THE TRANSITION OF CHIEF NURSE EXECUTIVES INTO CHIEF EXECUTIVE OFFICER AND CHIEF OPERATING OFFICER ROLES

by

Sharon L. Smith

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Nursing)
in The University of Michigan
2009

Dissertation Committee:

Professor Richard W. Redman, Chair
Professor Ada Sue Hinshaw
Professor Lloyd E. Sandelands
Associate Professor Kristy K. Martyn

2009

DEDICATION

I dedicate this dissertation to my family and friends. First, my parents Regina and Maurice Smith, their love, devotion and commitment to higher education made the dream of doctoral studies a reality. Second, my sister Marsha Smith and my brother Howard Smith, their love, support and endless sense of humor kept me sane during this long journey. And last but never least, all my dear friends and colleagues who supported and cared for me during this journey. If it takes a village to raise a child, it also takes a village to support a doctoral candidate completing a dissertation. My sincere thanks and love to everyone in my village.

ACKNOWLEDGEMENTS

I would like to acknowledge the significant and meaningful input of my Dissertation Committee: Dr. Richard Redman, Dr. Kristy Martyn, Dr. Ada Sue Hinshaw, and Dr. Lloyd Sandelands. This dissertation would not have been possible without their wisdom, guidance and coaching. My sincere thanks and deep gratitude to these dedicated scholars.

TABLE OF CONTENTS

LIST OF FIGURES

Figure

LIST OF TABLES

Table

CHAPTER I

Introduction

The unprecedented changes that occurred in healthcare during the late 1980's and early 1990's were overshadowed by the chaos and turmoil associated with healthcare changes at the turn of the century. Legislative reform, increased competition, rapid advances in technology, and higher expectations from consumers created the strong turbulence present in today's healthcare environment. What does the future hold? Even more chaos with the depressed economy, growing numbers of underinsured and uninsured, shifting demographics (increasing elderly population with chronic and maintenance healthcare needs), greater consumer interest in self-care and complementary therapies, increasing cost constraints that influence the use of technology, and pressures that will force care rather than cure are likely scenarios. These challenges are nearly overshadowed by healthcare's human crisis: the shortage of nurses and other key healthcare professionals (Kimball & O'Neill, 2002). The critical shortage of nurses has only begun. The U.S. Bureau of Labor Statistics predicts that more than one million new and replacement nurses will be needed by the end of 2016 (Monthly Labor Review, November 2007). The turbulence in the environment will likely sustain or escalate as the economy continues to struggle, government and third party payers frequently and unpredictably continue to alter reimbursement, and the shortage of nurses and other healthcare professionals continues to grow.

Leadership is pivotal to successful navigation through this chaos. Having a competent, capable chief executive officer (CEO) to affirm mission, create vision, drive strategy, and establish key, critical external relationships is essential to a healthcare organization's success. Having a competent, capable chief

operating officer (COO) to implement the strategy, drive operations to achieve key financial and clinical targets, and obtain or appropriate the required resources is also a necessity for most organizations. Finding and keeping these valuable leaders is a challenge in itself. The American College of Healthcare Executives (ACHE) tracks CEO turnover annually. The 2007 data revealed a 15% turnover rate which is relatively stable. Turnover ranged from a low of 14% in 2002 to a high of 18% in 1999 (ACHE, 2008). To further complicate the challenge, a substantial cohort of senior healthcare executives is expected to retire over the next five to ten years (Garman & Tyler, 2004). The consequences of an organization losing a CEO/COO include disruption to strategic and operational planning and execution, "wobbly leadership," and additional financial burden, and often results in lengthy searches for replacement. A white paper prepared by ACHE entitled "The Impact of Hospital CEO Turnover in U.S. Hospitals" (Khaliq, Walston, & Thompson, 2006) identified that CEO turnover left the organization vulnerable and provided a ripe opportunity for the competition to recruit away top physicians, key employees, and patients. It was also noted that CEO turnover had a ripple effect on executive leaders (chief medical officers, chief operating officers, and chief financial officers) and could potentially leave the organization with a large void in strategic and operational leadership.

Historically, qualifications for the CEO position included an advanced degree in either business or healthcare administration and progressive senior leadership experience. It was rare to find a clinician (physician, nurse or other practitioner) advancing to the CEO level. That trend appears to be changing. A recent article in NurseWeek (March 28, 2005) reported on data available through the ACHE that stated 700 nurses are filling the job of CEO. This raises a host of questions: What would explain the growing trend of nurses becoming CEOs? Do nurses have the requisite skills, talents, and abilities to become the CEO? Are nurses preferred candidates for the CEO position? What are the implications for preparing nurses for these executive roles?

The literature on nurses as CEOs is scant and largely anecdotal (interviews) or informational (news articles). The majority of literature reviewed

involved a chief nurse executive (CNE) who moved into the CEO position. Nearly every CNE that made the transition to CEO believed that their clinical background was critical to their advancement and success. Most believed that a solid clinical background gave them the essential knowledge and perspective on the core work of the healthcare organization that was necessary to be successful (Cecchettini, 2002; McPeck, 2001). Positive, solid relationships with physicians were cited as another strength the CNE brought to the CEO position (McPeck, 2001). In an unpublished study by Kalisch and Escamilla (2001), 12 CNEs who became CEOs were interviewed, and the assets of the nurse CEO were identified as credibility, clinical and quality expertise, knowledge of frontline operations, positive relationships with physicians, positive relationships with patients and families, experience with human resources, experience with regulatory and accreditation requirements, and experience with program and project development. Two nurse executives who successfully transitioned to the role of CEO specifically identified the use of the nursing process (assessment, planning, and implementation) and an inherent ability to manage competing priorities as key, critical leadership skills they bring to the CEO position.

On the surface, nurse executives do appear to have the requisite skills, talents, and abilities to become CEOs. Yet, when reviewing the Leadership Competency Model posed by The Leadership Center (1999), it becomes evident that preparation as a nurse executive alone may not be sufficient for the task at hand. The Leadership Competency Model identifies fifteen competencies that address necessary skills, behaviors, and knowledge for executive leadership. Necessary skills are identified as change management, coaching and mentoring, communication, negotiation, and problem solving. Key critical behaviors for success as an executive include focus and drive, emotional intelligence, building trust, conceptual thinking, and systems thinking. Critical knowledge includes marketing, running the business, finance, human capital, and strategic planning. Educational and experiential preparation of the CNE may lead to the development of some of these competencies but would not necessarily address all of them. Most of the nurse CEOs interviewed in the lay and professional

literature stated that lack of financial acumen was one of the largest barriers to their success (Cecchettini, 2002; Kalisch & Escamilla, 2001; McPeck, 2001). Experience and education alone may not be enough to support a nurse executive in the new role as CEO.

Critical questions about the successful transition from CNE to CEO remain unanswered. Beyond the required skills, talents and abilities, what does it really take for a CNE to become a successful CEO? How does the CNE successfully "transition" from a clinical role focused on patient care to a larger, broader role focused on the performance of the organization as a whole, and its strategic growth and development? What are the potential barriers and facilitators to such a transition? A career move from CNE to CEO represents an expert to novice/advanced beginner/competent transition – a transition that has not been explored nor implications examined.

Sparse literature is available on the barriers to role transition that relate to the individual and the environment. Individual barriers identified include: stepping out of the role of being a nurse and looking at the entire clinical and administrative enterprise (McPeck, 2001), communication issues – governance and finance often speak another language (Smith, 2002), limited financial acumen (Kalisch & Escamilla, 2001), and, in some cases, gender issues and biases (ACHE, 2001; Kalisch & Escamilla; Smith). There are also organizational barriers to successful transition: the perception that the CNE has not always been accepted as a full-fledged member of the senior management team (Sanders & Bowcutt, 2004), the movement of healthcare from a service model to a business model (McPeck), politics and alignment with the previous CEO (Smith), and lack of adequate executive leadership development programs (Smith). The literature on facilitators to successful transition is also sparse. Individual facilitators identified include being a team player, life-long learning, and identification with staff and physicians (Smith). Organizational facilitators include having a mentor (Kalisch & Escamilla; Roemer, 2002; Smith), a philosophy of promoting from within (Kalisch & Escamilla), and the size of the organization (Kalisch & Escamilla).

There is a strong theory base to support an understanding of work roles. In the early 20th century, the social-scientific concept of "role" became firmly established in its own right as something consequential and different from the concept of person or self (Ashforth, 2001; Oately, 1990). Role theory is a science concerned with the study of behaviors that are characteristics of persons within contexts (Biddle, 1986). This science has been successfully applied to the work role (Ashforth) but is limited to how "characters" perform on a given stage. It does not address how characters move between and among roles. To address movement between and among roles, we must look at the role transition literature, specifically, the body of work that addresses work role transitions.

Ashforth (2001) proposed that role theory is missing a clear sense of transitioning – the social and psychological dynamics of disengaging from one role and engaging in other. Role transitions are fundamentally about crossing role boundaries and, in doing so, doffing one persona and donning another. This role transition may not be easy or even possible for some CNE executives moving into the CEO role. Velasco (2004) interviewed three nurse executives who became CEOs and all three believed that "once a nurse, always a nurse." Bolton (2003) conducted a longitudinal, qualitative study of nurses who moved from staff roles to management roles and the research demonstrated that nurses were clearly attached to their image as a nurse. Tension resulted from nurses viewing management roles as being "hard-faced" and concerned with numbers, for example, the number of patients treated and financial costs. Their role as nurses dealt specifically with patients and their needs. Any examination of nurses in a managerial role brought with it the realization that the roles of nursing and management are neither diametrically opposed or a simple dichotomy; rather, it is something much more complex.

Statement of the Problem

Little is known about how nurses who are CNEs transition to become CEOs. Anecdotal, experiential accounts are few but the message is clear – nurse executives are strong candidates to successfully lead healthcare systems

into the future (Everson-Bates, 1992; Kalisch & Escamilla, 2001). This trend in the advancement from CNE to CEO/COO roles is destined to continue as nurse executives prove their worth as chief executive officers and chief operating officers.

There is a need to understand the work role transition from CNE to CEO/COO to understand their experience of transition. What is clear is that it is not as easy as simply changing job titles, positions, and offices. It involves moving from one persona to another, perhaps in the face of a less than friendly environment. If this transition is not understood, it will be difficult, if not impossible, to prepare the next generation of CNEs for what appears to be the inevitable – movement into a CEO/COO position. If the transition is not smooth and if the transition is not complete, role conflict will result and may have serious effects on the success and tenure of the new nurse CEO/COO, as well as the performance of the organization.

The development of theory or a model to explain and guide the transition from CNE to CEO/COO is needed. Such a theory and/or model would serve to inform nurses aspiring to these executive level positions about the education and preparation required. Both theory and a conceptual model or framework offers an improvement in the performance of healthcare organizations with more effective, efficient leadership. Ultimately, successful transitions to executive level leadership would decrease or mitigate some of the effects of strong turbulence in the current healthcare environment.

Purpose

The purpose of this dissertation is to explore how CNEs transition to new roles as CEOs/COOs. Perceptions and experiences of CNEs who made the transition to CEO/COO were elicited in order to discover the individual and organizational processes that facilitated or posed a barrier to successful transition. The grounded theory research method was used to enhance understanding of the real world of the participants, a world that is holistic, complex, and contextually rich. Knowledge of what work role transition is like for

a CNE who moves into a CEO/COO role generated a theory and model or framework that will serve as a basis for recommended interventions that will facilitate CNE to CEO/COO transition.

Research Questions

The primary research question in this study was: How do CNEs transition to and learn the role of chief executive? Sub-questions included:

1. What individual factors and experiences facilitate transition from CNE to CEO/COO?
2. What organizational factors and processes facilitate transition from CNE to CEO/COO?
3. What individual factors and experiences pose barriers to the transition from CNE to CEO/COO?
4. What organizational factors and processes pose barriers to the transition from CNE to CEO/COO?

A semi-structured interview protocol was used to guide the general direction of this inquiry, yet allowed respondents to explore their experiences and reflections about the transitions from CNE to CEO/COO in a full and rich manner.

Grounded theory research was conducted because it allows a phenomenon to be investigated in the real world, in this case, the real world of healthcare. Using grounded theory allowed the researcher a glimpse into the life of a healthcare executive – a world that is wholistic, complex, contextual, and based on dynamic perceptions that were unique to each nurse CEO/COO that was interviewed. When little is known about a phenomena, such as role transition from CNE to CEO/COO, meanings acquired through grounded theory research are more empirically valid than data obtained with quantitative research methods alone (Blumer, 1969) because quantitative methods function under the assumption that the premises guiding the research are valid and the questions that need to be asked are known. Questions regarding the phenomena of transition from CNE to CEO/COO are not known, and participants' perceptions

are essential to the discovery of the factors and processes that contribute to successful transition.

Several theoretical concepts were used to guide the study on the experience of role transition. The concept of role, role theory, and models of role transition were used to form a conceptual schema that provided the basis for this inquiry into the experiences of CNEs moving into the roles of CEOs/COOs.

Significance for Nursing & Healthcare

This study has significance for nursing and healthcare in several ways. In a broad sense, it provides an understanding about expert to advance beginner and novice transitions (CNE to CEO/COO) and has implications for educating, training and mentoring in nursing and other areas of healthcare or other fields where similar work role transitions are occurring.

In a more specific sense, this study provides knowledge about the issues faced by nurse executives in the transition from CNE to CEO/COO, specifically, the issue of making the role of the CNE an ex-role. With the current and expected turnover of CEOs hovering about 15% annually and the apparent increased demand for nurse executives to move into these roles, it is essential that the transition to chief executive officer or chief operating officer roles be successful. Understanding the facilitators and barriers to leveraging the CNE's familiarity with core work of the healthcare organization is essential. As the demand for nurse CEOs/COOs grows, so will the demand for education, training, and mentoring programs that address the specific role challenges that nurse executives face in the transition.

Chapter II presents the literature review and a critical analysis of the theoretical models and research relevant to role transition.

Chapter II

Review of Literature

This dissertation examined the process of role transition, specifically, the role transition of CNEs to CEO/COOs. Using a grounded theory approach, this research focused on those experiences and insights that have been significant in work role transitions and in learning the new role of CEO/COO. The bodies of literature informing this inquiry included nursing and organizational literature, as well as role theory and role transition conceptual models and frameworks. This literature review was ordered in a manner to develop the necessary context, constructs, and theories to inform this study: using the literature in grounded theory research, role of the CNE, role of the CEO, role of the COO, CNE to CEO/COO movement and transition, the concept of role and role theory, and models of role transition.

Using the Literature in Grounded Theory

It is important to note that reading and reviewing the literature can be a problem for researchers doing grounded theory. Glaser (1998) stated that grounded theory's very strong dicta are: 1) do not do a literature review in the substantive area and related areas where research is to be done, and 2) when grounded theory is nearly complete during sorting and writing, the literature search in the substantive area can then be accomplished and woven into the theory as more data for constant comparison. The intent of these dicta are to keep the grounded researcher as free and open as possible to discovery and to the emergence of concepts, problems, and interpretations from the data. Glaser cautions pre-research literature review is inimical to generating grounded theory. There are six possible issues that can arise: 1) the researcher can be "grabbed"

by concepts that do not fit or are irrelevant; 2) the researcher may develop a preconceived “professional problem” of no relevance in a substantive area of research of which there is no yield except derailment from what is actually happening; 3) the researcher can become engaged in speculative, non-scientifically related interpretations and connections that find their way into the grounded theory, which may not be relevant or work; 4) there is a risk that the researcher may become so in awe of other authors, especially the pundits, that it detracts from one’s own self-valuation as a creator of a theory; 5) the researcher can become rhetoricalized, sounding more like the literature and less like the emergent theory; and 6) the literature which is truly relevant is not known until the substantive theory arises from data analysis.

Glaser (1998) did state there are two instances that may require pre-research literature review – one is a dissertation proposal (formal requirements for completion of Ph.D.) and the second is a grant application. In order to prevent preconceiving and the grabbing effects of the literature, Glaser recommends that the researcher should turn the literature review into data collection, to be constantly compared as the review is done. Glaser stated, “The attitude is data collection, not reverence for the authenticity and authority of the printed word and the published author. After all, that is all the literature is, just more data” (p. 72). Glaser explained that once the researcher gets into the study and starts generating grounded theory, the theory will be much stronger than the earlier review because of the grounding. Giving consideration to the implications of literature review on grounded theory research, the research and theory presented in this review were used to sensitize the researcher to key concepts, models, and theories that will inform or guide research on the experience of role transition for CNE moving into a chief executive or chief operating officer (CEO/COO) role.

Role of Chief Nurse Executive

In order to understand the depth and scope of transition necessary to move from CNE to CEO/COO, one must first understand the role of the CNE.

The literature is sparse when it comes to exacting the role of the CNE. There are job descriptions and advertisements for open CNE positions that explain the major functions of the role within the context of a given organization. The "gold standard" for defining the role of CNE is the American Nurses Association's (ANA) Scope and Standards for Nurse Administrators (2000). In this document, the ANA defines the nurse executive as "the nurse who is responsible for organized nursing services and manages from the perspective of the organization as a whole." The ANA identifies the five domains of activity as leading, collaborating, facilitating, integrating, and evaluating. Specifically, the nurse executive provides leadership and vision for nursing's philosophy, development, and advancement within the organization and society at large. Ultimately, the nurse executive is the person responsible and accountable for quality, cost-effective nursing services and is the chief spokesperson for organized nursing services and the voice of nursing in the organization. In this key role, the nurse executive acts as the catalyst for the integration and collaboration of nursing with all other professional healthcare disciplines and functional areas in an effort to achieve client-centered or patient-focused care and the goals of the organization. A critical aspect of the CNE role is to create and promote a practice environment that gives nurses the authority to control their practice.

The ANA standards clearly spell out primary accountabilities for the CNE as: 1) participation in the administration of the healthcare organization; 2) participation in strategic and long term planning; 3) provision of leadership in the determination of clinical and administrative goals; 4) participation in the determination of functions and processes to achieve clinical and administrative goals; 5) acquisition and allocation of human, material, and financial resources; 6) evaluation and revision of the systems and processes of organized nursing services to achieve client-centered outcomes; 7) provision of leadership in critical thinking, conflict management, and problem solving; 8) provision of leadership in human resource development and management; 9) provision of opportunities for consumer input into personal healthcare decisions and policy development;

10) insurance of the ongoing evaluation and innovation of services provided by organized nursing services and the organization as a whole; 11) facilitation of the conduct, dissemination, and utilization of research in the areas of nursing, health, and health management; 13) service as a professional role model and mentor; and 14) service as a change agent, assisting all staff in understanding the importance, necessity, impact and processes of change.

Rather than defining the role of the CNE, the American Organization of Nurse Executives (AONE) initially developed, and later clarified, competencies for the nurse executive. These competencies are based on foundational work that was conducted in 2004 by the Healthcare Leadership Alliance, AONE, ACHE, Healthcare Financial Management Association (HCFMA), Healthcare Information and Management Systems Society (HIMSS), and Medical Group Management Association (MGMA). AONE believes that the CNE must be competent in the following areas: communication and relationship building, knowledge of the healthcare environment, leadership, professionalism, and business skills.

The ANA standards and the AONE competencies received significant regulatory and accreditation support from The Joint Commission (JC). The Comprehensive Accreditation Manual for Hospitals (CAMH) dedicates an entire chapter to the provision of nursing care. The chapter's focus is the role, responsibilities, and accountabilities of the CNE in achieving quality nursing outcomes and contributing to the achievement of organizational goals and objectives (CAMH, 2009).

The ANA standards and the AONE competencies address the role of CNE in a generic sense, but what happens to the CNE role when an organization is undergoing a turnaround? The position is even more pivotal, because the turnaround is about effecting fundamental, sweeping change very rapidly. Burritt (2005) believed the CNE has three critical roles in the process: motivating the workforce, creating an environment and readiness for change, and creating, communicating, and operationalizing a common vision.

In response to the financial and operational challenges that occurred in the early to mid-1990s, many organizations moved to smaller, flatter organizational structures, empowered decision-making at the point-of-care, and greater collaboration and cooperation between and among disciplines. To facilitate these changes, many organizations expanded the role of the CNE to include operational responsibility and accountability for all “patient care services” (Galinas & Manthey, 1997). Typically, the role was renamed vice president of patient care and extended the accountabilities to the clinically intensive departments of the organization (for example pharmacy, anesthesia, respiratory therapy, and rehabilitation services). Despite the expansion of accountabilities and span of control, the vice president of patient care in most organizations also holds the title of chief nurse executive for regulatory and accreditation purposes. The Joint Commission requires that each organization have a CNE to direct the nursing care and be accountable for the practice of nursing wherever nursing care is delivered in the organization or system (CAMH, 2009).

In 1995 the VHA, a healthcare provider alliance of more than 2,400 members dedicated to the success of not-for-profit, community-based healthcare, began to study the impact of organization redesign on nurse executive leadership (Gelinas & Manthey, 1997). The VHA joined forces with AONE to study how the necessary skills and abilities (leading in a multi-institutional system and driving redesign in care delivery) for the newly designed nurse executive roles could be acquired quickly. This study gives credible evidence to the expanding role of the CNE.

Surveys were mailed to 5,800 nurse leaders from the VHA system and AONE. By December 31, 1995, 1,866 responses were received and used in developing the summary report. Gelinas and Manthey (1997) reported on the summary findings of the survey, and they were impressive. The survey revealed that 80% of all respondents and 75% of VHA respondents reported role changes, and nearly all identified expanded responsibilities as a major feature of change. The major change that affected nearly all the nurse executives was a dramatic increase in their span of control. A rapid expansion in the scope of the work

covering additional clinical departments occurred in just two years. Title changes before and after redesign and restructuring reflected role expansion with nearly 57% of the VHA respondents and 35% of the total respondents holding the title of vice president of patient care. The study concluded that the role of the nurse executive changed dramatically as a result of redesign and restructuring. Nurse executives were thrust into leading multiple disciplines and departments across the continuum of care.

In summary, the role of the CNE is centered on the planning, development, implementation, and evaluation of nursing services within an organizational context. The CNE is charged with building the necessary relationships and infrastructure to ensure that nursing services and organizational goals are met. In the expanded version of the CNE role, the vice president of patient care, the role is focused on the planning, development, implementation, and evaluation of clinical services within an organizational context. Again, the vice president of patient care is charged with building a collaborative, cooperative environment to ensure that patient care delivery and organizational goals are met.

Role of the Chief Executive Officer

Every healthcare organization has a Chief Executive Officer (CEO), the person who is responsible and accountable for leading the organization. Exactly what are the responsibilities and accountabilities of the CEO/? In a word, they are responsible and accountable for everything. The CEO is ultimately accountable for the fulfillment of the healthcare organization's mission to meet the healthcare needs of the community and provide a means of sustaining the organization's future. Typically, the CEO's responsibilities include responding to the challenges of an uncertain future, resource management (capital and human), philanthropy, marketing, responding to the competition's strategic moves, complying with the multitude of local, state, and federal regulatory and accreditation requirements, and ultimately ensuring the quality of care that is delivered by the organization. In short, the CEO must meet the present and the

future day-to-day operational needs of the organization (Wilson & Stranahan, 2000).

The job of CEO is so large that ACHE (2003), in advising organizations on the verbiage for CEO contracts, recommended that duties not be specifically spelled out for two reasons. First, the CEO should be involved in virtually every aspect of hospital strategy and operations and must not be "hamstrung" by a limited list of duties that would narrowly circumscribe the scope of responsibilities. Second, CEO duties would change with the frequency of change in the healthcare environment. Although this approach to looking at the role of the CEO is quite realistic, it does not provide comparative information to assist in understanding the difference in roles between the CNE and the CEO. One must have an idea of the operational difference in roles to be able to understand the scope and depth of transition necessary when moving from the CNE role to the CEO role.

A review of the literature that defines the role of CEO brings little information. Most information on the role and accountabilities of the CEO comes from organizations that support and facilitate non-profit organizations in their development (McNamara, 2008). Nearly all definitions of the CEO contain the same key language – the CEO is the highest ranked manager of a corporation with primary responsibility and accountability to carry out the strategic plans and policies as established by the board of directors and trustees. The typical major functions and responsibilities of the CEO include board and governance administration and support; program, product, and service delivery; financial, tax, and risk management; facilities management; human resource management; community and public relations; and fundraising. Core areas of knowledge and skill include basic management and leadership, business planning, organizing, leading, and coordinating activities and resources. In summary, the CEO is responsible and accountable for the performance of the organization; in essence, the CEO is the commander and chief.

Role of Chief Operating Officer

With the intense demands placed on healthcare leaders today, a team approach at the executive level is necessary. Membership and configuration of the executive team is determined by the CEO, and no two CEOs are alike. In making a decision to have a COO, the CEO must consider his/her individual needs and the contextual needs of the organization. The COO role has no formal definition and is relational to the CEO. Bennett and Miles (2006) found that, while other executive jobs are defined in relation to the work to be done and the structure of the organization, the COO role is defined in relation to the CEO as an individual. They described the relationship between the CEO and the COO as "a balancing act on the threshold of power."

A key to understanding the COO role is to acknowledge that it is an amorphous one. Finding the right "fit" is essential and involves the right personality, skills, style, leadership abilities, career aspirations, and the organization's succession plan. With that in mind, Bennett and Miles (2007) and McClenahen (2007) suggested the right reasons to have a COO. These can loosely be used to infer a role description and job responsibilities including providing day-to-day leadership in an operationally intensive business, such as a hospital; to drive strategic initiatives; to provide mentorship to an inexperienced CEO; to be a complementary asset to the CEO; and to be the successor to the CEO.

Comparison of CNE/CEO/COO Roles

In summary, there are three roles of interest in this study: 1) the CNE with primary responsibility and accountability for the clinical operations and outcomes of the healthcare organization; 2) the CEO with primary responsibility and accountability for fulfillment of mission and achievement of strategic objectives; and 3) the COO with a role that is relational to the CEO and typically has primary responsibility and accountability for the achievement of operational objectives. Table 1 summarizes the primary responsibilities and accountabilities and functions of each role.

Table 1

Comparison of CNE/COO/CEO Roles

Chief Nurse Executive	Chief Operating Officer	Chief Executive Officer
Participates in administration of healthcare organization as full member of the executive team	Leaders the operational team	Leads the executive team
Participates in strategic and long-range planning	Participates in strategic and long-range planning	Drives the strategic planning process
Provides leadership in the determination of clinical/administrative nursing goals and direction	Provides leadership in determining operational goals and direction	Provides leadership in determination of organizational goals and direction
Participates in function and processes to achieve clinical/administrative goals	Participates in and drives processes to achieve operational goals	Provides leadership and high-level oversight of functions and processes directly related to strategic and operational goals and organizational outcomes
Acquires and allocates resources for specific functions and processes related to delivery of patient care	Acquires and allocates resources for operations	Acquires and allocates resources for the entire organization
Evaluates and improves systems and processes in nursing/patient care service to achieve client-centered outcomes	Evaluates and improves systems and processes in system operations to achieve operational goals and targets	Ultimately accountable for the clinical and administrative and financial outcomes of the organization
Provides leadership in critical thinking, conflict management, and problem solving	Accountable for the skill set of operational leaders	Ultimately accountable for the skill set of organizational leadership
Provides leadership in human resource development and management	Accountable for the function of leadership development as it relates to operations	Ultimately accountable for leadership development, education and training
Provides opportunity for consumer input into personal healthcare decisions and policy development	Works with CNE on policy development and implementation re: healthcare decisions	Provides opportunity for community input into strategic growth and development and policy development
Ensures ongoing evaluation and innovation of services provided by nursing/patient care services	Ensures ongoing evaluation and innovation of services provided by all operational units	Ultimately accountable for the quality of services provided by the organization
Facilitate the conduct, dissemination, and utilization of research in nursing, health, and management systems	Accountable for ensuring that operational practices, policies and procedures are evidenced-based and standards-driven	Ultimately accountable to ensure that policy/procedure in the organization is evidenced-based and standards-driven
Serves as a change agent, facilitating change implementation in the organization	Serves as a change leader as well as a change agent, identifying need for change, designing change, and ensuring effective implementation	Drives necessary change within the organization and acts as change agent with leadership team
Summary/Analysis Accountable for patient care Operational focus Internal orientation	Summary/Analysis Accountable for operations Operational focus Internal orientation	Summary/Analysis Accountable for vision/strategy Organization & community focus Strategic focus External orientation

Table 1 clearly illustrates the major differences in roles of the CNE and CEO/COO. Moving from a role focused on nursing and patient care into a role focused on the performance of the organization as a whole (strategic and operation performance) and moving from a role deeply engrained in the clinical work of the organization into a role focused on the strategic and large scale operational work of the organization's direction is a large leap. Explaining how the experience of being a CNE may or may not contribute to one's effectiveness as a CEO/COO will provide insight into successful role transition.

Chief Nurse Executive to Chief Executive Officer – Making the Move

A review of current lay and scholarly literature reveals multiple accounts of the transition from chief nurse and patient care executive to CEO/COO. These accounts are typically anecdotal observations or opinions regarding role competencies, behaviors, characteristics and sources of stress (Everson-Bates, 1992). The majority of this literature is found in local newspapers (paper and electronic versions), and local and regional business and professional journals in the form of an announcement of appointment or interview with a new CEO/COO. Headlines from these papers and journals capture the nature of the content, for example, "Local hospitals look to clinician CEO/COOs for fiscal cure" (Connoly, 2001), "The goalkeepers" (McPeck, 2001), "Rough road ahead" (Shinkman, 2002), "Nurses' healing hands control hospitals' care" (Velasco, 2004), and "Nurse now CEO/COO" (Vadarevu, 2005). These news-related articles conveyed information about the newly appointed CEO/COO (educational background, experience, new responsibilities and accountabilities) but shed little light on how the new CEO/COO would transition into the new role.

Two studies were found that did provide data and information on the transition from CNE to CEO/COO. In a series of three interviews with CNEs who "made the move" to CEO/COO, Smith (2002) explored the following areas: career path and forces that guided the CNE/CEO/COO choices; nursing background in preparation for CEO/COO role; time when their career began to reach beyond nursing; rewards and challenges of new role; what skills, talents,

and abilities the nurse CEO/COO brought to the table; availability and influence of a mentor; peer group or support; and impetus or drive to become a CEO/COO. The findings of these interviews revealed several common themes: 1) the career paths of all three were self-directed and a journey of self-discovery; 2) hands-on knowledge of the core business gave them an advantage in the field of problem solving; 3) existing relationships with staff and physicians gave them advantage in forming partnerships and strengthening relationships; 4) none of the interviewees initially aspired to be CEO/COO; and 5) the ultimate advantage was being patient-centered.

These common themes were supported by Kalisch and Escamilla (2001) in an unpublished, qualitative study where twelve CNEs who became CEO/COOs were interviewed with the intent of identifying assets of the nurse CEO/COO and the barriers and facilitators to role transition. Assets of the nurse executive included: credibility, clinical knowledge, knowledge of frontline operations, positive working relationships, familiarity with regulatory requirements, and experience with project and program development. From the evidence available, nurses have multiple strengths when making the transition to CEO/COO.

The studies cited above (Kalisch & Escamilla, 2001; Smith, 2002) help to identify the barriers and facilitators to role transition and challenges faced in the new role of CEO/COO. Individual-level barriers to role transition that were identified include limited financial backgrounds and acumen, bias towards clinical issues and concerns, tendency to micromanage previous areas of responsibility, and gaps in business knowledge. Organizational barriers to role transition also exist and are related to resources dedicated to leadership growth and development. Most of the nurse CEO/COOs interviewed sited lack of formal leadership development, training and mentorship programs. As one nurse executive put it, “There is no CEO/COO school,” (Smith).

Both studies shared common themes regarding individual-level facilitators including credibility among staff, physicians and senior leaders; intimate knowledge of the core work of the organization; an in-depth understanding of the

healthcare system; solid relationships with staff and physicians; and advanced project and program management skills. Organizational-level facilitators include philosophy of promoting from within the organization, size of the organization, and having an engaged mentor.

Nurse executives faced several challenges in their new role as CEO/COO. One of the primary challenges was a lack of understanding and hands-on experience with the non-nursing areas. This challenge then led to the need for the nurse CEO/COO to make every effort to appear aligned with non-nursing issues and avoid overcompensating for a potential bias towards nursing. One nurse CEO/COO described it best as "the need to balance attention." Other challenges cited include developing a strong and effective relationship with governance, learning and dealing with the complexities of the political environment, and "earning" trust. Of the scarce literature available on those nurse executives who have made the transition to CEO/COO, none was found that described the phenomena of transition.

Role Theory

Fundamental to studying the phenomena of role transition is the need to understand the concept of "role" and the theories that inform us about how "roles" are actualized in organizational life. Role theory represents a collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role or under what circumstances certain types of behaviors can be expected. Hardy and Hardy (1988) believed that a solid understanding of theory, together with an ability to work with existing scientific knowledge of roles, is urgently needed by practitioners in the healthcare field today. The rapid pace of change in healthcare puts professionals in a prime position to make use of role theory and to expand it by studying new ideas and concepts germane to nursing and healthcare in general.

The concepts and propositions of role theory are useful in studying role transition because they offer a lens with which to view the issues that affect individuals who are making the transition between roles (doffing one persona to

take on another). The perspective of role theory can facilitate the identification of social, environmental, and individual aspects and processes that produce patterns of behavior and help to inform us about why expectations of these patterns are sustained or changed.

This section of the literature review explores the origins of role theory, the definition of role, the role of the individual in an organization, the two prominent role perspectives, and the significance of role theory in this research. It is important to note that the literature on role theory spans nearly 80 years with the initial work on role beginning in the early 1920s, the majority of theory development and testing occurring in the late 1960s and 1970s, and several new perspectives on role theory being added to the knowledge base more recently. The concept of role and role theory are hailed as the junction where sociological and psychological perspectives and theories meet to explain the relationship of an individual within the organization (Katz & Kahn, 1978). Despite recent developments in the literature, two basic approaches to role theory have endured over time – the structuralist and the social interactionist perspectives (Ashforth, 2001). The basic difference in these two perspectives is whether one "takes" (structuralist) or "makes" (interactionist) a role.

Historical Perspectives

The concept of role has been in the literature since the late 1920s and early 1930's when several social theoreticians formally created the basic knowledge of role theory. Initially, there were three distinct theoretical areas: the Dramaturgical, Symbolic Interaction, and Structural perspectives. These theoretical perspectives continued to evolve into the 1980s. One additional theoretical perspective has been presented since the late 1980s – Role as Resource (Callero, 1994). A brief review of each theoretical perspective is presented below.

The Dramaturgical Perspective

The Dramaturgical Perspective was developed by Moreno (1969), a psychiatrist who pioneered the innovative therapy of psychodrama – the use of groups and role-playing in psychiatric treatment. Moreno used artificially constructed groups and roles to provide opportunities for the socio-cultural reintegration of mentally ill patients. He was the first to introduce the idea of using role playing as an experimental procedure for learning to perform a role more adequately and the first to link role behaviors to role expectations. He believed there were several stages to role assumption, role perception, and role enactment. Moreno's approach was typical of a clinician, where ideas were developed in response to patient problems and many remained outside a theoretical body of knowledge. His work demonstrates the problems of linking the theoretical world with the practical world, translating ideas generated in the clinical setting into scientifically valid ideas that contribute to empirically-based theoretical knowledge.

Symbolic Interactionist

There are two perspectives on social interaction – the Symbolic Interactionist view and the Functionalist view. The Symbolic Interactionist perspective was brought forth by George Herbert Mead (1934), a social philosopher interested in problems with social interaction. His primary interest was understanding human nature in terms of groups and society. He studied reciprocal social relationships and the response to rapid social change. Specifically, he examined processes associated with adapting to change and finding one's social niche, thus the concept of "self" and "socialization." Mead went on to develop the notion of taking a "role" in which the individual would be influenced by others. This was the origin of the school of symbolic interactionism. Mead is credited with introducing the perspective that the human mind, the social self, and the structure of society all emerged through reciprocal social interaction.

The Structural-Functional Approach

The Structural-Functional Approach to role and role theory began at the University of Chicago in the 1920s with a sociologist named Park who identified that roles are linked to structural positions and, ultimately, the self is linked to playing many roles within the confines of the structural positions (Hardy and Hardy, 1988). Park (1926) proposed that the self emerges through playing multiple roles. This perspective complemented the symbolic interaction perspective as it identified the importance of structure and other processes. Linton (1936), an anthropologist at the University of Chicago, made a significant contribution by further conceptualizing the social organization and the individual embeddedness in it. He was the first to propose the difference between status (a collection of rights and duties) and role (the dynamic aspect of status) and make a clear distinction between structure and the individual. The combined knowledge and effort of these two scholars dominated the sociological literature during the 1950s and 1960s.

Other theorists who contributed during this era were Parsons, who developed the idea of social systems with complex conceptual schemes, and Merton, who developed the analytic approach of functional analysis. Biddle and Thomas (1966) built on Linton's work and suggested that an individual's behavior could be construed as role performance and implied that role was one linkage between individual behavior and social or organizational structure. Biddle later offered five basic propositions that underlie the science of this perspective: 1) roles consist of patterned behaviors that are characteristic of persons within contexts; 2) roles are associated with sets of persons who share a common identity; 3) persons performing a role are governed by expectations that exist and are shared about normative behaviors and performance; 4) roles exist and persist because of their function and perceived necessity in a larger social system; and 5) roles are learned through socialization. This interpretation is now considered the structural approach to the study of role.

Role as Resource

Limited elements of this perspective can be found in the work of various theorists (Gerhard, 1980), interactionists (Hewitt 1989; Turner 1962), and network theorists (White, Boorman, & Breiger, 1976). This perspective is markedly different from the structuralist and interactionist perspectives in that role is viewed as resource, while the more traditional perspective views roles as being enacted from preexisting positions. The most comprehensive account of this perspective was provided by Baker and Faulkner (1991), who used the concept of role as resource to study the United States motion picture industry. They proposed that role was a resource in two senses. First it is a means to claim, bargain for, and gain membership and acceptance into a social community. Second, it grants access to social, cultural, and material capital that role incumbents and role claimants' exploit to pursue their interests. When roles are used as a resource, they are part of a dynamic and fluid process. The study conducted by Baker and Faulker explored the impact of a major transformation (the rise of the blockbuster) on three key roles (producer, director, and screenwriter) in Hollywood filmmaking. Findings were significant; filmmakers adapted to the rise of the blockbuster film by shifting from a single role to combinatorial forms that were better able to solve organizational and technical problems. In addition, there was noted imitation of the combinatorial forms that were associates with the "right ingredients" for making blockbusters.

The work of Baker and Faulkner (1991) made four major theoretical contributions: 1) Role can effectively be conceptualized and analyzed as a social resource. 2) Roles are claimed and enacted into new positions in unique combinatorial forms. As these combinatorial roles are concretized, they are used to create new social structures. 3) Role dynamics are shaped by transformations in the environment. 4) Role enactments are consequential; shifts in the use of combinatorial forms are associated with redistribution of economic outcomes.

Callero (1994) provided theoretical support for the perspective of role as resource and posed the idea of role as a cultural object. Callero poses that roles are "real" because they are recognized, accepted, and used to accomplish

pragmatic, interactive goals within a cultural community. Roles are much more than a bundle of expectations. Roles are as complex or as simple as the cultural meaning of an object. There are two strong influences on role as a cultural object – the type of role one assumes and the use of the role that one assumes. Callero puts forward four propositions associated with variance in role type: 1) roles vary in terms of cultural endorsement; 2) roles vary in terms of cultural evaluation; 3) roles vary in terms of social accessibility; and 4) roles vary in terms of situational contingency. He also made four general propositions regarding the factors that account for much of the variance in role use: 1) roles are used to define self and others; 2) roles are used in thinking; 3) roles are used for acting; and 4) roles are used to achieve political ends.

Summary of Role Theory

The term role comes for the theater and refers to the part played by an actor (Thomas & Biddle, 1966). There are three major perspectives that are considered in this literature review: the interactionist perspective; the structural perspective; and the resource perspective. Table 2 provides a brief overview of these perspectives. Each perspective on role theory provides a unique conceptual frame within which to examine the data that was collected on the experience of transitioning from CNE to CEO/COO. Role theory alone does not provide enough insight or a solid conceptual framework for understanding work role transitions (the doffing of one professional persona to accept another). To better inform this study on work role transitions, the literature was reviewed for major theoretical frameworks that address work role transition.

Table 2

Summary of Role Theory Perspectives

The term role comes from the theater and refers to the part played by an actor (Thomas and Biddle, 1966)
Interactionist Perspective
• Definition: Roles are negotiated understandings between individuals (Blumer, 1969; Mead, 1934). • Based on perceptions and preference, individuals attempt to coordinate behaviors and come to jointly define what constitutes a given role. • Roles emanate from one's social structure. • Roles are enacted from preexisting positions.
Structural Perspective
• Definition: Roles are sets of behavioral expectations associated with given positions in the social structure (Ebaugh, 1988). • Roles are viewed as the behavioral expectations that are associated with and emerge from, identifiable positions in a social structure. • Roles are a bundle of norms and expectations – the behaviors expected from and anticipated by one who occupies a position or status in a social structure. • Roles are fixed and largely accepted whole-scale.
Resource Perspective
• Definition: Roles are seen as cultural objects assumed to be real, objective, meaningful features of the social world. Roles are ultimately used to construct the self. Through their use, they aid in the construction of social action, a feature basic to the argument that roles are employed as resources. • Role is a resource used to claim citizenship or membership in a social community with the rights and obligations thereto. • Role is a resource that grants access to a variety of resources (cultural, social and material) that allows role incumbents to pursue their interests.

Role Transition

A generally accepted definition of role transition is the process of assuming and developing a new role (Strader & Decker, 1995). There are several theories, models, or frameworks that served to inform this study about work role transitions and the process of transitioning. The models studied spanned multiple decades and enjoyed their greatest growth and development during the 1970s and 1980s (Katz & Kahn, 1978; Allen & van de Vliert, 1982;

Nicholson, 1984). Believing that the models of the 1970s and 1980s viewed role transition as a process of discrete steps, Ashforth (2001) and Bridges (1991, 2003) began to focus on the process of transitioning (the social-psychological state of doffing one persona and donning another). The first part of this section will focus on the four models mentioned above: 1) Model of the Role Transition Process by Allen and van de Vliert (1982); 2) A Theory of Work Role Transitions by Nicholson (1984); 3) Managing Transitions by Bridges (2003); and 4) Identity-Based Perspective – Role Transitions in Organizational Life by Ashforth (2001). A brief review of nursing models that address clinical role transition is also presented.

This section also presents those models that are not entitled "role transition" but informed this study on the process and variables involved in work role transitioning. These models included the organization as a system of roles (Katz & Kahn, 1978), role change (Turner, 1990), and role development (Benner, 1984).

Model of Role Transition Process

Allen and van de Vliert (1982) developed a Model of Role Transition Process that incorporates the social interactionist perspective of role theory. Their model is a dynamic model that accommodates the interplay of social positions, expectations, and behaviors that move individuals toward personal growth and adaptation in a role or role exit. The model presents sequential component parts of the role transition process, such as antecedent conditions, role transition (behavior shift), and moderators of behavior, role strain, reactions, and consequences.

Antecedent conditions represent those factors that motivate individuals to move from one role to another. Motivating factors work on both an individual and organizational level. On the individual level, antecedent conditions might be a change in skills, abilities, values, or financial needs. Consider CNEs making the move to CEO/COOs; motivation might be increased power, influence, and better compensation. On the organizational level, antecedent conditions might include

enhanced resource availability or a mission that attracts an individual to a new role or renders an existing role obsolete or unacceptable to the individual. Again consider the CNE who makes the move to CEO/COO; he/she may be motivated by the capital and operational resources available to the CEO/COO.

Role transition process, as a component of this model, represents the actual change in behavior that occurs when individuals exit one role and enter another. Allen and van de Vliert (1982) pose that there are three factors that influence the movement from old behavior to new behavior required in the new role. These three factors include: 1) the degree of discontinuity between old and new behaviors; 2) accuracy of the transitioning a person's anticipation of problems that will be encountered when shifting behaviors; and 3) the extent to which role entry is formally structured, as in orientation, apprenticeship, or internship programs.

Allen and van de Vliert (1982), Ashforth (2001), and Nicholson (1984) pose that the degree of discontinuity in expected behaviors between old and new roles can influence the degree to which old behaviors are carried into the new role and the degree to which new behaviors are accepted as more desirable. There would appear to be a minimum amount of discontinuity between expected behaviors of CNE and the CEO/COO roles.

Overly optimistic and overly pessimistic anticipation of problems associated with the new role caused more role strain than an appropriate anticipation of the problems (Hordijk, Muis & Van de Vliert in Allen & van de Vliert, 1982). CNEs are likely to have appropriate anticipation of the problems in the new role as CEO/COO. As part of the executive management team, the CNE is intimately involved in governance, strategic planning, and developing the culture of the organization. He/she is also typically well integrated into the organizational political structure.

The final factor in work role transition is the extent to which the change is normatively governed – the extent to which the challenges of role learning and socialization in the transitional phases are identified and planning thought-out (Eraut, 1994). In a study commissioned by the ACHE (Garman &Tyler, 2004),

succession planning in freestanding U. S. hospitals was examined. One part of the study looked at successor development and transition. Of the 631 participants cited, 87% had no developmental activities in their organization. Thirteen percent (13%) cited one or more developmental and transitional activities, such as mentoring, developmental or “stretch” assignments, structured socialization, 360-degree feedback, job rotation, and coaching from an external consultant. Clearly, the odds of the CNE having a planned role learning and socialization are small.

In this model, role strain refers to the subjective experience of the person in the transition process. Factors affecting the degree of role strain experienced by the individual making the transition include role clarity and boundaries. The role of the CNE is fairly well defined and has definite boundaries. The role of the CEO/COO is not well defined and the boundaries of the job are nearly limitless. The ACHE (2006), in advising organizations on the verbiage for CEO/COO contracts, recommended that duties not be spelled out for two reasons. First, the CEO/COO should be involved in virtually every aspect of hospital operations and must not be “hamstrung” by a limited list of duties that would narrowly circumscribe the scope of his/her responsibilities. The second reason for not listing specific duties is that with the frequency of change in the healthcare environment would require the CEO/COO duties to change as well. Movement from a well-defined role with clear boundaries into a role without clear definition and limitless boundaries may pose a challenge for the CNEs making the transition.

This model identifies moderators of role transition – individual and environmental variables that can influence the outcome of transition and produce role strain. Examples of individual-level moderators include: personality, locus of control, self-confidence and social identity. Any one of these factors can moderate the transition process to produce greater or lesser intensity of role strain. Contextual factors include social networks, support for learning, and resources available to facilitate reduction in role strain.

Reactions refer to the actions taken by an individual to reduce role strain. Reactions are typically strategies developed by the individual to modify something within them or within the environment to accomplish the transition. Seeking to change behavioral expectations of the new role to be compatible with existing skill levels and interest is also a reaction.

Consequences are those intended or unintended outcomes resulting from the attempts of the person in transition to deal with role strain. These outcomes can be any alteration in other components of the process and can be either short or long term.

In summary, using Allen & van de Vliert's of Model of Role Transition Process (1982) provided a conceptual framework within which to examine several dimensions of the experience of transition for CNE moving into the CEO/COO role. Using this framework will provide a structure to inquire about the individual, environmental, and social conditions that facilitate work role transition.

Theory of Work Role Transitions

Nigel Nicholson (1984) presented a conceptual framework for role transition that analyzed modes of adjustment to work role transition. The theory addresses two questions in organizational science: 1) how are change and stability interrelated; and 2) how does the interaction between the individual and the social system affect either? Nicholson treats the outcomes of transition between work roles as individual effects (behavioral and dispositional) and refers to them as "adjustments." This individualistic focus is the central premise of the theory that individual differences (characteristics) and the transitions they experience mediate the relationship of change versus stability and individual versus situational adjustment.

Predictor variables in the Theory of Work Role Transitions (Nicholson, 1984) fall into the following categories: 1) role requirements (requirements of the role between which the person is moving); 2) motivational orientation (psychological dispositions and motives of the person); 3) prior occupational socialization (socialization into past work roles); and 4) organizational induction

practices. The theory relates these variables to two individual outcomes of adjustment – personal development to accommodate new demands and role development to redesign situational demands. See Figure 1.

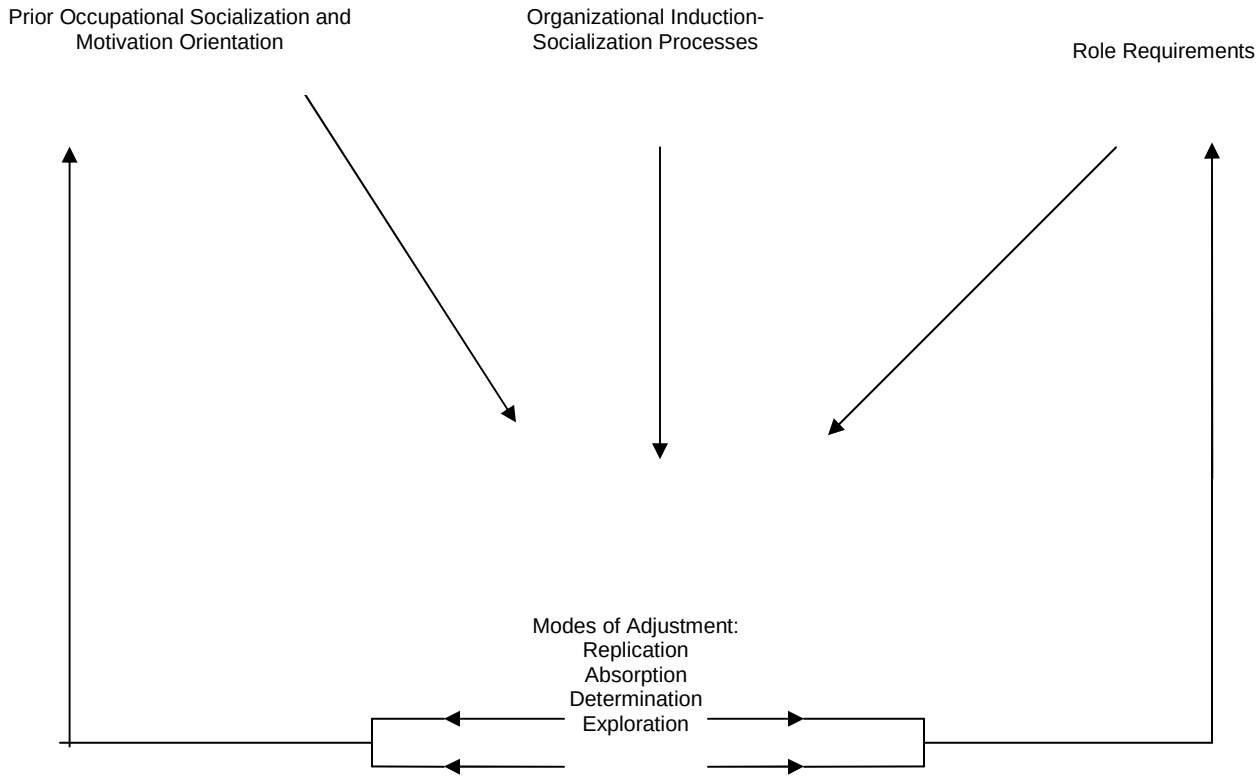

Figure 1. Schematic summary showing relationships of determinants in the theory of work role transitions (Nicholson, 1984).

A person's adjustment to role transition can be considered a type of personal development, where change is absorbed by the person altering his/her frame of reference, values, skills, and lifestyle. For example, a nurse executive transitioning into a CEO/COO role may alter his/her frame of reference from directing the clinical quality of the organization to steering the strategic objectives of the entire organization. A person's adjustment can also be proactive, where the incumbent tries to alter the role to better match his/her needs, skills, and abilities. This is considered role development. For example, a nurse executive transitioning into the chief executive office role may elect to maintain some of his/her clinical responsibilities and delegate some administrative activities to

another administrator or vice president. These types of development are independent and can be considered to be theoretically dimensional rather than categorical. Dividing each into classes of high or low development allows the extreme of each class to be considered and generates outcomes that span four modes of adjustment: replication, absorption, determination, and exploration.

Replication represents those transitions that generate minimal adjustment to personal role or role systems. Essentially, the person performs much in the same manner as in previous roles and in a similar manner to previous role occupants.

Absorption represents those transitions where the burden of adjustment rests almost entirely with the incumbent. The predominant characteristic is "role learning." Common examples of absorption would include nurse managers, directors, or executives that transfer between functionally dissimilar units, departments, and divisions in which the tasks and social environments are in stark contrast to the previous experience. Personal energy is primarily devoted to assimilating new skills, social behaviors, and frames of reference to meet the requirements of the new situation.

Determination represents those instances in which the incumbent's adjustment to the new role leaves the person relatively unaffected but alters the new role. The incumbent actively determines the elements and content of his/her role. These role occupants imprint their identity and unique skills upon the role and their surrounding milieu.

Exploration represents cases in which there is a change in the incumbent's personal qualities and the parameters of his/her role. These processes are likely to be characteristic of jobs in which "social contracting" and interpersonal role negotiation are central features. The two-way nature of these processes shapes both the person and the role.

The primary purpose of Nicholson's theory (1984) is to explain and predict the range of adjustment modes defined by personal and role development. Two characteristics of roles have a direct bearing on adjustment to the role – discretion and the novelty of role demands. In this model, work roles are viewed

as networks of goals and relationships involving people and materials. Arrangement of these relationships constitutes the task characteristics of the role. Discretion represents the incumbent's opportunities to alter these components and relationships. Novelty is the degree to which the role permits the exercise of prior knowledge, skills, and established habits into the new role.

Nicholson (1984) combined predictions for discretion and novelty of job demands to predict across the range of outcomes on the two principle dimensions. For example, combining a low discretion role with a low novelty role would likely produce an outcome of replication, combining a low discretion role with a high novelty role would likely produce an outcome of absorption, combing a high discretion role with a low novelty role would likely produce an outcome of determination, and combining a high discretion role with high novelty would likely produce an outcome of exploration. Nicholson acknowledges that there can be temporal shifts in adjustment mode based on dynamic changes in the individual and the environment.

In summary, the Theory of Work Role Transitions (Nicholson, 1984) informed this study about how key variables (prior occupational socialization and motivational orientation), organizational induction process, and role requirements contribute to a final mode of adjustment – replication, absorption, determination or exploration. Based on the schema presented by Nicholson, a CNE's transition to a CEO/COO may have an explorational outcome, as the new position is high discretion and high novelty.

Identity-Based Perspective on Role Transition

Ashforth (2001) explored the social psychology of role transition seeking to understand how roles, identities, and careers are socially constructed in a dynamic environment. He was interested in understanding how individuals struggled to define themselves, in part, by the roles they played in the work environment and, in doing so, find meaning and purpose. The focus of much of his study was the process of role transition – crossing role boundaries and, in doing so, doffing one persona and donning another. Ashforth posed there is a

missing link in understanding role transition; we do not have a clear sense of "transitioning." Transitioning is the social-psychological dynamic of disengagement from one role (role exit) and engagement in another (role entry). Ashforth puts forward a conceptual framework that reflects the key elements that influence individual transition, role transition, and the process of transitioning: role identities, psychological motives aroused by role transitions, attributes of role transition, role exit; role entry (situational contexts), role entry (individual dynamics), role transitions and the life span, and micro role transitions.

Ashforth defines role identities as role-based personas complete with goals, values, beliefs, norms, interaction styles, and time horizons. The more these concepts are closely linked and broadly understood, the stronger the role identity. Individual role identities interact in an ongoing reciprocal manner with the global identity such that each informs the other. The more the role is subjectively important and situationally relevant, the greater the salience of the role to the individual; however, individuals can occupy a role and assume the role identity without considering the role identity to be self-defining. The concept of role identity is essential in the study of role transition, because in order to exit one role and enter into another, the person must switch personas. If the individual identifies heavily with the role, then it may involve changing more than just persona; it may involve changing the definition of self. This insight suggests that role exit may be traumatic, and it may be difficult to learn a new role and be accepted as a legitimate role occupant by the role set.

Role transitions that occur within an organizational setting or between organizations are embedded in specific contexts. In the absence of a firm sense of context, it is difficult to settle into a role and focus on content. Adjustment in a new role is largely about becoming situated in a local context. Ashforth (2001) identified four psychological motives aroused by the process of becoming situated in the new context: identity, meaning, control, and belonging. The motive for identity is the search for self-definition (who am I) in the organization. The motive for meaning is a mix of sense making (what) and searching for purpose (why). The motives for control are the drive to master and to exercise

influence (how). The motive for belonging is the desire for attachment to others (who). These motives can be experienced simultaneously and have a tendency for interaction. Based on these concepts, motives are not just about settling into role and context; they are also about situating and learning about the self and using the new role as a platform for expressing that self. Ashforth cautions that as much as psychological motives may stimulate individuals to identify with their roles, they may also disidentify with certain features that they find repugnant and may lead to an overall sense of ambiguity.

Ashforth (2001) states there are seven attributes of role transition: magnitude, valence, social desirability, voluntariness, predictability, collectivity, duration, and reversibility. These attributes are substantiated by the work of other theorists – Ashford and Taylor (1990), Ebaugh (1998), Glaser and Strauss (1971), Nicholson (1987), and Schlossberg (1981). Regularity pertains only to micro role transitions, which will not be addressed in this dissertation. All other attributes are addressed below.

Magnitude is defined by the degree of role contrast. The smallest is a change of job, followed by a change in job plus hierarchical level, job plus job function, job plus occupation, and various combinations of these changes.

Valence depends on the equality of the role entered into and whether it represents a gain or loss relative to the exited role. Low-magnitude transition tends to be less difficult and more positively valent than a high-magnitude position.

A socially desirable transition is one that is generally regarded as positive by the role set. Social desirability also affects the valence of the transition. Socially desirable transitions tend to be less difficult and more positively valent than less socially desirable transitions.

Voluntariness is related to the individual's ability to exercise choice in a role transition. Voluntary transitions tend to be far less difficult and more positively valent than involuntary transitions.

Predictability is the ability to anticipate the date of role exit, the onset and duration of the role entry period, and the events surrounding departure and re-

entry. The better able a person is to predict, the better able one is to engage in anticipatory planning and preparation, which facilitates sense-making and control. Predictable transitions tend to be far less difficult and more positively valent than unpredictable ones.

Collectivity addresses the number of individuals exiting or entering the organization with a common set of role entry experiences. Collective exit and entry tend to be easier for the role occupants and more positively valent than individual entry and exit.

Duration addresses the length of time between when the role occupant seriously considers role exit, or when he/she learns of role exit, and when he/she is expected to be "up to speed" in the subsequent role. Typically, role occupants have more control over the role exit period than the role entry period. A long duration transition period tends to ease the transition and be perceived as more positively valent than a short period.

Reversible role transition occurs when individuals can exit a role and resume their career almost as if they had never entered the role in the first place. Typically, a role can be considered to be reversible if the role transition had little effect or no effect on the individual, how he/she perceived them, and how he/she was perceived by their role set. A reversible role transition tends to be easier and more positively valent than an irreversible one. The value in an irreversible transition may rest in the fact that it will arouse the psychological motives and galvanize change precisely because the transition cannot be undone.

In summary, the attributes of role transition have an impact on the difficulty of making the transition and the valence of the transition. Even though the attributes were presented as separate entities, they often are experienced jointly. Ashforth (2001) cautions us that each of these transition attributes ultimately exists in the eyes of the beholder.

Role exit occurs for a variety of reasons, for example resignation, termination, promotion, transfer, demotion, retirement, or fulfillment of terms of a contract. Role exit is a key attribute of transition, because it requires disengagement from the current role. The stronger the identification is with a

given role, the more difficult the exit from the role. Ashforth (2001) describes the phenomenology of voluntary role exit in four stages: first doubts (Stage 1), seeking and weighing alternatives (Stage 2), reaching a turning point (Stage 3), and, finally, creating an ex-role (Stage 4). The entire process boils down to a sense-making exercise when the individual seeks to resolve doubts that may emerge.

Ashforth (2001) poses five contextual variables that affect role entry: control systems; entry shock; socialization tactics; rites of transition; and strong situations. Newcomers are typically motivated to seek out an identity, find meaning, seek control, and find a sense of belonging and are predisposed to internalize organizational messages about what the role and the organization are all about. The stronger the use of normative control (via socialization tactics and rites of transition), the more likely the organization will be a prefabricated model for the newcomer to assimilate. Socialization practices mediate the impact of the context on self and adaptation.

Role entry is also mediated by individual dynamics. Ashforth (2001) presents six major topics that influence the individual dynamics of role entry: role learning, role innovation, individual differences, role identification, social validation, and stress. Role entry is about how newcomers work through the new role to find new identity, meaning, control, and belonging. With the pace of change in most organizations accelerating at an exponential pace, individuals must increasingly learn about, master and change the self and the situation. Newcomers may use a host of tactics to learn about their new role. Through role learning, role innovation, and personal change, individuals enact and may come to internalize a role identity that reflects a meld of institutionalized expectations and individually based refinements. They are likely to experiment with role boundaries, parameters, and content to personalize, even institutionalize the role. For the individually-based role to stick, it must be validated by the role set. The role entry process tends to be highly influenced by an array of individual differences.

In summary, the conceptual framework presented by Ashforth (2001) had several major themes for consideration in this dissertation: role and self, dynamic interactionism, transitioning, events, normalizing, role exit and entry, role identification, and social influence. Each of these themes informed this study and served as points of reference and understanding when analyzing data and developing ground theory.

Transitions

Change is the name of the game today, and organizations that cannot change quickly will cease to exist (Bridges, 2003). Change is occurring at a fast and furious pace, leaving less time to deal with the "people side" of change – helping people get comfortable with the changes that affect them. In today's world, people have to function efficiently and effectively without close supervision, be creative, and go the extra mile. People have to bring their hearts, passions, and minds to work. The way change was managed in the past did not address the "people issues" associated with change. Bridges believes that you simply cannot get the results you need without getting into at least some of the "personal stuff." The outcome of the change being sought is dependent upon getting people to stop doing things the old way and getting them to start doing things the new way. Since people have a personal connection to how they work, there is no way to get them to do that impersonally. "Change of any sort – even though they may be justified in economic or technological terms – finally succeed or fail on the basis of whether the people affected do things differently," (Bridges).

Organizations change and people transition; that is the principle on which the Bridges model of transition is based. Bridges (2003) poses a three-phased model of transition that provides a way of dealing with people in transition that he states "makes everyone feel more comfortable." Phase one is called the Ending, Losing, Letting Go. This is the time when leadership or management needs to help people let go of what used to be and deal with their losses. Phase two is called the Neutral Zone. This is an in-between time; the old is gone and the new

is not quite fully operational. Phase three is called the New Beginning. This is the period when people develop new identity, experience new energy, and discover a new sense of purpose that makes the change begin to work. These are not discrete, mutually exclusive phases with clear boundaries. In fact, they are more like curving, overlapping strata than sequential stages. Each of these processes starts before the preceding one is totally finished. You are likely to see one or more of these phases at the same time and why movement through the change process is marked by dominance in one phase over the other two rather than an absolute shift to another phase.

Bridges (2003) poses strategies to facilitate transition during each phase. During phase one "the ending," Bridges suggests the following strategies: identify who is losing what, accept the reality and importance of subjective losses, anticipate overreaction, acknowledge the losses openly and sympathetically, expect and accept signs of grieving, compensate for losses, give people information, define what is over and what is not; mark the endings, treat the past with respect, let people take a piece of the old way with them, and show how ending the past ensures the future. In phase two "the neutral zone," Bridges recommends giving the people in transition some space. It is a very difficult time (old is gone, new is not working so well), but it can also be a very creative time. He recommends the following strategies during this phase: normalize the neutral zone (recognition of fright and confusion), redefine the neutral zone developing a new metaphor for the change, create temporary systems to facilitate movement to the new way, and strengthen intragroup connections. Phase three "the new beginning" marks the psychological acceptance of the new way. Bridges cautions that it can be a period of ambivalence and recommends the following strategies: clarify and communicate the purpose, paint a picture of the how the change should look, create a definitive plan, and play the part.

Bridges' model of transition (2003) informed this study about potential phases that the CNE experienced in his/her transition to CEO/COO. It also served to enlighten about potential strategies that he/she may have used on an individual basis to facilitate movement forward into the new role.

Nursing Models of Clinical Role Transition

There are four nursing models that address transition: O'Brien and Spry (1994), Page and Arena (1991), and Baker (1979). These models are grounded in the concepts of clinical role transition – entry into practice or entry into advanced practice. The phase of each model will be briefly described below.

O'Brien and Spry (1994) studied the expanding role of the nurse consultant in the Australian healthcare system – movement from clinical nurse consultant to resource clinical nurse consultant. Five phases of role development and socialization were found: alienation, divorce, investment, ward development and contribution. Alienation occurs when the nurse consultant is isolated from his/her peer group, divorce follows when the nurse separates from the previous role, investment follows divorce and occurs when the nurse prepares self and area for change, ward development occurs when he/she begins to develop processes at the system or ward level, and contribution occurs when the nurse contributes at the ward and organizational level. It is critical to note that this model is based on the Australian/British model of healthcare, and roles and role expectations may not be similar in the United States system of healthcare.

Page and Arena (1991) studied master's prepared nurses moving into their first role as clinical nurse specialist (CNS). They identified four stages of role development or transition including honeymoon, shock and rejection, recovery, and resolution. The honeymoon phase is described as the new CNS being an apprentice and naïve about the role. Once the honeymoon stage is over, the new CNS moves into the shock and rejection stage where he/she faces the new responsibilities and rejection as other staff adjusts. Eventually, recovery occurs where the new CNS's locus of control shifts from an external to an internal locus. Finally, resolution about the role is reached, and new CNS becomes embedded in the new role.

Baker (1979) conducted a retrospective review of role development in clinical nursing. Four stages of development and transition were identified: orientation, frustration, implementation, and reassessment. Orientation was

defined as the period of time when the nurse is new to the role; he/she is optimistic, enthusiastic, and a bit anxious. Frustration happens as the nurse perceives no change to his/her role. Implementation follows and is marked by the nurse organizing, reorganizing, clarifying, and rethinking his/her role. Finally, reassessment occurs as the nurse confirms his/her new role.

The nursing models of role development and transition give insight into how nurses seek to understand and clarify their new roles, work through internal and external struggles to establish themselves in the role, and finally accept, confirm, and embrace the new role. These models may provide insight into the "nursing mindset" for role transition.

Role-Related Models

There are two role-related theoretical models or conceptual frameworks that provide additional insight and knowledge about how work roles are assumed (taken), developed, and changed. These models are not the major focus of this literature review, but key concepts in each model or framework must be examined, as they provide additional information about how roles are actualized in organizational life. The following models or frameworks will be explored for their relationship to process of work role transition: Role Taking (Katz & Kahn, 1978) and the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980).

Social Psychology of Organizations – Role Taking

Katz and Kahn (1978) gave a central place in their theory on the Social Psychology of Organizations to the concept of roles by defining human organizations as a system of roles. It is necessary to understand several definitions and concepts before exploring their framework of role taking. Katz and Kahn define role behavior as "the recurring actions of an individual, appropriately interrelated with the repetitive activities of others so as to yield a predictable outcome." This set of interdependent behaviors comprise a social system (or subsystem), a stable collective pattern in which people play their parts. Katz and Kahn use the concept of a role-set identified by Merton (1957) in

their theory. A role-set is a complement of role relationships in which persons are involved by virtue of occupying a particular social status. This concept is based on the fact that each person in the organization is linked to some set of other members by virtue of the functional requirements of the system that are implemented through the expectations those members have of the person. He/she then becomes the focal person for that role set. The organization can be viewed as a series of role-sets, one for each member of the organization.

The theory of role taking involves four key concepts: role expectations, role sending, role received, and role behavior. These four concepts interact in a dynamic, cyclical fashion to explain the taking of organizational roles. The process of role sending is dynamic and interactive. Members of a person's role-set depend on their performance in some fashion; they are rewarded by it, judged by it, or require it to perform their own work. Because members of the role set are vested in the focal person's performance, they develop beliefs and attitudes about what the focal person should or should not do in their role – these are called role expectations. In aggregate, role expectations define the role. Expectations are not limited to the thoughts of the role-set; they tend to be voiced, communicated, or "sent" to the focal person and are direct attempts to influence the focal person's behavior. Messages to the focal person take many forms – instructions about acceptable behaviors, incentives and disincentives, and evaluation of current performance. Every attempt at influence implies consequences for compliance or non-compliance. Every individual in an organization responds to his/her role-set; not because they are forced, rather they are expressed in behavioral ways.

For every role that is "sent," there is a role that is "received," consisting of that person's perceptions and conditions of what was sent. How closely these roles match depends on variables inherent in the focal person, the set of role-senders, content of what was sent, and the clarity of communication. It is the received role that is the immediate influence on each member's behavior and the source of his/her motivation for role performance. Additional sources of influence in role taking are objective, impersonal properties of the situation itself. Internal

sources of motivation are also important considerations – the intrinsic satisfaction derived from the content of the role.

Katz and Kahn (1978) introduced the concept of role episode – a cyclic process that involves all four concepts discussed above. The first two, role expectation and sent role, address motivation, cognitions, and behaviors of the role-set. The last two concepts, role received and role behavior address motivations, cognitions, and behaviors of the individual. Role sending and role behavior are seen as events in a continuous and interdependent cyclical process. Figure 2 demonstrates the factors and their interactions involved in the taking of organizational roles.

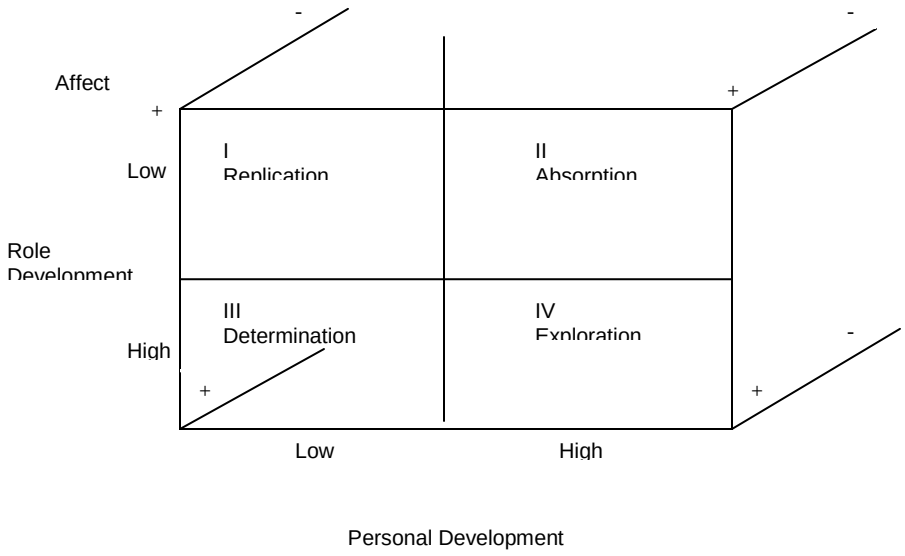

Figure 2. Modes of adjustment to transitions resulting from personal and role development (Nicholson, 1987).

In summary, this dynamic, interactive model of role taking informed this study about the influence of role-sets on the taking of an organizational role. This model also informed this researcher about the influence of role expectations, attributes of the person, and interpersonal factors on role behaviors.

The Dreyfus Model of Skill Acquisition

The Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980) provides a model to understand growth and development within a given role. The model posits that, as a newcomer acquires and develops skills, they pass through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. These different levels of development are based on three general aspects of skill performance: 1) movement from reliance on abstract principles to the use of past experience; 2) change in demand situation (the learner sees the situation less as a compilation of equivalent bits and more as a whole where certain parts are more important and relevant; and 3) movement from detached observer to involved performer.

Dreyfus and Dreyfus (1980) describe the behaviors associated with each level. The novice (level one) has a rigid adherence to rules or plans, little situational perception, and little or no discretionary judgment. The advanced beginner (level two) guides actions based on global characteristics of the situation that are recognized after some prior experience, yet all aspects of the situation are treated separately and given equal importance. The competent (level three) sees actions, at least in part, in terms of longer-term goals, is conscious of deliberate planning, and standardizes and routinizes procedures. The proficient (level four) sees the situation holistically, sees what is most important, perceives deviation from normal pattern, makes decisions more easily, and uses maxims for guidance. The expert (level five) no longer relies on rules, guidelines or maxims. The Dreyfus model is based on the premise that the situation and the experience distinguish between levels of skill performance that can be achieved through theoretical and classroom learning and the context-dependent judgments and skills that can be acquired only in real-life situations (Dreyfus, 1982). For example, a CNE may be an expert or proficient as the executive responsible for clinical care in an organization; however, when the CNE transitions to a CEO/COO, he/she may practice at the novice or advanced beginner level. The model is truly dependent on the situation and the experience of person undergoing the role transition.

Benner (1984) applied this model to clinical nursing and was able to successfully describe the performance characteristics at each level of development and to identify teaching and learning needs at each level. There are only a few publications citing the use of the Dreyfus Model of Skill acquisition when looking at management jobs in nursing and none address skill acquisition at the executive level.

This model provided a context for understanding growth and development within role. Typically, we think of role development as novice to expert; however, in the case of the CNE transitioning to chief executive office, the movement may well be from expert to novice.

Effects of Role Transition

This section of the literature review will explore key concepts related to the potential unwanted effects of role transition: role stress-strain, conflict, ambiguity, incongruity, over and under load, and over and under qualification.

When the social structure creates difficult, conflicting, or impossible demands for a role occupant, a general condition called “role stress” can result (Hardy & Hardy, 1988). Role stress for the focal person can result in role stress for others in interdependent positions. Merton (1957) proposed that one source of role stress may be the context of a particular status and another may be related to various functions of the status. Role stress is typically located in the social structure and is primarily external to the individual. Role stress may generate role strain – subjective feelings of frustration, tension and anxiety for people in a central or pivotal role. High levels of role strain can be disruptive and cause dysfunction, disrupting social interaction and preventing goal attainment for role systems and role occupants.

Katz and Kahn (1978) define role conflict as “the simultaneous occurrence of two or more role expectations such that the compliance with one would make compliance with the other more difficult.” Typically, this is thought to be a disagreement between two or more role senders, but as Katz and Kahn pointed out, two or more expectations of the same role-sender may be in conflict, and conflict can also appear between expectations of the role-set and those of the focal person for him/herself. Data on the incidence and prevalence of role conflict is difficult to find and interpret, as most studies have small samples and are based solely on self-report. Katz and Kahn believe that experience of role conflict is widespread.

Katz and Kahn (1978) described role ambiguity as uncertainty about what the occupant of a particular role is suppose to do. Besides the job requirements and actions, there may also be uncertainty about membership in the role-set, the purpose of the role, and evaluation of present role behavior. Katz and Kahn reported role ambiguity to be a significant organizational problem by any account and incidence varies widely. For some organizations, it is the modal condition.

Hardy and Hardy (1988) conducted research on role occupants that were having major difficulties meeting their role obligations. They initially analyzed data in terms of role expectations – conflict and ambiguity. Then other sources of role problems were considered, including the location of the role in the organizational social structure, resources available to the role occupants, and social context. From that research, Hardy and Hardy developed a typology for role stress. Role stress can be created by any one or more of the following seven conditions:

1. Role ambiguity occurs when there is vagueness or lack of clarity in role definition and/or expectations.
2. Role conflict occurs when there are incompatible role expectations between the role occupant and role set.
3. Role incongruity occurs when the self-identity and subjective values of the role occupant are grossly incompatible with role expectations.
4. Role overload occurs when there is too much expected of the role occupant in the time available.
5. Role underload occurs when there is a minimization of role expectations and underutilization of role occupant's skills, talents, and abilities.
6. Role over-qualification occurs when the role occupant's motivation, skills, and knowledge far exceed those required.
7. Role under-qualification (also called role incompetence) occurs when the role occupant lacks the necessary skills, talents, and abilities to fulfill the role.

In summary, it is clear that there are many variables that affect role transition. The variables are both structural and individual in nature, and the resulting outcome ranges from conflict and ambiguity to failure. This body of literature informed the researcher about the potential ill-effects of transition and raises the researcher's awareness to potential strategies that CNEs may use in their transition to CEO/COO.

Need for Further Research

The literature presented in this chapter was largely drawn from the sociological, psychological, and organizational development literature. Much of the literature presented was theoretical in nature, developing necessary concepts and frameworks for understanding the role of the individual within an organization. Only two of the models reviewed dealt specifically with the notion of transitioning – doffing one persona to assume another. None of the models reviewed dealt with the phenomena or experience of transitioning in an explicit manner. None of the models reviewed dealt specifically with role transition and the lived experience of transitioning at the executive level. Only a few of the research studies reviewed used the grounded theory method to further develop understanding of role transition and the act of transitioning. Using grounded theory to understand the phenomena of transitioning from CNE to CEO/COO is critical to building a theoretical and conceptual model that will provide strategies to facilitate role transition and provide targeted and focused education for CNEs moving into CEO/COO roles. It is clear that there is a void in the literature that this study will address.

Summary

Symbolic interactionism (SI) was used to guide a grounded theory approach to the study of CNEs that transition into the role of CEO/COOs. Symbolic interactionism is a social-psychological approach most closely associated with George Herbert Mead (1934) and Herbert Blumer (1969) that places great emphasis on the importance of meaning and interpretation as essential human processes that react against behaviorism and mechanical stimulus-response psychology. Simply stated, people create shared meanings through interactions, and those meanings become reality. Blumer defined the three premises that are fundamental to symbolic interactionism: 1) human beings act toward things based on the meanings that things have for them; 2) the meaning of things arise from social interaction with other individuals; and 3) the meaning of things are handled and modified through an interpretive processes

that is used by the person that one encounters. These premises can be applied to the organizational interaction influence affecting CNE's transition into a CEO/COO role. The CNE's new role is derived from social interaction with his/her role-set, and perception guides the transition.

Chapter III

Methods

Little is known about how nurses who are CNEs transition to become CEO/COOs. Anecdotal and experiential accounts are few but the message is clear – nurse executives are strong candidates to successfully lead healthcare systems into the future (Everson-Bates, 1992; Kalisch & Escamilla, 2001). The trend in the advancement of CNEs to CEO/COOs is destined to continue as nurse executives prove their worth in the chief executive and chief operating officer roles. There is a need to understand the work role transition from CNE to CEO/COO and to understand the experience of moving from a clinically focused executive role to an operationally and strategically focused executive role.

Grounded theory method (Glaser & Strauss, 1967) was used to explore the experience of transition from CNE to CEO/COO. Using grounded theory facilitated the development of a conceptual framework and initial theory that explains how CNEs experience the transition to CEO/COO. The new conceptual framework and initial theory informs healthcare leaders about movement across the continuum of role transition and defines the individual and contextual variables that facilitate movement from the CNE role, doffing one's persona as CNE, to assume the role of CEO/COO. The efficiencies realized by facilitated role transition at the executive level should decrease the downtime and chaos frequently associated with executive role transition, offering an improvement in the performance of the organization during times of executive leadership transition.

Grounded theory is the systematic generation of theory from data that contains both inductive and deductive reasoning. One goal of grounded theory is to formulate hypotheses based on conceptual ideas. Others may try to verify the

hypotheses that are generated by constantly comparing conceptualized data on different levels of abstraction, and these comparisons contain deductive steps. Another goal of grounded theory is to discover the participants' main concern and how they continually try to resolve it. The questions continually asked in grounded theory are, "What is happening, what is the main problem of the participants, and how are they trying to solve it?" These questions will be answered in the following chapters.

Grounded theory does not aim for the "truth" but rather to conceptualize what is happening and how the participants try to resolve the issue by using empirical data. Charmaz (2006) reflects on the value of grounded theory and the benefits of exploring new territory.

> "Grounded theory involves taking comparisons from data and reaching up to construct abstractions and simultaneously reaching down to tie these abstractions to data. It means learning about the specific and the general, and seeing what is new in them, then exploring their links to larger issues or creating larger unrecognized issues in entirety. An imaginative interpretation sparks new views and leads other scholars to new vistas. Grounded theory methods can provide a route to see beyond the obvious and a path to reach imaginative interpretations." (Charmaz, 2006, p. 181).

A qualitative study was selected as the appropriate method for seeking out knowledge about CNE role transition to CEO/COO, because it facilitated the exploration and description of the personal experiences of CNEs making the transition to CEO/COO and the meanings of such transitions within the context of various healthcare settings (Creswell, 2003). The methods of inquiry and analysis used in this research were based on the conceptual framework of symbolic interactionism, which holds that people create meaning from experiences through interactional responses to situations (Bogdin & Biklin, 1998). This method facilitated the in depth exploration of the interplay of personal meaning and situational factors that were described in the theories that informed this study. The review of role theories and work role transition theories led this researcher to explore the experience of role transition for CNEs moving into CEO/COO roles.

Research Design

Glaser and Strauss (1967) developed the grounded theory method of research based on the theory of symbolic interactionism. The basic theme of grounded theory is the discovery of theory from data obtained by conducting social research. "A grounded theory is one that is inductively derived from the study of phenomenon it represents," (Strauss & Corbin, 1990, p. 23). Glaser (1998) stated there are four criteria for judging and doing grounded theory: fit, workability, relevance, and modifiability. Fit is another word for validity. Does the concept adequately express the pattern in the data that it purports to conceptualize? Fit is sharpened by constant comparison. Workability means the concepts and the way they are related account for the main concerns of the participants. They are practicable and feasible. Relevance deals with the main concerns of the participants involved. Modifiability occurs when the theory is modified by new comparative data. The ultimate goal of grounded theory is to account for a pattern of behavior that is relevant and problematic for those involved (Glaser, 1978).

Nurses have used the grounded theory research method for many years to explore the human experience and develop meaningful, mid-range practice theories in nursing (Bowers, 1987; Hutchinson, 1992; 1993; Redfern-Vance and Hutchinson, 1995; Stern, 1982). Grounded theory is unique and Stern distinguishes grounded theory from other qualitative research in the following ways: 1) a conceptual framework is derived from data; 2) the focus of study is a primary process of concern to the individual within a social context; 3) data are continually compared with all other data throughout the process; 4) data collection processes are altered as indicated by developing theory; and 5) from the outset, data are analyzed and the beginning ideas for the research report are formulated.

Stern (1980) encourages rigorous use of grounded theory research method to facilitate discovery of accurate and useful analyses of social processes relevant to nursing science, such as executive-level role transition.

She promoted the use of the five-step method of grounded theory research developed by Glaser and Strauss (1967): 1) collection of data; 2) identification of the concept – main theme; 3) development of the concept – developing theory; 4) modification and integration of the concept – theory; and 5) writing the research report. That is the approach used in this dissertation.

Sample and Setting

A purposeful sample of fifteen CNEs who became CEO/COOs in a variety of healthcare settings and remained in those positions for at least one year were used in this study. Criteria for sample selection reflected the purpose of the study and guided the identification of information-rich cases (Merriam & Brockett, 1997; Seidman 1991). Maximum variation in cases selected contributed to the identification of the relative strength of shared patterns that emerged from data (Merriam & Brockett).

To ensure maximum variation in cases, participants were recruited using personal and professional contacts and experienced the transition from CNE to CEO/COO in a variety of healthcare settings including teaching hospitals, community hospitals, hospice services, and healthcare systems. Age, gender, and ethnicity were not part of the selection criteria.

There are no hard and fast rules for sample size in qualitative research. Sample size depends on what you want to know, the purpose of the inquiry, what will be useful and credible, and the available time and resources (Patton, 2002). Patton recommends that the exact sample size be determined as the data are collected and analyzed and when saturation of the conceptual information has been achieved. Lincoln and Guba (1985) recommend sample selection “to the point of redundancy.” There are limits to this strategy – normally time and resources. Morse (2000) poses that estimating the number of participants in a study required to reach saturation depends on a number of factors including the quality of the data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the use of shadowed data, and the qualitative study design used. Patton (2002) poses that the solution is judgment and negotiation and

recommends that sampling design specify minimum samples based on expected reasonable coverage of the phenomenon given the purpose of the study and the stakeholders' interest.

Giving consideration to the methodological literature, sampling was terminated when no new information came forward and saturation of the conceptual information was achieved. Selective sampling of the data (theoretical sampling) was conducted to advance the theory. Selective sampling of the literature occurred concurrently with data collection and analysis.

Data Collection and Recording

Approval of this study was obtained from the Health Sciences Institutional Review Board (IRB-Health) at the University of Michigan prior to data collection. All participants signed a Subject Consent to Take Part in a Study form, approved by IRB-Health, indicating their consent to participate in the study and their consent for audio recording of the interview (see Appendix). Participants could opt out of having the interview recorded and still participate in the study. A brief demographics sheet was also completed prior to the interview. The primary data collection procedure for this study was in-depth, individual interviews.

Interview Method

The primary assumption used in this data collection effort was that the perspectives of others are meaningful, knowable, and able to be made explicit (Patton, 2002). The purpose of using the interview method was to capture how the CNEs viewed their transition into CEO/COO roles, to learn their terminology and judgments, and to capture the depth of their perceptions and experiences. Qualitative interviewing maximized the researcher's ability to enter into another person's perspective. The guide used to conduct the interviews was composed of loosely structured, open-ended questions to prevent predetermination of phrases or categories used by the participants to express themselves.

Data Collection

The study purpose and method was explained to each participant and informed consent was obtained prior to the interview. At the beginning of the interview, the participants were reminded that the interview was being tape recorded and, if at any point in time they felt uncomfortable having their thoughts, feelings, and experiences recorded, the recording would be suspended and only handwritten notes would be used. None of the participants opted out of being recorded. Interviews began with a brief explanation of the purpose of the study. The operational definition of transition was briefly discussed with each participant to ensure that the participant and researcher shared common meaning prior to its use in the interview questions. If the participant had experienced more than one transition from CNE to CEO/COO, it was agreed that the initial transition would be discussed first and the subsequent transitions would be discussed in a comparative manner to the first transition.

An interview guide was used to ensure the same basic lines of inquiry were pursued with each participant interviewed. The interview guide helped to make interviewing the fifteen diverse participants more systematic and comprehensive by delimiting in advance the issues to be explored. Individual interview guide questions or prompts included:

1. Tell me about your career path to becoming a CEO/COO.
2. Tell me about what you knew, thought, and felt about CEO/COO role in your organization before you became CEO/COO, and what you know, think, and feel now.
3. What did you believe were the responsibilities and accountabilities of the CEO/COO when you were CNE, and what do you believe now?
4. Tell me about how you made the decision to move into or become the CEO/COO.
5. Describe your experience with the transition from CNE to CEO/COO.
    a. In general, what was it like for you?
    b. Who influenced your transition from CNE to CEO/COO, and in what ways were they influential?

c. What organizational experiences or structures influenced your transition from CNE to CEO/COO?
d. What were the barriers or challenges to your transition from CNE to CEO/COO?

6. Describe any sources of stress, strain, or conflict you experienced in the transition to CEO/COO?
7. Tell me how you continue to develop in your new role as CEO/COO.
8. What do you find satisfying about your role as CEO/COO?
9. What would you tell other CNEs making the move to become a CEO?
10. Is there anything else that you would like to tell me that I have not yet asked regarding your transition from CNE to CEO?

Additional individual questions were asked for clarification or to prompt a deeper dive into one of the thoughts they presented. In addition to informal, semi-structured interviews, basic demographic information was collected on each participant at the individual and organizational level. The individual-level information collected included years in nursing service, entry degree into nursing, highest degree obtained in nursing, highest degree obtained, total years as a CNE, and years as CEO/COO. Organizational-level information collected included type of organization and a basic description of the organization. To provide additional qualitative information, the researcher conducted internet searches of the individuals and the organizations they represented.

Recording and Transcription

All participants were interviewed via telephone and were audio taped. The interview sessions were scheduled for one hour. The actual range in interview times was forty minutes to one hundred and ten minutes in length. Extensive notes were taken during the interview for use as back-up in the event of a technical failure and to document any nuances that might not have been captured on the audiotape. All audio recordings were transcribed within one week of the actual interview. A total of fourteen interviews were transcribed for a

total of two hundred seventy seven pages. One interview recording could not be transcribed because the digital file was corrupted. The comprehensive handwritten notes that were taken during that interview were used to develop the written responses to interview questions and used for analysis. After each interview, the researcher documented first impressions and observations in the form of a memo. Fifty six pages of memos supplemented the taped data transcription.

Ethical Issues

Qualitative interviewing, by nature, is highly personal and interpersonal. The researcher enters the real world where people live and work. Qualitative interviewing opens up what is inside most people and may be more intrusive and involve greater reactivity than surveys, tests, and other quantitative approaches (Patton, 2002). Realizing the potential for such intrusion and reactivity, this study was designed to address the ethical issues associated with interviewing and ensured that appropriate informed consent and confidentiality were maintained.

The informed consent protocol and opening statement of the interview contained the following information: purpose of the study, intended use of the study, how the questions would be asked, how the responses would be handled (including confidentiality), and the risks and/or benefits for the participant. Grounded theory involves revising study questions as new data appears. None of the questions used throughout this study required substantive revision and no revisions to the informed consent were required.

Confidentiality of the data and anonymity of participants was maintained throughout the study. Participant names were coded, and these code names were used to identify transcripts and other data that was generated or used. The digital interview recordings, as well as the transcripts, were transferred from the computer to a compact disc and were kept in a secure location by the researcher.

Personal Issues

The role of the researcher in qualitative research is to become immersed in the world of the participants in order to understand their role and their experiences. In qualitative research, the researcher is one of the primary data collection instruments. As such, the researcher must identify personal values, assumptions, and biases at the onset of a study. This researcher's perceptions of the roles involved in this study were shaped by her experience as a CNE and by previous exposure in a close working relationship to CEO/COOs. Giving consideration to potential biases, this researcher believes that the experts on CNE role transition to CEO/COO are the participants in this study. Validation by key informants facilitated further understanding and accuracy.

Data Analysis

Constant comparative analysis was used for this grounded theory study. Following Glaser's lead to conduct "detailed grounding by systematically analyzing data sentence by sentence by constant comparison as it is coded until a theory results" (1978, p. 16) is exactly how this researcher analyzed the data. Data analysis occurred simultaneously with data collection because of the constantly changing sampling strategies inherent in the grounded theory method. In following Glaser's lead, the researcher attempted to discover the theory through a sequencing of activities. First, the researcher identified the basic social-psychological process – CNEs in transition to CEO/COO roles and the challenge of making the CNE role an ex-role. Once the basic social-psychological process was discovered, emerging theory continued to develop. Theoretical coding, memoing, and data-sorting facilitated concept modification and integration.

Coding

Using constant comparative analysis, three levels of increasingly theoretical coding were used. Analysis began with open coding (Level I) of the transcribed interview data. Level I coding consisted of line-by-line examination of

the data in order to identify the processes in the data. Throughout data collection, these processes or substantive codes were compared with other data and assigned to categories (Level II) that clustered together or formed similar patterns of information. Each category was compared to the other categories to ensure that they were mutually exclusive. Categories were then reduced by comparing them to each other to determine how they fit into a higher order category. Categories were again reduced in order to identify the primary social processes or core variables that explain role transition from CNE to CEO/COO (Level III). Conceptualization of the relationships between the three levels of codes occurred through the development of additional theoretical Level III codes (Glaser, 1978; Hutchinson, 1993).

Basic Social-Psychological Process

The goal in using the grounded theory method is to discover the participants' perspective of the main problem and how they deal with or manage those problems. The core variable is the primary problem of concern, a pattern of behavior that illustrates what is going on in the data, and the relevance of the problem as seen through the eyes of the participants.

The basic social-psychological problem (efficient and effective transition from CNE into CEO/COO role) and the basic social-psychological process that manages the problem (role exit and acceptance of the CNE role as an ex-role) were revealed through a systematic process of examining the data using constant comparative analysis and analytical thinking. Codes and categories were used to identify the variables and influences that accounted for most of the variation in behavior. Theory was further developed through the processes of reduction, selective sampling of the data, and selective sampling of the literature.

Selective Sampling

Selective or theoretical sampling was used as the prime mover of coding, collecting and analyzing data (Glaser, 1998). Selective sampling allowed the researcher to continually focus and delimit the collection and analysis of data to

avoid collecting the same data based on the same questions. Using this technique kept the data to a minimum and allowed for the collection of additional data that was more relevant to building new categories and properties.

Selective sampling of the literature occurred simultaneously with data analysis. As relevant literature was found, it was used as data and incorporated into the developing theory. Through the process of reduction, selective sampling of the literature, and selective sampling of the data, the initial theory was developed.

Theoretical Coding, Memoing, and Sorting

Memos were used as a primary method to collect additional personal, theoretical, methodological impressions, thoughts, and research ideas. Theoretical coding, memoing, and sorting of data facilitated concept modification and integration. Using the analytical schemes identified through coding increased the researcher's ability to abstract concepts and initial theory. Coding families identified by Glaser (1978) were used to facilitate analysis.

Use of the Literature

As the data were collected and analyzed, the literature was continually compared as an additional source of data. Literature on role transition of the roles of CNEs, CEOs and COOs in the healthcare and industrial setting was continually scanned for additional data to inform this study. Emerging data in the study lead the researcher to dive deeper into role transition, specifically role exit and developing an ex-role, to bring additional information about CNE transition to light. As analysis continued, the concept of role identity specific to nursing was also explored in the literature to create an awareness of the challenges the CNEs were experiencing during transition, specifically role exit.

Strategies to Enhance Scientific Integrity

Validity in qualitative research does not carry the same connotations as it does in quantitative research, nor is it a companion of reliability or

generalizability. Overall, reliability and generalizability play a minor role in qualitative inquiry. Validity is seen as the strength of qualitative research. Creswell (2003) recommends that researchers identify one or more of the following strategies to check the accuracy of findings: triangulation; member-checking; use of rich, thick description; clarification of biases; presentation of negative or discrepant information; prolonged time in the field; peer debriefing; and use of an external auditor. In this study, the researcher used the following techniques advocated by Glaser and Strauss (1967) to ensure credibility and relevance of data: 1) validation of developing theory by select participants and the identification of situations to which the theory is applicable; 2) constant comparison of the data throughout the data collection and analysis period that allowed the researcher to continually examine the consistency of the data, continually formulate new hypotheses and reject if not supported, identify any contradictory data by pursuing unexpected findings, and detect any potential misrepresentation of the truth; 3) saturation of the data, selective sampling, and confirmation by key informants; and 4) ongoing discussions with faculty and colleagues to help avoid biases, increase theoretical sensitivity, collaborate on analysis, and provide supportive resources. In addition, the researcher used rich, thick description to convey findings and continually clarified any potential biases brought to the study by the researcher.

Summary

The focus of qualitative research is analytical generalizability as compared to quantitative research which focuses on statistical generalizability (Hutchinson, 1993). Usefulness of a theory in explaining social phenomena is essential to grounded theory research. Grounded theory is considered substantive and valid based on its ability to fit with, work for, and be relevant to other people (Glaser, 1992). The substantive theory presented in this study is applicable to other CNEs experiencing transition to CEO/COO roles. In the next chapter, the basic social-psychological problem of CNEs moving from a clinically focused role to a

larger, more strategically and operationally oriented role (CEO/COO) will be presented and discussed.

Chapter IV

Results:
The Basic Social-Psychological Problem – Creating an Ex-Role

Introduction

When using Grounded Theory (Glaser, 1978), the key questions that the researcher continues to ask throughout analyses are “What is going on?” and “What is the main problem of the participants in the setting and how are they trying to solve it?” The answers to these questions are grounded in the data. This chapter describes the challenges faced by the chief nurse executives (CNEs) who transitioned into chief executive officer (CEO) or chief operating officer (COO) roles; specifically, the basic social psychological problem of role exit in the face of strong identification as a nurse and the strong sense of commitment to the profession of nursing. The challenge is created because role exit necessitates disengagement – psychological and sometime physical withdrawal from the role, the culture, and the network of relationships in which the role is embedded (Ebaugh, 1988). Role exit for CNEs and making that role an ex-role is a critical transition for successful movement into a CEO or COO role. The struggles, tensions, conflicts, barriers, and facilitators to the critical relinquishment of the CNE role, as revealed through the data, will be presented in this chapter. This chapter is organized in a sequential fashion, first presenting a description of the sample, then a presentation of how findings of the study are related to the four-stage model of the phenomena of voluntary role exit (first doubts, seeking and weighing alternatives, the turning point, an creating an ex-role), and ending with a presentation of the significant challenges of making the CNE role, an ex-role.

Description of Sample

The primary characteristics of grounded theory designs are theoretical sampling and constant comparison of data with emerging theory. Theoretical sampling requires that selection of participants be directed by emerging analysis. This researcher began with a focused sample of CNEs that transitioned into CEO/COOs roles and were current role occupants. As data emerged, the researcher saw value in adding participants who made the transition from CNE to CEO/COO, held the position for at least one year, and subsequently left the CEO/COO role. These participants were added because the perspective of a CNE turned CEO/COO, who no longer occupies the role, would provide a retrospective view of the experience.

Individual Descriptors

A purposeful sample of fifteen (15) CNEs who became CEO or COO in a variety of healthcare settings and remained in those positions for at least one year were interviewed for this study. The sample included fourteen females and one male. Thirteen of the participants had greater than thirty years of nursing experience and two had twenty-one and twenty-nine years of nursing experience. Nine of the participants entered the profession with a bachelor's degree in nursing, four with a diploma in nursing, and one with an associate's degree in nursing. The highest degree in nursing held by fourteen of the participants was a masters' degree in nursing, and one participant's highest degree in nursing was her entry level diploma degree. Highest degrees overall included six participants with doctorates (two in nursing, two in business administration, and two in education) and nine participants with master's degrees (six in nursing, two in health service administration/public health administration and one in business administration). All participants had been CNEs for at least four years, with a range in years of service as a CNE from four to thirty years. All participants had expanded CNE roles at the time of transition into CEO/COO roles. Most of the CNE role expansion included the addition of non-nursing clinical services (such as rehabilitation therapy, respiratory therapy, pharmacy, etc.) to their areas of

responsibility. In the sample, there were six current COOs and one former COO. The former COO is now in a consultant role. Four of the participants were currently in CEO roles and four were former CEOs. Of the four former CEOs, one is now a corporate vice president for planning/marketing; one is retired; and two are in consultant roles.

Groundbreakers

The participants in this study were inspiring, educated, dedicated men and women who had boldly gone where few nurses had gone before – into the executive suite. The participants shared their experiences of being the first to break barriers and lead the way for clinical leaders to become executive leaders. There were many pioneers in the group of participants. To advance to the CEO/COO level as a female and as a nurse was groundbreaking. Here are some of the "firsts" among the participants: Most of the participants were the first nurse CEOs/COOs in their organizations, one was the first minority female nurse COO in a large organization, another the first female nurse CEO in the state, and yet another the first female nurse CEO to run a large teaching hospital. There were challenges in breaking the ground for both women and nurses taking the CEO/COO role. These challenges will be presented in the final section of this chapter.

Career Trajectories

All participants in the study started their careers as staff nurses in the acute care setting and advanced through the ranks of entry level and mid-level management. Most had been or remain educators as part-time or adjunct faculty. Participants demonstrated a drive to achieve in whatever role they occupied – seeking the opportunity to do additional work or projects and broaden their scope of job responsibility. One participant RD who had been a CNE twice and a partner in a larger consulting firm expressed the sentiment that described many of the CNEs career trajectories: "advancement is a great opportunity – the benefit of serendipity and networking." Very few participants started out thinking

they were going to be CEOs or COOs; rather most saw movement into a CEO/COO position as an opportunity and an adventure. Movement into the CEO/COO was either chosen or viewed as a non-choice. Five CNEs moved into the CEO/COO role as a direct or indirect effect of reorganization or restructuring. When asked if taking the CEO/COO was a choice for these CNEs, three felt there was no choice if they were to do what was right for the organization. Two CNEs viewed the reorganization and movement upward as a choice.

Organizational Descriptors

Description of the healthcare settings where the CNE experienced the transition to CEO/COO is helpful in understanding at least part of the context in which they experienced the change. All participants were asked to complete a brief survey providing information about the healthcare setting in which the transition was experienced. If more than one CNE to CEO/COO transition had been experienced, the participants were asked to respond based on their most recent setting. The following organizational information was collected: teaching or non-teaching, for-profit or not-for-profit, secular or religiously affiliated, part of a healthcare system or stand alone organization, and total number of beds occupied (if appropriate). Table 3 (below) illustrates the healthcare settings in which the role transitions from CNE to CEO/COO occurred.

Table 3

Organizational Descriptor of Participants

Organizational Descriptor	Organizational Type	# of Beds	# of CEOs/ COOs
For-profit No religious affiliation	Teaching hospital; part of system	549	1
Not-for-profit No religious affiliation	Non-teaching hospital/system	243 to 304	3
Not-for-profit No religious affiliation	Non-teaching hospice (In-Home)	NA	1
Not-for-profit No religious affiliation	Teaching hospital/system	190 to 1,250	7
Not-for-profit Religious affiliation	Teaching hospital/system	276 to 636	3

In summary, the participants represented men and women that received primary education as a professional nurse, secondary education as a nurse administrator or administrator, and six of the participants were educated at the doctoral level. Their experience in the healthcare arena was wide and vast and all of the participants were upwardly mobile in leadership positions. Many of the female participants were ground breakers – the first nurses and the first females to become CEO/COO in their organizations. The nurse executives were grounded by virtue of education, experience, and identification as professional nurse and clinician.

Voluntary Role Exit

Role exits are prompted by a variety of reasons – termination, retirement, resignation, transfer, and demotion. No matter the reason, the departing individual must cease to think of himself/herself in the previous role. The individual leaving the role must actually disengage from the role. Likewise, members of the individual's role set must also disengage and significantly change their role-based relationships with the individual. The origins of role exit (voluntariness and locus of change) play a significant role in the occupant's ability to exit, whether the exit was voluntary or involuntary and whether the exit

was pushed (job dissatisfaction, resignation, retirement, uncontrollable forces, and termination) or pulled (resignation, retirement, role progression and failing health). All of the participants in this study were voluntarily "pulled" into their new roles as CEO/COO. Although the participants viewed the move as voluntary, it is important to note that four of the participants were reluctantly "pulled" into executive leadership – seeing no alternative but to move into the new role if the organization were to survive and/or continue strategic movement forward. Three participants hesitantly were "pulled" into their new roles by way of serendipity meeting opportunity. Eight of the participants were willfully "pulled" into their new roles as CEO/COO as they desired to advance their careers as executives and fulfill the vision of their career trajectories.

Ebaugh (1988) posed a model of role exit that focused primarily on intrarole (push forces) and voluntary transitions. He posed a four stage model of role exit. Stage 1: First doubts is the stage where a precipitating event (from momentous to innocuous, expected and unexpected) forces reflection on valued identities, goals, and life/career trajectories. These epiphanies can be disappointments, external changes, milestones, impending events, and internal changes (Denzin, 1989). Stage 2: Seeking and weighing alternatives is where individuals explore and examine alternatives. Alternative considerations are shaped by what the individual wants to achieve and constrained by what they know to be feasible. The more psychologically engaged the exiter became in future possibilities, the less engaged he/she remained in the current role. Stage 3: The turning point represents an event where the exiter realizes that old lines of action are complete or are no longer personally satisfying. This stage typically culminates in an external expression of intent to exit. Physically leaving the role does not complete the role exit process. Those who exit roles must also come to grips with their prior role occupancy. Decisions and choices remain: What (if any) of the previous role identity should I retain? What should I attempt to forget? How do I present myself to others? Stage 4: Creating an ex-role involves coming to grips with the tension in one's past, present and future. There are several factors that affect one's ability to create an ex-role. There are two

situational variables – magnitude of transition and visibility of role/transition and four individual variables – role identification, sentimentality, nostalgia, and coping resources. The process of creating an ex-role and the process of role exit are intimately connected with the process of role entry (Ebaugh).

Making the Move – Role Exit for the CNE

Ashforth (2001) stated that role identities are role-based personas and as such have goals, values, beliefs, norms, and interaction styles. The more tightly bound and widely understood these features are, the stronger the role identity. Identification with the role of a nurse carries with it strong professional values, beliefs, norms, and behaviors. The application of this theory to role transition is direct – if an individual is to exit from one role and enter another, one must switch personas. The stronger the identification with one's role/persona, the more difficulty there is with switching the very conception of self. Leaving a role (role exit) may be traumatic; learning a new role (role entry) and being accepted by the surrounding roles (role set) may be difficult at best. The four stages of role exit posed by Ebaugh (1988) are clearly supported by the data found in this study. In this section, each stage of role exit will be discussed as it related to the data revealed in participant interviews.

Stage 1 – First Doubts

With the chaotic pace of healthcare today and intense demands on executive leadership there is little time for personal reflection on values, goals, objectives, and career trajectories. Reflection and introspection are often prodded by a precipitating event that produces a significant insight or realization called an epiphany (Denzin, 1989). First doubts can be stimulated by internal changes, reaching a milestone, and disappointment. Nearly all of the participants reported such a turning point or startling realization about their need to move into a more powerful, strategically focused role.

Internal Changes

Ashforth (2001) describes internal changes as those that occur in the absences of identifiable external events. Burnout, a state where one is unable to derive satisfaction from the role is one such internal change. Several participants described their pivotal moment as the realization that a role change was necessary because leading, directing and changing nursing (and other clinical areas) was not enough to transform the organization. Participant RA, a seasoned COO in an academic medical center, believed that her "roots" for becoming a COO began when she took a financial management position in the nursing department. That experience as the financial lead for nursing strengthened her experience with knowledge (master's degree), and lead to her promotion as a director and vice president of nursing. She describes her pivotal moment, "I realized that if I wanted to transform the organization – I just couldn't change nursing…I had to change the system."

Participant DD was a strong CNE and a visionary leader. She described the pivotal point in her career when she realized that she needed a role larger than the CNE to appropriately influence and change the organization:

> "I thought that if I fixed nursing that the experience of the patient would be fixed and the experience for the staff would be fixed but what I learned is that we are still part of the system and there were many decisions being made at the CEO level. Many of the decisions that needed to be made were based on financial issues and clinical trade-offs and the CEO had no clinical background. As much as I could change the department of nursing, my goal was to make work a sacred place and I wanted not only to create a sacred place for the patients but also the staff…providing them enrichment and not having to fight the system. To really impact the way I felt, to impact the organization the way I felt I needed to as I had grown, I needed to become a CEO."

Participant JJ was the CNE in an academic setting and was dissatisfied with the leadership and direction of her organization. Having broadened her scope of responsibility during her tenure she knew she had the skills to get the job done, she just needed the authority. Her defining moment came when she became engaged with several of the non-clinical areas and realized the disparity

in resources and leadership and knew she could lead those areas. That is when she decided to pursue the COO role.

Participant RS expressed frustration with not being able to get all the departments on board for a large initiative like patient centered care in her role as CNE. Dealing with inefficiency and ineffectiveness of patient care delivery across multiple disciplines was challenging and frustrating and getting all the managers and leaders to work together was always a daunting challenge, especially as the CNE who did not have the formal power or authority to make the relationships work. Those frustrations led to the realization that role change was necessary. In her own words,

> "I mean we did a lot of patient centered care work and you could get some of the departments on board but having the ability to really sit down and move the organization forward as a whole, towards a goal like patient centered care was difficult as a CNO. And I made the decision that I wanted to be a CEO."

Milestones

Milestones are significant markers that conclude a journey. Arriving at a milestone or fulfilling a milestone stimulated several participants to make the move into a CEO/COO role. Participant BH was a seasoned CNE at the local and corporate level who was contemplating retirement. She described the movement to the COO role as a natural progression, and one that she desired to experience before retiring, "I knew I probably had another five to seven years that I wanted to work and I really wanted to have an opportunity for that kind of a role (COO). I wanted to experience that role during my career."

Participant SO had experience as a CNE in a large hospital before entering the world of consulting. After working for a large consulting firm and dealing with the CEOs/COOS in client organizations for three years, she evaluated her own skills, talents, and abilities and determined that she could do the job of COO. She had enough experience and confidence to take on a larger scope of leadership and move into the COO role.

> "Stepping out of a hospital base to management and then consulting, actually solidified in my mind that I had probably a stronger interest in

running, directing, managing, and leading a business than leading a professional discipline."

Disappointments

Participant TS came up through the ranks of nursing and was highly committed to the mission and vision or the organization. She had successfully traversed from staff nurse to nurse manager to director and finally to CNE. Her movement to the COO position was driven by disappointment in the leadership of the organization, specifically the COO. She described the COO as a very talented and kind man but he was not people centric and did not have the ability to get work done through others or drive strategy forward. TS had a vision that she saw what needed to be accomplished in order for the organization to thrive. She knew she could do it. "I just had come to the realization that I was just going to have to change roles within the organization in order to be able to achieve the type of change that I was looking for."

Other Motivators – The Right Fit

The participants that did not have a clearly defined moment of clarity or an epiphany that spoke of a general readiness to progress, a sense of confidence to move forward and seek leadership at the CEO/COO level. Some of the participants expressed readiness for movement in terms of "fit" – the CEO or COO position now seemed to fit their skills, talents and abilities. It was clear in the data, first doubts stimulated the participants to make the move to explore the CEO/COO position.

Stage 2 – Seeking and Weighing Alternatives

Once an individual makes a decision to change roles, doubts begin to take center stage. Individuals begin seeking out and weighing possible alternatives. The alternatives considered are shaped by what is desired and constrained by what the individual sees as feasible. Ebaugh (1988) found that the process of seeking alternatives often took place in a sporadic and inconsistent fashion over a period of years until pressure mounted or events occurred that altered the

perceived advantage of staying in the current position. Nearly all participants articulated a developmental approach to their leadership careers and demonstrated interest in expanding their scope of control while in the CNE role. Most participants had "toyed" with the idea of being a CEO or COO. It is interesting to note that eight (8) participants had clear career trajectories to become CEOs and COOs. Three (3) perceived that their role change was a match of serendipity and opportunity. The remaining four (4) felt that they had no choice…the decision was thrust upon them if the organization was to survive. All of the participants had the educational backgrounds and necessary experience to be upwardly mobile.

The participants who had clear career trajectories gave evidence of seeking and weighing alternatives. Participant RA, a seasoned CNE and former consultant continually sought out experiences to build her resume, to fill the gaps in her experience. When in a nursing role she worked closely with administrators of non-clinical areas to learn more about their area of responsibility and how they were managed. She strategically looked for positions that would facilitate her movement into a COO role. Other participants explored opportunities in academe versus service. Participant DD who had two master's degrees (one in nursing, one in business) explored several options including the pursuit of doctoral education and advancement into a CEO position. She believed the best use of her gifts and skills (if she really wanted to impact the patient experience) was to become a CEO. "The two options for me for career development were to get a Ph.D. in nursing and become a nurse researcher or become a CEO. And I felt that my gifts were more in-line with being a CEO."

Those who perceived the movement into a CEO/COO role as serendipity demonstrated a pattern of movement to organizations and positions that attracted them, seeking and weighing alternatives in a more intuitive fashion. Those participants who felt that the CEO/COO role was thrust upon them stated that they had willfully accepted the role in the best interest of the organization but had no alternative other than to accept if the organization was to survive and

even thrive. Participant KV who progressed through the ranks at a very young age explains the circumstances that lead to her movement into the CEO position.

> "I think because I was there and nobody else was, and because I knew it was not the right time to go out and recruit…I accepted the position. I didn't think I would stay a long time but I knew there was going to be a tough period of time, a stabilizing period of time that I could handle and then we could go out and recruit somebody else."

Stage 3 – The Turning Point

Even with solid, viable alternatives at hand, Ebaugh (1988) found that it took a final push to trigger the explicit act of leaving. He described the turning point as a focused awareness that old lines of business are complete, or have failed, been disrupted or the role is no longer personally satisfying. Much like first doubts, the turning point is often precipitated by an external change, milestone, impending event, or internal change. The turning point usually culminates in an external expression of the intent to leave the current role, typically a letter of resignation, transfer or acceptance of another position. Once the external expression of intent to leave is made a host of emotions typically ensue from relief over the decision, to guilt over leaving role obligations and ongoing ties with members of the role set.

Ebaugh (1988) posed that the turning point serves three functions. First, the turning point becomes the opportunity to announce one's decision to exit. Second, the turning point helps to reduce any cognitive dissonance that may be created by complex package of costs and benefits that each role represents. Third, the turning point facilitates mobilization of resources necessary to carry a role occupant through the transition.

Participants who strategically chose to move into a CEO/COO role explored possibilities through recruitment agencies and aggressively worked their professional networks and used their professional organizations to find their new roles. These participants were willing to leave their organizations to achieve their career objectives. The turning point for these participants typically came when circumstances in their current organization were no longer satisfying, a desirable CEO/COO role at another organization was available and the fit was right. After

the new CEO/COO position was confirmed, these participants typically announced their intent to leave their current role.

Participants who viewed the move into a CEO/COO as part opportunity and part serendipity were open to whatever the next steps in their careers might bring. Most expressed the desire to use their talents to improve patient care, whatever form that may take. This group of participants essentially "laid in wait" until there was a leadership change or restructuring effort. Then, realizing their potential, they seized the opportunities at hand. Once a decision to accept the position was made, an announcement followed shortly thereafter. Participants that felt they had no choice but to accept the CEO/COO position all moved up within their system or hospital. The turning point for these individuals came when executive leader of the organization or governance encouraged acceptance of the vacant CEO/COO role and the potential role occupant perceived there was no other choice.

It is interesting to note that each of the above groups faced different challenges in role transition based on whether they moved up in their existing organization or moved into the CEO/COO role in a new organization. The challenges of transition and making the CNE role an ex-role will be discussed in the next section.

Stage 4 – Creating an Ex-role

Physical role exit does not complete the exit process. Those who exit roles must come to grips with their prior role, what that role meant to them, and how much of the prior role and/or role characteristics they will retain. Ebaugh (1988) poses that this is a time of great introspection, a time when one must look at the tension between one's past, present and future roles. Those who exit roles must now determine how they should present themselves to others – should they play up or down their previous role? To be an "ex" is different from never having been a member of a particular group or role. How willing an individual is to retain or shed aspects of their prior roles depends on the socially desirability of the role.

Several factors affect ease of creating the ex-role: situational factors such as magnitude of the transition and visibility of the role; and individual factors such as role identification, sentimentality, nostalgia, and coping resources. Ashforth (2001) identified these factors as moderating the connection between the turning point and formation of an ex-role. The factors listed above posed the largest challenges to the participants in this study when transitioning from the CNE role into CEO/COO role. Details of these challenges that are borne out in the data are discussed in the section that follows.

Challenges of Creating an Ex-role

Magnitude of Transition

High magnitude transitions (for example a shift from temporary secretary to a registered nurse) are more difficult to bridge because the gap between the old and the new roles are wide and deep. Lower magnitude transitions, for example from CNE to CEO/COO (executive level to executive level transition) in theory should be less difficult to accomplish because they are likely to maintain valued features of the old role (executive/operational oversight) and contacts with the old role set (if transition is made in the same organization). One issue with low magnitude transitions is difficulty distancing oneself from undesired aspects of the former role. This seemed particularly challenging for the nurse executives that participated in this study. If the participants in this study were perceived by their role set as a nurse who is as an executive, a leader centered only on nursing, or a nurse who is "soft" in the business aspects of healthcare delivery – the transition was viewed as being difficult with additional barriers to overcome. The ease or difficulty of role transition role from CNE to CEO/COO depended not only on the perceptions of the participant making the move, but also how the role set perceived the participant in their new role.

All of the participants had experience working with CEOs and COOs and all felt that they understood the scope, depth and purpose of the CEO/COO role prior to transitioning into the new position. Eight of the participants did not have large issues with the magnitude of the transition…they had clear concepts of

what the new role would require and the expectations for their performance. The other seven participants expressed some challenges with the magnitude of the change or transition – the scope of the new role was deeper or broader or had more interface with the medical staff than they had anticipated. Participant RD advanced internally from CNE to COO in a small rural hospital. It was the first time the organization had a COO. The role was essentially designed for the CNE. Despite the internal movement, there were still surprises and challenges with the magnitude of the transition in both breadth and depth:

> "I thought the position was about running hospital operations. I thought it would be about clinical quality…our journey to clinical excellence. My responsibilities as COO were to the system, include a long term acute care facility, hospice and community clinics. It was far more eclectic than I expected. It was more about Board and medical staff issues and less about clinical quality and excellence."

Several participants articulated that the role was much broader than anticipated; BH was a CNE at both the local and corporate level before moving into a COO role. The newly appointed COO described the new role as "not just maintaining operations but more – it was about growing operations." The end result…a scope of responsibility much larger than anticipated. Participant JJ was a seasoned CNE and became COO as a result of structural reorganization. It was assumed that the new scope of responsibility would be centered around clinical operations. With that assumption, JJ felt confident moving into the role of COO. During the transition into the new role JJ realized that many non-clinical areas would be under her scope of service. Needless to say, the scope and depth of the transition was much greater than JJ had anticipated.

> "I thought I would get stuff that was clinical but I didn't. I had departments that I knew absolutely nothing about – construction, facilities, protective services, etc. It was a huge surprise. Most people believed that what I was given was so screwed up…I would fail."

Another participant BL had twice been a CNE, clearly understood the role of COO, but admitted that depth and scope of the COO role was not realized until it was experienced. "The weight of accountability was much larger all of a sudden – all of operations, not just the clinical operations reported to me."

Nearly all of the participants who made the move to the CEO role saw the magnitude of transition in a different light. The magnitude of their transition was broader in scope reaching beyond the walls of the hospital and into the community where their organizational delivered care, treatment and services. These newly appointed CEOs moved from an internal focus on organizational operations to an external focus on the community, the needs of the community, and the market in which they were delivering care. BR, a first time CEO, articulated it best.

> "Since I have become CEO I have realized that it's not only establishing the vision and working to inspire and lead the organization forward, but it's also really to on a regular basis be out into the community to understand the community needs and be a face in the community and make sure that the work that we're doing matches the community need. I think the role is more about relationships than I understood it to be. It's incumbent upon CEOs not only to look strategically forward and work with the board and physician leadership and the community to advance the mission of the organization and serving that community but it's also to sty in tune with the relationships to make sure we're continuing to meet community needs."

BR readily admits:

> "I don't think I really understood the accountability and connectedness that was necessary in the community. The other thing that I didn't mention is the accountability the CEO has to be connected with all the political people that are involved at the local, state and national level. I spend a lot of time trying to influence health care and perception of what healthcare is about."

This sentiment about not understanding the political ramifications of the CEO was echoed by other participants, most notably one CEO who worked for a publicly-owned hospital. Participant RS stated the nature of the CEO role was pretty much what was anticipated with one exception – the politics involved in running a city-owned organization:

> "Because this was a public hospital supported by the usual payers (Medicare and Medicaid) and a big supplement from the city – the CEO had a dotted line to the mayor. And the politics, I mean I knew about politics, but the extent of this was just mind boggling. That was my biggest learning curve. I thought I could be more involved in operations, but with this level of political involvement…I just couldn't be."

Although various magnitudes of transition were experienced, there were few surprises, none that stopped or greatly impeded the transition to CEO/COO. All the participants were able to bridge the magnitude of their gaps in role performance relying heavily on what they knew best – the core business of patient care delivery. The magnitude of transition was a challenge for the participants but did not have a significant effect on their ability to make the CNE role an ex-role.

Visibility of Role

Visibility of CNE role did pose challenges for the participants when transitioning to the CEO/COO role. Ebaugh (1988) stated that the more visible the prior role, the more susceptible one is to the judgments and intrusions of others. Ebaugh found that people in highly visible roles had a particularly hard time extricating themselves from their former roles. That proved true with the participants in this study who were highly visible in their previous roles CNEs and found they were under increased scrutiny in their new role CEO/COO. Nearly every participant noted that they were under the microscope with the staff – the nursing staff looking to see if they would maintain their allegiance to nursing, and the non-nursing staff to see if they would favor nursing. This focus on the new CEO/COO (former CNE) led to conflicting feelings among the participants and a heightened awareness of the need to be objective and unbiased, especially in such a visible role.

Having been highly visible in the CNE, some participants had heightened sensitivity to continued visibility with caution not to compete with the new CNE and their needs and desires for visibility. Participant RA best explained the additional scrutiny that was placed on the CNE turned CEO/COO a as delicate balance, “You must keep visible as the COO but must be careful not to usurp the new CNEs authority.”

Several participants commented that an integral part of the CNE role is visibility on the frontline, rounding on the nursing units and clinical staff at the

point of care. Visibility is so deeply engrained in the role of CNE that in the Magnet Recognition Program (American Nurses Credentialing Center, 2008) the Transformational Leadership Standard specifically spells out that the CNE is visible, accessible, and communicates effectively. As a result of such visibility, nurses throughout the organization perceive that the voices are heard, input valued and their practice is supported. This visibility does create tension for both the new CEO/COO and the nursing staff once the transition occurs. For those participants who made the transition from CNE to CEO/COO in the same institution, the staff expressed initial concerns that their voices might not be heard with CNE now the CEO/COO. Participant BH who moved from a corporate CNE role to an organizational level COO stated that one of the most difficult pieces of transition was stepping back, letting go of nursing and letting another be the visible head of nursing. Participant MM echoed the difficulty of letting go of nursing and stated with the transition into the COO role that all eyes were focused upon her – what would she do as COO. To facilitate transition into the COO role, participant SO moved the focus of her rounding and visibility from the nursing units to the non-nursing, non-clinical areas in a purposeful move to shed her image as the CNE and deal with the operational issues in the non-nursing departments.

Balance was another concept that related directly to visibility. Several participants discussed the need to change their behavior and balance the scope of visibility in clinical and non-clinical areas so that they might be perceived differently by their new role set. As revealed above, visibility in the role of CNE did pose some challenges while transitioning to CEO/COO role. Although challenging, visibility was not the largest barrier these CNEs faced when attempting to make the CNE role an ex-role. By-in-large the most significant barrier faced by the CNEs turned CEOs/COOs was dealing with their identity as a nurse, contributor to the profession of nursing and the tensions felt when attempting to make the CNE role, an ex-role. Role identity is addressed in the next section of this paper.

Role Identification

Role identification may act as a brake on role exit and may ease or impair the creation of an ex-role depending on the specificity of the identity (Ashforth, 2001). The more specific an identity, the harder it is for one to generalize one's identification to another social group or role. There is difficulty exiting a role with which one has strong identification. Role exits where a strong identification exists tend to be traumatic. In a sense, one leaves part of oneself behind. The stronger one's identification with the role, the stronger the grip on the past and the harder it is to let go of the former role. The participants in this study had such strong identities as nurses it made transition to their new roles as CEOs/COOs more difficult and created role conflict and tension.

Often, it is not only the role occupant who has difficulty letting go of a previous role, the occupant's role set also has difficulty letting go. This was the case with the participants in this study. The participants reported that their role sets had difficulty letting go of their perceptions and identification of themselves as nurses and nurse executives – making the job of role exit even more challenging. Just when the participants thought they had their arms around their new role and new identity, their role set posed an additional challenge and a harsh reality set in – role transition was not a solo activity.

The key variable in role transition is role exit which depends on successful change in role identity. The task at hand for the CNEs making the role transition was to shift from an internal and external identity as a nurse CEO/COO to an internal and external identity that the CEO/COO is prepared as a nurse or grounded in nursing. A fine line separates those two concepts but a critical point to distinguish and one that is pivotal to successful transition from CNE to CEO/COO. Both of these challenges to role exit are discussed in the following sections.

Role Identification – Participant Perspective

Role identification was the "deal breaker," the true challenge for the nurse executives when transitioning from CNE to CEO/COO. Every participant that

made the transition from CNE to CEO/COO was keenly aware that their preparation, education and experience as a nurse leader and executive was a facilitator to their achievement of and movement into CEO/COO role. Participant JW was a long standing COO and expressed the positive aspects that nursing experience brings to the role of CEO/COO "nursing brings an understanding of how the system works, how teams work, and nurses have the strongest sense of relationship building." JW viewed nursing as the foundation to executive level leadership. Another participant BU believed that being a nurse executive facilitated strong, efficient and effective decision-making because a former CNE understands the downstream effect of decisions on the patients and staff.

The strong assets that come with being a CNE also hinder the ability to immediately let go of the identity of being a nurse – the chief nurse and the chief patient advocate. Two key variables merit discussion regarding identity: internal conflict that develops during the transition from CNE to CEO/COO and conflict that develops within the role set for the CNE turned CEO/COO.

Most participants experienced some degree of internal conflict and tension when they perceived that they were giving up nursing. Many expressed difficulty with trusting the direction of nursing to someone else – even when they selected their predecessor. Every participant had a strong identity as a nurse and a nurse leader. Participants stated that they felt a sense of commitment and obligation to the patients and staff. That sense of commitment and obligation were so strong, it nearly overpowered their ability to see and perceive themselves as organizational leaders. Participant BH expressed it best, "It's hard to step back on the nursing piece and trust others with your baby. Probably the most difficult part of transition was letting others do nursing."

Participant DD had twice been a CNE and was well known in the geographic region as an influential nursing leader. Most recently she transitioned to the CEO role and shared her thoughts on the transition. "The toughest part of transition was getting positioned as the CEO after being identified as a CNE, they never taught you how to deal with that in school."

Participant MM was a seasoned leader with multiple executive level transitions under her belt, having moved from CNE to COO and then to CEO. She later transitioned into a corporate CEO position. She expressed that no matter what executive role she occupied, her strong identity as a nurse and strong sense of patient advocacy remained and was both a positive and negative force in role transition. The positive force stemmed from her grassroots level of understanding the core business of patient care, while the negative force or barrier to fully entering and executing her new role because exiting the role of nurse was nearly impossible. She expressed the challenge of role exit best as "once a nurse, always a nurse." Using many different words and means of expression, the core theme remained the same – identity as a nurse was a strong and powerful force, one that facilitated their success in the CEO/COO role but challenged their ability to fully exit the CNE role. The data were clear. Even in the CEO position, which is externally and strategically focused, patient advocacy and the quality of patient care remained a central focus and influenced their ability to exit the CNE role, bridge the transition to their new role, and fully enter the CEO/COO role.

Role Identification – Role Set Perspective

Participants reported some type of push-back on their appointment as CEO/COO from other clinical disciplines, physicians, administrators, and even nurses. Most of the pushback was related to their identification as nurse and preconceived notions about how a nurse would enact the role of CEO/COO. Much of the pushback and need to challenge the new leader were related to concerns of a nurse having a limited focus on hospital operations, limited business skills, a pre-set biased to nursing and/or clinical operations.

Participant JJ who had twice experienced role transition from CNE to COO in different organizations presented a global picture of issues with identity as a nurse. "There are some groups that view a nurse as just being a nurse – you can't add, subtract, etc. So, there is a group that sees a nurse in the COO position as not very strong."

JW was the CEO of a specialty hospital in an academic medical center, she echoed the sentiment of JJ:

> "When I was in the rehabilitation setting the pushback came from the physical and occupation therapists, like "oh my god, we are going to have a nurse overseeing us." And so you kind of have to earn your stripes…that you can stay up with them."

Several participants who transitioned within their organizations noted the greatest pushback came from other members of the executive team who applied for the CEO/COO position and were not selected. These participants noted that their former peers did not acknowledge their new identity and continued to treat their relationship as a peer-to-peer relationship rather than a subordinate-to-supervisor relationship.

Physicians also posed an interesting challenge in accepting the new identity of the former CNE. Most participants reflected that their physician partners welcomed having a "clinical type" at the helm – acknowledging the benefit of having a leader who understood the core business of the organization. Several participants mentioned if the physicians supported the former CNE in quest of the CEO/COO role, a "quid pro quo" was expected that the "nurse" would grant their every wish and desire. Conflict also arose with the physicians as there tended to be rather lose boundaries between the role of the COO and the role of the vice president of medical affairs – role confusion and identity issues typically ensued.

Sentimentality, Nostalgia and Coping Resources

There are three (3) other factors that can influence role transition – Sentimentality, Nostaligia and Coping Resources. Sentimentality is the tendency to maintain emotional ties to one's past. Nostalgia is longing for one's fondly remembered past. Coping resources refers to psychological, social and organizational resources available to help with the transition. None of the participants in this study expressed thoughts, ideas, or opinions related to sentimentality, nostalgia, or coping resources that would lead the researcher to believe these were factors in role transition from CNE to CEO/COO.

Summary

It is necessary to exit from one role to successfully transition into another role. In this study, it was necessary for the participants to exit their roles as CNEs and enter their new roles as CEOs/COOs. There are four stages to role exit that must be traversed for successful transition into a new role – first doubts, seeking and weighing alternatives, the turning point, and creating an ex-role. The participants in this study clearly gave evidence to successfully moving through the first three stages of role exit with little stress or strain. In fact, for most it seemed like a natural profession. The fourth stage, creating an ex-role was the basic social-psychological problem that the CNEs had to address during their transition to the CEO/COO role.

Several factors moderate a role occupant's ability to create an ex-role – magnitude of the transition, visibility of the role or transition, role identification, sentimentality and nostalgia, and coping resources (Ashforth, 2001). Of these factors, two posed challenges to the participants during their transition – visability of the role and role identity. The largest barrier these CNEs faced when transitioning to the CEO/COO was letting go of their persona as a nurse and a member of the nursing profession to embrace their new persona as a CEO/COO. This level of disengagement (psychological and physical withdrawal) from the CNE role and context) is necessary to be able to enter a new role (Ebaugh, 1988).

Creating an ex-role means coming to terms with role exit. The creation of an ex-role and the process of role exit are intimately connected with process of role entry (Ashforth, 2001). Chapter Five will describe how the participants derived meaning from their experiences as CNEs that enabled them to develop strategies to let go of the CNE role and enter into the role of CEO/COO.

Chapter V

Results:
The Basic Social-Psychological Process of Reframing Identity

The goal for a research study using grounded theory is to discover the core variable as it resolves the main concern or problem of the participants. Essentially, there are two quests for discovery. The first quest is the discovery of the main social-psychological problem the participants are trying to address. Once the problem is revealed through the data, the quest moves to discovery of the basic social-psychological process that explains how the participants continually resolve their main concern or problem (Glaser, 1998). Chapter 4 presented the first discovery of this grounded study – the basic social-psychological problem the participants had with creating an ex-role (especially their identity as a nurse) to take on their new persona as a CEO or COO. Chapter 5 presents the second discovery – the basic social-psychological process that was used by participants to transition into their new role as CEO or COO.

Reframing Identity

Data analysis and interpretation revealed that the basic social-psychological processes used by the participants to successfully create an ex-role, fully exit their role as CNE and enter into their new role as CEO/COO was a process of reframing their identity as nurse. This process of reframing was essentially a journey, one that markedly changed the participant's professional sense of self and the perceptions of their role set regarding their identity as a nurse and a CEO/COO. In essence, the participants and their role sets moved from seeing and perceiving the participant as a nurse who is a CEO/COO (nurse

first, CEO/COO second) to a CEO/COO who is a nurse (CEO/COO first, nurse by educational preparation and experience second).

The data in this study revealed that reframing identity from a nurse CEO to a CEO who has the educational background and experience as nurse was a process that had three stages – creating the ex-role, learning the new role, and embracing the reframed identity. Each stage involved a series of activities that created a continuum of growth and development in the new CEO/COO role, from disengagement as the CNE through self-identification as a CEO/COO. In the first stage, the participants created the ex-role by establishing distance with their previous role and relationships, letting go of need to control nursing operations, and creating physical and mental space for the new CNE. In most cases the participant facilitated the CNE's entry into their new position, guiding them through orientation. In the second stage, the participants sought to learn their new role by increasing their visibility as the CEO/COO, changing the nature of existing relationships or building new relationships, and developing new networks. The final stage of reframing identity involved psychological acceptance of the CEO/COO role as demonstrated by strategic movement forward in the new role, creating their vision of the organization's future, building teams of leaders to achieve the vision, and refining their ability to balance their leadership between clinical, operational, and strategic initiatives. The three (3) stages of reframing identity are presented below.

Creating the Ex-Role

Establishing Distance and Letting Go

Role exit for the participants began when they had first doubts about their role as CNE, continued as they sought alternative roles as CEO/COO, and reached a turning point when they accepted the new position as CEO/COO. The fourth and final stage of role exit, creating the ex-role, posed a significant barrier to successful transition for nearly every participant. Upon initial movement into the CEO/COO role, participants struggled with their identity as a nurse. What does this new role mean to my identity as a nurse? How can I let go of nursing

operations and shift to system-wide operations and strategy? How can I maintain those parts of my nursing identity that make me a strong CEO/COO? Is it true…once a nurse, always a nurse? These were the struggles of the participants as they moved into their new roles as CEOs and COOs.

Every participant intuitively understood that the first step of letting go of nursing and clinical operations and their identity as the CNE/vice president of patient care was to draw a line in the sand between old role as CNE/vice president of patient care and their new role as CEO/COO. But what is the most effective way a drawing the line and holding to it? The first strategy that most participants used to create their ex-role was to establish physical and/or psychological distance between the CNE/vice president of patient roles and the CEO/COO role. Most participants realized that if they were to truly exit from the CNE role, any public appearances of them in the CNE role or representing nursing needed to cease immediately. Most of the participants drew that hard line in the sand and stated that once they left the CNE role, they never represented nor spoke for nursing again at unit, department, and organizational levels. That strategy was as much a matter of discipline, a mental prompt to change their identification as it was to create a mental space for their successor. Participant TS grew up in her healthcare system, transcending from a new graduate staff nurse to the CNE. When she accepted the COO position in her organization, she knew what needed to be done to accomplish her transition. After all, for twenty years the organization had perceived her as nurse leader.

> "My promotion to COO was announced on Thursday and when I came to work on Monday I didn't go to nursing meetings anymore. I was very clear about what meetings I would and would not attend. Because, I knew if I didn't transition quickly I would never transition."

Participant SO was a seasoned CNE who had twice transitioned into the COO role. She recalled her first transition from CNE to COO and discussed the vigilance it required to distance her from nursing.

> "The other strategy that I did very consciously was that I would make sure that whatever meetings I was in I would only comment on things that were

generic to the business operations. I would not comment on what it was going to do to the nurses or how the nurses would react to it."

How well the participants were able to create distance and step back from nursing operations was often related to their ability to trust that the new CNE would continue to support the growth and development of nursing at the organization. Participant JW was a CEO who reflected on several of her transitions from vice president of clinical/patient services to the CEO position.

> "I think when you first get a new job there is a tendency to want to go back to what's comfortable and where you were successful and you've really kind of put yourself out on a limb and you're doing different things. You're stretching yourself and you don't know all the answers. So, I think that's a very common desire to want to go back. But I think if you really want to be successful you've got to kind of have an internal discussion with yourself that you're got to trust the people in those roles. It doesn't mean you don't question, but you've got to pull back from that. And so, I sort of had this internal dialogue with myself going on. I could go down to the nursing office and see how it's going but I'm going to wait until they let me know or I'm going to wait until I have my meeting tomorrow and hear what's going on."

Another participant BU echoed similar thoughts regarding having the internal discussion with herself about letting go and trusting in the new CNE. She affirmed the level of vigilance that was required to focus on the organization versus focus on nursing and the temptation to return to the comfortable past.

> "I think the key thing is that you have to have people working for you that you trust and then you have to delegate to them and let them do their jobs. Because I think it's very easy to concentrate on that which you know best and clearly a CNE coming into a COO role knows nursing better than she knows anything else but when you walk into any executive role everybody watches everything that you do. Every decision that you make, every time you nod your head and I don't think that's paranoia, you know for the first few months you're there and until they get to know you and your style and what you believe in and what you really value and if that's the same as what you say you value, people watch you and the signals that you send. So you have to be very on your game, especially for the first few months that you're working with people. So that you don't look like you're favoring one or the other but at the same time I don't think that I would ever say that I would separate myself from nursing because you know we have a saying in Texas dance with the one that brung you."

One participant MM described the struggles she had with leaving nursing and creating distance as the basic struggle of giving up control and finally letting go. This was something that she learned to do with time and maturity in her new role as CEO.

> "And what I had to learn was being more comfortable in letting go of needing to know all of the detail because I couldn't possibly know it all. To do that I had to make sure that I hired good people and that I delegated appropriately and that I held people accountable. And I trusted them and I would then just watch for indicators, I didn't have to know the whole ball of wax but that was a real important lesson for me."

Three of the participants who transitioned into COO roles were aided in their transitions by CEOs who told them to "drop the nursing piece," "leave nursing at the door," and "shed the nursing bit." These CEOs told the newly appointed COOs that they had new roles that required new behaviors. The general sentiment expressed by these CEOs to the new COOs was that it is not just about nursing anymore. Expectations now were that they had to think and behave to the common good of the entire organization. Participant MM remembers her very strong relationship with the CEO when she was the CNE. She recalled the behaviors he expected of her in the CNE role. When he promoted her to COO, she remembers being rather stunned when he told her to "drop the nursing piece."

> "One of the things that I learned early on and which may raise the hair on some nurses' necks was I was told drop the nurse piece, you're not in this position as a CNO/COO, you're not here as the advocate for nursing. That facilitated my movement forwarded as a COO."

Knowing on an intellectual level that one needs to distance oneself from the previous role as CNE and leave nursing operations behind is easy. Matching one's behavior to that intent is difficult. Most participants reported a strong urge to meddle in the business of nursing and return to familiar moorings. The urge was strongest in the early period of transition when the participants were not certain about or confident in their abilities to execute the new role as CEO/COO. Most expressed that and returning to their point of confidence as the CNE

seemed desirable. Various strategies were used to block this urge to meddle in nursing operations including introspection, heightened awareness of behavior, and diversion. RA was an experienced CNE who transitioned into the COO role. She shared her struggles with creating distance and the questions she asked herself to avoid meddling in operations.

> "I found that what I wanted to do was to meddle in operations and when that's not what you need to do. Meaning you've got a CNO that does that work, you've got an associate in those clinical departments, you've got a facilities administrator, you have to ask for the higher level operational questions and you have to be responsible and accountable to have them work back and forth among themselves and be a catalyst for that kind of collaboration. As opposed to being the collaborator from department to department, etc. And that's different, it's very different."

Participant KV was a young CNE who transcended very quickly to the CEO position due to organizational restructuring. She also expressed the desire to return to the familiar but eventually reached a point where she knew the best course forward was to create distance and stop meddling in nursing and hospital operations.

> "One of the role transition issues in going from CNO to CEO is that you are so used to being operational that it is very hard to give up that day-to-day viewpoint of the organization. I think that, particularly early on, you tend to dabble in operations as well as take on a new role and people are a little bit confused about that…it's hard to let go and essentially you've hired your replacement. So you have a choice of what you are going to do with your time, and if you dabble too much in the day-to-day, you don't get your other job done."

Participants knew their desire to meddle in nursing operations was strong and immediately began to invest their time, energy, and effort in the non-nursing and non-clinical areas, essentially creating a diversion. Participant SO was heavily invested in quality and performance improvement. When she transitioned from CNE to COO and felt the urge to meddle in operations, she refocused her energy.

> "I consciously have been a big proponent of understanding work processes and work flow. So I actually looked for other areas where I could focus my direct attention and add value to the organization. And I

> did that around the very un-sexy kinds of things of really going to school and learning logistics and material management and launching a major project that I owned around that. And then a second one in IT, and the third area I focused my attention on was just the generic quality improvement and understanding physician scorecards and things of that sort. So I created for myself consciously, with the guidance of the CEO and these other folks that I worked with, a portfolio of things that I could be visibly accountable for in the organization, none of which had a direct line of sight into the nursing department."

Participant JJ had her defining moment as COO when she looked back and realized that nursing had "special privileges." Other departments worked in far less favorable conditions with less connection to purpose.

> "I had placed a significant emphasis on the support service group because of the plight that they were in and at times could be, not detriment, but I kind of shortchanged the nursing side, until I brought them all together and then they were treated as equals, that was interesting."

Another participant RS was brought into the organization as a CEO to create a turnaround. She had experience outside of the system as a CNE and COO. New to the organization and the CEO position she made the decision to create the ultimate distance and stay completely out of nursing. In retrospect, she questions that decision.

> "I made it my business to completely stay out of nursing except for you know getting a report on the usual things, you know the financial ends, the staffing ends, the quality stuff. I chaired basically the quality committee so that was my way of making sure patient safety and care were done. And I co-chaired it with my CME. I did real hands off nursing and I'm not so sure that was the best thing. It took nursing much, much longer to turn around than it did any other department area. So, I don't know that I would, you know it's a hard thing to say, I think every organization is different."

It was clear through the data, creating distance from nursing and the CNE role was the first step to creating an ex-role. As participants established a distance from nursing, a space opened that allowed a new professional identity to emerge.

Creating space for the new CNE, both mentally and physically, was a strategy that facilitated transition into the CEO/COO role. Participants expressed

a heightened awareness of the effect of their own presence in meetings and forums with the new CNE and were very careful not overshadow them. Nearly every participant expressed their desires for the new CNE to put his/her fingerprints on the role, developing their own style and approach to the CNE role and nursing operations.

> "I was consciously trying to do was shed the CNE role so that there was role distinction between the person who now reported to me (the new CNE) and myself. I was trying to not fall back into doing that job again even though you knew how to do it. I was trying to let somebody put their own fingerprints on the role and I was trying to focus on running the business and producing results across cost, quality and service."

Some had help in creating distance, often a mentor or colleague who would remind them of their new found role. BH stated:

> "So in his own style he's really been a great mentor. He definitely helped with the transition and he would frequently call to question me about remember you are in a COO role now you are no longer CNE, you know, we need to look at things differently, we need to be aware, so he really helped to keep me focused."

Establishing distance between clinical and operational responsibilities of nursing and the role of the CNE was critical to creating an ex-role. It was this phase of transition that allowed the former CNEs turned CEO/COO to start seeing themselves in a different light and begin to see a broader perspective of the organization and develop a vision for the organization, not just nursing. They began to come to terms with the fact that their primary focus was now on the organization and not just on the department of nursing. Coming to grips with their ex-role, successfully letting go of nursing operations and embracing organizational strategy and operations facilitated a boost in the participant's confidence. This new found confidence allowed them to move forward and truly begin to learn and grow in their new roles as CEOs and COOs.

Learning the New Role

Visibility in the New Role

In Chapter 4 the researcher reported that the CNEs had highly visible roles in their organizations. Because of that visibility, the participants had a particularly hard time extricating themselves from their former roles. If the participants advanced from CNE to CEO/COO in the same organization, the same visibility that gave them strength as a CNE posed a strong barrier to role transition as staff continued to see the participant as the CNE rather than CEO or COO. The concept of rounding on units and in departments is second nature to nursing leaderships and participants believed that rounding was the single best strategy to get to know staff and key or core operational processes. Participants wanted to be visible and wanted to round but in a new light, in a new way, and in a persona that would promote their role transition to CEO/COO.

Tension existed as the participants believed in being visible to the front line staff, understanding the core work processes from the staff perspective but struggled with how they could accomplish this task without stepping on the toes of the new CNE and potentially reinforcing the staffs' perceptions of them as a nursing leader. Most of the participants began to frame their orientation to the new areas of responsibility through the activity of rounding. Nearly all of the participants used orientation to their new areas of responsibility as a chance to experience life on front lines and be seen in their new role as CEO or COO. Nearly every participant had an orchestrated and coordinated plan for getting to know their new areas of responsibility with specific strategies for being seen as the CEO/COO. Often the participants used their knowledge of clinical operations to create a connection to patients and to create sense of purpose for the work that the staff were doing in non-clinical areas. Participant RA articulated this when she was asked what helped her transition into her new role as COO.

> "What helped me? Well, it's the action of going around. And what that means is that you make as many rounds in different departments and go around the building as much as you can. And everybody becomes your best friend. I mean I know the names of the people in environmental

> services and housekeeping and um dietary and the clinical kitchen. I go in and see how they put trays together for patients etc, etc. So that I was not focusing just in on you know nursing. But the other thing I did in doing those things was to compliment them and tie it back to why they were there. For example, if they were setting up a patient tray that was a special menu, I'd talk about if that was a cardiac menu and that the patient up there has special foods so that heart works better. And using their terminology, their words but connecting why they were there. And the other thing that I did was I would always take the non-clinical managers on rounds with me and I would take them to the clinical areas and I would get clinical managers to the other non-clinical areas. I was really visible throughout and people knew me and knew that I was there for them. And I never had to say I'm here because I'm a nurse or because of nursing. I am here and we are all here because of the patients and that is why this place is open."

Visibility was a major strategy that JJ used for orientation to her new role as COO. She had been in the organization for nearly fifteen years in various nursing roles (including the CNE role) before her transition into the COO position. She had a profoundly moving experience when she used rounding to become oriented to her new areas of responsibility.

> "You know I think one thing that I learned that day when I got all of these departments, and mind you I'd been at that hospital for 15 years, the first thing I did was go down into the departments. So I went into the kitchen, I went into environmental services and all these other areas and I had been there before but I never really saw it, I had never really saw the environment that we as an institution had placed these individuals in which were areas that I wouldn't work, neither would you, so I went back to my office absolutely ashamed and embarrassed that my office was beautiful compared to where they were. So, it was a very, very significant leveling experience and I realized that I had blinders on investing so much time in patient care and nursing for so many years really to the exclusion of other hospital departments. So, that was a very important moment I think in my baptism into this broader role and I don't forget to this day. The ability to recognize how certain departments and the hospital as a whole and the folks that make up those departments are treated in comparison to what your core focus has been, that I think has probably had the biggest impact on me and still does today."

Participant DD left the position of vice president of patient care in a large teaching setting to become the CEO of a large home-based healthcare operation. It was a very different setting, extremely different environment and

she still used rounding to orient herself to the core business. As an external candidate, DD found rounding to be an invaluable experience. She described it as follows:

> "I was going out to every team around the state and going on visits, giving out eggs and bathing patients and going with nurses and going with social workers, going spiritual care counselors. But what I also did was meet with billers in the billing department and with compliance. I actually went to every department that existed within the company so that I could understand from a very fundamental way how the organization was structured, what was working, what wasn't and what was keeping the organization from meeting its full potential. Because when you bathe a patient with a home health aide or you go on a visit with a nurse I mean, I could see the paperwork that she was struggling with and spending 50% of her time with the paperwork. I saw her open up the trunk and I saw the entire inventory that she had in her trunk because she didn't have the right bedpan or whatever."

The participants that transitioned into CEO/COO roles with an external component realized how critical visibility in their new roles was to the community and the future of their organization. These participants were used to being visible at the unit and departmental or organizational level as a CNE but did not have experience being visible as the CEO of the healthcare organization in their community. Visibility in their new roles also represented an internal and external shift – the participants were now seeing themselves as CEOs/COOs and consequently were being seen by others as the new CEO/COO. Participant DD made the big move from an acute care CNE to a home-based healthcare system CEO; she expressed the importance of visibility.

> "And so the amount of effort to get positioned as the CEO was endless. It all had to be planned and I went to everything. My husband and I went to every black-tie event in the southeastern and western regions just to be seen and get the organization out there. These regions represent our biggest markets. Because in big game hunting you have to go where the game is and you have to be seen."

Participant BR had been the CNE in a large corporate setting and transitioned into one of the local hospital's COO role. She was successful in the COO role and in several years when the CEO left the organization she assumed the role of CEO. She had an intimate view of the CEO from her COO seat but

never realized that visibility as the CEO outside of the organization was as critical as visibility inside the organization as COO.

> "Our hospital was jointly owned by two large corporations. Shortly after I became CEO the organization was bought out by one of the corporations and our transformation began. I knew in that first year that I really needed to get out and put a face on the newly formed entity. So, I spent a lot of time out meeting leadership in the community, getting to know the influential people, getting them to know who were and what we were about. And it has been a tremendous learning experience for me."

It was clear from the data visibility was a critical element in the participants' learning their new role. Visibility also facilitated the participants reframing their identity – being able to see themselves as CEOs/COOs and being seen by other key stakeholders as CEOs/COOs.

Becoming Multilingual

Becoming multilingual was a critical step in learning the new role of CEO or COO. Nearly every participant commented on the key or critical task of learning how to speak and understand the languages of governance, business and finance. Most participants felt fluent in the language of medicine and nursing; after all, it was their native language. Participants stated that it was not only necessary to understand these languages but also to be able to interpret and translate these languages for major stakeholder groups. Participants realized that in their roles as CEO/COO they would frequently be negotiating between clinical and non-clinical stakeholders, nursing and finance, finance and governance. They also realized if large-scale change efforts were to be successful, business and finance speak would need to be translated into clinical efficiency/effectiveness for the change effort to be successful.

Participant RA was clear – it was not only about learning the languages that she did not understand (for example reimbursement), but also about becoming an interpreter and translator for desperate groups of professionals that spoke very different languages.

> "I feel that you have to be a translator, you have to be able to take the nursing component of what we do, the patient care component of we do

> and translate it into language that hospital administrators understand. Today it's easier because the national environment is quality and safety but back then when I first started in those translations it was not. And that to me was one of the key skills to be able to learn and to be able to speak their language when it was the right time."

Participant SO left the world of consulting to take a COO position at a large academic medical center. She immediately recognized the need to become a linguist, to become comfortable and confident in speaking another language if she was to be successful in her new COO role.

> "There is a different language, the language of managing a corporation that is not the language of leading a clinical discipline. And it's something that you have to become comfortable with and comfortable speaking in that language and using words and jargon and terminology in a way that indicates that you actually understand the concept behind it. And it has to be practiced and it has to become like wearing a comfortable suit of clothes. Because if it's not it looks like you're simply uttering the words but you aren't really vested in the concepts. So, whether it's an internal rate of return or return on investment or asset activity or any of those concepts if you're not comfortable with the language it's going to feel, and it's going to appear to people that you're less confident, less sure of yourself and that you're going to be, I think, less perceived as being able to answer penetrating questions around those things."

Participant BU spoke about language in a more generic sense, language as a sense of understanding. She had strong passion and resolve about first knowing the language of your constituents and then helping them to understand your language.

> "I've always said to people you have to learn the language of the place you are then you can teach them your language. You have to talk in their language if you're going to get their attention and dialogue. You can't just walk in talking yours because they won't hear you. I think that's a skill that CNEs have to develop to be successful."

Participant DD echoed these thoughts.

> "There are all different kinds of languages, we're all wired differently, everybody perceives the world in different ways to really be effective as a CEO you may know what your particular language is, what your preference is for how you take in information and all those sorts of things but to be really skillful you need to learn how to speak other languages.

> You may not be fluent in them but you need to know that they exist and how to tap into those."

The data were clear that becoming multilingual was critical to the participants' successful transition into their CEO/COO roles. Speaking multiple languages helped the participants to seem themselves outside the role of a clinical administrator who speaks only the clinical language. Being able to speak the language of governance, business, and finance with confidence was critical to role in transition and reframing their identity.

Changing Relationships

A major driver of reframing professional identity was the ability and willingness of the participants to change the nature of existing professional relationships, develop new professional relationships and build new professional networks. Participants discussed the challenges and successes in changing the nature of these key or critical relationships with their role sets – the physicians, nurses, and the executive team with whom they worked. Role conflict frequently resulted as the nature of these professional relationships began to change. Role clarification and relationship building were the most common strategies used to resolve the conflict with their role sets. On rare occasions participants reported that role conflict could not be resolved and members of their role set (peers and subordinates) elected to leave their roles and/or the organization.

Nearly every participant who advanced within their healthcare system to become CEO or COO was challenged by their peer and subordinate groups to overcome a very narrow perception of their skills, talents, abilities and professional image as a nurse. One very seasoned COO noted that you are frequently viewed as "just being a nurse." Another participant JJ, a seasoned COO, stated that some of her role set viewed her as being "light" having been a CNE for fifteen years.

> "I think my challenges were um gaining the respect of a whole different set of individuals who had viewed me as light having been at the institution in the CNO role for 15 years prior to an extended engagement."

Participant TS was in the organization for her entire career as a nurse with her terminal nursing position as CNE. She now faced the challenge of differentiating her role as COO from the role of her peers.

> "I think the biggest challenge that existed was with my peers. You know, it was a transition for them too, they kind of had to warm up to the idea that I was moving from being a peer to a boss. The individual who actually competed for the job actually left the organization after not being selected for a promotion."

Participant BR moved from an external CNE position to a COO position and recently had moved internally to the CEO position. Executive level leadership at the organization had come to know her as the COO – the person responsible for operations. She openly discussed some internal role conflict as well as conflict with former peers.

> "It was interesting the only conflict that I might have felt and again this was more with myself is moving to a role where the people that I had been peers with are now reporting through me and to me. I had to move away and change the relationship, not in terms of respect and regard but that I was now in a position that I was accountable to help them to become the best they could be and have them learn and grow in their roles. And I asked them to help me learn and grow in my role. So it was just kind of changing the nature of the relationship."

Two participants who transitioned into COO roles cited strong role conflict with the chief financial officer (CFO). Stress between clinical or operational and financial roles is not uncommon. Participant BH was the first COO in her organization in ten years. Prior to her arrival the executive team divided up the typical responsibilities of the COO between themselves. It seems that the CFO fancied herself as the COO and tension arouse when BH official stepped into that role.

> "I definitely had a significant amount of stress, strain and conflict with our CFO. We had not had a COO at this organization for some time, so in some aspects when I came into the role other members of senior leadership felt maybe a bit devalued or were questioning the need for this kind of a role. They were concerned about what it meant for their own power base. So it was somewhat threatening to others and that took me by surprise. The CFO in particular, I think she was used to almost considering herself the COO, so that was definitely difficult. I would say

> relationship building with other members of the senior team, creating that senior leadership team that was collaborative and worked together was a critical activity."

BH learned a tremendous amount about herself and her role as she tried to make a connection with the CFO and build a functional relationship. That connection was never made and the relationship was never formed. The CFO felt that she had been displaced and decided to leave the organization. BH took the energy that was consumed by the CFO conflict and put it into creating a highly function executive operational leadership team.

Participant MM advanced in her hospital from CNE to COO. She was familiar with the CFO and was well aware of his need to control, especially the money. She had been able to work around his need to control when she was CNE. When she became the COO, the relationship changed dramatically. Since she was now accountable for the operations and financial performance of the entire organization, she needed to understand in a detailed way, how the finances of the organization were structured.

> "Well, the CFO was just, well to be a little short – he was just a maniac. It was just, you know I have found at the time he was, you know I've seen it in other CFOs, they're always, there's a lot of ways, I'm not going to say you can cook the books but that they hold money in reserve which is a common practice and is an okay practice. But, I would sometimes feel and so did some of my colleagues that the CFO would come to the table with, you know, here are the numbers they're not good this month this is all of you people, you know you folks this is your problem. And then he would proceed to tell us how to fix it. That didn't go over well."

She went on to say that she confronted this behavior head-on and asserted herself as the COO with the full confidence and backing of the CEO. It was the first time she asserted herself as the COO.

> "And more than once we had a closed-door discussion and one shortly after I became COO. You know you cannot play on the team and expect the fact that I'm here and I'm not going anywhere and I have the support of the CEO and I've got the support of the rest of the team. You want to get on the bus, get on the bus, you know you don't like it on the bus, don't get on the bus but we're here. So, I think, you know, sometimes you might have to step up and have those types of conversations. And a lot of it is the way you handle it too."

Participants reported a special and unique role tension with their clinical peers and partners, the nurses, therapists, and physicians. The tensions and conflicts were wide and varied, from nurses who feared loss of nursing leadership to nurses and physicians who expected favored status. One participant reported initial role conflict with her own director group as they expected her to show favoritism in terms of approval and resources to their efforts and projects. A similar sentiment was echoed by three participants about their physician partners. These physicians supported having a clinical person in the COO role expecting favored status and full support of their efforts or projects stating that a nurse would understand the necessity of their requests and understand their downstream effect on patients. Participant RA shared the conflicts she experienced with her physicians.

> "I think there is one thing that people probably need to think about and I wouldn't say that it was a huge conflict for me but it is something that really comes up. I think sometimes physicians think because you're a nurse you're in that role that you're going to give them everything. So, sort of similar to the nursing staff and the conflict is that you're making a business decision, it's also a quality decision but bringing them along to understand that is a key."

RA was able to deal effectively with the conflict by reframing the issue, concern or project that the physicians were trying to negotiate as a business proposition. RA was effectively reframing her identity as business woman with a clinical background.

Participant SO was a strong nursing leader who had become CNE and advanced into the COO role. She knew and understood the physicians and other clinical partners. She viewed building relationships in her new role as critical to her success.

> "In terms of physician relationships I think it's been unbelievably valuable to be a nurse. Even with the ancillary testing departments and things of that sort, just the knowledge base and comfort level of feeling comfortable walking in anywhere in the organization and not being concerned that you're in some place where either you shouldn't be or you don't know anything about. So, I found it invaluable."

The participants who were now COOs reported the single most important relationships to build and nurture was their relationship with the CEO. The role of COO is not firmly subscribed like that of the CNE. In fact, the COO role has no formal definition and is relational to the CEO. Bennett and Miles (2006) pose that while other executive jobs are defined in relation to the work (for example the CNE) and the structure of the organization; the COO role is defined in relation to the CEO as an individual. Bennett and Miles described the relationship between the CEO and the COO as "a balancing act on the threshold of power." Several participants mentioned that the best way to ensure a solid working relationship with the CEO is to negotiate your severance agreement upfront – it creates a common understanding of the need to build a strong bond. Nine out of the ten participant COOs were successful in building strong relationships with their CEOs. The tenth participant remained in the COO role until her goals were met, the organization was stabilized and then exercised her right to leave the organization. She quickly moved on to another COO role where the "fit" was well aligned with the CEO. Here are some of the participants' thoughts regarding the COO-CEO relationship. Participant BH clearly articulated that her role as COO was dependent on the desires of her CEO.

> "I would say the role probably ended up to be much broader than what I might have initially thought. And some that is based on the style of my boss, who believes that you should be performing on all cylinders at all times. And also I would say the role is much broader than maintaining operations but instead a huge influence on growing operations. So not just adhering to budget and performing to productivity metrics etc. but new program development, growing the business, new physician relationships, you know, much broader from a growth or business development perspective. And I think a lot of that is driven by what the CEO sees as success measures."

Participant SO expressed the desire to understand and have clarity about her role from first point of transition from CNE to COO.

> "The first challenge is to understand whether the CEO wants you to be the second in command versus the head of operations? Or what role do they want you to fill? You have to generally carve it out yourself and not overlap with their role. Establishing clarity of the role is I think one of the bigger challenges."

Participant BU also expressed the need to be clear up front about the role one is assuming – not all COOs are created equal.

> "To move into the COO you have to know what's the relationship going to be like with the boss, what's the relationship with anyone else because sometimes the COO doesn't have the whole building, you know what I mean, sometimes the COO has everything but finance and they report to the CEO so you need to have disclosure on what you've got and what you've don't got. I think you have to know your relationship with the board."

Participant JJ was extremely successful in her transition to the role of COO. She was able to produce a turnaround. Departments that were non-contributory in the past were now fully productive, collaborative and contributing to the success of the organization. She was eager to work with the CEO to roll out her strategies for success across the organization.

> "I guess the hindrance was, well I don't know how to put this, it was the reactance on a part of CEO. You know I had been enormously successful and I did that in a very structured way, that's how you have to do this if you really want to orchestrate culture change and you know finance there were other areas that didn't report to me, like finance etc. So the hesitancy on the part of the CEO to roll this out hospital-wide in a fashion that really mirrored what I had done I found to be an obstacle. And because that was never done, the initiative itself in terms of rolling it out to the rest of the institution never reached its full potential, never. And I think it was just, I don't know, lack of guts, I don't know why else, he believed in it, liked the outcome but didn't have the guts to step off the curb."

Gender

One might wonder if gender and gender issues ever entered into the picture of role transition and potential role conflict that the participants faced. Gender was rarely mentioned by the participants during the interviews. Any mention of gender was historically linked and was not influential in the participants' course of transition. Other than an awareness of their gender, participants' did not see gender as a key or critical factor in their transition to CEO/COO role.

Mentors and Advisors

It is interesting to note that none of the participants freely mentioned having a strong or influential relationship with a mentor. Once the researcher questioned the participants about relationships that facilitated transition, for example mentors, preceptors, or advisors, only two participants mentioned formal mentors. These two participants had formal mentor-mentee relationships that were established fellowships while in doctoral and post-doctoral studies. The mentor-mentee relationship continued throughout their transition from CNE to CEO/COO. The remaining participants used a broad and varied group of individuals to serve as advisors during their period of transition. Some of the advisors mentioned included peers and colleagues, former colleagues, other individuals holding the same position in other healthcare systems, members of their professional organizations, members of governance, and academic partners. Most participants selected their advisors to complement areas where they had perceived weaknesses and/or vulnerabilities. At least half of the participants were part of a corporation or professional organization that had CEO and COO forums and networks. The participants often used those forums and networks to seek advisement and counsel.

Nearly every participant, using a wide variety of words to express the same sentiment – relationships are everything in the CEO/COO role, role clarity is a must, and trust in the relationships is essential. Working through the conflict they experience in their role transitions, participants began to reframe their identity – separating and distancing the nurse CEO/COO from the CEO/COO who had a clinical nursing background.

Building New Networks

Every participant in the study stated that a primary strategy used to facilitate their role transition from CNE to CEO/COO was the expansion of their current professional network beyond the scope of nursing. There was a wide variety of ways the participants engaged in expanding their networks – joining professional organizations, leading professional organizations, expanding the

scope of literature they read, joining local business groups and organizations, teaching health service/hospital administration at the graduate level, and becoming active in community activities that related to healthcare. The stretch outside the nursing and patient care perspective was refreshing and at times overwhelming, especially if this was the participant's first transition to the CEO/COO role.

Participants expanded their networks by joining healthcare leadership and management organizations such as the American College of Healthcare Executives (ACHE), and the Academy of Management. Others sought positions of leadership in the American Hospital Association (AHA), appointment as Commissioners at The Joint Commission, and appointment in state and local professional associations. Participant RA immediately became engaged with a larger professional network.

> "You need to get out of your comfort zone and out of your networks in terms of the nursing circles, that doesn't mean you have to abandon them but you have to get into the AHA circles. And that was an important part, I volunteered and was on some of the AHA committees and I sit in the AHA Joint Commission seat, I've been in that seat for seven years. I'm an ACHE Regent and also in ACHE. So you have to make sure that you're networking outside of your comfort zone. It's not easy but it has to be done."

Participant MM not only joined a healthcare executive organization, she sought to become certified by that organization.

> "I encourage every new COO to take part in ACHE programs. And go for those certifications; go for the diplomat and fellowship status there, which I did. I would attend other educational programs. At that time we were a VHA Hospital member and we would go to their educational programs. We would also bring in their management development program, some of which we taught some of which we brought in people for. So I think it was a variety of resources. Make sure you read your journals; read the Wall Street Journal – it is a must."

Participant JW made the transition to CEO successfully and led three different organizations. During her second engagement as a CEO she joined a city-wide women's leadership group, working and learning side-by-side with other women CEOs. She describes the experience this way.

> "I was part of an organization in the X city that was called the X City Network. It was a group of women presidents and COOs. I was asked to join that and I did. And I went to the meetings and I would sit, most of the meetings were a program and a dinner so it was after work on a week night, and I would sit at a table with women, one of them owned a trash business and one of them owned a flower business, totally different businesses than health care, but those women were very supportive and very helpful. One was a chef, one was the head of you know a big philanthropy consulting firm, one was a lawyer – head partner in a law firm, so that was a wonderful opportunity to network with other women."

Every participant expanded the literature they read, searching out business news and information. Nine out of the fifteen participants specifically mentioned The Wall Street Journal, Business Week and Fortune as providing new and invigorating approaches to executive leadership. Professional journal subscription was also broadened to include Harvard Business Review, MIT Sloan Management Review, Academy of Management publications and ACHE publications.

In summary, by changing the nature of their relationships with their role sets, the participants were able to see themselves in a new light; they had a new position and a new role. Working to achieve clarity of their new role (establish boundaries and accountabilities) and resolve any role conflict with their role sets; others were able to see the participants in a new light as well. By broadening their professional networks and associating with other professionals in their roles, the participants were able to see themselves as CEO/COO and be seen as a CEO/COO. These two activities, changing the nature of relationships and broadening professional networks facilitated the reframing of identity from the nurse CEO/COO to the CEO/COO who had preparation and experience as a nurse.

Embracing the Reframed Identity

The third stage of reframing identity was characterized by behaviors that demonstrated psychological acceptance of the new role and the new identity as CEO/COO. Participants not only accepted their new roles, they embraced them. The new CEOs/COOs took over the reigns and began to lead. They began to

articulate their vision for the future, build their dream teams, and make decisions from a balanced, objective perspective. They were comfortable in their new skin.

Creating a Vision, Building the Team

As the participants created their ex-role and learned their new role, they came to a deep understanding of the true mission, vision, and values of the organization. They assessed the capacity and capability of the organization to move into the future and meet the challenges of healthcare in today's economic climate. They had a picture of the past strategies, a snap-shot of today's goals and objectives and needed to paint a picture of the future. For most of the COOs, the task at hand was to create a vision of the future – a vision of the strategies and tactics that would be necessary to meet or exceed operational objectives. For the CEOs, the task at hand was to create a vision for the future – a vision so clear that everyone in the organization could act on and move toward the vision. One CEO participant BR knew what it would take for the organization to survive. She knew the level of employee engagement it would take to achieve the organizational objectives. Here vision was around sacred work.

> "We created our culture and vision. We created it around sacred work in essence. And it was during the course of us learning what that meant, we took a journey into an area we had not forged before, we did it together."

BR believed in her vision of sacred work but knew it would take a committed team to achieve such a vision. Perhaps the strongest indication of acceptance of the CEO/COO role was the participant's eagerness to build teams committed to the new vision and loyal to the new leadership. Many of the participants built teams directly related to their operational and strategic goals and objectives. Participant JJ was a COO with a vision of purposeful work.

> "I had a series of retreats, really equipped the team with a new load of confidence, a new skill set, the desire to excel, made them feel that they really were a piece of the success of the institution and got them to a point where I could then get them and nursing division together as one. I did that through a series of really I think creative team building experiences all designed under the rubric of improving the culture of the hospital that I was at. It was extra-ordinarily creative, it involved job exchanges, it

> involved leadership coming together, it involved the hospital that whole area that reported to me planting flowers and beautifying the entire campus together and I can tell you that when you spend eight hours on your knees in the mud side by side with folks that you maybe 5 years ago wouldn't have even talked to it puts you in a different perspective and you make friends. And you realize at the end of the day when you're standing in that line at McDonald's it doesn't matter who you are, you are only equal to the person next to you. And that was a series, a good year and half of very serious team building and the initiative catapulted that hospital into the forefront in the region and it was enormously successful."

Participant RA talks about building a clinical business model and teams based on the Baldridge Health Care Criteria of strategy, alignment, and teams.

> "We developed the health care teams and clinical management teams, and really all of our business development teams around quality and patient services delivery. So it was quite interesting, the areas where we had the greatest difficulty with team building were those that were just learning a lot more about the non-clinical areas like finance services and environmental services and the things like that. We were extremely successful building teams based on this model."

The two statements above are indicative of the tremendous emphasis the new CEOs/COOs placed on building teams around their visions and strategic objectives.

Leadership and Balanced Decision-Making

From the moment that the participants entered their new roles as CEOs or COOs there was a strong sensitivity to having a balanced and objective perspective of clinical and non-clinical departments and their contributions to the organization. They all had a passion for ensuring balanced decision-making, a process that included objective analysis from the clinical and business perspectives. Initially they were hyper-sensitive to their potential clinical bias. It took time and experience to end this hyper-sensitivity and achieve this balance. With time and maturity in their roles, the participants learned to embrace and even welcome their clinical expertise and judgment as being a value added trait for leadership and decision-making.

Participant BH is a COO who was prepared as a clinical nurse specialist. She has been a CNE at the hospital and corporate level. Her clinical roots run deep. Balanced decision-making was key point in her transition from CNE to COO.

> "I think in terms of hindering my decision-making, there's always that sensitivity around making sure that you've got a balance between your business objectives and your clinical objectives. And it certainly is hard sometimes to step back a bit from the clinical side and say while it would be wonderful to have A,B and C we from a business perspective can't afford that or have to look at things a little differently. It's probably harder for me to divest any portion of clinical operations than it may be for other people because it's tugging at my heartstrings at the same time. But I also think it's easier for me to garner support for decisions with having my nursing background because people know that I have thought it through in a very different way. So they trust the decision I made balances both."

Participant MM echoes BH's sentiments. She discussed the need to be balanced and objective even during times of financial hardship when cutting the budget and potentially positions must be addressed.

> "You know sometimes you're, you have to be seen as objective. So, I was always, especially in the beginning, very conscious of that because one of the things that I learned early on is that all eyes are watching you and they're just waiting for that first time you say oops, see you know everyone else has to do it but nursing doesn't have to, you know what ever it is. So I had to put, you know make a conscious effort to make sure that everything I was doing, every initiative that I was looking at, if I was looking as a

> reduction in workforce, if I was you know particularly stringent in looking at overtime that I was looking at that across the board objectively. And that had to be very, very conscious, very, you know, until it became ingrained in the way I worked."

Participant JW was the CEO of specialty hospital. She worked with many disciplines and was always sensitive to her potential clinical bias.

> "Well, I think everybody is always looking to see if you're going to favor nursing because you are a nurse – know what I mean. Are you going to go soft or easy on nursing and stick it to everybody else, so you have got to make sure that you're very fair and consistent and balanced in your approach."

The concept of reframing identity really does work. From creating the ex-role, through learning the new role and finally embracing the new identity, participants successfully completed the journey moving from a nurse CEO/COO to a CEO/COO who had education and experience as a nurse and patient advocate. Perhaps the best evidence of reframing comes from the participant's statements. Participant MM gives great testimony to reframing.

> "I do remember having one conversation that I did say you know I'm not here in my role as a spokesperson for nursing, I am an advocate for delivering good patient care and the best way that we can do that on all parameters. And you know eventually they got that message."

Participant BU was more articulate about reframing her role. She clearly articulates that it is not just about nursing, even though one is a nurse, one represents everyone and must make decisions on everyone's behalf.

> "If you're a nurse going from nursing to the patient care exec or the CNE role to the COO role I think what you have to remember is that it ain't all about nursing anymore. You still have to have your clinical knowledge and I think that's really important. I think people with clinical backgrounds make very different decisions than people without clinical backgrounds. So, you can't forget everything you know but at the same time you can't just be a nurse. You can't talk about nursing departments and non-nursing departments as if one's normal and one's not. You know like when we talk about well there's medicine and there's alternative medicine. You know it's like you're everybody's COO or you're everybody's CEO."

Participant JW was now a CEO. She never forgot her clinical background and used it to inform her decision-making. She was proud of being a nurse and reflects that nursing has benefited from her executive position.

> "I am supportive of nursing and I will never deny my roots and how good they were but I also think that I have made nursing better by representing the wider health care system too."

Participant BH reflected on her thoughts about being a nurse COO and how she reframed her identity to begin to share knowledge with others.

> "You know, I'm a nurse, I've been a nurse, I'll always be a nurse and that should be good with people because I have clinical insight. And so I would never say that I would never separate myself from nursing, I would rather say that I would like to extend my clinical knowledge to lots of other specialties."

Summary

The participants in this study moved through a three stage process that included creating the ex-role, learning the new role, and embracing the new role. During this journey the participants reframed their identity as nurse, preserving the best aspects of the profession and using them to support the organization at higher level. As the participants moved through the various stages of reframing, they began to see themselves differently – they were no longer nurse CEOs/COOs (nurse first, CEO/COO second), rather they were CEOs/COOs who were nurses (CEO/COO first and nurse second). Because they themselves saw differently, they asserted themselves differently and their role sets began to see them in their reframed identity. All participants completed their quests to become CEOs/COOs. The process of reframing their identity facilitated successful role transition.

CHAPTER VI

Summary and Recommendations for Research and Practice

Summary

Chapter 6 is designed and written to provide the reader with a summary of this study and recommendations for research and practice. The first section of this chapter is the summary of the study and includes the need and purpose for study, theoretical and conceptual frameworks used for the study, methodology used, and the key or critical findings. The second section of this chapter presents recommendations for practice and education, limitations of the study, and recommendations for future research. The final section presents conclusions and contributions this study makes to the literature and the profession.

With the current and expected turnover of hospital and healthcare CEOs hovering around 15% annually (Thrall, 2008), there is an increased demand for nurse executives to fill these roles. It is critical that the role transition from CNE to CEO/COO be efficient and effective. Such a transition is not as easy as simply changing job titles, positions, and offices; it involves moving from one persona to another. If the transition is not smooth or if the transition is not complete, role stress and role conflict may result and have serious effects on the success and tenure of the new CEO/COO, as well as the performance of the organization. Understanding the experience of role transition and identifying facilitators and barriers to role transition from CNE to CEO/COO is essential. As the demand for CEOs/COOs continues to grow, so will the demand for CNEs to fill those roles and the need to prepare the next generation of CNEs for what appears to be the inevitable.

The purpose of this study was to explore and gain insight into the perceptions and experiences of CNEs who made the transition to CEO/COO roles. The ultimate goal of this study was to discover the individual and

organizational processes that facilitated or posed a barrier to successful role transition. The grounded theory research method was used to enhance the understanding of the real world of the participants – a world that is wholistic, complex, contextual, and based on dynamic perceptions that were unique to each CEO/COO that was interviewed. When little is known about a phenomena or experience, such as role transition from CNE to CEO/COO, meanings acquired through grounded theory research are more empirically valid than data obtained with quantitative research methods alone (Blumer, 1969). Several theoretic concepts were used to guide this study – the concept of role, role theory, and models of role transition were used to form a conceptual schema that provided the basis for this inquiry into the experiences of CNEs transitioning into CEO/COO roles.

This study was submitted to and approved by the University of Michigan Health IRB. All participants completed a written informed consent prior to the scheduled interview.

A purposeful sample of fifteen CNEs who became CEO/COOs in a variety of healthcare settings and remained in those positions for at least one year were used in this study. Maximum variation in cases selected contributed to the identification of the relative strength of shared patterns that emerged from the data. Sampling was terminated when no new information came forward and saturation of the conceptual information was achieved. Theoretical sampling was conducted to advance the theory. Selective sampling of the literature occurred concurrently with data collection and analysis.

The interview method was used to capture how the CNEs experienced their transition into the CEO/COO role. Qualitative interviewing maximized the researcher's ability to enter into another person's perspective. A guide was used to conduct the interviews that were composed of loosely structured, open-ended questions. Additional questions were asked for clarification or to prompt a deeper dive into the thoughts the participants presented. Basic demographics were also collected on all the participants.

Participants were interviewed via telephone and were audio taped. Copious notes were taken during the interview as a back-up for technical failure and to document any nuances that might not have been captured on audio tape. Audio recordings were transcribed within one week of the actual interview. Constant comparative analysis was used for this study. Three levels of increasingly theoretical coding were used – open coding (Level I), assignment of categories (Level II), and reduction of categories to identify the core processes or core variables that explained the experience of role transition from CNE to CEO/COO (Level III). Conceptualization of the relationships between the three levels of codes occurred throughout the study.

The results of this study provide insight into the issues faced by nurse executives in their transition from CNE to CEO/COO. The section that follows presents the basic social-psychological problem that was revealed through the data (role exit and creating an ex-role), and the basic social-psychological process (reframing identity) that was used to resolve the problem.

Creating an Ex-Role

The participants in this study moved from chief nurse executive roles to chief executive officer or chief operating officer roles. Successful transition depended on the participant's ability to fully exit the CNE role and learn the new CEO/COO role. Successful movement into the new role involved the participants traversing four stages of transition to their new CEO/COO role. The first stage began when the participants had doubts about their current role as CNE. In the second stage, participants began to explore and evaluate alternative roles (CEO/COO). Eventually, participants reached a turning point (stage three) and made the decision to leave their current role as CNE for CEO/COO role. The fourth and final stage of role transition involved the participants creating an ex-role. Creating the ex-role is essential to successful role transition as it finalizes and symbolizes the role transition, allowing the participant to doff one persona (CNE) to take on another persona (CEO/COO).

The participants in this study traversed the first three stages of role transition with relative ease. After all, the participants were highly educated, experienced, and motivated leaders who saw movement into the CEO/COO as a natural and/or planned progression in their careers. What the participants did not anticipate with this role transition was the difficulty they would experience trying to create an ex-role. Participants experienced internal conflict and tension as they tried to doff their persona as a CNE to establish a new persona as the CEO or COO. Creating an ex-role was the basic social-psychological problem that the participants faced.

Multiple factors moderated the CNE's ability to create an ex-role including magnitude of role transition, visibility of the role, visibility of the transition, role identification, sentimentality, nostalgia, and coping resources (Ashforth, 2001). Of these moderators, only two posed challenges to the CNEs in creating an ex-role – visibility of the role and role identity. Visibility of the role as a CNE was a double-edged sword. Although visibility was initially a challenge, as most peers and colleagues continued to view the participant in their prior role as CNE, most of the participants turned the paradigm around and used visibility as a means and method to learn their new role as CEO/COO. Identification as a nurse posed a far greater challenge. Letting go of their persona as a nurse and a member of the nursing profession to embrace their new persona as a CEO/COO was extremely difficult. Role exit required both psychological and physical withdrawal from the CNE role to be able to enter the new role as CEO/COO.

There is scant information in the literature about role transition from the CNE role to CEO/COO role. The experience of moving from CNE to CEO was discussed by Smith (2002) in the form of three in-depth interviews with CNEs who moved into CEO/COO roles. These interviews affirmed this study's findings regarding the demographics of those CNEs most likely to make the move and also affirmed that knowledge of the core business, strong relationships with the physicians, and being patient-centered facilitated their movement into the CEO/COO role.

The four stages of role transition that were identified in the participants' experience of transition were strongly supported by the four stages of role exit identified by Ebaugh (1988) and Ashforth (2001). Ebaugh succinctly identified the struggles with creating the ex-role that were reflected in this study by stating that the process of becoming an ex involves tension between one's past, present, and future. Ebaugh also noted that to be an ex is different from never having been a member of a particular group or role set. The staged approach of transition that was revealed in the data was also supported by the work of Bridges (2003). Bridges described three phases to transition – ending, neutral zone, and new beginning. This model of role transition supported the need to end what used to be and, in Ebaugh's terms, create the ex-role. Bridges' states that you must let go of the old reality and identity before you can accept the new reality and identity. He believes that nothing undermines transition more than the failure to let go. The final two stages of Bridges' work provided a framework for looking at the transition beyond the creation of the ex-role and will be addressed in the paragraphs to follow.

The data revealed that the strong assets that come from being a CNE (knowledge of the core business, patient advocacy, and relationship building) also hinder the ability to immediately let go of the identity of being the chief nurse executive. The participants had strong urges to meddle in nursing operations once they left the CNE role. Kalish and Escamilla (2001), in their study of nurse executives who became CEOs, also identified a bias of the new CEOs to micromanage their previous areas of responsibility (nursing and other clinical departments). Such tension created role stress and conflict.

The participants in this study experienced internal conflict and tension when they perceived they were giving up nursing. They felt a sense of commitment and obligation to the profession and the patients they served. It was a juggling act of identities – to be a nurse or not to be a nurse was the question. The stress felt in the new role as a CEO/COO was first supported in the literature by Merton (1957). Merton posed that role stress maybe created by the context of particular status and/or related to various functions of the status, as is the case of

the CNE turned CEO/COO. Hardy and Hardy (1988) found that role stress occurred when the social structure (in this case the hospital) creates difficult, conflicting, or impossible demands for a role occupant (the CNE turned CEO). In general, the concept of role exit is supported and documented in the literature. The most developed model of role exit was created by Ebaugh (1988) and strongly supported the findings in this study, contributing the concept of creating the ex-role as a necessary component for role exit.

Reframing Identity – Letting Go

The data revealed three stages to reframing identity – letting go or creating the ex-role, learning the new role, and embracing the new role. The first stage of reframing identity required that the participants fully exit their role as CNE and enter into their new role as CEO/COO. As the participants reframed their professional identity, they also changed their professional sense of self and the perception of their role set in their new role as CEO/COO. The participants and their role sets moved from seeing and perceiving themselves as a nurse in a CEO role (nurse first, CEO second), to seeing and perceiving themselves as a CEO/COO who is a nurse (CEO/COO first, nurse by education and preparation second).

Reframing identity began with creating the ex-role and learning to let go of nursing operations. Understanding the need to let go, move on, and disengage from the CNE role, yet feeling the urge to meddle in nursing operations, may be partially explained in the work of Ebaugh (1988) and Ashforth (2001) who posed the notion of role exit noting that psychological exit from one role continues after physical entry into the next role. Those concepts are well aligned with the findings of this study. Ebaugh and Ashforth also believed that a process of de-identification continued with strategies like grieving the exited role, indulging in nostalgic recollection, and constructing a salutary ex-role all enable the individual to attain closure and create identity narratives that portray the exited role as an important but closed chapter. The reframing of identity that was found in this

study did not close the chapter, rather re-wrote the chapter with a subtle but critical difference.

Reframing Identity – Learning the New Role

As distance from nursing and nursing operations was created, the participants began to learn their new role as CEO/COO. Most of the participants used their skills in unit and department rounding and participation on key or critical teams to increase visibility in their new roles, affirming their new role and position in the organization. The participants in CEO roles also noted the need to increase visibility in the communities they served at the local and regional levels. The CEOs also discussed the need to be visible at the state and federal levels where legislation and subsequent reimbursement issues were in play. Being seen and seeing themselves in their new role as CEO/COO was a critical part of reframing their professional identity. The participants gained perspective in their new role that gave them confidence to move forward.

After visibility was established, the participants began to focus on efficient and effective communication by becoming multilingual. Participants clearly articulated the need to communicate with all key stakeholders, no matter what discipline or diverse mindset they may represent. Some languages, like medicine, required only refinement, and other languages, like finance and business, required remedial education and then advanced education. Learning to speak to more diverse stakeholders and becoming multilingual was an essential part of reframing identity as a CEO/COO who is a nurse.

A major driver of reframing professional identity was the ability and willingness of the participants to change the nature of existing professional relationships, developing new relationships, and building new professional networks. Participants who advanced within their system were challenged by peers to overcome a narrow perception of their skills, talents, and abilities. Participants who competed against peers for their CEO/COO roles experienced stress and strain in those relationships after their appointment. For the participants that moved into COO roles, the relationship with the CEO was

critical. These participants needed to clearly understand their role boundaries and their relationship to the CEO. Being a nurse, a professional centered on relationships, and being no stranger to conflict in the clinical setting, participants faced role stress and conflict head-on. They were able to successfully restructure existing relationships and/or build new relationships. Participants had strong clinical backgrounds that were centered on multidisciplinary collaboration. Those relationships and experiences served as facilitators for reframing professional roles, relationships, and identities.

Participants also reframed their identities by building larger, broader professional networks and professional affiliations. Participants joined American College of Healthcare Executives and the Academy of Manager to broaden their professional network. Participants became actively engaged as appointees to The Joint Commission of Healthcare Organizations and the American Hospital Association. Many participants joined networking or support groups for CEOs and COOs that were sponsored by the Voluntary Hospital Association and/or the corporate office of their healthcare system. There were no limits to the support networks that these participants sought, even city-wide women's leadership groups. For each and every network joined, the new professional identity as a CEO/COO grew stronger and stronger.

The concept of role using visibility, communication/language, and building effective networks is broadly supported in literature under the rubric of social influence (Ashforth, 2001). A role is embedded in a role set of interdependent positions. Role occupants (like the neophyte CEO/COO) tend to be influenced by members of their role set, recognizing they can learn from their counterparts, share expectations for organizational performance, and have potential to facilitate their role entry and learning. The concepts of networking, visibility, common language, and shared performance expectations are aligned with the rubric of social support.

Reframing Identity – Embracing the New Identity

With successful movement through each stage of reframing, the participants demonstrated psychological acceptance of their new role and new identity as a CEO/COO. Participants not only accepted the new roles, they embraced their reframed identity as a CEO/COO who was educated, prepared, and experienced as a nurse. As participants moved through the process of reframing their identity, they began to assert themselves as CEOs and COOs. By driving vision, developing strategy, and establishing operations to achieve their goals and objectives, they made their organizations stronger. Participant BH's sentiments best reflect how the participants reframed their identity, began to share their knowledge with others and contribute to their organization's success.

> "You know, I'm a nurse, I've been a nurse, I'll always be a nurse and that should be good with people because I have clinical insight. And so, I would never say that I would separate myself from nursing, I would rather say that I would like to extend my clinical knowledge to lots of other specialties."

Recommendations for Practice

This research has many lessons on role transition at both the individual and organizational level. Perhaps the most significant lesson in this research is that reframing identity should begin as early as first doubts about staying in the CNE role or when the CNE begins to seek and explore alternative roles such as the CEO or COO. The first step of reframing is having a clear understanding of the CEO and COO requirements and the quantifiable differences between the CNE and CEO/COO role. Once the desired CEO/COO role is understood, an intensive self-assessment must ensue, a self-assessment that will reveal the skills, talents, abilities, and experiences that the CNE brings to the table. The self-assessment must then lead to a willingness to seek out and gain those skills, talents, abilities, and experiences that the CNE is lacking and must have prior to moving into the CEO/COO role.

During the stages of first doubts and seeking and exploring alternative roles, the CNE should seek out opportunities to significantly broaden the scope of their role beyond nursing by accepting a larger span of control and taking on, even requesting, leadership responsibilities and accountabilities for key strategic

projects and programs. The increased visibility in a role with a scope larger than nursing will facilitate reframing identity – both for the CNE and his/her role set. Learning the preferred communication styles and languages used by of all the healthcare disciplines and governance would also facilitate reframing identity early in the role transition period. Investing in building strong relationships with the executive leadership team and key members of governance would also facilitate role transition and reframing of identity. The more the CNE sees himself/herself in an expanded role and is seen by peers, colleagues, and governance in the expanded role, fewer barriers would present during reframing of identity.

Although most participants thought it would be helpful to have a true mentor, few actually had true mentor relationships. Most of the participants had a core group of individuals that worked as a reference team for them, sharing expertise and experience in focused areas. For the CNE seeking the CEO/COO role, identification of a true mentor and building the mentor/mentee relationship would be well worth the time and effort. With the growing number of CNEs who have become CEOs and/or COOs, a professional network of mentors for neophyte nurse CEOs/COOs would facilitate reframing identity.

On the organizational level, a solid succession plan for the CEO/COO role would help to identity those CNEs who have potential to move into the CEO/COO role. The organization could then begin to provide the CNE with the experiences, education and training that would be necessary to assume the CEO/COO role. The organization could also help to reframe the CNEs identity by expanding roles and responsibilities beyond nursing and making the CNE visible in a new light and a new role.

Recommendations for Education

Graduate nursing administration and business programs must begin to build a broader curriculum and prepare nurses for executive roles as CEOs and COOs. The broadened curriculum must focus on the entire organization and the necessary system-wide leadership skills including governance, strategic

planning/execution, high-level finance, language/interpretation skills, and large scale change. These graduate programs' internships and fellowships should include experiences with CEOs/COOs that are prepared as nurses. A strong focus must be placed on professional identity and how to appropriately and gracefully transition to a CEO/COO without forsaking the profession of nursing.

Doctorate of Nursing Practice (DNP) programs that have tracks or specializations in nursing/healthcare business and administration are strongly encouraged to prepare and position DNP students for entry into the CEO/COO role. The curriculum for the DNP must address the essential elements of role transition addressed in this study – identity as nurse and reframing identity as a nurse. Preparation for leadership at the highest level in the organization can be accomplished by taking an evidenced-based, systems approach to organizational strategy, operational execution of strategy, and leadership development. The program would essentially be the masters in nursing administration "on steroids." Expectations would be the assumption of an executive level position 2 – 5 years after completion of degree.

The first step in resolving any issue is to admit that there is an issue. Role transition is rarely discussed in the professional healthcare literature, nor is it a topic of presentations at healthcare conferences and seminars. Professional organizations, such as the American Organization of Nurse Executives (AONE) and American College of Healthcare Executives (ACHE), must begin to openly discuss, acknowledge, and embrace the movement of clinical executives (chief medical officers, chief nursing officers, vice presidents of operations with clinical backgrounds, for example physical therapists or medical technologists) into the CEO/COO roles and begin to accept their organization's responsibilities in facilitating executive level role transition.

The leadership of AONE and ACHE could develop core competencies that would address the requirements for role transition from a clinically focused role (CME or CNE) to a strategically focused role (CEO/COO). Seminars and programs in multi-media could be developed to bridge the gap in learning about and successfully achieving transition into the CEO/COO role. Professional

organizations could sponsor on-line discussions, chats, and blogs to facilitate shared learning; even virtual mentoring during periods of role transition is a real possibility.

Even the local healthcare organizations can conduct leadership development activities and build leadership networks that facilitate role transition into the CEO/COO roles. Mentors for new CEO/COOs could be identified to facilitate role transition into the executive ranks. Support at the local organizational level can be meaningful, as the role set for the new CEO/COO could be brought into the education to facilitate role transition, team building, and relationship building. The possibilities for easing role transition are limitless.

The moral of the story is clear – nurses (and other clinical leaders) have the ability to become successful CEOs and COOs. The transition into such roles requires individual introspection, self-assessment, self-directed growth, and organizations ready and willing to provide the necessary support for efficient and effective role transition.

Limitations of the Study

Strauss and Corbin (1998) provide an abbreviated framework for evaluating qualitative research, the adequacy of the study's research process, and the grounding of the findings. When evaluating an empirical study, Strauss and Corbin look for the following: generation of concepts, systematic relationship of concepts, conceptual linkages, variation, appropriate research process, significant theoretical findings, and theory that stands the test of time. These criteria will be used, in part, to determine the limitations of this study.

Concepts were both affirmed and generated in this study. The concept of role exit, first discussed by Ebaugh (1988), was affirmed in this study. The participants moved through a four-stage process of role exit. The concept generated in this study was the concept of reframing identity to facilitate role exit, specifically creating an ex-role. There were strong conceptual linkages – the concept of role exit directly linked to the concept of reframing identity. For participants to fully exit their role as CNE, they had to reframe their professional

identity. There was variation in how each participant experienced and managed the reframing of identity. The research process used was solid from sampling methodology through data analyses (refer to Chapter 3 for study methodology and rationale for method selection). There were significant findings at the conceptual level and initial findings related to professional identification at the theoretical level. As to standing the test of time, this is one of the first studies completed to identify how transition occurs when CNEs move into CEO/COO roles. By the Strauss and Corbin criteria, this is a solid study. Although solid, limitations or opportunities for improvement remain.

This study was geared to look at the transition of CNEs to CEO/COO roles and was designed to look at the process of transition. One limitation is the extent to which this study did not directly address the outcomes of transition, specifically whether or not the CEO/COO who was prepared and experienced as nurse enjoyed long-term success in the CEO/COO role. The sample did include current CEOs/COOs and those who left the CEO/COO role to retire, consult, or take a corporate-level position. The sample did not include any CEO/COOs that elected to return to the CNE position, which would have been an interesting exploration. Also, the study did not explore whether or not the organization was successful because a clinical executive was at the helm.

The sample in this study was largely female, as would be expected since the participants are all nurses. The issue of gender and gender-bias was rarely mentioned by the participants, and when it was mentioned, it was an historical perspective. Further exploration of gender as a facilitator or barrier to transition may provide interesting, gender-specific strategies for facilitating role transition.

Future Research

As noted above, future research should expand to look at the outcomes of transition from CNE to CEO/COO and the long term effects of the transition both on the individual and the organization. A focus on outcomes may provide additional insight into the type of nursing executive who would best fit in the CEO/COO role and have the greatest opportunity for individual and

organizational success. It would also be interesting to exploring the efficiency of role transition and reframing identity – are there strategies that might facilitate the timeliness of transition and reframing? Exploring the effectiveness of role transition and reframing is also recommended – are there strategies that would enhance the experience of transition and reframing while providing a better outcome for the organization? Considering the chaos of healthcare today and the necessity to be efficient and effective in every piece of work, finding a way to make role transitions more efficient and effective would certainly contribute to organizational outcomes.

Future research should also focus on physicians and other clinical executives, for example, vice presidents of operations who are physical therapists, pharmacists, and medical technologists to explore their transitions into CEO/COO roles, determining if the barriers and facilitators of role exit and role entry are similar to those found in nursing. With the rise in physician MBA programs, it is most certain that more physicians will also be transitioning into CEO/COO roles.

Last but not least in recommendations for future research is the need to continue to test the initial theory of reframing identity presented in this study. Further development and expansion of this work would address the short and long term outcomes of role transition, gender as a variable in role transition, and the effects of leadership development and mentorship programs on role transition.

Conclusions and Contributions to Literature

Chief nurse executives are excellent candidates for the CEO/COO role. They understand the core business, have solid relationships with key stakeholders, understand complex regulatory requirements, and, above all else, they are patient-centric. One large barrier stands between the CNE and successful transition into the CEO/COO role and that is the ability to fully exit the CNE role and make the CNE role an ex-role. Identity as nurse and commitment to the patient and the profession pose significant barriers to making the CNE role an

ex-role. To fully exit the CNE role and create an ex-role, CNEs must reframe their identity as a nurse.

Reframing identity involves successful movement through a three stage process of creating the ex-role, learning the new role, and embracing the new role. While moving across these stages of reframing, participants began to see themselves differently – preserving the best aspects of the CNE role and the profession and using them to support the organization at a higher level. As participant moved across the stages of reframing, they began to see themselves differently. They were no longer nurses who were CEOs/COOs (nurse first, CEO/COO second); rather they were CEOs/COOs who were nurses (CEO/COO first, nurse second). Because the participants saw themselves differently, they asserted themselves differently, and their peers, colleagues, and staff began to see them in their reframed identity.

Reframing really does work. From creating the ex-role, through learning the new role, and finally embracing the new identity, participants successfully completed the journey. The words of one participant, MM express the concept of reframing beautifully

> "I do remember having one conversation that I did say you know I'm not here in my role as a spokesperson for nursing; I am an advocate for delivering good patient care and the best way that we can do that on all parameters. And you know eventually they got that message."

This study makes a significant contribution to the literature, as it identifies the real-life issues that CNEs encounter when they transition into CEO/COO roles. It highlights the largest barrier to efficient and effective transition – completion of role exit by creating an ex-role. The concept of role exit has been defined in the past (Ebaugh, 1988), but has never explicitly looked at role exit for CNEs. The most significant contribution this study makes to the literature is the conceptualization and initial theoretical work on reframing identity; specifically, how nurse executives fully exit the CNE role, develop an ex-CNE role, and embrace their new role as CEO or COO. These little known, seldom utilized concepts of role exit and role transition now have grounding for further research

and continued development of the theory of reframing nursing identity to facilitate role transition into CEO/COO roles.

Appendix

Subject Consent to Take Part In A Study

Title of Study

The Transition of Chief Nurse Executives into Chief Executive Officer Roles

Names of Researchers

Sharon L. Smith, RN, MS, Doctoral Candidate, University of Michigan – School of Nursing
Richard Redman, RN, Ph.D., Faculty Advisor, University of Michigan – School of Nursing

Description of Research and Your Involvement

We are asking you to take part in a research study on the transition of Chief Nurse Executives (CNEs) into Chief Executive Officer Roles (CEOs). Your perceptions and experiences of the transition from CNE to CEO will be elicited in order to discover the individual and organizational processes that facilitate or pose barriers to successful transition into your new role as CEO.

If you decide to take part, we will:

1. Ask you to provide background data including your age, gender, entry level degree into nursing, highest degree obtained in nursing, highest degree obtained, years as a chief nurse executive, span of control as chief nurse executive, years as chief executive officer, and span of control as chief executive officer.
2. Ask you to provide information about your current organization including type of organization, basic description of the organization, and basic organizational structure.
3. Ask you to participate in an interview that will be conducted face-to-face or via telephone conference. The interview will explore your transition from chief nurse executive to chief executive officer and will last approximately one hour.
4. You may be asked to participate in a follow-up telephone conference to clarify and affirm information that was given during the initial interview.

Risks and Discomforts of Participation

There are no known risks for you. However, discomfort because of the sensitive nature of some of the interview questions could occur.

Efforts to Minimize Discomforts

If discomfort occurs during the interview related to questions that you perceive may be too sensitive, you will be asked if you would like to go to the next question or stop the interview entirely.

Expected Benefits

Although you may not receive direct benefit from your participation, others may ultimately benefit from the knowledge obtained in this study. The information learned from this study will be used to identify particular issues faced by nurse executives in the transition from chief nurse executive to chief executive/operating officer. This data may help in the design and development of education, training, and coaching programs to facilitate the adaptations that nurse executives face in the transition.

Payment for Participation

There is no compensation for participating in this study.

Cost for Participation

The only cost to you for participating in this study will be the cost of your time.

Confidentiality of Data and Records

Everything we learn about you and your organization will be confidential. The data will not be provided to anyone except the researcher and the members of her dissertation committee. The data may also be subject to monitoring by the Institutional Review Board of the University of Michigan. Your name and the organization's name will be coded and code names will be used to identify transcriptions and any further data that is generated or used. Transcribed tapes will be kept in a secure location by the researcher. The data will be held for five years and will be destroyed at the end of that period. The data will be used for scientific, teaching, or research purposes only. If we publish the results of the study in a scientific book or magazine, we will not identify you in any way.

Your decision to take part in this study is entirely voluntary. You are free to choose to take part in the study or stop taking part in the study at any time.

Further Information and Contact Information

If you have any questions, feel free to ask me during the interview. If you have additional questions later or wish to report a problem which may be related to this study, please contact Sharon L. Smith, Doctoral Candidate at the University of Michigan @ 734-945-5168 or slsmith@umich.edu. You may also contact The University of Michigan Institutional Review Board @ 540 East Liberty Street, Suite 202, Ann Arbor, MI 48104-2210, Phone: (734) 936-0933 or email irbhsbs@umich.edu.

We will give you a signed copy of this form to keep.

Consent of Subject to Participate

YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO TAKE PART IN THIS RESEARCH STUDY AND THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION GIVEN ABOVE AND EXPLAINED TO YOU.

ADULT SUBJECT OF RESEARCH

_____

Printed Name Consenting Signature Date/Time

SIGNATURE OF PERSON OBTAINING CONSENT

_____

Printed Name Signature Date/Time

Audio Recording Consent

In order to maximize data collection and analyses, your interview will be recorded. Transcribed tapes will be kept in a secure location by the researcher. The tapes will be held for five years and will be destroyed at the end of that period.

SIGN BEFLOW IF YOU ARE WILLING TO HAVE THIS INTERVIEW RECORDED. YOU MAY STILL PARTICIPATE IN THIS STUDY IF YOU ARE NOT WILLING TO HAVE THE INTERVIEW RECORDED.

_____

Signature Date

BIBLIOGRAPHY

Allen, V., & van de Vliert, E. (Eds.). (1984). *Role transitions explorations and explanations.* New York: Plenum Press.

American College of Healthcare Executives. (2006, December). *A comparison of the career attainments of men and women healthcare executives.* Retrieved November, 2006, from http://www.ache.org/PUBS/research/gender_study_full_report.pdf.

American College of Healthcare Executives. (2008, November). *Terms of employment for healthcare executives.* Retrieved April, 2009, from http://www.ache.org/policy/employmt.cfm.

American College of Healthcare Executives. (2005, April 18). *Hospital CEO turnover increases slightly.* Retrieved April 30, 2005, from http://www.ache.org/PUBS/Releases/041805_ceo_turnover.cfm.

American College of Healthcare Executives. (2006). *Model chief executive officer employment contract.* Retrieved January, 2007, from http://www.ache.org/newclub/career/SAMPCEO.cfm.

American College of Healthcare Executives. (2009, April 16). *CEO turnover rate decreases slightly*. Retrieved, May 15, 2009, from http://www.ache.org/Pubs/Releases/2009/CEO_Turnover09.pdf

American Nurses Association. (2000). *Scope and standards for nurse administrators* (3rd ed.). Washington, DC: American Nurses Publishing.

American Nurses Credentialing Center. (2008). *Application manual Magnet Recognition Program.* Silver Springs, MD: American Nurses Credentialing Center.

American Organization of Nurse Executives. (2005). AONE nurse executive competencies. *Nurse Leader, 3*(1), 15-21.

Ashford, S., & Taylor, M. (1990). Adaptation to work transitions: An integrative approach. In R. Ferris & M. Rowland (Eds.), *Research in personnel and human resources management* (Vol. 8, pp. 1-39). Greenwich, CT: JAI.

Ashforth, B. (2001). *Role transitions in organizational life.* Mahwah, NJ: Lawrence Erlbaum Associates.

Baker, V. (1979). Retrospective explorations in role development. *Nurses Digest, 6*(4), 56-63.

Baker, W., & Faulkner, R. (1991). Role as resource in the Hollywood film industry. *American Journal of Sociology, 97*(2), 279-309.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley Publishing Co.

Bennett, N., & Miles,S. (2006). Second in command: The misunderstood role of the chief operating officer. *Harvard Business Review, 84*(5), 70 – 80.

Biddle, B., & Thomas, E. (1966). *Role theory: Concepts and research.* Chichester, West Sussex, UK: John Wiley & Sons.

Biddle, B. (1979). *Role theory: Expectations, identities and behaviors*. New York: Academic Press.

Biddle, B. (1986). Recent developments in role theory. *Annual Review of Sociology, 12,* 1267-1292.

Bogdin, R., & Biklin, S. (1998). *Qualitative research in education* (3rd Ed.). Boston: Allyn & Bacon.

Blumer, H. (1969). *Symbolic interactionism*. Englewood Cliffs, NJ: Prentice Hall.

Bolton, S. (2003). Multiple roles? Nurses as managers in the NHS. *The International Journal of Public Sector Management, 16*(2), 122-130.

Bowers, B. (1989). Grounded theory. In B. Sarter (Ed.), *Paths to knowledge.* New York: National League for Nursing Press.

Bridges, W. (2003). *Managing transitions* (2nd Ed.). Cambridge, MA: DaCapo Press.

Burritt, J. (2005). Organizational turnaround: The role of the nurse executive. *JONA, 35*(11), 482-489.

Callero, P. (1986). Toward a median conceptualization of role. *Sociological Quarterly, 27,* 343-358.

Callero, P. (1994). From role-playing to role-using: Understanding role as a resource. *Social Psychology Quarterly, 57*(3), 228-243.

Cecchettini, D. (2002). From bedside to board room: interviews with nurse COOs and CEOs (Part III). *Nursing Econonics, 20*(5), 222-224.

Charmaz, K. (2006). *Constructing Grounded Theory.* London: Sage.

Connoly, A. (2001). Local hospitals look to clinician CEO for fiscal cure. *Boston Business Journal, June 11, 2006.*

Corbin, J., & Strauss, A. (1990). *Basics of qualitative research.* Newbury Park, CA: Sage.

Creswell, J, (2003). *Research design*. Thousand Oaks, CA: Sage.

Denzin, N. (1989). *Interpretive interactionsim*. Newbury Park, CA: Sage.

Dreyfus, S., & Dreyfus, H. (1980, February). A five-stage model of the mental activities involved in directed skill acquisition. Retrieved October, 2006 from http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA084551

Dreyfus, S. (1982). Formal models vs. human situational understanding: Inherent limitations on the modeling of business expertise. *Office: Technology and People, 1,* 133-155.

Ebaugh, H. (1988). *Becoming an ex: The process of role exit*. Chicago, IL: University of Chicago Press.

Eraut, M. (1994). *Developing professional knowledge and competence*. London: The Falmer Press.

Everson-Bates, S. (1992). First-line nurse managers in the expanded role: An ethnographic analysis. *Journal of Nursing Administration, 22*(3), 32-37.

Garman, A., & Tyler, J. (2004, October). *CEO succession planning in freestanding U.S. hospitals: Final report.* Retrieved November 2006, from http://www.ache.org/pubs/research/pdf/SuccessionRpt04.pdf.

Garman, A., & Tyler, J. (2004). What kind of CEO will your hospital need next? A model for succession planning. *Trustee, 57*(9), 38-40.

Gelinas, L., & Manthey, M. (1997). The impact of organizational redesign on nurse executive leadership. *JONA, 27*(10), 35-42.

Gerhardt, U. (1980). Toward a critical analysis of role. *Social Problems, 27,* 556-569.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: strategies for qualitative research*. Hawthorne, NY: Aldine De Grutyner.

Glaser, B., & Strauss, A. (1971). *Status passage*. Chicago: Aldine-Atherton.

Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: The Sociology Press.

Glaser, B. (1998). *Doing grounded theory: issues and discussion*. Mill Valley, CA: The Sociology Press.

Hardy, M., & Hardy, W. (1988). Role stress and role strain. In M. Hardy & M. Conway (Eds.), *Role theory perspectives for health professionals (pp. 159-239).* Norwalk, CT: Appleton & Lange.

Hewitt, J. (1989). *Dilemmas of the american self.* Philadelphia, PA: Temple University Press.

Hochgraf, L. (2006). *These nurses mean business*. Retrieved November, 2006 from http://www.minoritynurse.com/features/graduate/05-15000a.htm.

Hutchinson, S. A. (1992). Nurses who violate the nurse practice act: Transformation of professional identity. *IMAGE: Journal of Nursing Scholarship, 24*(2), 133-139.

Hutchinson, S. A. (1993). Grounded theory: The method. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing research: A qualitative perspective* (2nd ed., pp. 180-212). New York: National League for Nursing Press.

Kalish, B., & Escamilla, A. (2001). Nurse chief executive officers: A qualitative study. An unpublished manuscript, University of Michigan.

Katz, D., &Kahn, R. (1978). *The social psychology of organizations*. New York: John Wiley & Sons.

Khaliq, A., Walston, S., & Thompson, D. (2006). Perceptions of hospital CEOs about the effects of CEO turnover. *Hospital Topics, 84*(4), 21-27.

Kimball, B., O'Neil, E., and Health Workforce Solutions. (2002). Health care's human crisis: The American nursing shortage: The Robert Wood Johnson Foundation.

Lincoln,Y., and Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Linton, R. (1936). *The study of man*. New York: D. Appleton-Century Company, Inc.

McClenahen, J. (2007). Do you need a COO? *Industry Week: Cleveland, March 256,* 32-34.

Garvey, H., Chambers, M., & Boore, J. (2004). The influence of context on role: Behaviors of perioperative nurses. *AORN Journal, 80*(6), 1103-1120.

McNamara, C. (2008). *Basic overview of role of chief executive*. Retrieved May 2009 from http://www.managementhelp.org/chf exec/chf exec.htm

McPeck, P. (2001). The goalkeepers. *Nurse Week, October 1*.

Mead, G. (1934). *Mind, self, and society*. Chicago: University of Chicago Press.

Merriam, S., & Brockett, R. (1997). *The profession and practice of adult education*. San Francisco: Jossey-Bass.

Merton, R. (1957). *On theoretical sociology*. New York: Free Press.

Merton, R. (1957). The role-stress: Problems in sociological theory. *British Journal of Sociology, 8,* 106-120.

Monthly Labor Review. (2007). *U.S. Bureau of Labor Statistics*. November, 2007.

Moreno, J.L. & Moreno, Z.T. (1969). *Psychodrama Vol. 3.* Beacon, NY: Beacon House.

Morse, J. (2000). Determining sample size. *Qualitative Health Research, 10*(1), 3-5.

Nicholson, N. (1984). A theory of work role transitions. *Administrative Science Quarterly, 29*(2), 172-191.

Nicholson, N. (1987). The transition cycle: A conceptual framework for the analysis of change and human resources management. In K. Rowland & G. Ferris (Eds.). *Research in personnel and human resources management*, 5, pp. 167-222. Greenwich, NY: JAI.

Oatley, K. (1990). Role transitions and the emotional structure of everyday life. In S. Fischer & C. L. Cooper (Eds.). *On the move: The psychology of change and transition*. Chichester, West Sussex, England: Wiley.

O'Brien, B. & Spry., J. (1995). Expanding the role of the clinical nurse consultant. *Australian Journal of Advanced Nursing, 12*(4), 26-32.

Page, N., & Arena, D. (1991). Practical strategies for GNC role implementation. *Clinical Nurse Specialist, 5*(1), 43-48.

Park, R. (1926). Behind our masks. *Survey, 56*, 135-139.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks: Sage Publications.

Redfern-Vance, N., & Hutchinson, S. (1995). The process of developing personal sovereignty in women who repeatedly acquire sexually transmitted diseases. *Qualitative Health Research, 5*(2), 222-236.

Roemer, L. (2002). Women CEOs in health care: Did they have mentors? *Health Care Management Review, 27*(4), 57-67.

Sanders, L., & Bowcutt, M. (2004). CEO/CNO relationships: Survey findings. *Healthcare Executive, September/October*, 22-26.

Schlossberg, N. (1981). A mode for analyzing human adaptation to transition. *Counseling Psychologist, 92*(2), 2-18.

Seidman, I. (1991). *Interviewing as qualitative research*. New York: The Teachers College Press.

Shinkman, R. (2002). Rough road ahead. *Nurse Week, April 4, 2002*.

Smith, A. (2002). From bedside to board room: Interviews with nurse COOs and CEOs (Part I). *Nursing Economic$, 20*(3), 109-112.

Smith, A. (2002). From bedside to board room: Interviews with nurse COOs and CEOs (Part II). *Nursing Economic$, 20*(4), 171-173.

Smith, A. (2002). From bedside to board room: Interviews with nurse COOs and CEOs (Part III). *Nursing Economic$, 20*(5), 222-224.

Strader, M., and Decker,P. (1995). *Role transition to patient care management*. Norwalk, CN: Appleton & Lange.

Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. *IMAGE: Journal of Nursing Scholarship, 12*(7), 20-23.

Stern, P. N. (1982). Affiliating in stepfather families: Teachable strategies leading to stepfather-child friendship. *Western Journal of Nursing Research, 4*(1), 75-89.

Stern, P. (1985). Using grounded theory methodology to study women's culturally based decisions about health. *Health Care Women International, 6,*(1-3), 1-24.

The Joint Commission. (2009). *Comprehensive Accreditation Manual for Hospitals.* Oakbrook, IL: The Joint Commission Publications.

The Leadership Center. (1999). *The development guide: Group leader-program manager & project-team leader development.* Retrieved October 2006 from http://www.au.af.mil/au/awc/awcgate/gov/lanl-ldr-devguide.pdf.

Thrall, T. (2008). Finding your next CEO. *Hospitals and Health Networks, December 2008.*

Turner, R. (1962). Role-taking process vs conformity. In A. Rose (Ed.), *Human Behavior and Social Processes.* Boston: Houghton Mifflin.

Turner, R. (1990). Role change. *Annual Review of Sociology, 16*, 87-110.

Vadarevu, R. (2005, February 7, 2005). Nurse now hospital CEO. *St. Petersburg Times Online Tampa Bay.*

Velasco, A. (2004). Nurses' healing hands control hospitals' care. *Birmingham News, January 25, 2004.*

White, H., Boorman, S., & Breiger, R. (1976). Social structure from multiple networks. Part I: Blockmodels of roles and positions. *American Journal of Sociology, 81*, 730-780.

Wilson,C., & Stranahan, H. (2000). Organizational characteristics associated with hospital CEO turnover. *Journal of Healthcare Management, 45* (6), 395 404.

Zambroski, C., and Freeman, L. (2004). Faculty role transition from a community college to a research-intensive university. *Journal of Nursing Education*, 43(3), 104-107.