, it gives me some leeway and maybe a little lower expectations.”

(Participant 7, male, age 45)

Reasons for delivering patient care may differ among managers. New managers have to balance delivering patient care and developing management skills. This is not to say that managers should “never or infrequently” contribute to patient care, or avoid helping their direct reports if help is needed. Mastery of management skills is not different from mastering anesthesia skills; both require development with time and practice. The reasons why managerial CRNAs have more than 50% clinical versus managerial duties should be explored in future studies. The frequent phenomenon of these manager CRNAs performing clinical duties over managerial duties may be unique to CRNA managers.<sup>109,110</sup> Whether this phenomenon contributes to or hinders a manager’s success is also recommended for future study.

#### Why CRNAs Choose Management: Phenomenon 2

Many of the participants reported reluctantly or unexpectedly entering into management. Either they were picked from among their peers or they agreed to duties that propelled them into an increasingly larger role as a manager. The lack of desire to enter into management was a recurring phenomenon expressed among the population studied in this project. Fifteen of the 18 (83%) participants stated explicitly or implicitly that they either fell into the role or were asked to accept a managerial role (Figure 3). This phenomenon with CRNAs confirms studies that have suggested many clinicians are not seeking managerial roles.<sup>8,38,39,45</sup>

Lack of interest in managerial roles may be due to stigma associated with managers as agents of the status quo or bureaucracy, lack of organizational support, increased stress, and increased workload with little financial or home/life balance reward.<sup>106-108</sup> Clinical CRNAs in this study did not seek a managerial pathway, but instead volunteered due to lack of interest by

their peers or because they were encouraged by a previous manager or administrator. Resistance to first entering into managerial roles has been documented within the research of physician colleagues.<sup>106-108</sup> Nursing colleagues, although not as resistant to entering management, have left the position at higher rates than physician colleagues.<sup>106,107</sup>

“They thought I would be good in that role. There were seven people nominated from among all of the anesthetists of the group. None of the other ones accepted the nomination, except for me. I, by default, became the next chief.” (Participant 15, female, age 41)

“...asked me if I wanted to be the manager and I said no, and he said ‘I don't want the other person to be the manager,’ so I said, well, I guess I'm it then.” (Participant 16, male, age 56)

The legitimacy of the hybrid manager may be questioned when reluctant managers prioritize clinical duties over managerial duties.<sup>107</sup> The unpredictability of clinical work, such as emergent intubations or cesarean sections, releases the hybrid manager from their managerial duties and back into comfortable, familiar tasks. Nonclinical directors or managers may need to withhold decisions (or worse, make decisions without anesthesia input), which can create tensions. The new manager must recognize the value and importance of managerial duties both horizontally and vertically within their organizations.

A recommendation for these hybrid managers includes negotiation with their supervisors about their dual roles and the expectations of how they will be managed, preferably before entering the management position.<sup>107</sup> Derailment is less likely to occur if other managers or administrators feel that the CRNA manager contributes to clinical duties in a way that does not imply clinical work is superior to the work of administration. How and when a CRNA manager prioritizes their clinical duties is important to their direct reports and their administrative superiors.

The current and increasing nursing shortage, lack of organizational and leadership support, and lack of interest may cripple CRNA momentum within hospital organizations.<sup>8,14,38,58,59,76</sup> The spotlight on healthcare by the government, media, and public will require leaders in health organizations to explain, defend, and share their visions of healthcare. CRNA managers and their anesthesia departments can help shape and influence hospital organizations' visions. To influence a healthcare organization in a meaningful way, reluctant individual managers will need to become passionate drivers of change. Support from organizations and departmental staff can improve the chances that new managers not only succeed but thrive in their new roles.

### Common Barriers

The expectations of a manager's duties are difficult to define for any new manager. One organization may require a different level of participation than another organization; one manager may prefer to champion different goals than the prior manager. The elusive nature of defining a manager's position was the most common barrier to overcome for many of the participants in this study (5 of 18 [28%]). The difficulties associated with management during a transition (Figure 4) showed a lack of direction and training as a common theme with the participants.

“...it really wasn't a well-defined position...the previous chief really didn't have a lot of responsibilities, so that in itself—defining my role—was definitely a huge challenge.”

(Participant 13, female, age 41)

Lack of direction was universally an issue among new managers.<sup>11-13</sup> CRNA managers have varied job descriptions that differ in each organization. Understanding and balancing the expectations of colleagues horizontally and vertically (above and below) can be elusive and difficult. During transition periods, management experts recommend spending 3-6 months asking questions and listening to staff.<sup>20,111</sup> During this time, it is recommended that managers avoid

making major decisions or exerting any power or authority (if possible) in favor of building relationships with staff and colleagues, both horizontally and vertically.<sup>20,111</sup> It is crucial for a new manager to understand the expectations that can change from one manager or administration to another. Newly created management positions require still more focused effort to determine the expectations of the role. Participant 14 from this study is a good example of navigating through unknown expectations.

“The hardest thing was coming into a role that really wasn’t at this hospital. I wasn’t replacing somebody coming into the hospital: it was kind of a new role and so pretty much I was told, all right this is kind of how the budgets are going to work, the kind of reports you’re going to see.” (Participant 14, male, age 37)

Managing expectations, including their own, is a delicate balancing act that can be a cause of derailment for a new manager.<sup>1,19,66</sup>

Of the 18 research participants, 14 described some surprises as a new manager. Six of the 14 (43%) described managing conflicts and staff personalities as surprising for them during their transitions. The participant managers felt they understood before transitioning that dealing with conflict would be part of the position. What did surprise them was the intensity of time, severity of issues, and how quickly they had to address these issues during the transition. Lack of preparedness in conflict management aligns with nursing and physician research that has described the same difficulties during a transition.<sup>8,9,19,106,107</sup> Staff conflicts, resistance, relationship changes among staff, and organizational changes were other common hurdles experienced by our participants.

“...it became very stressful trying to manage the two of them [CRNA staff] and to keep them from actually becoming physical...” (Participant 1, male, age 44)

“...making a transition from friend to manager leader is a bit of a challenge for certain staff [that] you’ve been colleagues and friends with for a decade or longer, and now you are their boss. That transition took a little bit of time...” (Participant 11, male, age 53)

These subthemes (staff conflicts and relationship changes) recurred within the different codes (Appendix E). For example, when participants were asked what surprised them, what difficulties they encountered, and what important knowledge they needed as they transitioned into a new manager role, many repeated the same themes: staff conflicts and relationship changes (Figures 5, 6, 7). The expertise of a clinical CRNA does not equate to being an expert in conflict management, communication, and relationship (organizational behavior) issues, and these issues do not wait for a new manager to become adept at management before they arise. Strategic planning for these common obstacles could ease the transition.

Other surprises encountered by these new managers included time spent on menial tasks or human resource duties, as described by 5 of the 14 (36%). According to Hill, this is common with new managers who do not yet understand the importance of these tasks.<sup>1</sup> Often, first-time managers disregard the “menial tasks” as a barrier to the individual contributions of themselves and their team.<sup>1,2,11</sup>

“...the amount of time, really, it takes to text, to answer emails, and all the paperwork that is involved in hiring, and orienting. I would say that was a little bit of a surprise, I kind of knew a little bit about it. But it was just pretty burdensome...” (Participant 11, male, age 53)

The tasks associated with management, such as human resource tasks or the development of departmental relationships, to name a few, are just as important as the clinical functions of a CRNA. The importance of these contributions may not be understood during the transition. Derailment can occur if a CRNA manager demeans these tasks as “below” them. These tasks are

then rerouted to other departments or their supervising manager, which may prevent or stall the development of meaningful relationships.

### Resources to Recommend

Participants were asked what resources they relied on during their transition. Fifteen participants (83%) cited *people* (other managers or medical staff) as their primary resource. Some research participants described relying on managers above themselves, such as bosses and supervisors; others relied on managers in lateral roles to themselves, such as managers in other departments. Participant 11 is an example of a research participant who relied on a variety of management resources from positions above and lateral to him.

“I have a manager above me—CRNA manager above me. I also have direct access, in fact I meet every other week, with the administrator. They are good sources for information, questioning, talking about mentoring, so they are—those two are—my primary sources...My other supervisor is, like, a little bit [of a] source of information, but mostly as a colleague to talk through issues with.” (Participant 11, male, age 53)

Participant 8 explained how managers in other departments became resources and eventually mentors during his transition to management.

“I found one or two other departmental level managers within the institution I was at, and then they, with time, became mentors to me... [I relied on a] former director, as a mentor, as well.” (Participant 8, male, age 49)

The 2011 Institute of Medicine report on the future of nursing urged mentorship programs in the form of residencies and leadership training.<sup>112</sup> Managerial experts believe that mentors are necessary during a transition.<sup>1,8,10,36</sup> They have recommended having varied relationships between veteran and new managers through both formal and informal channels.<sup>1,2,12</sup> Mentors can be inside or outside of the organization in which the manager works.

“My husband came from a management position, is now retired, but he was also a great resource for me.” (Participant 4, female, 44)

A mentor provides guidance and support. Transitioning managers who find and develop relationships with mentors or who seek self-awareness have been rewarded for their efforts with positive outcomes such as job satisfaction and performance.<sup>1,2,21,24,71,72</sup> Developing these relationships can provide the new CRNA manager with emotional support, constructive feedback on real-time issues, and guidance in the organization’s politics.

A majority of our participants (13 [72%]) had previous management experience. Eight of the 13 participants with experience as a manager (62%) felt that their previous education or experience was a valuable resource during their transition. Experts have agreed that most managerial learning is done on the job.<sup>1-3</sup> Some have recommended that new managers learn 70% on the job, 20% through relationship management training, and 10% from formal education.<sup>58</sup> This Experience-Driven learning suggests that experience is more important than formal education. Five of our 18 participants (28%) described previous education in management as a resource that assisted them during transition. Managers with minimal experience who had formal education felt that their academic education assisted them in their transition.

“I think my MBA training was advantageous along with previous leadership experience in larger organizations...also AANA training at national meetings and leadership conferences was a definite benefit in organizational management.” (Participant 18, male, age 39)

“So, I was able to get my Master’s in Health Management and Supervision...I relied a lot on the graduate program that I had been at...it is entirely different from anesthesia education because, I mean nothing we learn in anesthesia touches on that...even the things that they address now about the business of anesthesia. Still, they don’t address the administration [management] of anesthesia” (Participant 6, female, age 60)

Managers with past experience felt their experience helped them ease their transition into management.

“Mostly experience from dealing with other managers and I didn’t want to be like them.

So, I guess you’d say life experiences...I mean an accumulation of 34 years of experience of, you know, being around other managers.” (Participant 9, female, age 61)

“Experience brings an education that is hard to get elsewhere, and so I’ve learned that though I am a leader in my own line, there are certain blind spots that we all have and I think that’s partly due to lack of experience, most of them skills, because it can be learned...” (Participant 11, male, age 53)

### Knowledge, Skills, Abilities

Ten of the 18 CRNA participants (56%) agreed that having people skills was most important during a transition (Figure 7). People (or soft) skills can be described as skills associated with building relationships, communication, empathy, and emotional intelligence; these skills have been cited by employers as lacking in the workforce.<sup>113,114</sup> People skills require practiced, mindful, deliberate focus, and this is hard to achieve under stressful conditions, such as during a transition.

“So, I’ve got several struggles—some of them have gotten better and some of them are still the same—I just have to deal with. People skills—dealing with handling people is the biggest skill set that I think a manager needs.” (Participant 1, male, age 44)

The next most cited KSAs were financial knowledge (6 of the 18 [33%]) and communication skills (5 of the 18 [28%]). Again, communication was a common theme that recurred throughout the different nodes.

“Communication. 100%. That’s the biggest thing out of all of my DNAP education that focuses a lot of leadership; the number one thing that I took away from it was communication.” (Participant 17, female, age 31)

“It is the business part of that; it’s money, and we’ve not been educated in the money part of it...how do you express what you do to someone business-wise to get them to represent you? It’s a business and you have to understand the lingo.” (Participant 6, female, age 55)

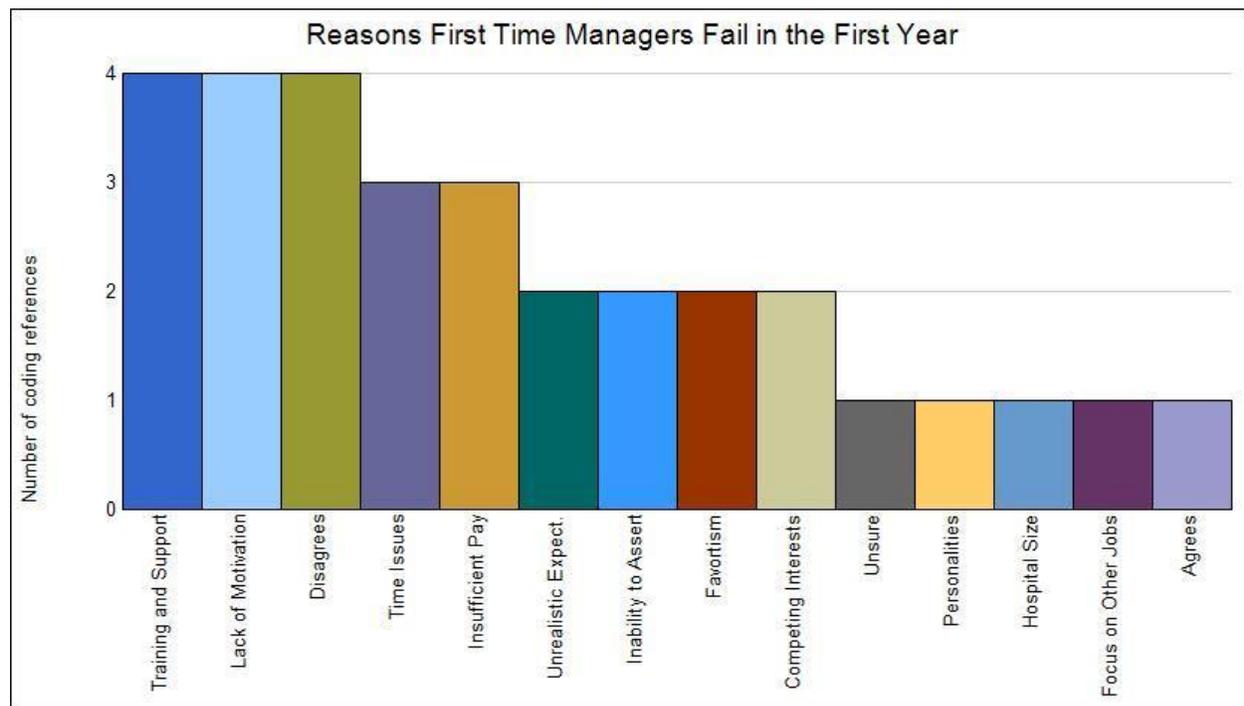
Communication and relationship development are learned together as one competency, and this is the first one that should be mastered. The ACHE has described both communication and relationship development as interconnected and as one of the most important and difficult competencies to master.<sup>84</sup>

### Avoiding Derailment

Of the 18 research participants, 13 (72%) had previous management experience as a CRNA. Reasons for participants leaving their first management positions were not explored and are beyond the scope of this study. The research participants were asked if they believed that CRNAs are similar to other professions that cite 50% derailment rates of first-time managers.<sup>34,66,69-72</sup> Of the 18 participants, 12 (67%) agreed that half of all first-time CRNA managers might have a high probability of derailment in their first position as a manager.

“A lot of people think they know it and walk in. I would say they politically position themselves; they’re very good at manipulating and the popularity bit. But they don’t grasp all of the responsibilities, they play favorites. In the same respect, you got to be a disciplinarian; when you become a manager you’re out on a limb by yourself. So, you walk in a lounge, there is a tone that changes and you’ve got to be able to live with that tone.” (Participant 12, male, age 67)

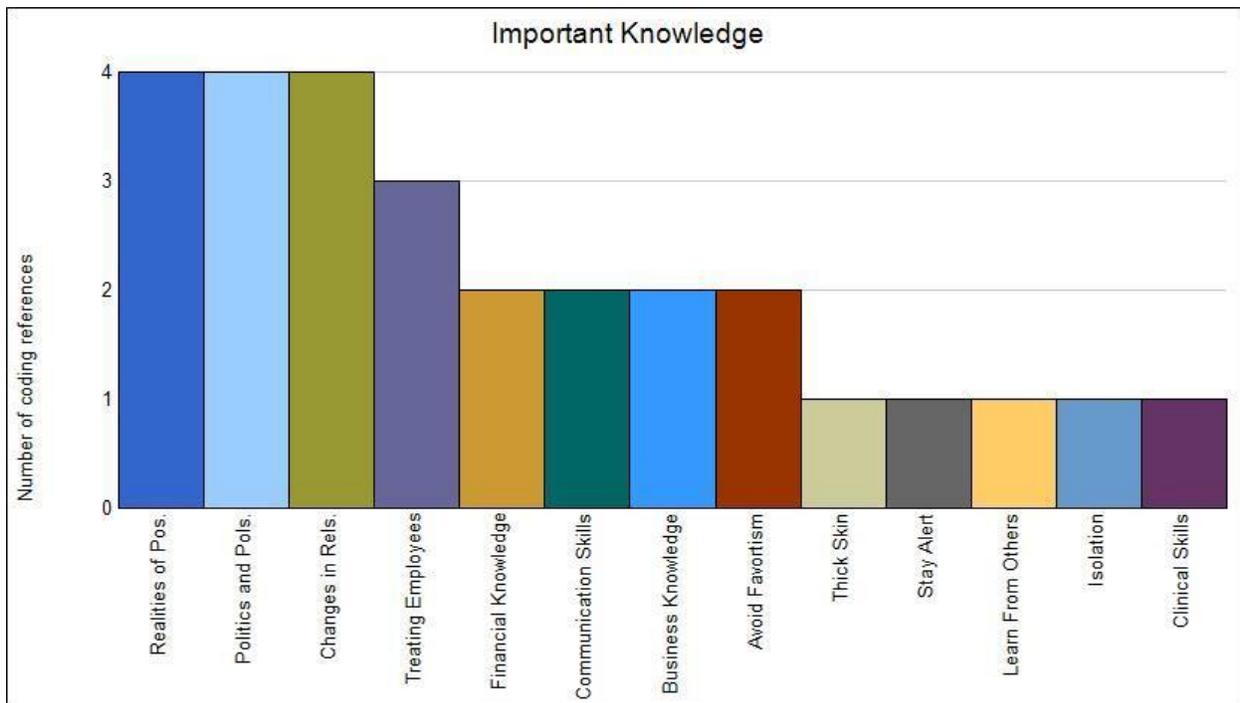
Participants cited what they believed to be reasons for derailment issues with CRNAs, including lack of training and support, lack of managerial motivation, lack of time given to managers to perform managerial duties well, and insufficient pay (Figure 8).

**Figure 8.** Issues That CRNAs Believe Cause Derailment with Nurse Anesthetists.

Research has documented the biggest reason managers fail in management positions as being their inability or difficulty in establishing interpersonal relationships.<sup>69,71,72</sup> The majority of our participants' biggest hurdles—staff conflicts and relationship changes—recurred within our codes, creating a common theme with new managers. Based on this study and existing research, new CRNA managers would be wise to prioritize their learning to focus on enhancing their communication and relationship management skills.

### Thriving in the New Role

Research participants were asked multiple questions regarding what worked for them as they transitioned and what they believed would help others coming into the new role of management. The top four cited knowledge issues for new CRNA managers are described below, with the fourth (people skills & communication) cited more frequently throughout the coding references.

**Figure 9.** CRNA Managers' Beliefs on How to Thrive.

Preparing for the realities of the position;

“And the past chief was like, ‘you know, you really got to think about whether this is what you want, because it affects, like, your whole life, not just work’...She was like, ‘talk to your boyfriend, see if he’s on board, because it is more demanding on your time if there’s a call out and there’s no other staff and I’m not scheduled then they’re calling me...’” (Participant 15, female, age 41)

Preparing for the changes in relationships;

“The first and the hardest one for me to learn was ‘even if you think you act the same people will view you differently.’ The person that was your very best teammate yesterday will be one of the leaders against you tomorrow...It’s not necessarily against you as an individual, it’s against the role, and you’re the persona of that role, and because of that, it really does change a lot of dynamics...” (Participant 8, male, age 49)

Preparing for changing policies and politics of anesthesia;

“I think CRNA management needs to understand the business of anesthesia whether it be different practice models (I mean a rudimentary understanding of life practice models), different billing processes, and the local and federal regulations that govern each state. There were multiple...[examples of] this and actually I walked in on [one] probably the first week we had our first meeting...” (Participant 18, male, age 39)

And preparing to work on people skills and communication.

“You just need to treat people decently and know that situations may come up that will be uncomfortable that you have to deal with, and right away; if you don’t know how to deal with it, do some research and be prepared, and state your point. But sometimes you are going to win, sometimes you are going to lose with what you want. Just keep on going—keep on keeping on.” (Participant 9, female, age 61)

Communication and people skills were also cited by the participants in other questions’ coding references, which belabors the need to ensure communication skills as a top priority. The five competencies recommended for managers from the ACHE Association include communication and relationship management, business and financial knowledge, professionalism, healthcare knowledge, and leadership (Figure 1). This study highlights what KSAs and competencies the new transitioning manager should focus on to prevent derailment and thrive in their new role.

### Strengths/Limitations

The high nonresponse rate associated with obtaining interviewees may have skewed the qualitative data by including participants who felt a greater desire to volunteer in the study (such as military CRNAs) or who volunteered because they had a favorable or unfavorable experience in their management position. Those with a military background may have skewed the data

toward a military management framework, which is one type of approach to managerial training. Despite attempts to gain a representative sample and improve validity, a generalization of results should be avoided.

This study did not differentiate between managers of large or small hospital or surgery center settings. Speaking to the managerial needs of specific settings may lead CRNAs in those settings to focus on different KSAs or to address different balances between clinical and managerial duties. Despite the limitations, the research has verified the phenomena of the unintentional movement into management by CRNAs, the hybridity of many CRNAs' management positions that include a strong clinical component, and a consensus on the importance of learning communication and relationship management.

### Recommendations

Recommendations for future research includes a detailed assessment of actual CRNA managerial duties, both administrative and clinical; studies investigating the reasons for CRNA hybridity with a clinical focus and whether this helps or hinders their effectiveness as a manager; and assessment of types of leadership styles used by CRNA managers. Interviews with CRNA mid-level managers versus CRNA executive managers may further provide a long-term view of the KSAs needed to withstand the healthcare arena. Lastly, future studies inquiring about or acknowledging employees' perceptions of their managers could provide an interesting view of the success or effectiveness of a manager.

### Dissemination

The author presented this qualitative study for publication at the AANA Journal on October 10, 2017. The study was peer reviewed and accepted for publication on December 4, 2017. The publication is tentatively scheduled for the Fall 2018 issue of the AANA Journal with the title: "Certified Registered Nurse Anesthetists' Transition to Manager".

### Conclusion

Adding to current literature, this qualitative study found that CRNAs are often reluctant managers who spend more time performing clinical duties than managerial duties. This answered our research question: are there common barriers or experiences that CRNA practitioners encounter when transitioning into a new role as a manager. The incidental finding of CRNAs being reluctant managers, and of having to divide their time between managerial and clinical responsibilities, indicates a lack of mentoring and succession planning within the anesthesia departments of hospitals.

Two additional research questions: what knowledge, skills, and abilities are most important in the first year of transitioning to a CRNA manager and what do CRNA managers recommend transitioning CRNA managers utilize as resources were answered similarly. Corroborating current research, the most important resources and skills that helped new CRNA managers through transition included people (or mentors); and mastering “people skills” either through relationship management or communication skills. Our participant managers agreed that formal or informal knowledge in finance or business, as well as having previous management experience, was important to becoming an effective manager as they progressed into their management career.

To influence a healthcare organization in a meaningful way, reluctant individual managers will need to become passionate drivers of change. Support from organizations and departmental staff can improve the chances that new managers not only succeed, but thrive in their new roles. The current and increasing nursing shortage, lack of organizational and leadership support, and lack of interest may cripple CRNA momentum within hospital organizations.<sup>8,14,38,58,59,76</sup> The spotlight on healthcare from the government, media, and public

will require leaders in health organizations to explain, defend, and share their visions of healthcare.

Previously derailed managers can contribute to a new or changed management position by learning from their experience. New transitioning managers should focus on gaining insight into the expectations of their new role and the people around them; learning people and communication skills; and finding a trusted mentor to guide them through their transition. The hope of this study is to guide future or new transitioning CRNAs to avoid derailment, or to get back into management if derailment has occurred—a task that will require purposeful and focused effort from autonomous, self-reliant, and potentially reluctant new CRNA managers.

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**Appendix A. Phone Interview Questions for CRNA Managers:**

1. Demographic Questions: What is your current age? Ethnicity? Gender?
  2. How many years of experience do you have as a practicing CRNA?
  3. How many years of experience do you have as a manager CRNA?
  4. Is this your first management position as a CRNA?
  5. What percentage of the time are you performing clinical versus management duties?
  6. Did you have previous management experience or education before becoming a CRNA?
  7. What factors led to your assuming a CRNA management role?
  8. Describe your transition to management—for example, any certain tribulations, triumphs, or successes that you have experienced. What surprised you as a new manager that you did not know as a clinician, e.g., difficulties with peers, MDAs, or management?
  9. What resources did you rely on during your transition to a CRNA manager? Do you still rely on those same resources?
  10. What education do you think is important for CRNAs to have about understanding the management of an anesthesia department?
  11. What abilities or skills do you have that have been the most useful (or that have kept you successful) as you transitioned into a manager?
  12. What abilities or skills do you perceive would have initially assisted you when transitioning into a managerial position?
  13. The research has suggested that half of all first-time managers fail in their new role. Do you believe this is true with CRNAs? Why?
  14. Is there anything you think is important for CRNA practitioners to know before or during a transition into management? IF PAUSE or NO ANSWER: For example, having certain knowledge before starting a management position, employee relations, skills, knowing department policy, etc.?
  15. Is there anything you would have done differently if you could go back and do it again?
  16. Are there additional comments or concerns that you believe are important for novice CRNA practitioners to be aware of as they transition into managerial roles?
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**Appendix B. Potential Participant Email/Informed Consent.**

To Potential Study Participants:

As a graduate student at the University of Michigan–Flint in the Doctor of Anesthesia Practice program, I invite you to cooperate with a research project by taking a few minutes to participate in a phone interview. I am examining clinical CRNAs’ experiences as they transitioned into a new managerial role, what resources were used, and what knowledge, skills, or abilities were effective as a new manager. Our goal is to help assist future clinical CRNAs transition into new managerial roles and maintain success in such roles.

Your participation will provide valuable information. The study will consist of a phone interview of approximately 15-20 minutes with potential for a follow-up interview if necessary. Any participation or information in this study will remain confidential. No real names or identifiers will be used in this study. You do not need to answer every question, and you may disengage from the study at any time. **If you are interested in participating in this study, please reply to this email with your phone number and a good time to contact you.** If you are uninterested, disregard this and the next reminder emails. I look forward to hearing about your experiences.

Thank you,

Jennifer A. Martens, CRNA, MSN  
jemarten@umflint.edu [Questions about the Research](#)

If you have questions regarding this study, you may contact the principal investigator, Jennifer Martens, at jemarten@umflint.edu or call 248-372-1760.

Questions about your Rights as a Research Participant

If you have questions that you do not feel comfortable asking the researcher, you may contact Dr. Jane Motz, CRNA, DrAP at jane.motz@umflint.edu or call 810-762-0058.

Or contact the chair of U of M Institutional Review Board Marianne McGrath, Professor of Psychology, at mmcgrath@umflint.edu or call 810-762-338

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**Appendix C. Potential Participant Facebook/Informed Consent.**

As a graduate student in a Doctor of Anesthesia Practice program, I am looking to interview, *by phone*, current or past managers for a study. I am examining CRNAs as they transitioned from a clinical into a new managerial role. I want to assess what resources were used, and what knowledge, skills, or abilities were effective as a new manager.

The study will consist of a phone interview of approximately 15-20 minutes with potential for a follow-up interview if necessary. Any participation or information in this study will remain confidential. No real names will be used, and you may disengage from the study at any time. **If you are interested in participating in this study, please private message me with your phone number and a good time to contact you.** The goal is to help assist future clinical CRNAs transition into new managerial roles and maintain success in these roles.

I look forward to hearing about your experiences.

Thank you,

Jennifer A. Martens, CRNA, MSN

Questions about the Research

If you have questions regarding this study, you may contact the principal investigator, Jennifer Martens, at jemarten@umflint.edu or call 248-372-1760.

Questions about your Rights as a Research Participant

If you have questions that you do not feel comfortable asking the researcher, you may contact Dr. Jane Motz, CRNA, DrAP at jane.motz@umflint.edu or call 810-762-0058.

Or contact the chair of U of M Institutional Review Board Marianne McGrath, Professor of Psychology, at mmcgrath@umflint.edu or call 810-762-3383.

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**Appendix D.** Photo of Facebook post for potential participants.

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**Appendix E. Coding Tree**
**1. Demographics**

- 1.a Age
- 1.b Ethnicity
- 1.c Gender
- 1.d Years Experience as CRNA
- 1.e Years Experience as Manager
- 1.f First CRNA Manager Position
- 1.g Previous Management Exp/Edu
- 1.h Clinician vs. Manager Split

**2. Leading Factors**

- 2.a Experience
- 2.b Qualifications
- 2.c Seniority
- 2.d Dissatisfied with Job
- 2.e Schedule
- 2.f Fell into Role
- 2.g Position Open
- 2.h Encouraged to Take or Offered Role
- 2.i Desire to Improve
- 2.j Challenge

**3. Transition to Management**

- 3.a Difficulties
- 3.b Surprises
- 3.c Successes

**4. Resources**

- 4.a Previous Work Experience
- 4.b Education Experience
- 4.c Medical Staff
- 4.d Management
- 4.e Politics
- 4.f Human Resources
- 4.g Institutional Knowledge
- 4.h Personal Network
- 4.i Books
- 4.j Professional Organizations
- 4.k Online Resources
- 4.l Trainings
- 4.m Intuition

**5. Important KSAs**

- 5.a Can't Be Taught
- 5.b Education
- 5.c Experience
- 5.d Obstacles

**6. Reasons for Failure**

- 6.a Favoritism
- 6.b Inability to Assert Authority
- 6.c Lack of Motivation or Passion
- 6.d Unrealistic Expectations
- 6.e Looking for Other Positions
- 6.f Time Issues
- 6.g Disagree 50% CRNAs fail
- 6.h Lack of Training and Support
- 6.i Competing Interests
- 6.j Hospital Size
- 6.k Insufficient Compensation
- 6.l Unsure
- 6.m Personalities
- 6.n Agree 50% CRNAs fail

**7. Important Knowledge**

- 7.a Learn from Others
- 7.b Clinical Skills
- 7.c Stay Alert
- 7.d Favoritism (or perceived)
- 7.e Maintaining Respect
- 7.f Ability to Research
- 7.g Consensus
- 7.h Managerial Skills
- 7.i Changes in Relationships
- 7.j Politics and Policies
- 7.k Financial Knowledge
- 7.l How to Treat Employees
- 7.m How to De-stress
- 7.n Awareness of Realities of Position
- 7.o Communication Skills

**8. Do Differently**

- 8.a Nothing
- 8.b Stand Up for Yourself
- 8.c Authority
- 8.d Define Role Earlier
- 8.e Get MBA

Coding Tree with codes and sub codes. Tri-level coding not shown.

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