A Certified Registered Nurse Anesthetist's Transition to Manager

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The purpose of this exploratory qualitative study was twofold: (1) to identify common experiences or barriers that arise during the first year as Certified Registered Nurse Anesthetists (CRNAs) move into management and (2) to identify knowledge, skills, abilities, and resources needed to ensure a smooth and successful career transition for new CRNA managers. A sample of 18 current and past CRNA managers participated in one-on-one phone interviews using a 16-question, semistructured interview protocol. Interview data were analyzed for emergent themes using qualitative data analysis software.

Results identified 2 common phenomena among CRNA managers. First, many managers did not seek management opportunities but fell into their management role, with 11 (61%) having no management experience. Second, 14 (76%) of the participants performed greater than 50% clinical duties as a manager, thus a hybrid manager. Important knowledge, skills, abilities, and resources identified as valuable during a transition into a managerial role included mentorship (83%), previous relevant education or experiences (67%), and people skills (56%). This study found lack of direction or training (28%) as the most common difficulty during transition. Results of this investigation may assist current and future CRNA managers to be better prepared to assume managerial roles.

Keywords: First-time manager, hybrid manager, nurse manager, physician manager.

Many first-time managers in healthcare were successful in their roles as individual practitioners;[1,2] however, success as an individual practitioner may not translate into success as a new manager. New Certified Registered Nurse Anesthetist (CRNA) managers must have an understanding of management tenets while producing departmental results. Research suggests that nurse and physician transitions to management differ based on previous clinical identity.[3] An examination of the nurse anesthetist's managerial transition, and that of CRNA practitioners, is lacking in the literature.

Existing literature makes clear that the transition for new nurse anesthesia managers is more challenging than ever before, because of the changing political and financial landscape in healthcare.[4,5] Management positions require a type of knowledge that deviates from the physiology and pharmacology of clinical anesthesia practice. The weight of representing a department and interacting as one contributor in a complex organization, coupled with the need to acquire a vast amount of management knowledge, may cause new managers to have feelings of inadequacy and disappointment in the new role.[1,2]

This project aimed to answer these research questions:

1.Are there common barriers or experiences that CRNA practitioners encounter when transitioning into a new role as a manager?

2.What knowledge, skills, and abilities (KSAs) and resources are important during transition to a CRNA manager?

Review of Literature

The transition into management is a critical time and is perhaps one of the biggest challenges any manager will face in his or her career.[6] A new manager must adapt and learn new skills that are based in management, not clinical skills. These managers, who have more direct reports (staff reporting to a manager) than their own supervisor, and less organizational support than their physician or administrative peers, are leaving management, thus creating a leadership gap.[7] New managers commonly find they have to learn and practice management skills on the job. Before acceptance of a managerial role, CRNAs should be grounded in the actual realities of what that role is within an organization.

First-time or frontline nursing managers are frequently required to balance patient-care duties and new management duties with more direct reports and fewer resources than senior-level administrators.[7,8] Turnover of nursing managers is double that of clinical nurses, attributable to expectation mismatch and lack of organizational and psychological resources.[9] A lack of clinician desire to enter frontline managerial positions, lack of succession planning, and nursing shortages in healthcare have created discussion in the literature about engaging staff in hospitals to enter into management positions.[7,10]

• ***Leadership Gap.*** The leadership gap in nursing will catch up to nurse anesthesia leadership in the form of a crisis.[11-13] Healthcare organizations are starting to create methods to develop nursing executives, which may eventually carry over to first-time managers.[14,15] It is important for the nurse anesthesia profession to recognize the need for leadership development for frontline CRNA managers. Frontline managers have the unique opportunity to make a direct impact on healthcare policy in organizations. Well-educated nurse anesthesia leaders have the potential to affect healthcare policy that advocates for the profession.

• ***Managerial Development, Characteristics, and Derailment.*** Peter Drucker, a famed management expert, is quoted as saying that "healthcare is the most difficult, chaotic, and complex industry to manage today."[16] Management relies on getting things done through others.[1,2,4,17] Nurse anesthetists are typically determined, highly skilled, and independent, so relying on others for success may be difficult to embrace upon first becoming a manager because it contradicts how CRNAs function in a clinical setting.

It is commonly accepted that companies with good managers outperform other companies by decreasing absenteeism and turnover, and by increasing employee satisfaction, productivity, and net profits.[18] Effective managers are credited with improving patient safety and developing relationships based on fairness and empathy, in addition to making employees feel valued and respected.[15,19] Effective managers can reduce the costs for organizations, and yet these same organizations do little to nurture new managers. Many professions promote exemplary employees to management positions as a mechanism to increase employee wages or offer greater autonomy.[20] The greater workload and increased stress, related to the removal of middle management positions (or organizational flattening) prevents potential qualified managerial candidates from desiring a management position.[1,7,11,20]

How to develop a good manager is disputed in the literature.[21] The skills needed to be a star employee are rarely ever the same skills required to become an effective manager. In fact, some researchers have suggested that, contrary to popular opinion, a focus on a new manager's "strengths" as a method of building management skills may be the start of a new manager's downfall.[21,22]

Although mostly ignored over the past decade, well-documented research on identifying what makes a poor manager is currently resurfacing.[20-22] These research findings have suggested a consensus on what makes a bad manager; therefore, it may be more important to understand why failure occurs.[21-23] The mistakes of a new manager do not preclude a successful career; they are, in fact, to be expected of anyone taking on a new professional role. Mistakes can, however, slow a new manager's effective transition.[1,2,6,17] Failure or derailment in management positions occurs at a rate of more than 50%, which has been true since the 1980s, and the numbers of derailed managers have remained constant.[21] Managers who derailed (were unsuccessful in their management position, resulting in voluntary or involuntary resignation) were shown to have common faults or behaviors that contributed to their derailment. These faults can be sorted into 3 broad categories: problems with interpersonal relationships, leadership problems, and the inability to adapt.[22,24]

Emotional intelligence (EI) of a manager is considered an important factor in effective leadership.[25,26] Leaders who have low EI have been found to exhibit a lack in establishing interpersonal relationships, thereby decreasing a leader's effectiveness. Lacking in interpersonal relationships include the inability to deal with conflict, betrayed trust, insensitivity, aloofness, being arrogant, and being overly ambitious.[21-23] A failure to attain interpersonal relationships is the most cited cause of manager derailment, preventing managers from building relationships with bosses, peers, and people who report directly to them.[22,23] Derailed managers were also found to lack self-awareness.[22,23,25] Providing a new manager with honest feedback may promote self-awareness or increase EI, which is a learned skill.

Most management derailments have occurred after a transition to a higher level in management.[23] To avoid having to cut one's losses as a derailed manager and start over in a new position, the new manager may be able to manage certain behaviors that predictably lead to derailment before the derailment occurs.[22,23] The first year as a manager can shape a career either by setting up good foundational habits or by starting with poor practices that create cyclical events that are difficult to undo, thus having a greater potential to derail a promising management career.[1,2,6,17]

Materials and Methods

• ***Study Design.*** A phenomenological qualitative design was chosen to develop an understanding of participating CRNAs' perception of the phenomena of transitioning into a manager.[27] Permission to implement this study was obtained from the institutional review board of the University of Michigan-Flint in Flint, Michigan.

Six to 10 participants were chosen as the minimum target sample. Data saturation was used to determine sample size, thereby enhancing the validity of the research. Data saturation was achieved once existing themes became exposed, and further data did not reveal new information or new themes. Participants were included in the study if they were previously or currently a CRNA manager or chief of an anesthesia department and if they had no previous relationship to the author. Participants were obtained from 2 sources: first by email

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

Table 1. Phone Interview Questions for CRNA Managers
Abbreviation: CRNA, Certified Registered Nurse Anesthetist.

to American Association of Nurse Anesthetists (AANA) members and second by a Facebook post to a group titled "CRNAs & SRNAs." Eleven participants responding from email and 9 responding from Facebook were interviewed. All participants were interviewed despite achieving saturation after participant 16. Two participants were excluded: 1 because a recording error occurred during the interview, and the other was unable to be reached after initial contact. Therefore, the total number of participants was 18.

The narrative data from the participating managers were analyzed by constant comparison analysis, word count, and classical content analysis; these 3 methods were used to ensure triangulation of data for descriptive and interpretive validity.[28] Data saturation was used to determine the final sample size (N = 18), thereby enhancing the validity of the research.

Participants were asked a 16-question interview protocol (Table 1) designed to illicit answers to this study's research questions. Of the 16 questions, 10 qualitative questions were designed to elicit open-ended responses to ensure rich data compilation. The remaining 6 questions were quantitative and intended to assess a representative sample of CRNA managers and to associate specific phenomena with age, gender, and experience. The interview protocol was not tested before the study.

All phone interviews were conducted and recorded by the principal investigator to ensure consistency with the interview protocol. The phone interviews were then transcribed by a professional transcriber and were reviewed and deidentified by the principal investigator for content accuracy and participant protection.

• ***Coding Method.*** A mixed methods approach employing both etic and emic techniques guided data analysis for this research study. This approach resulted in the creation of themes, codes, and subcodes based on both the demand characteristics of the interview protocol and on emerging thematic trends in the data. The primary analyst used a 4-wave process to code the data. This coding procedure was preferred because it provided a way of looking at the data from various points of view and it improves the quality and reliability of coding.[29]

• ***Reliability Measures.*** To establish reliability in the coding process, transcribed interview data were coded by 2 independent qualitative analysts using quantitative data analysis software (NVivo 11 Pro, QSR International Inc, Burlington, MA). The coding method allowed the coders to detect sources of disagreement and correct bias, thereby training one another to code independently, reducing subjectivity and increasing validity. The interrater reliability κ between the 2 coders for this study was 0.93186. A κ above 0.90 is considered to be a very high coder agreement. Furthermore, NVivo analysis demonstrated that the coders had an interrater agreement of 99.1219%, which is exceptionally high considering the large number of codes used in the analysis.

Results

• ***Response Rate.*** The response rate to the email solicitation and Facebook post was 0.4% and 0.07% respectively, which is similar for other research using email or Facebook methods to recruit participants.[30] The response rate in this study may be due to the following factors: CRNA managers were not targeted in recruitment, study participation required participants to reach out to the interviewer, the study required larger amounts of time and commitment than other online studies, the Facebook post may have had limited exposure because of the timing of the post; and general study fatigue of potential participants.[30]

• ***Demographics.*** From the study sample of 18 participants interviewed and recorded by phone, most participants, 12 (67%), were between the ages of 41 and 60 years (Table 2). Seventeen participants (94%) were white, and 10 (56%) were male. As *clinician* CRNAs, 16 (89%) had 6 or more years of clinical experience. Despite this clinical experience, most participants (12, or 66%) had less than 5 years of CRNA management experience. For 76% of participants (13 of 17), their managerial role required more than 50% of their time performing clinical duties vs managerial duties.

Seven participants (38%) described previous military or law enforcement experience, without this being prompted for directly. Thirteen participants (72%) had previous experience as a managerial CRNA before their current role. Eleven participants (61%) had no previous management experience or management education before accepting their first role as a CRNA manager.

• ***Difficulties, Resources, Knowledge, Skills, and Abilities for Transitioning Managers.*** Eleven (61%) of the 18 research participants indicated that they simply fell into the role (Figure).

> *"Quite honestly, we are [at a] very small hospital, small anesthesia department, and I just kind of fell into the role."* (Participant 1, man, aged 44 years)

Six research participants (33%) described how they were encouraged to take the role. Four (22%) of the participants indicated that they were led to a CRNA management role because there was an available position (see Figure).

The most common difficulty during transition—lack of direction or training—was cited by 5 (28%) of the 18 participants. Transitioning CRNA managers perceived the most valuable resource during their transition period to be mentorship, such as that of current, past, or medical colleague managers, as cited by 15 participants (83%). Ten participants (56%) cited people skills as the most important skill to acquire when transitioning into management.

Characteristic	No. (%) of participants
Gender	
Female	8 (44)
Male	10 (56)
Age, y	
31-40	3 (17)
41-50	7 (39)
51-60	5 (28)
61-70	3 (17)
Previous management experience/education before becoming a CRNA manager	
Yes	7 (39)
No	11 (61)
First position as CRNA manager	
Yes	5 (28)
No	13 (72)
Years' experience as a clinical CRNA	
3-5	2 (11)
6-10	6 (33)
11-20	3 (17)
> 21	7 (39)
Years' experience as a manager CRNA	
0-2	8 (44)
3-5	4 (22)
6-10	2 (11)
11-20	2 (11)
> 21	2 (11)

Table 2. Demographics and Experience of Participants (N = 18)

Abbreviation: CRNA, Certified Registered Nurse Anesthetist.
[a]Percentages may not equal 100% due to rounding.

Discussion

• ***Characteristics of CRNA Managers.*** In this study, most CRNA managers (89%) had greater than 6 clinical years of experience. Only 28% were in a first-time management position, perhaps a reflection of commonly held perceptions that managers must be the most knowing and have the most experience within a professional group. Eleven (61%) of the 18 participants had no previous management or education before accepting their first role as manager, and 12 (66%) had less than 5 years' experience as a CRNA manager. High turnover in healthcare management may have created positions for these new managers.[8,9] Many first-time managers are promoted based on clinical and/or professional abilities, not on management skills or experience,[1-3] and this study confirms that CRNA participants are no exception.

The question of military duty was not asked of the participants, yet 38% did include military training in their responses. An incidental finding, this number might have been larger had the interview protocol included a direct question about military experience. One possible explanation for the high frequency of military experi-

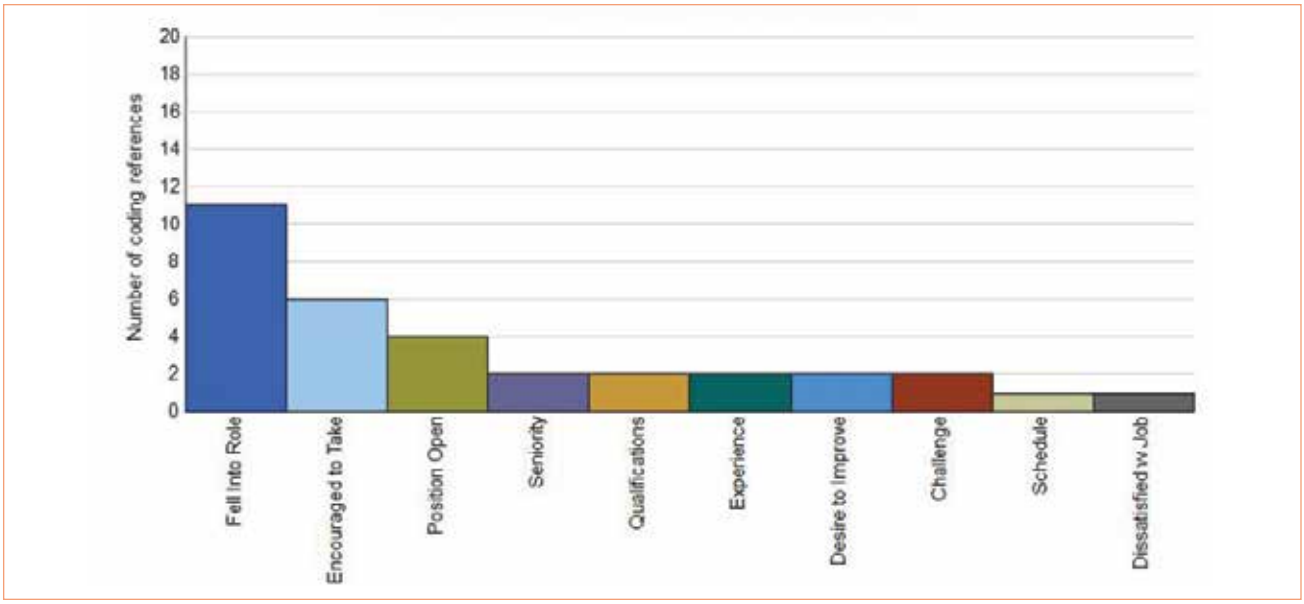

Figure. Factors That Lead to CRNA Participants Entering Management
Abbreviations: CRNA, Certified Registered Nurse Anesthetist; w, with.

ence among the respondents could be that the study required participants to volunteer, which is shown to be higher among military veterans, likely because of their increased sense of duty and citizenship.[31] Another possible explanation may be that military CRNAs are apt to accept leadership roles based on this sense of duty and military training.

• ***Clinical or Managerial Skew—The Hybrid Manager: Phenomenon 1.*** The expectations of managers vary depending on the size of the hospital and scope of anesthesia services throughout the hospital. Of the 17 participants asked this question, 13 (76%) spend at least 50% of their time providing clinical anesthesia services. Results suggest that the smaller the hospital, the less opportunity a manager had to perform managerial duties. This creates a manager who functions both clinically and managerially, a hybrid manager.

> *"We are not big enough for me just to do management."* (Participant 1, man, aged 44)

Possibly, CRNAs devote more time to clinical duties to avoid the stigma associated with management. Other healthcare management professionals, both physician and nursing colleagues, recognize that management is viewed as an added layer of bureaucracy that some clinicians may view as a hindrance to their practices.[32,33]

> *"I was always clinical as well. That sort serves you well. If you're locked in an office and nobody sees you doing anything, that breeds contempt."* (Participant 3, woman, aged 68)

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

> *"They want you to do the work, but you cost them money when you're not sitting on a stool. So, you have to have dual roles, and it's the dual roles that put the stress on the job because … you have to talk to pharmacy, talk to maintenance, talk to the [operating room.] You know, you're multitasking tremendously because at 7:30 in the morning you got to be doing a case."* (Participant 5, woman, aged 55)

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

> *"If anything, it gives me a lot of leeway. I think everybody recognizes that as I come running and I'm 5 minutes late with a set of scrubs on—that nobody really gives me any flack for it … like I said, it gives me some leeway and maybe a little lower expectation."* (Participant 7, man, aged 45)

The hybrid manager provides an individual and departmental contribution, which can increase workload and errors.[8] Healthcare managers with less patient contact were more likely to stay in their position as a manager.[8] A balance of hybrid duties can create stress not experienced by other clinicians or nonhybrid managers.

> *"I spend a lot of my free time doing admin[istration] stuff. When I'm, you know, working at my facility as chief and I'm clinical 8 hours during that day, I still have all of those stresses, people coming to me with complaints, concerns, not just the CRNAs, other administrators in the hospital with issues.… My level of stress is way higher than it should be."* (Participant 13, woman, aged 41)

This is not to say that managers should never or should infrequently contribute to patient care or avoid helping their direct reports if help is needed. However, mastery of management skills is similar to mastering anesthesia skills; both require development with time and practice.

• ***Why CRNAs Choose Management—The Happenstance Manager: Phenomenon 2.*** The lack of intention in entering into management is a recurring phenomenon in this study. Fifteen (83%) of the 18 participants stated they either fell into or were asked to accept a managerial

role (see Figure). This finding confirms study results that suggest many clinicians are not seeking managerial roles.[7,11,12,21] Clinical CRNAs in this study did not seek a managerial pathway but instead volunteered for the job because of lack of interest by their peers or because they were encouraged by a previous manager or administrator.

> *"They thought I would be good in that role. There were 7 people nominated from among all of the anesthetists of the group. None of the other ones accepted the nomination, except for me. I by default became the next chief."* (Participant 15, woman, aged 41)

Lack of interest in managerial roles among physicians and nurses may be due to stigma associated with managers as agents of status quo or bureaucracy, a lack of organizational support, and increased stress and workload with little financial or home/life balance reward.[32,33] The current and increasing nursing shortage, lack of organizational and leadership support, and lack of interest in managerial roles may cripple CRNA momentum in hospital organizations at a time when the public spotlight on healthcare will require leaders in health organizations to explain, defend, and share their visions of healthcare.[7,11,33]

• ***Common Barriers.*** The elusive nature of defining the expectations of a new manager's position was the most commonly cited barrier to overcome (5 of 18, or 28%).

> *"[I]t really wasn't a well-defined position.… [T]he previous chief really didn't have a lot of responsibilities, so that in itself, defining my role was definitely a huge challenge."* (Participant 13, woman, aged 41)

Lack of direction is universally an issue among new managers.[3,18] Managing expectations, including one's own, can be a cause of derailment for new managers.[1,16,22]

Six (43%) of 14 participants described being surprised about managing conflicts during their transitions.

> *"[I]t became very stressful trying to manage the 2 of them [CRNA staff] and to keep them from actually becoming physical."* (Participant 1, man, aged 44)

> *"[M]aking a transition from friend to manager leader is a bit of a challenge for certain staff [whom] you've been colleagues and friends with for a decade or longer, and now you are their boss. That transition took a little bit of time."* (Participant 11, man, aged 53)

Lack of preparedness in conflict management aligns with nursing and physician research studies whose results describe the same difficulties during a transition.[7,16,32,33] The participant managers felt they understood before transitioning that dealing with conflict would be part of the position but were surprised by the intensity of time involved, the severity of issues, and how quickly they had to address these issues during the transition. Strategic planning of these common obstacles may ease the transition.

• ***Resources to Recommend.*** Fifteen participants (83%) cited *people* (other managers or medical staff) as their primary resource during transition. Some research participants relied on managers above themselves, such as bosses and supervisors; others relied on managers in lateral roles, such as managers in other departments.

> *"I have a manager above me, CRNA manager above me. I also have direct access—in fact I meet every other week with the administrator. They are good sources for information, questioning, talking about mentoring, so they are, those 2 are my primary sources.… My other supervisor… is mostly as a colleague to talk through issues with."* (Participant 11, man, aged 53)

The 2011 Institute of Medicine report on the future of nursing urged development of mentorship programs in the form of residencies and leadership training.[34] Managerial experts believe in the necessity of having mentors during a transition[1,7]; they recommend having varied relationships between veteran and new managers through both formal or informal channels.[1,2,18] Mentors can be inside or outside the organization where the manager works. Transitioning managers who find and develop relationships with mentors or seek self-awareness have positive outcomes, such as job satisfaction and performance.[1,2,21,24] Developing these relationships can provide the new CRNA manager with emotional support, constructive feedback on real-time issues, and guidance in the organization's politics.

A majority (13, or 72%) of participants had previous management experience. Eight (62%) of these 13 participants with management experience believed that previous education or experience was a valuable resource during their transition. Experts agree that most managerial learning is done on the job.[1,2,35] Five (38%) of the 13 participants with previous experience described previous education in management as a resource that assisted them during transition.

> *"I think my MBA training was advantageous along with previous leadership experience in larger organizations.… [A]lso AANA training at national meetings and leadership conferences was a definite benefit in organizational management."* (Participant 18, man, aged 39)

• ***Knowledge, Skills, Abilities.*** The CRNA participants (10 of the 18, or 56%) agreed that people (or soft skills) were the most important skill to have during a transition. Soft skills are those associated with building relationships, communication, empathy, and emotional intelligence.[36] Soft skills require practiced, mindful, deliberate focus and can be difficult to achieve under the stressful conditions of a transition. The American College of Healthcare Executives describes communication and relationship development as interconnected competencies that are learned together and that comprise one of the most important and difficult skill sets to master.[37]

> *"So, I've got several struggles; some of them have gotten better and some of them are still the same, I just have to deal with [them]. People skills—dealing with handling people—are the biggest skill set that I think a manager needs."* (Participant 1, man, aged 44)

The next most cited KSAs included financial knowledge (6, or 33%) and communication skills (5, or 28%). Research demonstrates that the biggest reason manag-

ers fail is lacking ability in establishing interpersonal relationships.[21,22,24] Most participants' biggest hurdles, staff conflicts and relationship changes, recurred in the analysis, creating a common theme. Based on the results of this study and existing research, new CRNA managers may benefit from focusing their learning on enhancing communication and relationship management skills.

• ***Strengths/Limitations.*** Study limitations include possible skewed data toward a military management framework, which is one type of approach to managerial training; a lack of diversity in the sample; and no data collected from the participants to differentiate between managers of large or small hospital or surgical center departments.

Recommendations for future research include an investigation of the reasons for CRNA hybridity and the impact such a role has on effectiveness as a manager, as well as assessment of types of leadership styles used by CRNA managers. Despite the limitations, the research does verify phenomena of unintentional movement into management by CRNAs, the hybridity of CRNAs with greater clinical focus, and consensus on learning communication and relationship management as important knowledge and skills.

Conclusion

Adding to current literature, the results of this qualitative study found that CRNAs are happenstance managers who spend more time performing clinical duties than managerial duties. This study finds that new transitioning managers should focus on gaining insight into the expectations of their new role from both administrative and clinical staff. New CRNA managers should become proactive in gaining KSAs regarding how to develop, interact, and communicate with people. Administrators who hire these new managers should ensure these managers have access to mentors, education for communication techniques, and frequent feedback regarding their effectiveness as a manager. Most participants in this study agreed that finding a trusted mentor to discuss or work through the difficulties of management helped ease their transition period. To influence a healthcare organization in a meaningful way, happenstance individual managers will need to become passionate drivers of change.

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