SOURCES OF OCCUPATIONAL STRESS FOR NURSE EXECUTIVES IN RURAL MANITOBA'S COMMUNITY HOSPITALS

BY

SHARON MARY EDMUNDSON

A Thesis
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ABSTRACT

Today's hospitals are becoming increasingly complex and stressful organizations. Few studies have examined the stressors experienced by nurse executives working in this highly stressful environment. None have considered the stressors experienced by nurse executives working in a rural hospital setting.

An exploratory descriptive design was used to explore and describe the major stressors that have caused nurse executives in rural Manitoba's community hospitals to experience job-related stress. As well, the relative intensity of the identified stressors was determined. Cooper and Marshall's (1978) Sources of Managerial Stress Model served as the conceptual framework for the study.

The Delphi technique, consisting of three successive rounds of mailed questionnaires which incorporated feedback from the previous round, was used for data collection. Data were analysed after each round of questionnaire using both qualitative and quantitative procedures. Fifty-four nurse executives completed all three questionnaires.

Forty-four stressor items were identified. Findings of the study generally supported Cooper and Marshall's (1978)

intra-organizational stressors. Two additional categories of extra-organizational stressors, namely the governing board and physical-related issues, arose. As well, contextual stressors related to the provincial government's health reform initiatives were also evident. The stressors that ranked highest in the degree of perceived stressfulness pertained to health reform, certain factors intrinsic to the rural nurse executive's job and problems with staff and staff relationships.

Strategies to prepare rural nurse executives to individually and collectively address the identified stressors are recommended. Ways that employers, the professional nursing association, and educational institutions can help to lessen nurse executives' perceived stress are also suggested. Design and methodological considerations for future research are addressed.

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This thesis is

lovingly dedicated to

my husband, David

and

daughter, Carmen

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OVERVIEW OF THE STUDY

Introduction

Today's hospitals are becoming increasingly complex and stressful organizations. "The management of interpersonal relations, the importance of services offered, and the ever changing technology in the hospital all contribute to a highly stressful environment" (White & Wisdom, 1985, p.113). Nurse executives are particularly vulnerable in this environment as they manage the largest number of employees and material resources (Scalzi, 1988). Rural hospital nurse executives are no exception. Furthermore, Henry and Moody (1986) found that nursing directors' jobs in small rural hospitals were more complex and demanding than they had anticipated.

Dynamic changes in health care have produced complex situational stressors, such as limited financial resources, changing governmental regulations, and competition for clients and funding, that can adversely affect nurse executives (Cohen, 1989). Nurse executives are likely to experience many situational stressors given the multiplicity of their roles and functions (Cohen, 1990). Key issues challenging Manitoba's rural nurse executives today are

budgetary cutbacks and uncertainty as to the future of their organizations and their roles related to rural health reform.

Work-related stressors can cause physical and psychologic disorders, affect nonwork life, and have potential deleterious consequences for their organization (Cohen, 1990). These outcomes may negatively influence the nurse executive's job performance. As the nurse executive has overall responsibility for the department of nursing, the delivery of patient care may be adversely affected. This possible outcome provides substantial justification for investigating the occupational stressors for nurse executives. The success of efforts to minimize stress depends on the accurate diagnosis of stressors, since different stressors will require different actions (Cooper & Marshall, 1978). This assumes that the stressors are amenable to interventions.

Scalzi (1984, 1988, 1990) and Cohen (1989, 1990) have studied the sources of job-related stress in top-level nurse executives. Having worked as a rural nurse executive for over ten years, the investigator had personally experienced many of the identified stressors. Furthermore, through discussions with other rural nurse executives across the province, the investigator was aware that they too

experienced tress related to their roles as nurse executives. These experiences led the researcher to wonder what caused the stress in their roles as rural nurse executives.

Scalzi's (1984) study on role stress was conducted in a large metropolitan county in the United States. Cohen's (1989) research on occupational stressors was set in California's public health departments. The question arose: Were the occupational stressors for nurse executives in rural Manitoba's community hospitals similar to those stressors identified in the above studies? Previous interactions with both urban and rural nurse executives suggested that the rural nurse executives had certain stressors unique to the rural setting. For example, the nurse executive was often the only non-unionized nurse in the facility and was solely responsible for labour management in the department. In addition, rural nurse executives frequently assumed a variety of additional roles such as pharmacist, material manager and inservice coordinator. As nothing had been documented in the literature regarding the perceived sources of occupational stress for rural nurse executives, it was a valid focus for a research study. A clearer understanding of the rural nurse executives' stressors was seen as key to stress prevention and reduction for this vulnerable group.

Statement of the Problem

The objective of this study was to explore and describe major stressors that have caused nurse executives in rural Manitoba's community hospitals to experience job-related stress and to determine the relative intensity of the identified stressors.

Research Questions

The research questions that guided this study were:

1. What are the perceived sources of occupational stress for top-level nurse executives in rural Manitoba's community hospitals?

2. Which stressors do rural nurse executives perceive as most stressful?

Significance of the Study

Investigation of the major sources of occupational stress can provide valuable information and direction for rural nurse executives. Once the sources are identified, nurse executives can individually and collectively address these issues. Individually, each nurse executive can anticipate stressors and develop personal strategies and skills to manage his/her workplace stressors. In addition, nurse executives can share or jointly develop strategies for

dealing with these major stressors. Regulating bodies, such as Manitoba Health and the Manitoba Association of Registered Nurses, can use this information when providing policy direction for rural hospitals and rural nurse administrators. This information will also be useful to employers when developing organizational structures and nurse executives' job descriptions. Nurse educators can incorporate this information into planning educational programs that will better prepare nurse executives to deal with anticipated stressors.

Conceptual Framework

Cooper and Marshall's (1978) Sources of Managerial Stress model served as the conceptual framework for this study. This model posits that managers have sources of stress both within and outside the organizational boundary (Figure 1). The fulcrum of the model is the individual manager. Factors such as the manager's personality, motivation, tolerance for ambiguity, adaptability and behavioural patterns (Type A or Type B) contribute to differences in the manager's ability to cope with stressors (Cooper & Marshall, 1978). The methodology chosen for this study did not address the characteristics of the individual manager that predisposed them to stress but focused on identifying and prioritizing intra- and extra-organizational stressors.

Intra-organizational Source of Stress

Cooper and Marshall (1978) described five categories of stressors within the organizational boundary: 1) factors intrinsic to the job, 2) role in the organization, 3) relationships at work, 4) career development and, 5) organizational structure and climate (Figure 1). An overview of the sources of managerial stress in each category follows.

Intrinsic job factors that cause stress involve having too much or too little work, time pressures and deadlines, poor physical working conditions, having too many decisions, having to cope with changes, and the consequences of making mistakes. Excessive travel, long and/or inconvenient hours, and having to work too fast are examples of stressful working conditions. Workload is seen as being either quantitative (too much work) or qualitative (work is too difficult). Both types are linked with symptoms of stress.

Potential stressors associated with a manager's role in an organization include role ambiguity, role conflict, having responsibility for people, having too little responsibility, lack of managerial support, having to deal with increasing standards of performance, and coping with rapid technological change. Role ambiguity exists when

managers have inadequate information about their work roles, whereas role conflict occurs when managers are torn by conflicting job demands. Differences between organizational structures will determine the extent of these stressors in the workplace.

Poor relationships with superiors, colleagues and subordinates are suggested as sources of stress at work. Difficulty in delegating responsibility, the manager's skill in participatory management, collegial rivalry, and a lack of social support in difficult situations are also potential stressors for managers.

Lack of job security, few job opportunities, and over or under promotion are potential stressors in the career development category. Frustration with having reached one's career ceiling and the resultant fear of redundancy, obsolescence or early retirement also cause career development stress. Status incongruency, the inconsistency between a person's achieved and ascribed status ranks, or the incongruency between an individual's social status and that of his/her family, can also be stressful for managers as it generates role conflict from incompatible expectations of a social position.

The organizational structure and climate can be stressful when it involves limited participation in decision

making, no sense of belonging, lack of effective consultation, poor communications, restrictions on behaviour, and office politics. These factors may threaten the manager's freedom, autonomy and identity.

Extra-organizational Source of Stress

Extra-organizational sources of stress arise from the interfaces between the manager's worklife and life outside the organization. Family problems, life crises, financial difficulties, company versus family demands, and company versus personal beliefs or interests are possible external stressors for managers. The dual career marriages common today may also add stress to the manager's life as there is no longer the traditional segregation of work roles for men and home roles for women. The resultant sharing of roles may require excessive energy inputs and may prevent any of the roles from being fulfilled successfully.

Cooper and Marshall (1978) posited that knowing the possible sources of managerial stress would assist in the development of suggestions for minimizing its negative consequences. They, therefore, compiled the research findings from the management and organizational stress literature into a framework that would facilitate the clear identification of managerial stressors. This framework is

thus appropriately suited for the proposed study of occupational stressors experienced by rural nurse executives.

SOURCES OF MANAGERIAL STRESS

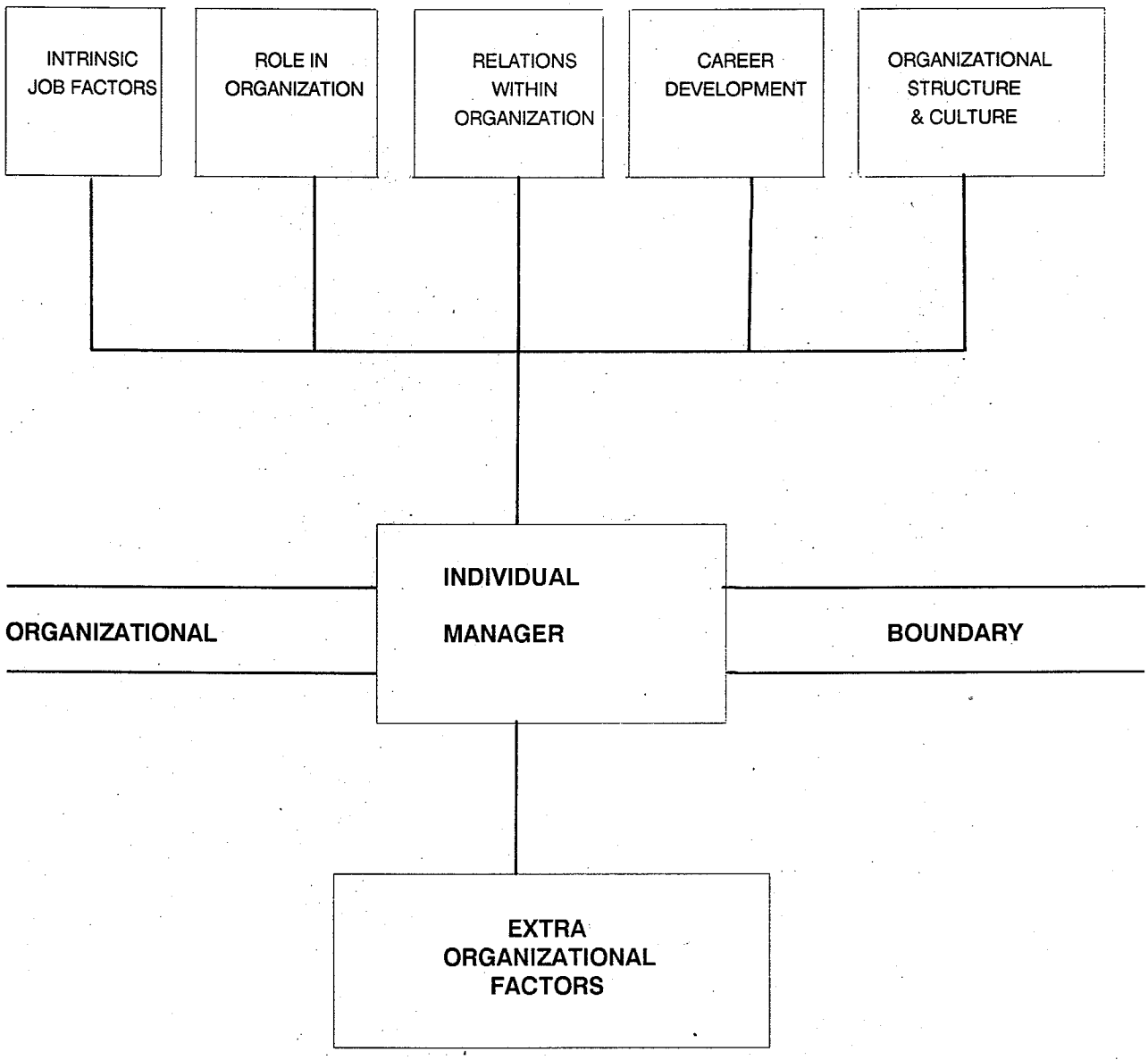

FIGURE 1: **Adaptation from the Sources of Managerial Stress Model. From Cooper, C. L. & Marshall J. (1978). Stress at Work (Figure 3.1) New York: Wiley.**

Definition of Terms

For this study the following terms are defined below:

1. Rural Hospitals - (acute care) community hospitals located outside the cities of Winnipeg and Brandon; excluding federal and provincial nursing stations.
2. Nurse Executive - the one registered nurse from each hospital with overall administrative responsibility for the department of nursing and who reports to the chief executive officer.
3. Occupational Stressors - events or conditions in the working environment that promote perceptions of increased work-related stress.
4. Stressfulness - "the degree to which events or conditions involve uncomfortable feelings or sensations such as fear, anxiety, worry, concern, frustration or anger" (Mullen, 1985, p. 370).

Some of the literature pertaining to occupational stress has its basis in role theory. Terms unique to role theory appear in the literature review and therefore require definition to enhance the reader's understanding of the review.

5. Role - "the expected and actual behaviours associated with a position" (Hardy & Hardy, 1988, p. 165).

6. Role Set - "designates the various role relationships inherent in occupying a particular position" (Scalzi, 1990, p. 85).
7. Role Set Diversity - requirement of a person to maintain working relationships with others in wide variety of complimentary roles (Snoek, 1966).
8. Role Stress - "a social structural condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet" (Hardy & Hardy, 1988, p. 165).
9. Role Strain - "felt difficulty in job performance" (Arndt & Laeger, 1970a, p. 253).
10. Role Conflict - role expectations are contradictory or mutually exclusive (Hardy & Hardy, 1988).
11. Role Ambiguity - role expectations are vague or lack clarity (Hardy & Hardy, 1988).
12. Role Overload - role expectations are excessive relative to time available (Hardy & Hardy, 1988).
13. Role Diffusion - the inability to keep separate the activities and behaviours of an individual's various roles (Long & Weinert, 1989).
14. Boundary Position - one in which some members of the individual's role set are located in another department within the same organization or in another organization entirely (Kahn, Quinn, Rosenthal, Snoek & Wolfe, 1964).

Organization of the Thesis

This introductory chapter has presented the statement of the problem, the research question, the significance of the study, and the conceptual framework and a definition of terms used in the study. The second chapter provides a review of literature relevant to the study. Chapter 3 outlines the methodology used in conducting the study. Chapter 4 focuses on the results and analysis of the study. The final chapter discusses the findings, the implications for practice and the recommendations for future research.

CHAPTER 2

REVIEW OF THE LITERATURE

Very little research reviewed proved relevant to the topic under study. Much of the available literature is anecdotal in nature and originated in urban areas of the United States. The literature review critically examined the following topics: (1) Rural health factors relevant to rural nursing administration; (2) Rural nursing issues that predispose the nurse executive to occupational stress; (3) Rural nursing administration; (4) Stress related to work and families; (5) Executive stress; (6) Work stress among health care administrators; (7) Occupational stress among nurse executives.

Rural Health Factors

A number of rural health factors and issues relevant to rural nursing administration are evident in the literature. Forty percent of Manitoba's population lives outside the cities of Winnipeg and Brandon (Manitoba Health Services Commission, 1992). This rural population is served by 71 community hospitals, excluding the northern and provincial nursing stations (Manitoba Health Services Commission, 1991). Fifty (70%) of the 71 hospitals have 30 or fewer beds. The majority of these hospitals are clustered in the

extreme southern part of Manitoba often within a 30 minute drive of each other (Appendix A). Most rural hospitals continue to offer traditional medical-surgical, pediatric and obstetrical services for their communities (Canadian Hospital Association, 1993).

Rural people and rural communities have unique values and beliefs about health and health needs. A descriptive study, that used both qualitative (ethnographic interviews) and quantitative (survey) methods to collect data over a six year period in rural Montana, identified concepts important to understanding rural health needs and rural nursing practice (Long & Weinert, 1989; Weinert & Long, 1987). Health was defined as "the ability to work or to be productive in one's role" (Weinert & Long, 1987, p. 452). Health was of secondary importance to work; a work ethic that may affect the use of social and health services. Health care must therefore be geared to rural work practices. Self-reliance and independence were also key concepts for rural people. As well, they preferred the informal support of friends and families and resisted help from persons seen as outsiders to their support system and newcomers to the community. Consequently, formal health care services need to be blended with the community's informal helping system. Health care providers living in

rural communities were found to experience lack of anonymity and greater role diffusion. Establishing networks for information exchange and peer support would help nurses deal with the stresses of rural practice.

Bushy (1990) attributed rural dwellers' reluctance to seek other's assistance to their work ethic, pride in self-reliance, fear of receiving insensitive treatment, and fear that confidentiality may be broken. Functional illiteracy may also deter them from seeking health care. Rural communities were described as being slower to change traditional cultural values, preferring less organized bureaucracy, having limited employment opportunities and fewer special interest groups. Intergenerational businesses are common in rural communities and the family's income is often dependent on the financial success of the area's major industry. The recent farm crisis in America was cited as contributing to the increase in unemployment, accidents, domestic violence, child abuse and neglect in the rural population.

Fenton, Rounds and Iha (1988) refer to rural dwellers as economically and socially intertwined. As a result, gaining support and acceptance for health programs and changing health behaviours is greatly influenced by peer pressure. Health care must be accessible and integrated into daily routines of rural people's lives.

Socioeconomic and health concerns specific to rural areas in the United States included an urban bias in resource allocation, a higher proportion of elderly, a declining utilization of services and the high incidence of work- related injuries, hospitalization and deaths among farmers (Wakefield, 1990). Coupled with the disparity in funding, rural hospitals faced increased financial burdens related to an increase in medical tests and procedures, as well as, escalating costs for capital equipment and employees' salaries and benefits (Jamieson, 1981). Manitoba's rural hospitals share many of these problems. The allocation of financial resources is one part rural to three parts urban despite the 40:60 ratio in population (Horne, 1989). Horne justified this disparity in funding by saying that rural dwellers use urban health care facilities. Manitoba data confirmed that many rural Manitobans admitted to Winnipeg hospitals do not require complex care; however, alternative services are often not available in their community (Manitoba Health, 1992).

As in the United States, rural Manitoba has a higher proportion of elderly. Winnipeg has 12.5 percent of its population over 65 years whereas 14.1 percent of Manitoba's rural population is in this age category (Manitoba Health Services Commission, 1990). Rural hospitals will likely