

HOSPITAL ADMINISTRATION STUDENTS' ORIENTATION
TO PROFESSIONALIZATION

by

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ABSTRACT

The purpose of this study was to examine students' attitudes towards the professionalization of an occupation. Hypotheses tested the relationship between exposure of Hospital Administration Students to educational influences, and attitudes towards professionalization of Hospital Administration as well as between individual, demographic, occupational and organizational backgrounds of these students and their attitudes towards professionalization of their occupation.

In order to test the six hypotheses data were collected from two different classes of students enrolled in the H.O.M. programme of the Canadian Hospital Association. One class had received a professionalization teaching exposure while the other class was unexposed to this material at the time the study was conducted.

The method of investigation focussed on association and correlation analysis of students' demographic backgrounds on the one hand and a measure of professionalization orientation on the other. A professionalization index and several sub-indices were constructed based on factor analytic procedures. Attitude to professionalization was measured by questionnaire and composite analyses were undertaken to determine whether the two samples of students came from similar populations; to generate dimensions of professionalization; to examine the teaching programme effect; to ascertain whether differences, other than the programme exposure, would be associated with differences in orientation to professionalization; and to test the hypotheses regarding differences in orientation for groups of students with similar demographic characteristics.

The findings of this study indicated a significant positive relationship between exposure to educational input on professionalization and a student's orientation to professionalization with regard to the occupation of Hospital Administration. Students exposed to educational input had a higher overall orientation to professionalization. Differences in degree of orientation appear to relate specifically to the Dimensions of Acceptance and Public Recognition; Work, Standards and Establishment of the Profession; and, Utilizing Professional Judgement and Sharing of Knowledge.

In addition, nurses and accountants, two sub-categories in the sample, were found to differ significantly in terms of one professional index dimension, Realism. Students with a nursing background had a higher professionalization orientation towards Standards and the Quality of the Body of Knowledge, the components of the dimension of Realism. This could indicate that students with a nursing background wish to identify with a professional model for an occupation in order to improve their own professional status.

Implications of the study findings are discussed as to sample size and structure and its limitations and sponsorship by the Canadian Hospital Association. It is recommended that further research should be undertaken on the dimensions of professionalization in order that occupations could then be provided with an easy index for assessing such attitudes of the members, of their organizations. They could then have criteria for measuring what attitudes should be reshaped in order to alter the professionalization process of the occupation.

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HOSPITAL ADMINISTRATION STUDENTS' ORIENTATION
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1.0 INTRODUCTION

This thesis has been developed to examine students' attitudes towards the professionalization of an occupation. One area of concern, within the health field, which is gaining more importance and requires research, is the relationship between individual, demographic, occupational and organizational backgrounds of students of Hospital Administration and their attitudes towards the professionalization of the occupation of Hospital Administration. An unanswered question is: do the demographic, occupational and organizational characteristics influence students' attitudes towards professionalization of their occupation. The chief reason for this neglect may be due to the fact that Hospital Administration is a relatively new occupation and one whose importance, until recently, was not recognized by the public, governments, the health care system and to some extent by the majority of Hospital Administrators.

The Canadian Hospital Association (C.H.A.) at its Convention (June 1971) indicated that "During the past few decades and in particular the last ten years, the greatest impact of change on the health care Administrator has been the quality and quantity of change itself." There have been changes in the health care delivery system, an explosion of knowledge, emergence of new disciplines, new categories of non-medical health personnel and medical specialities. The increased population has higher standards of living and levels of education, and patients have become accustomed to higher levels of service than ever before. There has also been a gradually changing emphasis on the long-run health needs of defined populations, rather than on the short-run maximization of institutional

objectives. Consequently, the health care Administrator's responsibility has increased enormously as health services increase in quality, quantity, complexity and cost. These "Many factors give increased visibility of the Administrator to the critical eye of the public" (C.H.A. 1971). The Administrator is therefore exposed more than ever before to public criticism and has little or no refuge within a professional association, in a union, or as an anonymous staff member in an organization. In order to improve their image and position they are challenged to acquire and demonstrate competence and to create a system that appeals to the health care industry and the public.

Until very recently, research on professionalization was left to the occupational sociologists, like Carr-Saunders and Wilson (1933, 1964). Wilensky (1962) and Vollmer and Mills (1966), whose major foci were on the stages of professionalization within an occupation or within the ranking of occupations as to their professional status. Work has also been done on the choice of 'entry' of students into a professional education career system of medicine and nursing (Krause 1971, p. 115); and the 'socialization effect' such as studies done by Becker et al. (1961), on physicians in medical school. To date, little has been done that directly relates to the professional training for Hospital Administrators. But, as indicated earlier, with the impact of change within the health field, there is a need for research in this area.

The study reported below attempts to examine whether variables, particularly individual variables, act to influence a student's attitude towards the professionalization of his or her occupation (Hospital

Administration). Additional questions relate to whether particular attributes of individuals or organizational variables cause the student to respond to such educational experience in different ways, or whether students are more greatly influenced by an educational exposure. Specifically, the research questions addressed were as follows:

- 1) Do individual and organizational characteristics relate to the student's attitudes towards professionalization?
- 2) Is there an interaction between the educational process and the individual and organizational characteristics with the attitudes towards professionalization?

The literature within this area has been researched so an understanding of the study could be formulated. Coverage of the literature on the above has been divided into six sections. These sections cover an Overview of Professionalization; Attitudes; Professional Socialization; Need Fulfilment and Professionalization Attitudes; and Organizational Factors and Professionalization Attitudes.

1.1 Overview of Professionalization

"At least as early as 1907 arguments for the professional status of an occupation were presented in the social science literature" (Vollmer and Mills 1966, p. 34).

Wilensky (1962) states that there are more than 30,000 occupations. He continues by saying that occupations seek professional status but only thirty to forty have acquired the same. Therefore occupations can be described in terms of their professional characteristics as they are placed somewhere on the continuum between the ideal-type 'profession'

at one end and a completely unorganized occupational category of a 'non-profession' at the other end. Vollmer and Mills (1966, p. 2) state that "Professionalization is a process, then, that may affect any occupation to a greater or lesser degree." According to Wilensky, the closer the occupation follows a given sequence of professionalization steps, the more likely it is to be professionalized (Hall 1972, p. 48).

Wilensky (1964) discusses professions and their emphasis on autonomy, expertise and service ideals. What is more, members of an occupation tend to develop social and cultural mechanisms to protect or enhance their careers. Thus there is a trend towards establishing more formal occupational associations and more formalized codes of behaviour in many diverse lines of work. Vollmer and Mills (1966, p. 2) describe this as a movement towards professionalization. Millerson (1964) and Weaver (1975) make the point that professions have to be objectively, and not only subjectively, recognized.

Membership in occupational associations endows the member with certain attributes and attitudes. Through an association, jurisdiction or authority can begin to be exerted over a technical area by convincing the employer and public that services cannot be provided adequately by outsiders and this jurisdiction may become exclusive later. Legal definition may be brought in to protect the control of maintaining or expanding the practice of an occupation. Through various means professionalizing groups will take action to protect themselves, their status and their prerogatives.

The association's standards and code of ethics controls its

members and determines technical and ethical aspects as they apply to the occupation, and also the behavioural rules regulating relationships between other members, clients and unauthorized practitioners. These standards are usually more exacting than those that the layman would be willing to accept. These features apply to the professional whether he is self-employed or employed by an organization.

The exclusiveness of professional groups, engaged in personal service, is built around learning (theoretical knowledge and practical skill) and an ethical code. The latter differentiates them from occupations generally. Carr-Saunders (1966, p. 4) indicates that the specialization arising around the application of new scientific knowledge and techniques of public administration and business organization and control, to perform some skilled service, has created the emergence of a new profession (i.e., civil service).

Barker substantiates that a profession is based upon knowledge and skill. He states:

The person in a trade practices his art by doing what he learned to do, although he improves his technique through practice. In a profession, a person does what he did not learn to do by using his knowledge to meet new situations and apply his art to these. A professional is continually engaged in making important but individual judgements that grow out of practical experience and a significant body of knowledge. (Barker 1966, p. 5)

1.1.1 Elements of Professionalization

Greenwood (1966) summarizing Greenwood (1957) and Gross (1958), gives the elements of the professionalization process of an occupation to be:

- 1) development of a systematic theory and a wide knowledge of a

specialized technique, acquired through a long period of training, that requires a degree of personality involvement of the professional to produce an unstandardized product;

- 2) significance of the occupational service to society producing authority which is recognized by the clients of the professional group;
- 3) broader community sanction and approval of this authority;
- 4) sense of obligation to one's art where there is a code of ethics regulating the relations of professional persons with clients and with colleagues; and
- 5) sense of a group identity culminating into a professional culture sustained by a formal professional association.

To the above Blain (1975, p. 2) and Wilensky (1962) emphasize:

- 6) service orientation prevailing over financial orientation with devotion to the client's interest guiding decisions when the two are in conflict.

1.1.2 Steps Involved in Professionalization

Caplow (1954, 1966) defines the steps of professionalization as:

- 1) establish a professional association, with definite membership criteria designed to keep out the unqualified;
- 2) change the name, to reduce identification with the previous occupation's status, confirming a technological monopoly, and providing a title which can be monopolized;
- 3) develop and promulgate a code of ethics which asserts the social utility of the occupation, set up a public welfare rationale, and

develop rules which serve as further criteria to eliminate the unqualified and the unscrupulous;

- 4) agitate politically to obtain the support of the public power for the maintenance of the new occupational barriers; and
- 5) create training facilities directly or indirectly controlled by the professional society.

To the above Wilensky (1962), and also Hall (1972, p. 144) have introduced the initial stage:

- 6) create a full-time occupation that is a reaction to the needs in the societal structure.

However an occupation can go through all of these steps and still not be considered a profession until the critical variable of public recognition has been achieved, giving the occupation full professional status. Weaver (1975, p. 46) states, "Often when we speak of 'professionalization' we are implicitly recognizing the efforts of professional associations, academic programs, and prestigious individuals to establish a given set of role expectations as authoritative for a particular occupational group." Consequently this leads to the final professionalization step:

- 7) establish status and recognition for the profession.

1.2 Hospital Administration

The emerging profession of Hospital Administration is unlike other established professions because in Canada there are no mandatory academic credentials or professional certification required of its members before they can engage in this occupational activity. "Indeed, it is a

commonly-voiced complaint among provincial health authorities that there is decided lack of management talent in the health care system" (McLeish and Nightingale 1973, p. 18).

Even within the field itself, there is a division as to the title which should be utilized--Manager, Hospital Administrator, or Health Service Executive--these are informal and undefined terms which are developing some common usage. Generally the term Hospital Manager is used to designate the possibly lesser qualified (in education and position held) persons who basically perform duties that are required for the day-to-day operation of the hospital facility. Hospital Administrator, as a title, has professional connotations and is often designated for only those who are in the top echelon of the Hospital field. They deal primarily with hospital boards and governments in order to integrate and direct the functions and operations of the health facility as it is determined by these bodies. The Health Service Executive is a name developed for members of the Canadian College of Health Service Executives (C.C.H.S.E.). It includes those persons with senior managerial responsibilities within the health care system throughout Canada whose duties involve planning and policy making. This concept essentially covers the following hospital titles that were operationalized by McLeish and Nightingale (1973, p. 2) in their study: ". . . Administrator, Executive Director; Associate Administrator, Assistant Administrator, Assistant Executive Director; Medical Director, Director of Medical Services; and Director of Nursing." This title is applied not only to people within hospitals but also to those who are in the vague field of health. "There is currently no consensus among

officials surveyed as to the definition of a health service executive (nor is there agreement among the professional associations, such as ACHA [American College of Hospital Administrators] and CCHSE, and among the directors of the master's programmes in hospital health administration in Canada)" (McLeish and Nightingale 1973, p. 4).

According to Brown (1970, p. 13), reviewing the American scene, "The position of hospital administrator has been filled by many types. Until 30 years ago, the majority of hospital administrators were physicians or nurses. Many of the positions, particularly in rural areas, were also filled by ex-used-car salesmen, retired ministers, or deposed politicians."

Little is known about what causes people to enter the field. In a study done by Weaver (1975) on the profile of the professional Health Care Administrator in California, he found that few middle- and top-level administrators are without previous administrative experience. As almost one-half of those sampled had health care administration as their only career, this would suggest that there is a good deal of vertical mobility within the industry.

Dolson et al. (1966) found that in both Canada and the U.S.A. the average age of administrators was forty-six years. Austin and Strauss (1975, p. 53) state that "Careers in health administration follow no set pattern." Weaver (1975, p. 20) and Dolson (1967, pp. 100-105) found that in America women were employed as department heads in large non-profit hospitals, but they were nearly excluded from senior administrative positions in large institutions. Dolson (1967, p. 100) states that "Although

women make up most of the work force in hospitals, only one out of five administrators is a woman and typically she is paid less than a man." Women also hold a lesser position, are older than male peers and only half as many as the men have post-graduate degrees. Women are more likely to be found as administrators of smaller hospitals. However, medium-sized hospitals varied only a little in the distribution between men and women. Although nuns have previously played an important administrative role within the Catholic Hospital system, this has now been changed as the church believes that acute hospital care is a public responsibility and should be funded and operated as such. Therefore the 'church' is no longer required within the administration of this field.

North American graduate programmes in hospital administration came into being when the University of Chicago, one of the first programmes, began to teach students in 1934. In Canada there are presently seven universities involved in the training of hospital/health administrators. "Five of these courses are post-graduate programs, of two years' duration. . . . The sixth university involved sponsors a two-year correspondence program which is not necessarily post-graduate" (Pickering 1972, p. 14). The University of Montreal has a three-year undergraduate credit programme, in French (McLeish and Nightingale 1973). The C.C.H.S.E. has had a Kellogg Foundation grant (since 1973) for the purpose of developing baccalaureate programmes designed for accessibility of the practicing health service manager. The Canadian Hospital Association also sponsors a correspondence programme that is available to students who do not necessarily have under-graduate training, but who are working in

administrative or supervisory positions within the health field. They are selected by being nominated by their hospital or agency to the provincial screening board of the C.H.A., which determines which candidates are accepted. Only a restricted number are taken in each year.

Dolson et al. (1966, p. 103) found then that 45 per cent of Canadian administrators had graduated from college, 22 per cent of these with advanced degrees, while another 13 per cent had some post-graduate work. When C.C.H.S.E. (1975) studied their 1975 membership they found 17 per cent of the members had graduate programmes in health administration, 23 per cent had under-graduate degrees, and 58 per cent had completed one correspondence programme in health administration (some of this group also held under-graduate degrees). "Output of graduates from these [university] programs is now sufficient to provide administrators for most senior posts in hospitals in Canada" (Pickering 1972, p. 14). Pickering continues by stating that there is a considerable demand for entrance into most university programmes and only graduates in specified fields gain entrance. The trend is moving away from the medically-trained administrator.

"Yet we cannot say, for example, that [in Canada] the professional qualifications of a hospital administrator are equal to, or greater than, his counterpart in industry" (McLeish and Nightingale 1973, p. 19). Hospital Administrators differ from managers in other fields as they are not generally risk takers with regard to their consumers, the management of their professional staff, or the management and control of their industry. Although it should not be overlooked that Hospital Administrators

are being placed into and fulfilling the risk-taking role.¹

Managers at the lower level of the hospital hierarchy are basically not risk takers but tend to be administrators. Often they have come by their positions through promotion from a staff position in a specific field. In order to gain security and knowledge they often take the Hospital Organization and Management (H.O.M.) course and then try to ratify their new position by seeking membership in a professional association. One could question whether consciously or subconsciously they want to be perceived as being equal to the physicians with whom they compete so that they can at least obtain the same status.

Within the health field, unlike management in other industries, Austin (1975, p. 145) indicates that hospital administration has been viewed as a function of less significance, and in some ways subordinate to, the direct provision of patient services. When discussing Etzioni's typology, Schein (1965) states hospitals have predominantly *normative* authority, where membership, status and intrinsic value rewards are utilized to gain power and authority. Sheldon et al. (1970, pp. 37-38) state "Hospitals are large, relatively self-contained health care units; they have imbedded in their several hierarchies an administrative function which has undergone a partial professionalization. As is usual, the professionalization process (Vollmer and Mills 1966) has included an

¹ Miner (1973, p. 81) says that unlike scientists, managers often have to make decisions with insufficient or inadequate data. Managers are frequently faced with problems that cannot be answered with "I don't know." As they must act on the information accumulated in the time available, decisions may have a large element of risk as there are no alternatives if judgement cannot be deferred.

attempt to establish a body of knowledge which would legitimate the hospital administrator's status." In this manner the administrator strives to gain normative authority over his organization.

"The non-physician hospital administrator is referred to by many members of the medical profession as a 'lay' administrator. This is particularly offensive to the trained administrator who has met the criteria generally established for professionals (i.e., attained a prescribed level of education, subscribes to a defined body of knowledge, upholds certain ethical standards, promotes professional education, etc.). In other words, the modern administrator considers himself a 'professional' in the field of hospital administration and a 'layman' in the field of medicine" (Brown 1970, p. 14).

Austin and Strauss (1975, p. 46) state that "Whether desirable value sets come with an individual when he enters health administration education or practice, or can be instilled by the educational system, is not clear." Etzioni (1964) states that knowledge and creativity are largely individual attributes that cannot be transferred to another person by an organizational decree. As the application of knowledge is basically an individual act the inherent managerial skills cannot be overlooked. But it must be remembered that Drucker (1954) and Newman (1951) have shown that management as a science can be taught, so that, no longer is there only an argument that managers are 'just born.' Hospital Administrators, in addition to formal education, pass on their skill and value sets through example by trained practitioners, to students in educational programmes.

Professionalization of Hospital Administration is taking place. Some authors like Letourneau (1969, p. 191) taking a subjective view state "Today hospital administration is recognized as a profession and takes its place truly along side other esteemed, learned professions who are admired and respected by the public."

1.2.1 Professionalism vs. Managerialism as a Model

Although this thesis is dealing with professionalization of Hospital Administration it should be noted that Hospital Administrators have two or more models to choose from. Hospital Administrators are placed into a position where they have to relate to the 'managerial' oriented Board, as well as the 'professionally' oriented staff. This creates a great deal of uncertainty as to which model should be utilized. Sloan (1966) discusses the role of the administrator and his need to harness the two contrasting factors--the strictly business and the strictly professional--in the hospital.

The administrator, according to Blishen (1969, p. 74), sees the hospital as having an institutional mission of its own. The administrator is able to undertake some of the things that doctors cannot do, either as individuals or as a group, as it is not always clear where hospital care ends and medical care begins.

Hospital Administrators want to become professional and use professionalism as their occupational model. At present they appear to be following their dominant reference group, the medical profession. This is so they can identify with and become more acceptable to their internal working environment. Thus they then would be able to meet and become

part of the 'normative' pressures of the organization, as discussed by Etzioni (1964). This is necessary in order for Hospital Administrators to bridge the schism between the administrative and hotel services of a hospital, and the treatment or curative functions of the hospital.

In Canada, as hospitals are non-profit organizations, and do not handle a marketable commodity (not even hospital insurance), they are unable to become independent from their support systems (i.e., governments). Therefore Hospital Administrators cannot obtain full managerial control over their own institution, or industry, and they are faced with finding another means of gaining control. Thus they may assume that they can gain a stronger position if they adopt the professional model rather than an industrial administrative model.² Through a professional model they can obtain security, freedom, prestige and a corner of the market due to the monopoly that would be accorded to them by societal acceptance and legislative definition. Also by obtaining a high professional status they would be on more equal grounds with the medical profession who at present have a considerable free reign within the hospital setting.

One could argue though, that this decision is behind the times as hospitals are moving towards an administrative industrial model. They are confronted with new pressures. Unions are increasing in strength and moving towards parity with other industries as well as incorporating

² Hall (1967) found the following when he compared administrative with professional organizations. The administrative organizations were more bureaucratic than the professional organizations. They had a more pronounced hierarchy of authority, greater division of labour, more emphasis on rules and organizationally designed procedures and were more impersonal than professional organizations.

professional groups into their membership. Hospital Administrators are also being faced with more managerial pressures. They are becoming involved in systems pressures of effective and efficient management methods, budgeting, staffing and governmental involvement. In addition Hospital Administrators have gained more authority and control over the physicians within their institution. Thus the role of the administrator is changing and requires more managerial skills and the development of a stronger more independent position. Hospital Administrators' activities are thus moving towards an industrial model, falling somewhere between Etzioni's 'normative' model and the administrative model. Consequently one could question the desirability of Hospital Administrators adopting the medical model when possibly they should be seeking an industrial independent position.

The structure of the health field is very complex, so much so that very little actual control remains at the hospital administrator's level. No other industry is faced with the same complexities. The role of the Hospital Administrator is such that he does not have full control over his domain. This is because there is so much legal definition which gives sanction to outside groups, etc., that influence or control his decisions.

Hospital Administrators recognizing the erosion of their domain through regionalization and governmental control realize that they must now play an active part in planning and policy aspects of their field. In order to have an impact upon this endeavour they need to establish their professional status so that they will not be overlooked or down-trodden by some other occupational group.

1.3 Attitudes

As this study looks at the students' attitudes towards professionalization of their occupation, this section of the paper reviews the definition of attitudes and the changing of attitudes.

An attitude may be defined as "A mental position with regard to a fact or state, a feeling or emotion toward a fact or state; the position of something in relation to a frame of reference" (Merriam-Webster 1969). Bandura (1969, p. 597) cites "An attitude is variously defined as a disposition to behave favorably or unfavorably toward a given object (Brown, 1965); . . . an effective evaluative response toward an object (Rosenberg, 1960); or an implicit anticipatory mediating response (Doob, 1947)."

Bandura (1969) reports that according to most contemporary theories there is a drive to maintain consistency among beliefs, feelings and actions. Mackenzie (1971, p. 12) states that attitudes develop through training and education with the student observing and thinking for himself.

1.3.1 Changing Attitudes

There are three general approaches which can be employed, either singly or in various combinations, to bring about attitude changes. Bandura (1969) calls these three approaches: "belief-oriented" through persuasive communication, "affect-oriented," and "behaviour-oriented." Only the first is applicable to this thesis. It attempts to modify people's attitudes by changing their beliefs about the attitude object through exposure to persuasive communication. "It is assumed that people can be induced to change their evaluations of an attitude object by presenting them with new information about its characteristics" (p. 599).

Most of the research generated by the informational or persuasive communication approach has been done by Cohen (1964); Hovland and Janis (1959); Hovland, Janis and Kelly (1953); and Rosenberg et al. (1960). It has been constructed to isolate the situations under which a given communication will have its maximal effect upon the recipient's attitude.

"Studies of the persons being influenced have generally been concerned with their personality characteristics, the level of their intelligence or sophistication, the nature of their pre-existing attitudes, and the strength of their commitment to a given position" (Bandura 1969, p. 599). Bandura states that the form and organization of persuasive arguments involves such things as the optimal order of presenting weak and major arguments, the sequence of supporting and opposing arguments, the degree of explicitness of the stated conclusions, the amount of repetition, the affective properties of the contents, the degree of discrepancy between the subject's views and the ones advocated, and whether the influence programme relies upon a one-sided presentation or includes some consideration of counter arguments.

"Taylor" speaks of the person's previous experiences, psychological set, and functional fixedness which can create perceived constraints on, or facilitation of future experiences. "An individual interacts with his environment by breaking it down and organizing it into meaningful patterns congruent with his own needs and psychological make-up" (Harvey et al. 1961, p. 1).

McKenzie (1965) says that an important part of the context of a person's behaviour is the "culture" of the society. This being the

background of laws, customs, conventions, values, ways of behaving and ways of thinking that are accepted and taken for granted in a particular society. "These cultural pressures constantly shape and determine needs, goals, perceptions, and meanings" (McKenzie 1965, p. 38). Shull et al. (1970) also speak of man's affiliative tendency. The socialized man is dependent upon his social environment due to cognition and communication. He is influenced through education, indoctrination, intimidation and social trade-offs.

McKenzie (1965, p. 48) states that the behaviour of an individual is controlled not so much by his own reasoning power as by the pressure of the group. He cites the situation where an honours graduate of high intelligence took a job as a semi-skilled operative in a factory and within weeks had altered many of her attitudes towards work such that they were indistinguishable from those of other operatives. The important point being that many of her attitudes showed little reflection of her high intelligence and critical faculties. This, of course, does not deny that in particular circumstances the contribution of intelligence, of education and qualifications may be crucial.

1.4 Professional Socialization

Mills (1966, p. 87) states that "Becoming a professional is a gradual process--it doesn't happen all at once." There is a gradualness of career decisions that must generate ambition that will sustain a student through many years of preliminary training. Of great importance is the formal education where the occupational role is learned. Through an extended period of socialization a psychological and social commitment

to a professional career is developed. Hence the professional becomes "inner-directed."

Through setting educational standards the professional association crystalizes the norms for future professionals. A great deal has been written on the socialization process of a professional. The choice of applicants, the education and the internship or apprenticeship have a strong influence in producing a professional who fits the standard norm as prescribed by the profession. In general the longer and harder the socialization period, the more techniques, culture and deep attitudes are learned. This produces a situation where each profession has its limited field, special environment and group psychology which are not likely to be comprehensible to the layman.

Westby (1960) and others found that in many occupations the professional commitment is not sufficient to ensure a pleasant and orderly career development. Problems arose as forces within and without the occupation undermined the expectations of the individual.

Beginners must first perceive the multiple expectations that characterize their roles, and then acquire complex skills needed to match those expectations. They must learn the values of their profession so that they will have moral decisiveness to fulfil their professional roles in the presence of others, perceive the evaluation of their performance and receive confirmation of their identity. The training school thus plays a part in the professional socialization of its students transforming the layman into a self-assured member of the professional "culture." Hughes' thesis (1958) substantiates that professional education involves

the replacement of stereotyped images by more subtle, complex and even ambiguous perceptions of the professional role. Professional thoughts may be internalized more significantly after the student graduates as demonstrated by Lortie (1966) in his discussion of a study of law students.

Hall (1972, p. 160) found that the structural and the attitudinal aspects of professionalization do not necessarily vary together. Some "established" professions have weakly developed professional attitudes when compared to some of the less professionalized groups. The strength of the attitudes is dependent upon the kind of socialization which has taken place in the professional training programme, in the work itself and the place of the occupation. He found that when an occupation received relatively few material rewards, the level of dedication was usually higher. Also, if an occupation was allowed to be self-regulating, it tended to believe quite strongly in self-governance.

The work setting can also act as a socializer. Organizations develop formal norms and through these the employees are influenced to comply. This process leads to internalized behaviours. Vollmer and Mills (1966, p. 2) indicate that when people move from job to job, "Whatever skills or knowledge they have acquired in one job, they carry to the next." But Whyte (1956) has shown that the setting and the organization can subjugate the occupation, as it has done with most non-academic scientists. Conversely Glaser (1964) shows the occupation, e.g., chief physicians, may rule the setting in the name of their profession.

Krause (1971, p. 52) states that "Settings have their own informal

rules which do not exactly correspond with the occupational ideologies of the settings' members, in part because of the need for working out ad hoc compromises between *different* occupational groups in a setting, in part as a way of coping with a lack of any overt structure."

1.4.1 Attitudes on Professional Socialization

McLeish and Nightingale (1973, p. 14) say that little is known about what causes people to enter the field of Hospital Administration. But it is felt that to fill the future needs individuals will come more and more from a variety of disciplines. The selection procedure also has implications. In selecting administrators it is difficult to discover accurately and objectively the characteristics and abilities that are actually needed by people to produce effective performance on the job. As mentioned the C.H.A. selects people already working within the health field for the H.O.M. programme.

It is interesting to note the contrast in educational exposure between dentistry and hospital administration. Dentistry has "captive" students who are given relatively long high educational exposure as compared to the C.H.A. students who are "non-captive" and given low exposure.

More and Kohn (1960) describe certain subjective factors that induce individuals into dentistry. Their findings indicate that as in other high status but less professionalized occupations, individuals are apparently motivated to enter dentistry in part because of its general social prestige, its financial rewards and its opportunities for human service and, probably in contrast to many less professionalized occupations, by the independence it offers in relation to managerial control.

In this study the need for autonomy is the most decisive. Krause (1971, p. 115) says according to Sherlock and Cohen (1966) dentistry was an example of a "second-choice" medical career, with medicine not being chosen due to its longer training period, greater expense and stiffer enrolment competition.

Hughes (1966) states that in North America people are class self-conscious and seek social advancement in two manners. The first is individual; a person will try to get into an occupation of high prestige, or to achieve special success in his occupation. The second is collective; the effort of an organized occupation to improve its place and to increase its power, in relation to others. This leads us to examine in more detail the ways in which groups of people use professionalization as a means to contribute to their social mobility.

Krause (1971) found that for nursing the recruitment pattern varied for the type of programme. The hospital-based programmes tended to recruit from the lower middle-class; whereas college programmes recruited from the middle- and upper-class. He found that these patterns are central to the question of career commitment. The college programmes aim to create "nursing administrators" and stress social science jargon, whilst the hospital-based programmes are more practically oriented. Within the hospital setting the hospital-trained nurses appear to be able to stand the stress and strain, the long hours, and the frustrations better than the college nurses, who appear to have higher rates of drop-out from the profession.

1.4.2 Relationship Between Pre- and Post-Academic Training Attitudes

Attitudes are not formed in isolation but are differently influenced by a host of extrinsic and intrinsic factors. However, educational programmes have to be based on a common ground. Therefore, a certain level of background experience will be assumed so that students can comprehend and benefit from knowledge and concepts being taught.

White (1972, p. 5) developed distinct conclusions from his investigation into the effectiveness of various management training strategies, developed by the Faculty of Health Service Management at the University of Missouri. He was trying to identify learning methods appropriate to the capacity of students who were mainly in their thirties, forties, and fifties, many years out of school, not particularly good at conceptualizing, or even at systematic reading or concentrated listening to unfamiliar material. But he found that "What they *do* have, collectively, is an enormous amount of experience of endeavoring to 'manage' within health organisations and that collective experience already possessed by the wide variety of health professions represented on the course is itself the most important teaching resource available to the instructor" (White 1972, p. 8). It was found that management courses are only likely to improve the quality of management within the hospitals if:

- a) *there is emphasis on the use of specific skills rather than on the mere acquisition of knowledge (retention of which is in any case very limited in the absence of reinforcement);*
- b) *lectures are acceptable to the health care audience and, if reliance is placed on technical college staff, teaching is based on health situations to which participants can readily relate rather than on "industrial" models;*
- c) *the organisation which nominates participants understand the*

objectives of the courses and put value on the development of competence by their nominees such that they will expect them to demonstrate their improved ability on return to the job and will create opportunities for them to do so, in conscious reinforcement and follow-up of the course learning. (White 1972, pp. 6-7)

He also found that teaching by face-to-face contact over an extended period offered the best learning opportunities. And for this age group emphasis should be placed on *participative learning* such as the practical exercise, role-playing, videotape recording, demonstration and group problem solving assignments. "Tutored project work on the job and practical assignments inside an organisation were thus identified as the type of teaching method most likely to facilitate a permanent increment of managerial effectiveness. Purposeful activity of this kind serves both to reinforce external learning (by requiring the application of new skills, knowledge and attitudes on the job) and to promote interests of the host organisation, which must be committed to the learning objectives and to their successful accomplishment" (White 1972, p. 8).

1.4.3 Professional Socialization in Health Care Organizations

In a hospital there is an interaction of people of different sub-cultures as indicated by McKenzie (1965, p. 40). Doctors are trained to stand on their own two feet, to be individualistic, if not competitive. Yet, still they are bonded together by common training, exclusive secretive and powerful professional membership and by the status accorded them by society.

Nurses, another group of 'people apart,' have threads of religion in their sub-culture from the hospice run by female religious orders.

This is echoed by Hall's (1972, p. 151) findings that the belief in service to the public and a sense of calling to the field, attitudes which are related to a sense of dedication to the profession, emerge as strongly developed professionalized in the nursing profession.

The position of the Hospital Administrator is quite an ambiguous one. He models on the service professions, medicine in particular, but this may not be a satisfactory model. Administrators are striving for public recognition and are entertaining the thoughts of licensure through which at least official recognition is acquired.

In the United States the Social Security Amendment of 1967 required the states to enact nursing home administrator licensing laws by 1 July 1970 (Somers 1969, p. 80) in order to qualify for Medicare participation. But there is no such requirement for Hospital Administrators as the United States does not have an universal governmental hospital/health plan, and hospitals fall under all types of ownership and jurisdiction. In Canada there are no licensure requirements for either administrative group.

A true professional is not an employee but instead he negotiates privileges set out in by-laws which he abides by and may be dismissed from, whereas Hospital Administrators are employees and are dependent upon the Hospital Board for a job in which the Board has the right over hiring and firing. Also their role and function is determined by the Board, and the Board's expectations may not even be set out in a good job description, and thus in turn may interfere with the professional's job. This relationship constrains the Hospital Administrators' struggle for professionalism.

Possibly by belonging to the Canadian College of Health Service Executives, Hospital Administrators can convince Trustees that they are professionally competent. Hospital Administrators are seeking more professional definition through professional or educational standing, and there are indications that they are beginning to negotiate work contracts. But mainly they are seeking security.

Licensure provides exclusiveness over the use of the title and gives the profession a monopoly which is said to be in the public's interest. The control over entry into the profession, the quality and quantity of their education as well as the control over professional standards are important by-products. "Further, since the work of a profession involves an essential service which no one else can perform, no one else can claim the right to tell the members of the profession how to do it or even how it should be evaluated. Consequently, professionals attain great autonomy and power" (Somers 1969, p. 80).

But the professional model may do a disservice as stated by Brown (1969). Licensure does not discourage professional and educational obsolescence but may provide legal and professional respectibility which can serve to deceive the public, and mask incompetence. The rules and regulations are often barriers to new approaches and use of health professionals even for the sake of increased productivity. Also licensure may hamper the mobility of practitioners in their career development.

1.5 Individual Motivational Aspects

It is contended that there are other factors which motivate or formulate people's attitudes. This section will look at certain aspects

that can contribute towards individual's attitudes.

1.5.1 Need Fulfilment and Professional- ization Attitudes

Maslow (1970) argues that needs are existing in and intrinsic to human nature. He has identified sets of needs and ordered them as to their prepotency, in the sense that a particular need has to be at least partially satisfied before the next category of needs, in the prepotency hierarchy, emerges and has a stronger influence. A description of the first five needs, as discussed by Maslow, follows:

- 1) *Physiological Needs*--These needs serve to sustain life and are undoubtedly the most prepotent of all needs.
- 2) *Safety Needs*--Safety, or security needs, are required for personal safety, basic satisfaction, understandable and predictable situations and for certainty about the future. For most people in industrial societies these needs are believed to be well satisfied. In such societies safety needs are only expressed in such phenomena as, a preference for job tenure and protection, monetary security, and for various kinds of insurance schemes. A broader aspect, though, is demonstrated in the common preference for seeking familiar rather than unfamiliar things or the known rather than the unknown.
- 3) *Belongingness and Love Needs*--Next emerges the need of love and belonging. Here the individual deserves and strives for affectionate relationships and for a place in his peer group.
- 4) *Esteem Needs*--All people in our society (with a few pathological

exceptions) have a need or desire for a stable, firmly based, usually high self-evaluation of self-respect, and for the esteem of others. Most individuals never progress beyond functioning primarily at the level of social or the esteem needs.

- 5) *Self-Actualization Needs*--These are the growth needs. They refer to the desire of becoming more and more what one is, or that which one is capable of becoming. The needs for self-actualization may be seen to operate to a certain extent as the desire to do a good job, to be creative or to use whatever capacities one has.

Maslow's theory of need hierarchy has been widely accepted in the literature of organizational behaviour. However, the theory has not been used to explain differences in psychological attitudes towards professionalization of an occupation.

In the present research study, an attempt has been made to use need hierarchy theory to predict individuals' attitudes towards professionalization of an occupation.

Maslow's theories have many areas of application. Clark (1965) discusses the problem of educational qualifications. He states:

One qualifies for work through education, and the threshold of qualification constantly rises as the bottom of the occupational structure shrinks (decrease in unskilled jobs), the middle is upgraded in skills, and the top (professional and technical) expands rapidly. . . . This pressure, already greatly expanded since 1945, is intensified by the emerging task of keeping men qualified to work through reparation, as a rapidly changing technology makes obsolescent old skills and jobs and new demands on competence. (pp. 225-26)

This process places demands that may cause the individuals to seek ways to satisfy their Safety Needs, as defined by Maslow, as their security is threatened. Thus one might hypothesize that those who have lesser

educational qualifications would respond at the level of their safety needs.

Fulfilment of the safety needs would also be sought by those who are in lower socio-economic occupations. People who are secure in a high status occupation, may seek to fulfil Esteem or Self-Actualization Needs. They may attempt to do this through the further professionalization of their occupation or by involvement within a broader association, i.e., activity within a professional association.

Maslow's theory could thus be used to explain differences between student's attitudes towards professionalization of their occupation.

1.5.2 Organizational Factors and Professional Attitudes

Two organizational factors--size and structure of the organization --may affect the degree of need for professionalization of an occupation. It is to be argued that the larger the size of the organization inversely affects attitudes towards professionalization as Hall (1972, p. 159) says that increased bureaucratization threatens professional autonomy.

A small-size organization represents a relatively simple system compared with the large-size organization. The small organizations have fewer people, fewer levels in the organization hierarchy and less sub-division of labour (Worthy 1950). An organization primarily operates through a personal relationship of its members and only secondarily through impersonal, institutionalized relationships. As the size of the organization increases, there tends to be at the lower hierarchical levels an increasing amount of reliance upon impersonal bureaucratic forms of control

(Indik 1963). Therefore, one might hypothesize or argue that in a large organization structure the reliance on bureaucratic, inflexible controls over workers' behaviour creates a work environment in which it is difficult for workers to incorporate attitudes of their occupation towards professionalization.

Hall (1972, p. 151) says that ". . . professionals working in large organizations are not, by definition, confronted with situations which reduce the level of professionalization." Thus it would appear that attitudinal variations should probably be attributed to the organizational "climate" in which they work. Parsons (1956) expresses similar views saying that in the conduct of an organization there are rules or norms which govern conduct independently of any particular organization membership. "They are universalistically defined for the society as a whole or for transorganizational sectors of the society's structure" (p. 84). The essential point is that the conduct of an organization must generally conform with the norms of "good conduct" as recognized and institutionalized by society. Katz and Kahn (1966, p. 201) report that members of formal organizations respond to visible environmental pressures and are often motivated by shared values. They stress that the dominant solution to achieve reliable performance or lawfulness is for organizations to promulgate and enforce rules of conduct.

But there is a contention that organization size affects workers' attitudes. Durkheim (1960, p. 267) stated that small industry displays relative harmony between worker and employer which is not necessarily present in large-scale industry where with more points of contact they

are exposed to conflict. In the nineteen-fifties investigators started to examine the relationship between organization size and workers' attitudes. Most empirical studies have made comparisons across different sized sub-units of larger organizations rather than across independent total organizations. These studies show a remarkable consistency in their findings. Evidence shown by Kerr et al. (1951); Worthy (1950); Indik and Seashore (1961); Katzell et al. (1961); and Cummings and ElSlami (1970) tend to support the negative consequences of increased organization size on workers' job attitudes. This would lead to the question concerning organization size and its effect on attitudes towards professionalization.

Hall (1972, p. 160) says that "The organizations in which professionals work vary rather widely in their degree of bureaucratization. . . . There is, however, a general tendency for the autonomous professional organization to be less bureaucratic than either the heteronomous organization or the professional department. This suggests that the nature of the organizational groups in an organization affects the organizational structure. The workers (professionals) *import* standards into the organization to which the organization must adjust." To this Austin (1975, p. 139) adds that professionals identify more closely with professional goals than organization or sub-system goals. Austin (1975, p. 138) proclaims that the health and medical care industry is the most highly professionalized industry.

Hall (1972) states that there is generally an inverse relationship between the levels of bureaucratization and professionalization, except for technical competence. Autonomy, as a professional attribute,

has the strongest inverse relationship. To prevent conflict, professionalization may require a certain level of bureaucratization in order to maintain social control. "Too little bureaucratization may lead to too many undefined operational areas if the profession itself has not developed operational standards for these areas" (Hall 1972, p. 161). In turn, a more bureaucratic system for less professionalized groups may act as an inhibitor to their further professionalization.

Gibson et al. (1973) refer to an organization structure as being the relatively fixed relationship that exists among the employees of an organization. Literature identifies two types of organization structure--tall and flat. The distinction between these two is based on the number of levels in the organization relative to the total size of the organization. A flat organization structure has few levels relative to the total size of the organization while a tall organization structure has many levels relative to the total size.

The degree to which a structure is tall, or flat is therefore determined by the average span of control within the organization. Flat organizations, therefore, have a large average span of control. In a flat organization subordinates usually enjoy greater freedom and autonomy to make decisions about their work activities. In such a situation, professional groups would also be allowed to enjoy more freedom to introduce their 'sub-culture.'

With the degree of bureaucratization occurring within the health system, one could question whether the organization structure within a hospital would have any effect on the professionalization attitudes of

its employees. Canada is drifting into a national health system where all levels of government are becoming concerned. This has the consequence of the development of regionalization. Although progress in the efficient development of organization of services is slow and full of political and personal stumbling blocks, Pickering (1972, p. 15) still feels regionalization by provincial governments is imminently expected. Already there is a considerable impact upon the hospital systems where budgets, programmes, number of personnel, building and equipping, and standards are regulated by the provincial governments through their financial and legal control. Consequently, the hospital industry is not left solely to the prerogatives of its managers but it is under surveillance of the public authority.

Keeping these bureaucratic or standardization tendencies in mind, one should then question if the health organizations (size and structure), in which the students are employed, have an impact on professionalization attitudes. Consequently, this thesis examines the organization structures to see if there are any such implications.

1.6 Summary

The researcher questions if a short correspondence teaching programme will develop the same attitudes towards professionalization in all students. This fits with Mills' (1966) opinion, as stated earlier, that to become a professional is a gradual process requiring an extended period of socialization so that the professional can become "inner directed." However, there are other forces to be contended with such as stereotype images (Hughes), perceived constraints (Taylor), culture of his society (McKenzie), affiliative tendencies (Shull et al.), organizational

influences (Vollmer and Mills and Whyte), and undermining forces within and without the occupation (Westby) that would appear to outweigh the "persuasive communication" (Bandura) that would be provided through an exposure to one lesson in a correspondence programme. The researcher can conceive that to undertake, or be exposed to the teachings could affect the attitudes of the students since the students have chosen this form of educational exposure and are thus motivated to learn. Consequently, it is accepted that there is the possibility of interaction between the professionalization teachings and the predisposed attitudes of the students but that this educational experience only acts as a moderator. However, it is argued that the predisposed attitudes which are related to certain individual demographic and organizational characteristics of the students are the main determinants. These would act as a control mechanism in relation to the teaching exposure and its outcome.

2.0 MODEL AND STUDY DESIGN

2.1 Theoretical Model

The theoretical model of this study, represented in Figure 2.1, indicates the principles of the study and their linkages.

2.1.1 Scope of the Model

The scope of the model, as shown in Figure 2.1, was as follows:

- 1) educational exposure → a socializing effect;
- 2) individual characteristics plus an educational exposure → professionalization attitudes;
- 3) individual characteristics → professionalization attitudes;
- 4) occupational characteristics → professionalization attitudes; and
- 5) organizational characteristics → professionalization attitudes.

The model would also allow other linkages and interaction between the variables but these were not pursued for this study.

2.2 Measures

The study variables were operationalized as shown in the following sections.

2.2.1 Independent Variables and Study Population

- 1) Education--
 - a) Exposure--to teachings on professionalization as outlined by Lesson 10, of the C.H.A. correspondence programme, to the class of 1975-76. The Lesson was considered as the treatment effect.
 - b) Non-exposure--class of 1976-77 had not been exposed to Lesson

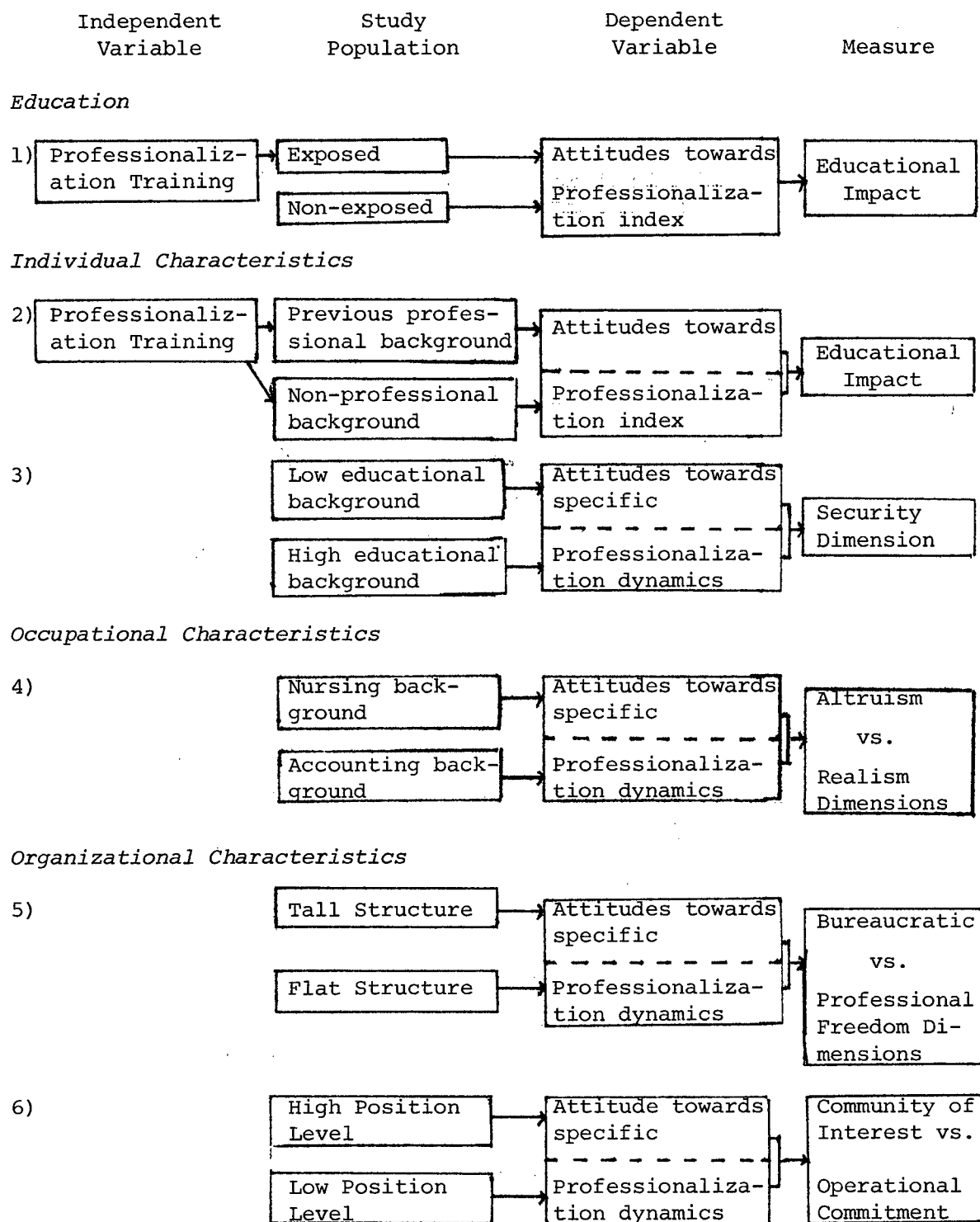


Figure 2.1 Study Relationships

10 and therefore acted as a control group.

- 2) Individual characteristics--
 - a) Education--professional; non-professional.
 - b) Education--minimal; certificate/diploma; university degree.
- 3) Occupational characteristics--
 - a) Nursing; accounting; other occupations.
- 4) Organizational characteristics--
 - a) Structure--tall; intermediate; flat.
 - b) Position level--top one-third; middle one-third; lower one-third.

The method utilized and the distribution of the samples across these independent variables are expanded in Chapter 3.0, "Methods and Procedures."

2.2.2 Dependent Variables

- 1) Professionalization dimensions--
 - a) Themes--developed through a literature review and from the material on professionalization in Lesson 10.
 - b) Outcome--students' attitudes were obtained by a questionnaire that was designed to seek attitudes towards specific aspects of professionalization. These aspects were arranged as a set of dimensions.

2.2.3 Independent Variables Influenced by Need Fulfilment

- 1) It was assumed by the researcher that students with less education have more insecurity about their academic qualifications for the

occupation of Hospital Administration than those with a high degree of education. They would easily feel threatened by better educationally qualified personnel who were either in or entering the field of Hospital Administration. Therefore it was argued that educational qualifications would be negatively related to job security and degree of need fulfilment. Consequently, the students' basic Safety Needs, as outlined by Maslow, could be threatened by the possibility of losing their job or through job mobility being blocked by better educated personnel.

- 2) Students who were employed in high hierarchical positions have at least partially satisfied their basic Safety Needs and have now moved on to fulfil their Social and Esteem Needs. This could be represented by the students looking outside of the organization in order to satisfy their need fulfilment. Need fulfilment at these levels could be dispelled through identification and the development of comradeship, and boundary spanning roles. Therefore, it was argued that a high position level within an organization hierarchy is positively related to the Social and Esteem Needs and the necessity to fulfil these needs.
- In turn, people in low level positions who are involved in day-to-day routines and activities would seek means that would assist them with their operational commitments.

2.3 The Study

The study was an attempt to analyze if certain variables influenced students' attitudes towards the professionalization of their

occupation, or if an educational exposure was the main determinant of their attitudes. In so doing, specific individual, occupational and organizational characteristics and their effect on professionalization attitudes were examined. In turn these were reconsidered in light of the educational exposure to see if education had an overall effect or acted as a moderator to enhance attitudes already present.

The issue being studied was whether various demographic characteristics (individual, occupational, organizational) create or shape, particular attitudes of an individual regarding professionalization. These preconditioned views may be:

- 1) consistent with the educational teachings;
- 2) inconsistent with the teachings; or
- 3) neutral or of no consequence.

Education may be a moderator, therefore, as illustrated in the theoretical model.

These pre-programme views thus make a student:

- 1) susceptible to the lesson content so that their views become broadened or reinforced; or
- 2) doubtful or questioning of the lesson ideas being presented.

Therefore, this paper looks at the various backgrounds to see which set of variables has the strongest effect upon specific professionalization attitudes.

2.4 Research Hypotheses

It may be recalled that the model postulates six types of relationships, to be tested, between the students and their attitudes towards

professionalization of their occupation. These relationships lead to different kinds of predictions about the students' attitudes; and the influence of the educational exposure. The predictions relate to the degree of acceptance of professionalization orientation and to the acceptance of certain specific dimensions, or aspects, of the professionalization process.

The hypotheses tested were:

- 1) Hospital Administration students who have been exposed to education about professionalization by Lesson 10 will have a significantly higher degree of professionalization orientation than students who have not been exposed to such education. [H-1]
- 2) Hospital Administration students, with a previous formal professional background, who have had a previous exposure to 'professional' education will have a significantly higher degree of professionalization orientation than 'non-professional' students who have had no previous professionalization educational exposure. [H-2]
- 3) Hospital Administration students with poorer academic qualifications have a significantly higher degree of professionalization orientation towards the particular aspects of professionalization that represent security than students which are better academically qualified. [H-3]
- 4) Hospital Administration students with a nursing background have a significantly higher degree of professionalization orientation towards the particular aspects of professionalization that

represent attitudes of altruism and dedication, than students from an accounting background who are trained to be more calculating and thus would have attitudes towards realism. [H-4]

- 5) Students from a tall-structured organization have a higher degree of professionalization orientation towards the particular aspects of professionalization that represent bureaucratic rules and standards, than students from flat-structured organizations who would seek professional freedom. [H-5]
- 6) Students employed in top-level hierarchical positions have a higher degree of professionalization orientation towards the particular aspects of professionalization that represents a 'community of interest,' than students in low-level hierarchical positions who are involved in day-to-day operational commitments. [H-6]

2.4.1 Discussion of the Hypotheses

Hypothesis 1: Hospital Administration students who have been exposed to education about professionalization by Lesson 10 will have a significantly higher degree of professionalization orientation than students who have not been exposed to such education.

Exposure to education on professionalization should influence attitudes towards the positive acceptance of such teachings. As Mills (1966) believes that to become a professional and have professional attitudes is a gradual process requiring an extended period of socialization, it is questionable if a one-lesson correspondence exposure can influence student's attitudes. Due to the lack of 'persuasive communication' the researcher believes that this type of educational exposure can only act as

a moderator. Even though the educational exposure was brief and its influence expected to be slight, its effect was tested. If the education exposure influenced professionalization attitudes, the exposed class of 1975-76 would then have a higher degree of professionalization orientation than the unexposed class of 1976-77, holding other influences constant.

Hypothesis 2: Hospital Administration students, with a previous formal professional background, who have had a previous exposure to 'professional' education will have a significantly higher degree of professionalization orientation than 'non-professional' students who have had no previous professionalization educational exposure.

This hypothesis would test Mills' (1966) belief that professionalism requires an extended period of socialization. Consequently, students with previous 'professional' educational background would be similarly predisposed to professionalization attitudes and would display a higher acceptance of professionalization teachings than students who have non-professional backgrounds.

Hypothesis 3: Hospital Administration students with poorer academic qualifications have a significantly higher degree of professionalization orientation towards the particular aspects of professionalization that represent security than students which are better academically qualified.

Jones and Jeffrey (1964), Nealy (1963), and Larke (1953) found that non-professional personnel tend to value job security, opportunities for advancement, interesting work, and interesting co-workers as the most important motivators. This could be explained by Maslow's need hierarchy. This would lead to the belief that 'non-professional,' or students with a poorer academic qualification, would have strong attitudes towards those

aspects of professionalization that represent security. Consequently the 'non-professional' student should have more support of organizational restrictive dynamics than the laissez faire professional dynamics of professionalization.

Hypothesis 4: Hospital Administration students with a nursing background have a significantly higher degree of professionalization orientation towards the particular aspects of professionalization that represent attitudes of altruism and dedication, than students from an accounting background who are trained to be more calculating and thus would have attitudes towards realism.

It has been shown by McKenzie (1965) and Hall (1972) that nurses believe in service to the public and have a sense of dedication or calling. Nurses, therefore, would demonstrate these characteristics by having more altruistic attitudes towards professionalization than students from many other occupational backgrounds. One profession expected to differ in degree of altruism is accountancy. While nurses typically are concerned with people and have a service orientation, accountants typically focus on things, data and administrative efficiency.

Hypothesis 5: Students from a tall-structured organization have a higher degree of professionalization orientation towards the particular aspects of professionalization that represent bureaucratic rules and standards, than students from flat-structured organizations who would seek professional freedom.

Indik (1963) indicates that Tall (bureaucratic) organizations have a great need for operational rules and standards as means of control than do Flat organizations.¹ Students working within a bureaucratic structure,

¹The researcher believes that regardless of a standardization effect within the health field due to 'regionalization,' the health industry is not unlike other industries. In both situations, tall organizations

according to Hall (1972) would therefore have less exposure to professionalization attributes, with professional autonomy being threatened, and more exposure to operational rules and standards. The students would likely be influenced by the degree to which operational rules and standards exist in their organizations. Due to organizational influences (Vollmer and Mills 1966) and affiliative tendencies (Shull et al. 1970) students in Tall organizations should demonstrate support for the bureaucratic aspects of professionalization, i.e., standards, code of ethics, restricted entry and licensure. It would therefore be assumed that in these areas they would have more positive or supporting views than students who are employed in Flat organizations. In turn, students from Flat organizations would demonstrate attitudes supporting decisions allowing freedom to work independently and to use professional judgement.

Hypothesis 6: Students employed in top-level hierarchical positions have a higher degree of professionalization orientation towards the particular aspects of professionalization that represents a 'community of interest,' than students in low-level hierarchical positions who are involved in day-to-day operational commitments.

The level of a position within an organization hierarchy creates different needs. People within top-level positions may seek to fill their Belongingness and Esteem Needs by developing interest outside of the organization as they reach to identify with parallel organizations

would demonstrate more bureaucratization. While flat organizations would allow more personal freedom to express professional attitudes and to make work decisions which enhance feelings of responsibility. Consequently, the organizational structure would influence the attitudes of the employees, and in turn their attitudes towards professionalization of their occupation.

and seek camaraderie, or a community of interest, with outside sources. These are known as 'boundary spanning activities' as defined by Thompson (1967). In addition Abraham (1967, pp. 59-60) states ". . . there are pragmatic pressures toward collegiality based upon the need to share information in an environment which generally isolates the professionals from their colleague groups located outside of the organization." Subsequently these outside needs influence attitudes towards professionalization. The researcher, therefore contends that people in top-level positions require outward identification through a community of interest. Consequently they would have a strong professionalization orientation towards such aspects which are represented by such things as a professional association and professional activities, while students in low-level positions will have attitudes towards operational commitments.

3.0 METHODS AND PROCEDURES

3.1 Setting and Subjects

The following discussions detail the setting and subjects related to this study.

3.1.1 Canadian Hospital Association

The Canadian Hospital Association has offered correspondence courses, over a period in excess of twenty years, for people who are working in administrative or management positions within the health field. The educational programmes have been undertaken by students representing extremely diverse backgrounds.

"It [the programme] was initially developed to meet a recognized void in the availability of administrative knowledge and expertise in the hospital field. The objectives at that time were set out as follows:

1. To provide an organized program of training in the basic principles of hospital organization and management to persons employed in senior executive positions in hospitals and related agencies who are unable to enrol in existing graduate or undergraduate university programs in hospital administration.
2. To provide a recognized yardstick by which an individual's training might be assessed and evaluated.
3. To improve the quality of administration in Canadian hospitals" (Stefanuk 1973).

The C.H.A. is an association that represents employers and thus has the employers' (hospitals') needs at heart. Therefore, the C.H.A.'s

educational programmes are administratively based so as to improve the quality of hospital administration in Canada. In contrast the C.C.H.S.E., which is a professional association, primarily represents the individual Hospital Administrators' (Health Service Executives') interest. Consequently the perspective of the College is different as its main activities dwell around the needs of the profession and its members.

3.1.2 Lesson 10

Each year the C.H.A. sponsors an Extension Course in Hospital Organization and Management (H.O.M.). This two-year programme commences in September and continues until the end of May. It is presented through a correspondence teaching format, concluding each year with an educational seminar in Winnipeg.

Lesson 10, "The Chief Executive Officer," is presented within the first year of the programme. Assignments for this lesson are due at the end of January, but the final deadline is the beginning of April.

This Lesson discusses the Chief Executive Officer in the health field and the profession of Hospital Administration. Contents include the following:

- 1) history and the evolution of the chief executive officer as a professional;
- 2) the public's knowledge, attitude, demands and acceptance of the chief executive officer and the profession of hospital administration;
- 3) the role, duties, responsibilities and relationships of the chief executive officer;

- 4) characteristics or composition of a profession;
- 5) evaluating the performance of a hospital administrator;
- 6) ways to develop executives within the work setting; and
- 7) the role of the wife.

This thesis does not examine the whole lesson content, but focuses on areas which pertain to the professionalization process of an occupation. It contains no discussion as to the quality of the teaching material or as to how the lesson themes had been addressed or presented to the students. The intention of the research was not to assess the programme, or its approach, but to assess the impact of one segment, professionalization, of Lesson 10 on the students. It should be realized that the subject of professionalization was embedded with other subjects within Lesson 10. This had the consequence of being a weak but nevertheless existing educational treatment. The teaching impact was evaluated by assessing the change in the students' attitudes towards professionalization due to Lesson 10 exposure. Additional hypotheses were tested which relate individual and organizational variables to attitudes towards professionalization, independent of the educational exposure of Lesson 10.

3.1.3 Study Sample

As stated, primarily the thesis was an analysis of the attitudes of the H.O.M. students to the professionalization of Hospital Administration. The sample for the study was composed of the 120 students of the 1975-76 class and a comparative group of 128 students from the 1976-77 H.O.M. class of the Canadian Hospital Association. These students are

employed in various types of positions within the health field across Canada. They have diverse occupational and educational backgrounds.

Due to the timing of the research project, pre- and post-lesson evaluations could not be obtained from the same sample. Consequently, the 120, 1975-76 students were surveyed in terms of demographic characteristics and for post-lesson assessment of their professionalization attitudes. The new 1976-77 H.O.M. class was surveyed for pre-lesson professionalization attitudes and also for demographic characteristics. It was assumed that people entering the programme, who had similar backgrounds, had coinciding attitudes on professionalization and that they could be compared to other similar samples. As such, the 1976-77 class were considered representative of the students' attitudes of the 1975-76 class before exposure to Lesson 10, the assumption being that the 1976-77 students have attitudes towards professionalization of Hospital Administration which were only related to the students' demographic characteristics.

As the 1976-77 group of students had not been exposed to Lesson 10, a "base line" was available which described and measured an attitude towards the professionalization of Hospital Administration. The use of the 1976-77 sample thus provided a "base line" from which the influence (success) of Lesson 10 on the attitudes to professionalization could be determined, given that the 1975-76 sample only had received Lesson 10.

The composition of the two classes was analysed for similarities in their demographic characteristics. Analysis of professionalization attitudes was then done on comparable groups, i.e., those with similar

demographic characteristics. Also analyses of the pre-lesson findings were conducted to examine whether the 1976-77 group of students differed amongst themselves regarding their professionalization attitude. Differences in attitudes were correlated with individual demographic characteristics. In explaining attitude differences or similarities amongst individuals, specific demographic attributes were directly linked to the differences. For example, it was possible to investigate whether the teaching material had a different impact on people of different educational backgrounds.

3.2 Data Collection

Data were collected in three ways. The C.H.A. records were used to obtain demographic material relating to student enrolment. On the basis of the theoretical model described, two questionnaires were developed. One to obtain the necessary demographic and organizational information, and the other to assess the students' attitudes on particular dynamics of the professionalization of Hospital Administration. The response to these questionnaires plus information obtained through the C.H.A. records provided the data base for this study.

Both questionnaires were distributed through the auspices of the C.H.A. with a covering letter indicating a study of students was being conducted regarding the H.O.M. course. The content of the letters (see Appendix A) indicated the study was concerned about the occupation of Hospital Administration with Lesson 10 being the main resource for analysis. The questionnaires were distributed through the mail with self-addressed stamped envelopes included so that the students could return

the completed questionnaires directly to the researcher.

All students in both classes received the questionnaires. A second mailing was undertaken to those students who did not respond. The second mailing improved the response rate by an additional 0.8 per cent for the 1975-76 class bringing its total to 65.8 per cent while 3.9 per cent was added to the 1976-77 class, for a total of 65.6 per cent of the students returning the questionnaires. Questionnaires continued to be returned well after the closure of the study. By the middle of November, six weeks later, 89.2 per cent of the 1975-76 class and 78.9 per cent of the 1976-77 class had returned the questionnaires. These late responses were not included in the study.

Consequently for the study, of the 120 students in the 1975-76 class, complete information was obtained on seventy-nine students. Eighty-four of the 128 in the 1976-77 class responded to both questionnaires. The demographic characteristics of the students in these two classes are illustrated in Table 3.1.

3.3 The Measuring Devices

The measures used to tap the variables in the study are described below. Copies of these measures may be found in Appendix A.

3.3.1 Influence of the Teaching Programme

Influence of the educational exposure on attitude toward professionalization was assessed using a Professionalization Questionnaire. The items for the questionnaire were developed from themes on professionalization that were indentifiable and defined in the literature on

Table 3.1. Distribution of Individuals in Each Sample on
Demographic Variables

Variable	1975-76 Class		1976-77 Class	
	Frequency	Total	Frequency	Total
<i>Educational Level</i>				
none/minimal training	12		17	
certificate/diploma	25		33	
university degree	37		31	
missing data	5	79	3	84
<i>Educational Background*</i>				
no training	4		4	
general management	8		15	
laboratory tech.	1		2	
radiology tech.	2		2	
respiratory tech.	2		3	
fine arts	1		1	
computer	1		1	
B.A.-B.Ed.	8		10	
B.Comm.-B.Admin.	9		2	
B.Sc.	1	occupational therapy >	1	
social work	1		1	
physiotherapy	3		3	
dietetics	2		1	
engineering	1		4	
mathematics	1		0	
nursing	11		15	
accounting	12		12	
pharmacy	3		3	
medicine	3		2	
missing data	5	79	2	84
*Educational background was divided also into:				
non-professional	18		27	
professional	18		17	
<i>Position within Organization</i>				
top 1/3	14		10	
middle 1/3	44		48	
bottom 1/3	15		18	
missing data	6	79	8	84
<i>Organization Structure</i>				
tall	15		21	
intermediate	44		41	
flat	15		14	
missing data	5	79	8	84

professionalization, as covered in Chapter 1.0, and in Lesson 10. The questionnaire is reproduced in Appendix A. Questions concerning the professionalization themes were designed so student's attitudes could be ascertained. The study could thus explore the differences in the degree of orientation to professionalization that existed between students. The students were asked to indicate their feelings to each question by marking the point, using a Likert's (1932) five-point attitude scale, which best represented their respective opinions. The coding system utilized to score the questionnaire is explained in Appendix A.

Thirty-three items of the questionnaire were used to compare the degree of professionalization attitudes of the two samples of students. A measure of the degree of professionalization orientation of individuals prior to the lesson exposure was obtained using the 1976-77 respondents' replies to the thirty-three items of the questionnaire. Degree of professionalization orientation subsequent to Lesson 10 exposure was measured using the responses of the 1975-76 respondents.

This approach was adopted as a means of control in the study, the 1976-77 sample representing the pre-exposure condition and the 1975-76 sample representing the post-exposure condition. Mean scores for the two different classes were used to test for differences in attitude to professionalization. Thus the study was conducted in the nature of a Static-Group Comparison design as described by Campbell and Stanley (1973). This design appeared as the best to utilize in the face of the situation and time constraints.

This 'one shot' type of analysis is not affected by history or

motivation, although this could be questioned because of the time delay between the lesson exposure and the completion of the questionnaire. In the study there was some self-selection of subjects as only just better than 65 per cent of the students had returned the questionnaires by the time the analysis was conducted.

3.3.1.1 Professionalization Themes

The following lists the conceptually intuitively derived professionalization themes that were used to seek the student's attitudes:

1) Full time occupation--service to society

6. The work of the Hospital Administrator holds special challenges.
9. Even though Hospital Administrators are employees, they should have the freedom to use their professional judgements in order to carry out their duties and responsibilities.
10. Hospital Administrators should delegate some of their less important duties to other personnel.
28. Hospital Administrators should spend the majority of their time exercising the skills that are distinct to their occupation rather than everyday administrative skills.

2) Establish a professional association--group identity to sustain culture

1. Hospital Administrators should not seek to be recognized as a separate profession but just be part of a management group that would include business executives in various types of organizations.

17. An association membership, which is limited to qualified Hospital Administrators, is necessary in order to further the cause of Hospital Administration.
 18. An association of Hospital Administrators should be able to control how membership within the Hospital Administration field is maintained.
 21. An association of Hospital Administrators should speak on behalf of Hospital Administrators' interest.
 23. The occupational association as well as the Hospital Trustees, should have disciplinary and expulsory powers over Hospital Administrators.
 24. The occupational association should protect its members against Trustees' disciplinary actions when matters of moral conduct are involved.
 25. The judging and disciplining of members by an occupational association, is only appropriate when the members are employed on a fee-for-service basis.
- 3) Change name--new identification
34. It is important for the occupation of Hospital Administration to undergo a name change to further its professionalization process.
- 4) Obligation to the art--code of ethics and standards
7. Hospital Administrators should perform their managerial duties without having to adhere to a set of standards that are laid down by a professional association.

8. When there is a difference, it is more important that Hospital Administrators adhere to their occupational code of ethics than that they follow the instructions of the Board of Trustees.
 20. Proof of continuing education should be required to maintain membership within an association of Hospital Administrators.
 22. Responsibility for raising standards and quality within the occupation of Hospital Administration should be held by:
(Indicate opinion for each group): The Universities; The Preceptors; and The Occupational Association.
- 5) Community sanction--acceptance of authority
2. It is important for Hospital Administrators to have an appreciation of the unique historical background that differentiates Hospital Administration from other administrative occupations.
 31. It is important that clients (patients) and the general community recognize the special expertise of the Hospital Administrator.
 32. It is important that the patients and the public accept the authority of Hospital Administrators because of their special expertise.
- 6) Service orientation above personal goals
11. Hospital administrators should work hard to share with Hospital Administrators in other organizations, all of their work information concerning new ideas, solutions and experiences.

27. Hospital Administration is a satisfying career.
 29. Hospital Administrators should give priority to their clients' (patients and public) needs before their own personal needs.
 30. The Hospital Administrator should be oriented towards service as opposed to seeking monetary rewards.
- 7) Agitate politically--power for new barriers
19. There should be a restriction of, or quota on, the number of people who can enter the field of Hospital Administration.
 26. It should be compulsory for all Hospital Administrators to be licensed under government legislation.
 33. A government Act is required to close the field of Hospital Administration to members only, before the state of the occupation can improve.
 35. Most legislation concerned with the occupation of Hospital Administration should be shaped by Hospital Administrators as a body acting through their occupational association rather than through political decision-making.
- 8) Education--training and dispersal
3. The field of Hospital Administration has developed a body of knowledge based on scientific and theoretical principles.
 4. Hospital Administrators use a vocabulary, or terminology, that is unique to them alone, and is not used commonly by administrators in other management fields.
 5. Hospital Administrators have definite and distinct work

skills that differentiates them from administrators in other types of organizations.

12. The job of the Hospital Administrator can be done effectively only by people who have undergone training in Hospital Administration at the level of: (indicate opinion for each level); No Additional Training; Diploma; Undergraduate Degree; Masters Degree; Doctoral Degree.
 13. Satisfactory completion of a prescribed course should be a mandatory requirement for anyone who is hired as a Hospital Administrator.
 14. Hospital Administrators should undertake the responsibility of providing students who are preparing for careers in Hospital Administration with practical experiences by acting as preceptors.
 15. In the university setting, Hospital Administration should: (indicate opinion for each setting): Establish its own faculty or school; Be placed under the faculty of Medicine; Be placed under the faculty of Commerce/Administration; Be jointly under Medicine and Commerce/Administration.
 38. During the past year my opinions have changed a great deal as to how Hospital Administration can become more professionalized.
- 9) Establish recognition and status
16. Research on the Administration of health care should be promoted in order to raise the status of the occupation of Hospital Administration.

36. Hospital Administration now constitutes a profession.
37. Developing the professional status of Hospital Administration is important to me.
39. The profession of Hospital Administration has gone too far and interferes with the daily functional role of the Hospital Administrator.

3.3.2 Educational and Occupational Variables

Educational background information was obtained by questionnaire. The information was classified on level of education acquired and on the nature of the educational background. The categories are shown in Table 3.1. Education level ranged from no additional education to that of a physician.

Occupational background information was determined by re-classifying the educational background. This was done in two ways in order to acquire a Professional/Non-professional classification plus a Nursing/Accountant classification.

Answers to the following question were used to determine the educational and occupational backgrounds of the respondents:

2. EDUCATION--Course, years completed, certificate or degree obtained.
 Canadian Hospital Association
 H.O.N.--1st year _____
 --2nd year _____
 DMC _____
 HFSS _____
 HRT (E) _____
 ECON _____
 Certified Hospital Course _____
 Technical College _____
 University _____
 Other _____

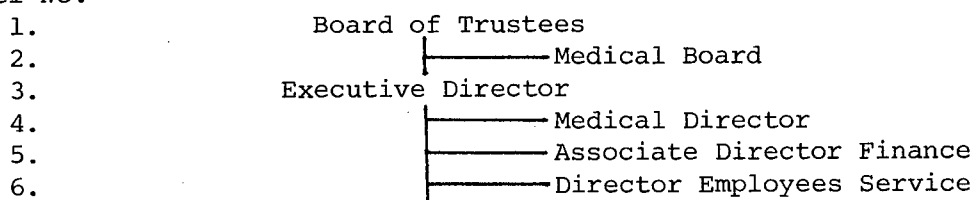
Grouping professionals and non-professionals was determined according to how occupations were judged on professional status in the literature, as outlined in Chapter 1.0. In addition, students in the Health Care and Epidemiological Planning Course, University of British Columbia, were asked to assign the educational backgrounds of the students in the study sample to professional or non-professional classifications. For this undertaking they were given the five criteria that determine a profession as defined by Lewis and Maude (1952). The five criteria being, Registration or State Certification; Practitioner-Client Relationship; Ethical Code; Ban on Advertising of Services; and Independent but Service of a Fiduciary Nature. Students in the study samples were assigned to the professional or non-professional classifications through a consensus of opinion where there was between 75 per cent and 100 per cent agreement of the Health Care students. The grouping of the educational backgrounds is illustrated in Table 3.1 (see * notation).

3.3.3 Organization Structure

The organization structure of the student's place of employment was obtained using the following questionnaire items:

5. ORGANIZATION STRUCTURE OF PRESENT EMPLOYMENT FACILITY--To assist consistency for this question an *example* Organization Chart is illustrated indicating various levels. This is *only* a guide. Please use *your own (hospital) organization chart* to answer.

Level No.



number of hierarchical levels in the organization and the total size of the organization could be computed. Thus organizations could be divided into Tall; Intermediate; and Flat structures. In turn, respondents were classified as one of these three, dependent upon which type of structure they were employed.

To compute this ratio of levels method, organizations were first grouped by size (number of employees) into four groups. The four size categories were Very Small--less than 200 employees; Small--between 200 and 599 employees; Large--600 to 999 employees; and Very Large--over 1,000 employees.

These size categories were then subdivided into three where the subdivisions relate to the number of levels within the particular organizations that fell into an established group size range. The organizations within each size category were ordered as to the number of hierarchical levels they contained. The size ranges were then subdivided so that approximately one-quarter of the organizations in the group that had the least number of hierarchical levels was rated as a Flat organization. In turn, approximately the one-quarter of organizations that had the most levels with a group were ranked as a Tall organization. The remaining organizations which fell between these two ends were designated as Intermediate shaped organizations.

The four size groups were subdivided into the three structure categories in the following manner:

Very Small--Flat, less than 5 levels--Tall, more than 8 levels.

Small-- Flat, less than 7 levels--Tall, more than 10 levels.

Large-- Flat, less than 7 levels--Tall, more than 11 levels.

Very Large--Flat, less than 8 levels--Tall, more than 13 levels.

Students were thus assigned to the number of levels within their organization relative to its size. Table 3.2 demonstrates the student sample breakdown.

Table 3.2. Distribution of Sample of the Organization Structure relative to its Size

Organization Structure	S i z e G r o u p				Total N for Structure Type
	0-199	200-599	600-999	1,000-3,000	
Flat	7	8	8	6	29
Intermediate	18	16	26	25	85
Tall	119	8	9	10	36
Total N for Size Group	34	32	43	41	150
missing					13
TOTAL					163

4.0 ANALYSIS AND RESULTS

4.1 Statistical Procedures

The first and foremost focus of the study was the influence of education on the students' attitudes towards professionalization of Hospital Administration. The investigation focused on correlations between the independent variables of the student's demographic background on the one hand and the dependent variable of the professionalization orientation (treated as an index and as a set of sub-indices) on the other.

There was a hypothesized expected influence of educational exposure to professionalization material on the students' attitude to professionalization. In addition sub-categories of students, differing in terms of demographic characteristics such as educational background, level in the organization, and so forth, were expected to be differentially influenced by exposure to the educational treatment. Effect of independent variables was measured in terms of differences in mean scores of students in each sample on the orientation to professionalization, the dependent variable.

The data in this study was subjected to association and correlation analysis. Investigations were carried out:

- 1) to see whether the two classes used as samples came from similar populations;
- 2) to generate dimensions of professionalization;
- 3) to examine the programme effect that occurred when students had been exposed to Lesson 10;

- 4) to ascertain whether differences other than Lesson 10 exposure would be associated with differences in orientation to professionalization; and
- 5) to test the hypotheses regarding differences in orientation for groups of students with similar demographic characteristics.

4.2 Similarity of Samples

The two class samples were analyzed in terms of several of their independent variables to see if there was an association between the two populations. The independent variables used for measuring the levels of association were: Type of Higher Education; Educational Degree Acquired; Organizational Level; and Structure of the Employing Organization (Flat versus Tall).

In order to test the association between the 1975-76 and 1976-77 classes, specific sets of relationships of independent variables were investigated. Contingency table (cross-tabulation) analysis was performed on the number of cases across the above-mentioned variables. Chi-square statistics were computed on the relationships of the frequency distribution of students across these variables to determine if the samples were statistically independent or associated. No significant differences were observed between the two samples on any of the independent variables. Chi-square values for the variables are given in Table 4.1.

From the analysis it can be concluded that the two samples are not significantly different on major variables used in the study and represent the same population. Therefore, the attitudes of the 1975-76

Table 4.1. Population Chi-square Values

Variable	Chi-square Value	Degrees of Freedom	Significance
Higher Education	2.900	4	0.58
Degree of Education	2.183	2	0.34
Position Level in Organization	1.053	2	0.59
Organization Structures	1.114	2	0.57

and 1976-77 classes can be compared and analyzed. For detailed information of the Cross-tabulation Tables refer to Appendix B.

4.3 Dimensions of Professionalization

In order to establish dimensions of Professionalization, a Pearson Product-moment Correlation Matrix was performed on the 1975-76 student's answers to the thirty-nine questions of the Professionalization questionnaire. This bi-variate correlation analysis was done to measure the relationship or association between pairs of variables, i.e., pairs of questions.

Generally the correlation values were low. In the correlation matrix there was a relative absence of a clear-cut pattern amenable to visual inspection. In the approximately 1,200 paired possibilities only ten questions paired to form "r" values above the 0.45 level of correlation. An additional sixty-nine pairs were correlated at the 0.001 level of significance with "r" values above 0.26. Eighty-nine were significant at the 0.01 level of significance, correlating between 0.20 and 0.26. Those with "r" values above 0.45 were the following:

Variables	"r's"	Variables	"r's"
Q12b with Q12c	-0.5539	Q26 with Q33	0.4825
Q12c with Q12d	0.4806	Q29 with Q30	0.4560
Q12d with Q12e	0.7587	Q31 with Q32	0.4645
Q17 with Q18	0.5712	Q31 with Q37	0.4519

As parts of Question 12 were highly correlated this question was re-evaluated as it was assumed that the various parts of Question 12 measured the same numerical dimensions (students' attitudes).

4.3.1 Restructuring Question 12

As parts of Question 12 provided the highest correlation scores and were likely tapping the same idea, this question was recoded to form one composite answer to avoid over-emphasis of the question in the matrix and to eliminate any confounding effects that it could create in the factor analysis. A composite answer was constructed by using coding values from one to five, where one represented No Post Highschool Training; two--Diploma; three--Undergraduate; four--Masters; and five--Doctoral levels of training. The level of education that the student indicated as his strongest or highest choice of acceptance provided the basis for assigning the scores for this composite answer. Examples of how the new scores were derived are given in Appendix C.

4.3.2 Decision Concerning Question 15

Only part of Question 15 was used for this study. It was felt that only the first part of the question regarding the establishment of a Hospital Administration School or separate Faculty produced an index

of the student's professionalization attitude. This part of the question was chosen since evidence from the literature suggests that strong professions work towards establishing control over the academic aspects of their profession. Consequently the other remaining parts of the question were deleted from the study. Question 15 can be referred to in Appendix A.

4.3.3 Factor Analysis

With the above decisions being made about Questions 12 and 15, the remaining forty-one questions (Question 22 had three parts: Universities; Preceptors; and Professional Association having the responsibility for raising the standards and quality of the occupation) were subjected to factor analysis to examine empirically for dimensions of professionalization. Students' attitudes towards the individual questions were factor analyzed to explore for factors in the matrix. Such factors should represent students' attitudes towards professionalization. Factor analysis was done to determine the minimum number of dimensions or factors that account for the total pattern of intercorrelations among a much larger number of measures.

A Principal Factor Analysis with iteration was utilized for the 1975-76 class of students. This was done by using Principal Factoring with Iteration (PA2) in the Statistical Package for Social Sciences (SPSS), Nie et al. (1975), which replaces the main diagonal elements of the correlation matrix with communality estimates and thus produces inferred factors.

Initially a free factor determination with a mineigen value of 0.5 was assigned and this produced twenty-two iterations before the

communality (the shared determinants that account for the observed relations in the data) of one or more variables exceeded 1.0. It showed that seven Factors accounted for more than 59 per cent of the variance, with an eigenvalue of 1.94 or greater. Ten Factors included 72 per cent while thirteen Factors included 81 per cent of the sample variance.

Oblimin, or oblique rotation, was performed to produce factor pattern loadings where the analyst could control the obliqueness of the solution. Runs designating thirteen, eleven, ten, and seven Factors were performed in order to establish acceptable dimensions for this research. By oblique rotation, factors could be extracted that were considered intuitively "meaningful" and so the results could be interpretable as dimensions. In turn factors could be named and have theoretical and practical utility. Oblique rotations allow the factors to become somewhat correlated with each other in order to arrive at simple structures that have definition. The constructs were expected to be somewhat correlated since it was felt that such factors, as in nature, are rarely independent of one another.

To define a "salient" factor, unit weights were chosen to include variables which loaded (correlated) 0.40 and above on any given factor. All variables which fell below the 0.40 level were not included in that factor dimension. In cases where there was a variate loading across more than one factor the variate was assigned to the factors to which it had the highest loading value.

The designation of seven Factors appeared to provide the clearest factor definition, as for this number of factors at least three of the

professionalization questions per factor had a value of 0.40 or higher. By establishing a 0.40 unit weight level for those variables to be included within a dimension, the professionalization questionnaire answers then became reduced in number to thirty-three questions to be used in this study.

4.3.4 Assignment of Professionalization Dimensions

The thirty-three questions of the seven Factors were assessed in view of the professionalization themes that they contained. The cluster of questions per factor were reviewed and titled and then designated as specific Professionalization Dimensions to be utilized for testing the hypotheses of the study. The dimensions created by factor analysis are the following:

<u>Question</u>	<u>Factor Unit Weight</u>
<i>Factor 1--Dimension of Establishing the Status and Security, or Position, of the Occupation</i>	
16. Research on the Administration of health care should be promoted in order to raise the status of the occupation of Hospital Administration.	0.56
17. An association membership, which is limited to qualified Hospital Administrators, is necessary in order to further the cause of Hospital Administration.	0.58
18. An association of Hospital Administrators should be able to control how membership within the Hospital Administration field is maintained.	0.44
19. There should be a restriction of, or quota on, the	

<u>Question</u>	<u>Factor Unit Weight</u>
number of people who can enter the field of Hospital Administration.	0.57
26. It should be compulsory for all Hospital Administrators to be licensed under government legislation.	0.42
33. A government Act is required to close the field of Hospital Administration to members only, before the state of the occupation can improve.	0.61
34. It is important for the occupation of Hospital Administration to undergo a name change to further its professionalization process.	0.46

The professionalization dimension created by Factor 1 was used to test Security attitudes of people with different degrees of academic education, as postulated by Hypothesis 3.

Factor 2--Dimension of Work, Standards and Establishment of the Profession

- | | |
|--|------|
| 1. Hospital Administrators should not seek to be recognized as a separate profession but just be part of a management group that would include business executives in various types of organizations. (A negative answer is expected for the professionalization index.) | 0.47 |
| 6. The work of the Hospital Administrator holds special challenges. | 0.47 |
| 7. Hospital Administrators should perform their | |

<u>Question</u>	<u>Factor Unit Weight</u>
managerial duties without having to adhere to a set of standards that are laid down by a professional association. (Negative answer.)	0.50
22. Responsibility for raising standards and quality within the occupation of Hospital Administration should be held by: The Professional Association.	0.60
23. The occupational association as well as the Hospital Trustees, should have disciplinary and expulsive powers over Hospital Administrators.	0.43
37. Developing the professional status of Hospital Administration is important to me.	0.55
39. The professionalization of Hospital Administration has gone too far and interferes with the daily functional role of the Hospital Administrator. (Negative answer.)	0.46

Factor 2 represented Bureaucratic Rules and Standards when the differences between students' professionalization orientation in Tall and Flat structured organizations were analyzed in terms of student scores on this dimension (Hypothesis 5).

Factor 3--Dimension of Utilizing Professional Judgement and Sharing of Knowledge

- | | |
|---|------|
| 9. Even though Hospital Administrators are employees, they should have the freedom to use their professional judgement in order to carry out their duties and responsibilities. | 0.44 |
|---|------|

<u>Question</u>	<u>Factor Unit Weight</u>
10. Hospital Administrators should delegate some of their less important duties to other personnel.	0.78
11. Hospital Administrators should work hard to share with Hospital Administrators in other organizations, all of their work information concerning new ideas, solutions and experiences.	0.46
14. Hospital Administrators should undertake the responsibility of providing students who are preparing for careers in Hospital Administration with practical experiences by acting as preceptors.	0.57

Factor 3, representing the dimension of Professional Freedom, was also used in Hypothesis 5 to test the differences in the students' orientation to determine if students from Flat organizations had a stronger professionalization orientation to this dimension than students in Tall structured organizations.

Factor 4--Dimension of A Profession with Distinct Skills Oriented Towards Service

5. Hospital Administrators have definite and distinct work skills that differentiate them from Administrators in other types of organizations.	0.42
21. An association of Hospital Administrators should speak on behalf of Hospital Administrators' interest.	0.41
27. Hospital Administration is a satisfying career.	0.56

<u>Question</u>	<u>Factor Unit Weight</u>
28. Hospital Administrators should spend the majority of their time exercising the skills that are distinctive to their occupation rather than everyday administrative skills.	0.50
29. Hospital Administrators should give priority to their clients' (patients and public) needs before their own personal needs.	0.68
30. The Hospital Administrator should be oriented towards service as opposed to seeking monetary rewards.	0.48

Factor 4 was utilized as two different concepts for two different hypothesis. For Hypothesis 4 it was used to test Altruism when determining if nurses and accountants had different attitudes towards this aspect of professionalization. Whereas, in Hypothesis 6, Factor 4 determined the dimension of Operational Commitment. It was used in Hypothesis 6 to test if students in low-level positions had a higher degree of professionalization for this dimension than students who were employed in top-level positions.

Factor 5--Dimension of Acceptance and Public Recognition

- | | |
|---|------|
| 25. The judging and disciplining of members by an occupational association, is only appropriate when the members are employed on a fee-for-service basis.

(Negative answer.) | 0.48 |
| 31. It is important that clients (patients) and the | |

QuestionFactor
Unit Weight

general community recognize the special expertise of the Hospital Administrator.

0.48

32. It is important that patients and the public accept the authority of Hospital Administrators because of their special expertise.

0.40

Community of Interest was represented by the dimension created by Factor

5. This was used to test Hypothesis 6 to determine if students in top level positions have a higher degree of professionalization orientation to this dimension than students who are employed in lower level positions.

Factor 6--Dimension of An Educational Index

12. The job of the Hospital Administrator can be done effectively only by people who have undergone training in Hospital Administration at the level of: (no additional training; diploma; undergraduate; masters; doctorate degree--composite answer).

0.47

20. Proof of continuing education should be required to maintain membership within an association of Hospital Administrators.

0.63

38. During the past year my opinions have changed a great deal as to how Hospital Administration can become more professionalized.

0.56

This factor was not used on its own, but it was included in the seven dimensions that were tested for Hypothesis 1 and Hypothesis 2.

<u>Question</u>	<u>Factor Unit Weight</u>
<i>Factor 7--Dimension of Standards and Quality of the Body of Knowledge</i>	
3. The field of Hospital Administration has developed a body of knowledge based on scientific and theoretical principles.	0.40
22. Responsibility for raising standards and quality within the occupation of Hospital Administration should be held by: (indicate option for each group)	
--The Universities (Negative answer)	0.53
--The Preceptors	0.50

The dimension created by Factor 7 was used to test Realism when determining for Hypothesis 4 if Nurses and Accountants had different attitudes towards this aspect of professionalization.

All seven factor dimensions were used to test the influence of the teaching programme to determine the differences in professionalization orientation between students of the 1975-76 and 1976-77 classes (Hypothesis 1) and students with professional and non-professional backgrounds (Hypothesis 2).

4.4 Hypothesis Testing and Results

Hypothesis 1 was tested by using all thirty-three questions of the seven professionalization dimensions as a single index of professionalization for the dependent variable. The different classes, 1975-76 and 1976-77, were used as the independent variable in order to determine if

the teaching programme had a positive influence as hypothesized.

Hotelling's T-square test was administered on the thirty-three questions to establish whether there were significant differences between the two samples in their orientation to professionalization.

When comparing the attitudes of the two classes there was a Hotelling's T-square value of 71.27 and an associated F-value of 1.722 ($P = 0.017$). The 1975-76 class had a mean score of 3.56 while the mean score for the 1976-77 class was 3.47. The significant difference, as indicated by the mean values, was in the direction of the observed 1975-76 class, indicating that they had a significantly higher degree of professionalization orientation than students in the 1976-77 class. Consequently, Hypothesis 1 was sustained. Hospital Administrators, therefore, who were exposed to education on professionalization (Lesson 10) had a significantly higher degree of professionalization orientation than students who had not been exposed to such education. (For more information concerning the Hotelling's T-square results refer to Appendix D.)

Interestingly, the profiles for the two classes are very similar. The differences of the mean scores for the two classes for each of the various seven factors range from 0.01 to 0.18 and no one question influenced the statistical outcome. Instead, the significant variance was due to an accumulative effect of the various question scores.

When viewing the mean score values of the seven different dimensions it shows that Dimensions 1 to 6 were most positively supported in terms of professionalization orientation by the 1975-76 exposed class.

Whereas Dimension 7 was more positively supported by the 1976-77 class. Factor 7 deals with the Dimension of Standards and Quality of the Body of Knowledge. As the mean values for the two classes only vary by 0.09 (3.16 and 3.07) with both classes indicating an "Uncertain" opinion as to their attitudes to the questions, a rationale as to why there was a difference on this dimension would be highly speculative.

The mean values of the various dimensions (see Table 4.2 below) indicate that only Factor 3, the Dimension of Utilizing Professional Judgement and Sharing of Knowledge, had a value of four or greater, indicating the students' Agreement. On the other hand, Factor 1, The Dimension of Establishing the Status and Security, or Position of the Occupation, had mean scores just below a three value, indicating that the classes showed their most Disagreement with the need for Hospital Administration to raise its status through research, limited and controlled membership, government intervention or by changing its name. Strong well-established professions achieve these aspects of control. Therefore if these activities are to be desired for the profession of Hospital Administration, more persuasive communications concerning these aspects should be introduced.

The differences between the two classes in scores on individual items were examined to provide some insight into the differences in attitudes between the two groups. The discussion on questions/items which follows, as well as subsequent discussions, are intended as guides to further hypotheses rather than as a rigorous statistical analysis, given the large number of t-tests involved.

Table 4.2. Profile of the Dimensions' Mean Scores

Dimension	1975-76 Exposed	1976-77 Unexposed	Mean Difference
Factor 1	2.91	2.89	0.01
Factor 2	3.81	3.65	0.17
Factor 3	4.36	4.34	0.02
Factor 4	3.70	3.55	0.15
Factor 5	3.83	3.65	0.18
Factor 6	3.36	3.24	0.12
Factor 7	3.07	3.16	(0.09)

When the difference of the mean scores of the two classes on each of the individual questions were tested by a Fisher two-sample t-test, only Questions 1, 22c, 28, and 32 were significant at a 0.05 level. These questions relate to the establishment and acceptance of the profession, and to the professional association's responsibility for raising the standards within the profession. Other questions (11, 18, 23, and 25) which had a 0.2 difference between the mean scores dealt with controlling and disciplining members and sharing information. (Mean scores are shown in Appendix D.) As the mean scores were greater for the exposed class in these important areas of professionalization, these results indicate where the teaching programme may have had a positive effect. Question 29 (placing clients' needs before personal needs) was supported by the 1976-77 class, thus indicating that with exposure, students moved away from this altruistic concept.

Hypothesis 4 supposed that students with nursing backgrounds

would have a significantly higher degree of professionalization orientation towards those aspects representing altruism and dedication than students with an accounting background who are trained to be more calculating and thus would therefore have attitudes towards realism.

Hypothesis 4 was tested in two parts. The first part examined whether there was a difference between students who were nurses and accountants in attitudes on the Dimension of Altruism, while the second part dealt with differences in attitudes on the Dimension of Realism.

Factor 4, the Dimension of "A Profession with Distinct Skills Oriented Towards Service," was used as the dependent variable to test Altruism. The Hotelling's T-square test did not show an observed significant difference at the 0.05 level of significance.

The Dimension of Realism was tested by utilizing Factor 7, the Dimension of "Standards and the Quality of the Body of Knowledge." For the Dimension of Realism the Hotelling's T-square test computed a T-square value of 11.60 and an associated F-value of 3.70 which produced a significant level of 0.018 but in the opposite direction than that which had been hypothesized. The 0.018 level showed that students who had a nursing background were observed to have a significantly higher professionalization orientation to the Dimension of Realism than students with an accounting background. (Refer to Appendix D for the statistical breakdown.)

The differences of attitudes on this dimension between the nursing and accounting students indicate that nurses have a stronger attitude towards the preceptors setting standards, rather than the universities, and that Hospital Administration has developed a body of knowledge. This could

be due to their own educational background or because they have their beginnings on a lower hierarchical level within a health organization. They therefore feel that through the mechanisms being tested by this Dimension their own position could be improved. Whereas accountants are less interested in this Dimension as they strongly identify with their own profession, which can be construed as being equal to, or superior to, Hospital Administration. They therefore do not have the same need or belief that Hospital Administration has a developed body of knowledge; also, the universities and not the preceptors should hold the responsibility of raising the standards.

When the individual questions were submitted to a Fisher two-sample t-test only Question 22b (Preceptors should hold the responsibility for raising the standards and quality within the occupation) showed an observed statistical difference at the 0.05 level of probability ($P = 0.013$), indicating that students from a nursing background showed a highly significant support of this question when compared with students from an accounting background.

None of the remaining hypotheses (2 through 6) showed significant findings when submitted to Hotelling's T-square test. On this basis as there were no observed differences between students in the two groups in orientation to professionalization due to academic; professional/non-professional; position level; or organization structure differences; these five hypotheses were not supported.

5.0 CONCLUSION

The findings of this study indicate that there is a significant relationship between exposure to educational input on professionalization (Lesson 10) and a student in Hospital Administration orientation to professionalization of the occupation of Hospital Administration. Students who had been exposed to Lesson 10 had a higher overall orientation to professionalization than students who had not yet been exposed to the teaching materials. Differences in degree of orientation appear to relate specifically to the Dimensions of Acceptance and Public Recognition; Work, Standards and Establishment of the Profession; and Utilizing Professional Judgement and Sharing of Knowledge.

Looking at sub-categories of administrators in the sample that were investigated in the study, Nurses and Accountants were found to differ significantly in terms of Realism. Students with a nursing background had a more positive professionalization orientation to this Dimension than students with an accounting background. This could indicate that students with a nursing background want to identify with the professional model for an occupation in order to improve their own status.

No other relationships were statistically significant. Organizational characteristics such as structure (Tall and Flat) or level as well as individual characteristics such as education and occupation appear to be unrelated to orientation to professionalization as measured in this study.

It is always difficult to draw conclusions and make recommendations

on the basis of a single study. Therefore the conventional statement that further research is needed applies in this study as in any other. It is important therefore to point out some of the limitations of this study. Firstly, a true pre- and post-treatment (Lesson 10) measure of a single sample was not possible. An approximation to this condition was obtained through measures on comparable samples differing only in terms of exposure to Lesson 10. Some support for this comparison comes from the analysis of the two samples on several demographic variables. No significant differences were observed between the samples of any of the demographic variables used. It is never possible to be completely comprehensive in controlling the sampling differences, nevertheless, the two-sample feature of the study had some limitations.

Sample sizes of seventy-nine (1975-76) and eighty-four (1976-77) are somewhat small for use in a factor analysis of thirty-three items. A ratio of at least five subjects per questionnaire item is ideal for factor analysis. However, no fixed rule exists and accepted practice tends to treat a ratio of 2.5 to 3 subjects per questionnaire item as legitimate. Future research on the factor structure of professionalization, as perceived by Hospital Administrators, ought to involve larger sample sizes and possibly a smaller set of questionnaire items. In evaluating the results of the present study, however, it should be pointed out that statistically significant differences were observed on mean scores of subjects derived from the total set of questionnaire items rather than on Factors involved, with the exception of differences between Nurses and Accountants on the Dimension of Realism.

A third feature of the study which must be dealt with is the sponsorship of the Research by the Canadian Hospital Association. It is possible that responses by subjects were biased in a direction thought to be required or performed by the C.H.A. It is not possible to eliminate this completely as a competing hypothesis for the results obtained. However, every effort was made to minimize this effect in communications with the subjects. The questionnaire was constructed by the researcher independent of any input from the C.H.A. Letters to the subjects did not specify directly the intent of the research questions, and a time lapse of seven months occurred between the exposure to Lesson 10 and the administration of the questionnaire, providing as far as possible some "distance" between the C.H.A. course exposure and administration of the research instruments used in this study. The researcher deliberately avoided using Lesson 10 responses of subjects as a measure of education effect because of the likely response bias in these answers.

Further research should be undertaken on the dimensions of professionalization so that such dimensions could be utilized for future studies to assess attitudes towards the professionalization orientations of different study samples in order that occupations could then be provided with an easy index for assessing such attitudes of the members, etc., of their organizations. They could then have a measure as to what attitudes should be reshaped in order to direct the professionalization process of the occupation.

Additional validation of these findings is therefore recommended if empirical research using this thesis instrument is to make a

contribution to a theory consisting of these specific professionalization themes forming particular professionalization dimensions.

BIBLIOGRAPHY

- Abrahamson, Mark. *The Professional in the Organization*. Chicago: Rand McNally & Co., 1967.
- Austin, Charles J. "Emerging Roles and Responsibilities of Health Administration." In *Education for Health Administration* 1: 137-51. Edited by Charles J. Austin and Janet A. Strauss. Ann Arbor: University of Michigan, Administration Press, 1975.
- Austin, Charles J. and Strauss, Janet A. *Education for Health Administration* 1. Ann Arbor: University of Michigan, Administration Press, 1975.
- Bandura, Albert. *Principles of Behavior Modification*. Toronto: Holt, Rinehard & Winston, 1969.
- Barker, W. Daniel. "Professional Self-Reliance or Self-Destruction: The Choice is Ours." *Hospital Accounting* 20 (May 1966): 3-5.
- Becker, Howard S.; Geer, Blanche; Hughes, Everett C.; and Strauss, Anselm. *Boys in White: Student Culture in Medical School*. Chicago: University of Chicago Press, 1961.
- Blain, Gilbert. "The Professional in a Bureaucratic Structure." *The Hospital Medical Staff* 4 (October 1975): 1-6.
- Blishen, Bernard R. *Doctors and Doctrines: The Ideology of Medical Care In Canada*. Toronto: University of Toronto Press, 1969.
- Brown, Bernard L., Jr. "The Profession of Hospital Administration." *Southern Hospitals* 38 (February 1970): 12-14.
- Brown, Montague. Statement to National Advisory Council on Nursing Home Administration, Atlantic City, N.J., 19 September 1968. Quoted in A. Somers, *Hospital Regulations: The Dilemma of Public Policy*, p. 82. Princeton: Princeton University, Industrial Relations Section, 1969.
- Brown, R. W. *Social Psychology*. New York: Free Press, 1965.
- Campbell, Donald T. and Stanley, Julian C. *Experimental and Quasi-experimental Designs for Research*. Chicago: Rand McNally College Publishing Co., 1973.
- Canadian College of Health Service Executives. "For the Development of External Baccalaureate Degree in Hospital Administration." *Proposal to the Kellogg Foundation* (October), 1975. (Drafted.)

Canadian Hospital Association Convention. Montreal, 2, 3 & 4 June 1971.

Caplow, Theodore. *The Sociology of Work*. Minneapolis: University of Minnesota Press, 1954.

_____. "The Sequence of Professionalization (General)." In *Professionalization*, pp. 20-21. Edited by Howard M. Vollmer and Donald L. Mills. Toronto: Prentice-Hall of Canada, 1966.

Carr-Saunders, A. M. "Professionalization in Historical Perspective: (General)." In *Professionalization*, pp. 3-9. Edited by Howard M. Vollmer and Donald L. Mills. Toronto: Prentice-Hall of Canada, 1966.

Carr-Saunders, A. M. and Wilson, P. A. *The Professions*. London: F. Cass, 1964.

Clark, Burton R. "International Patterns in Education." *Administrative Science Quarterly* 10 (September 1965): 224-37.

Cohen, Arthur Robert. *Attitude Change and Social Influence*. New York: Basic Books, 1964.

Cummings, L. and ElSalmi, A. "The Impact of Role Diversity, Job Level and Organizational Size on Managerial Satisfaction." *Administrative Science Quarterly* 15 (March 1970): 1-11.

Dolson, Miriam Terry. "Where Women Stand in Administration." *The Modern Hospital* 108, no. 5 (May 1976): 100-105.

Dolson, Miriam T.; White, Rodney F.; and Van Riper, Paul. "Study Reveals What Administrators Earn." *Modern Hospital* (April 1966): 103-6.

Doob, L. W. "The Behavior of Attitudes." *Psychological Review* 54 (1947): 135-56.

Drucker, Peter F. *The Practice of Management*. New York: Harper & Bros. Publishers, 1954.

Durkheim, Emile. *The Division of Labor in Society*. Translated by George Simpson. Glencoe, Ill.: Free Press, 1933; 4th printing, 1960.

Etzioni, Amitai. *Modern Organizations*. Englewood Cliffs, N.J.: Prentice-Hall, 1964.

Gibson, J. L.; Ivanoevich, J. M.; and Donnely, J. H. *Organizations: Structure Process, Behavior*. Georgetown, Ont.: Irwin-Dorsey, 1973.

Glaser, Barney. *Organizational Scientists: Their Professional Careers*. Indianapolis: Bobbs-Merrill, 1964.

Greenwood, Ernest. "Attitudes of a Profession." *Social Work* 2, no. 3 (1957): 44-55.

_____. "The Elements of Professionalization (Social Work)." In *Professionalization*. Edited by Howard M. Vollmer and Donald L. Mills. Toronto: Prentice-Hall of Canada, 1966.

Gross, Edward. *Work and Society*. New York: Thomas Y. Crowell Co., 1958, p. 77.

Hall, Richard H. "Some Organizational Considerations in the Professional-Organizational Relationship." *Administrative Science Quarterly* 12 (December 1967): 461-78.

_____. "Professionalization and Bureaucratization." In *The Formal Organization*, pp. 143-63. New York: Basic Books, 1972.

Harvey, O. J.; Hunt, David Ed.; and Schroder, Harold M. *Conceptual Systems and Personality Organization*. New York: John Wiley & Sons, 1961.

Hovland, Carl I. and Janis, Irvin L., eds. *Personality and Persuasibility*. New Haven: Yale University Press, 1959.

Hovland, Carl I.; Janis, Irving L.; and Kelley, Harold H. *Communication and Persuasion: Psychological Studies of Opinion Change*. New Haven: Yale University Press, 1953.

Hughes, Everett C. *Men and Their Work*. Glencoe, Ill.: Free Press, 1958.

_____. "The Social Significance of Professionalization (General)." In *Professionalization*, pp. 64-71. Edited by Howard M. Vollmer and Donald L. Mills. Toronto: Prentice-Hall of Canada, 1966.

Indik, Bernard P. "Some Effects of Organization Size on Member Attitudes and Behavior." *Human Relations* 16, no. 4 (November 1963): 369-84.

Indik, Barnard P. and Seashore, S. *Effects of Organization Size of Member Attitudes and Behavior*. Ann Arbor: University of Michigan, Survey Research Centre, 1961.

Jones, L. V. and Jeffrey, T. E. "A Quantitative Analysis of Expressed Preferences for Compensation Plans." *Journal of Applied Psychology* 48, no. 4 (August 1964): 201-10.

Katz, Daniel and Kahn, Robert L. *The Social Psychology of Organizations*. New York: John Wiley & Sons, 1966.

Katzell, R. A.; Barrett, R. S.; and Parker, T. C. "Job Satisfaction, Job Performance, and Situational Characteristics." *Journal of Applied Psychology* 45, no. 2 (April 1961): 65-72.

- Kerr, W. A.; Koppelman, G. J.; and Sullivan, J. S. "Absenteeism, Turn-over and Morale in a Metals Fabrication Factory." *Occupational Psychology* 25 (1951): 50-55.
- Krause, Elliott A. *The Sociology of Occupations*. Boston: Little, Brown & Co., 1971.
- Larke, A. G. "Workers Attitudes on Incentives." *Dun's Review and Modern Industry* (December 1953), pp. 61-63. Cited by John P. Campbell, Marvin D. Dunnette, Edward E. Lawler, III, and Karl E. Weick, Jr. In *Managerial Behavior Performance and Effectiveness*, p. 364. Toronto: McGraw-Hill, 1970.
- Letourneau, Charles U. *The Hospital Administrator*. Chicago: Starling Publications, 1969.
- Lewis, Roy and Maude, Angus. *Professional People*, Chapter 5. London: Phoenix House, 1952.
- Likert, Rensis. "A Technique for the Measurement of Attitudes." *Archives of Psychology* 22, no. 140 (June 1932): 5-55.
- Lortie, Daniel C. "Laymen to Lawmen: Law School, Careers and Professional Socialization." In *Professionalization*, pp. 98-101. Edited by Howard M. Vollmer and Donald L. Mills. Toronto: Prentice-Hall of Canada, 1966.
- MacKenzie, Norah. *The Professional Ethic and The Hospital Service*. London: English Universities Press, 1971.
- McKenzie, R. M. "The Behavioural Sciences and Organisations." In *Health Services Administration*, Chapter 3. Edited by R. J. Peters and J. Kinnaird. London: E. & S. Livingstone, 1965.
- McLeish, John A. B. and Nightingale, Donald V. *Health Service Executive Manpower Needs for the Seventies in Canada*. A preliminary Report for Manpower Planning, Department of National Health and Welfare, Ottawa, 1973.
- Maslow, Abraham H. *Motivation and Personality*. 2d ed. New York: Harper & Row Publishers, 1970, 1954.
- Merriam-Webster Trademark. *Webster's Seventh New Collegiate Dictionary*. Toronto: Thomas Allen & Son, 1969.
- Millerson, Geoffrey. *The Qualifying Associations; A Study in Professionalization*. London: Routledge & Kegan Paul, 1964.
- Mills, Donald L. "Status, Values and Certainty of Occupational Choice."

- Ph.D. dissertation. Stanford University, 1962. Cited by Howard M. Vollmer and Donald L. Mills, *Professionalization*, pp. 87-88. Toronto: Prentice-Hall of Canada, 1966.
- Miner, John B. *The Management Process: Theory, Research and Practice*. Toronto: Collier-Macmillan Canada, 1973.
- More, D. M. and Kohn, Nathan, Jr. "Some Motives for Entering Dentistry." *American Journal of Sociology* 66, no. 1 (July 1960): 48-53.
- Nealy, S. "Pay and Benefit Preferences." *Industrial Relations* 1 (1963): 17-28. Cited by John P. Campbell, Marvin D. Dunnette, Edward E. Lawler, III, and Karl E. Weick, Jr. *Managerial Behavior Performance and Effectiveness*, p. 364. Toronto: McGraw-Hill, 1970.
- Newman, William H. *Administrative Action: The Techniques of Organization and Management*. Englewood Cliffs, N.J.: Prentice-Hall, 1951.
- Nie, Norman H.; Hull, C. Hadlai; Jenkins, Jean G.; Steinbrenner, Karen; and Bent, Dale H. *Statistical Package for the Social Sciences*. 2d ed. Toronto: McGraw-Hill Book Co., 1975.
- Parsons, Talcott. "Suggestions for a Sociological Approach to the Theory of Organizations." *Administrative Science Quarterly* 1 (1956): 63-85.
- Pickering, Errol. "Hospital Administration in Canada." *Hospital and Health Administration, Australia* 5 (May 1972): 13-15.
- Porter, L. and Lawler, E. III. "The Effects of 'Tall' versus 'Flat' Organization Structures on Managerial Job Satisfaction." *Personnel Psychology* 17, no. 2 (Summer 1964): 135-48.
- Rosenberg, M. J. "An Analysis of Affective-Cognitive Consistency." In *Attitude Organization and Change: An Analysis of Consistency among Attitude Components*, pp. 15-64. Edited by M. J. Rosenberg, C. I. Hovland, W. J. McGuire, R. P. Abelson, and J. W. Brehm. New Haven: Yale University Press, 1960.
- Rosenberg, M. J.; Hovland, C. I.; McGuire, W. J.; Abelson, R. P.; and Brehm, J. W. *Attitude Organization and Change: An Analysis of Consistency among Attitude Components*. New Haven: Yale University Press, 1960.
- Schein, Edgar H. *Organizational Psychology*. Englewood Cliffs, N.J.: Prentice-Hall, 1965.
- Sheldon, Alan; Baker, Frank; and McLaughlin, Curtis P. *Systems and Medical Care*. Cambridge: M.I.T. Press, 1970.
- Sherlock, Basil and Cohen, Alan. "The Strategy of Occupational Choice:

- Recruitment to Dentistry." *Social Forces* 44 (March 1966): 303-13.
- Shull, Fremont A. Jr.; Delbecq, Andre L.; and Cummings, L. L. *Organizational Decision Making*. Toronto: McGraw-Hill, 1970, Chapter 4.
- Sloan, Raymond P. *Today's Hospital; A Guide for Trustees, Administrators, and Volunteers*. Toronto: Harper & Row Publishers, 1966, Chapter 6.
- Somers, Anne R. *Hospital Regulation: The Dilemma of Public Policy*. Princeton: Industrial Relations Section, Princeton University, 1969.
- Stefanuk, E. N. Extension Course in Hospital Organization and Management. Revision Project #606-22-4. Final Report. Canadian Hospital Association, Toronto (July 1973).
- Taylor, Ronald N. "Perception of Problem Constraints." Vancouver: University of British Columbia, 1974. (Mimeographed.)
- Thompson, James D. *Organizations in Action*. Toronto: McGraw-Hill Book Co., 1967, Chapters 6-7.
- Vollmer, Howard M. and Mills, Donald L. *Professionalization*. Toronto: Prentice-Hall of Canada, 1966.
- Weaver, Jerry L. *Conflict and Control in Health Care Administration* 14. Beverly Hills, Calif.: Sage Library of Social Research, Sage Publications, 1975.
- Westly, D. L. "The Career Experience of the Symphony Musician." *Social Forces* 38, no. 3 (March 1960): 223-30.
- White, D. K. "Management Education in Health Care." *The Hospital and Health Services Review* 68, no. 1 (January 1972): 5-9.
- Whyte, William H. Jr. *The Organization Man*. New York: Simon & Schuster, 1956.
- Wilensky, Harold L. "The Dynamics of Professionalism: The Case of Hospital Administration." *Hospital Administration* (Spring 1962): 6-24.
- _____. "The Professionalization of Everyone." *American Journal of Sociology* 70, no. 2 (September 1964): 137-58.
- Worthy, James C. "Organizational Structure and Employee Morale." *American Sociological Review* 15 (1950): 169-79.

APPENDIX A.0

QUESTIONNAIRE DESIGN, CODING AND DISTRIBUTION

- A.1 Demographic Questionnaire
- A.2 Professionalization Questionnaire
- A.3 Coding System Utilized
- A.4 Letters for Distribution

A.1 Demographic Questionnaire

Please leave Blank

1. NAME _____ (1-3)

2. EDUCATION--Course, years completed, certificate or
degree obtained.
Canadian Hospital Association
H.O.M.--1st year _____ (20)

--2nd year _____

DMC _____

HFSS _____

HRT (E) _____

ECOM _____

Certified Hospital Course _____ (21)

Technical College _____

University _____

Other _____

3. OCCUPATIONAL BACKGROUND--Last 3 positions or jobs
held, starting with the most recent position.

<u>Occupation</u>	<u>Position Title</u>	<u>No. years Held</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

(23) (24) (25-26)

Please leave Blank

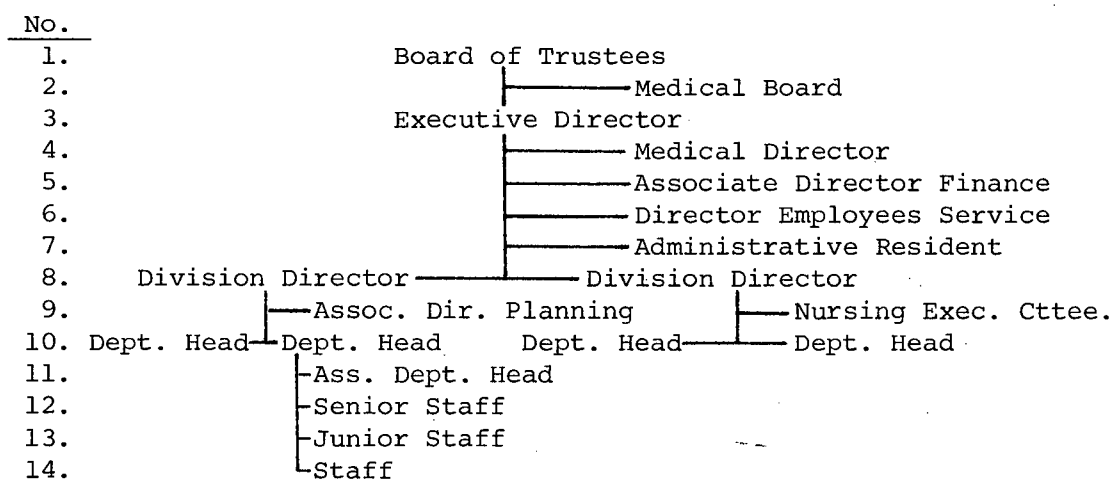
<u>Occupation</u>	<u>Position Title</u>	<u>No. years Held</u>			
			(27)	(28)	(29-30)
			(31)	(32)	(33-34)

4. TYPE OF FACILITY OF PRESENT EMPLOYMENT--Acute General, Psychiatric, Mentally Retarded, Extended Care, T.B., Rehabilitation, Nursing Home, Community Health Centre, Provincial Authority, Regional Health Programme, Volunteer Agency, etc. (if involved in more than one type indicate primary and secondary involvement)

		(36)	(37)
--	--	------	------

5. ORGANIZATION STRUCTURE OF PRESENT EMPLOYMENT FACILITY--
To assist consistency for this question and *example* Organization Chart is illustrated indicating various levels. This is *only* a guide. Please use *your own* (hospital) organization chart to answer.

Level



No. of levels within your Organization	(39)
Your Position Level (counting from top down)	(40)
No. of People that You Directly Supervise	(41)
No. of Personnel within your Dept. or Sub-unit	(42)
No. of Personnel within the total Organization	(43)

A.2 Professionalization Questionnaire

QUESTIONNAIRE ON HOSPITAL ADMINISTRATION

Please
leave
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NAME _____

(1-3)

This questionnaire is designed to obtain your views about Hospital Administration. There are no correct answers. In answering the survey, please indicate *your own feelings* concerning the various statements and do not solicit the opinions of others. The information will be handled in a confidential manner and only seen by the researcher.

I would like to thank you in advance for completing the full questionnaire and for your participation.--C. Bortnick, Research Assistant, U.B.C.

Complete the questionnaire by checking (✓) the one category, of the five provided, which most closely fits your opinion on each of the following statements.

1. Hospital Administrators should not seek to be recognized as a separate profession but just be part of a management group that would include business executives in various types of organizations.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(4)
Agree				Disagree	

2. It is important for Hospital Administrators to have an appreciation of the unique historical background that differentiates Hospital Administration from other administrative occupations.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(5)
Agree				Disagree	

3. The field of Hospital Administration has developed a body of knowledge based on scientific and theoretical principles.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(6)
Agree				Disagree	

4. Hospital Administrators use a vocabulary, or terminology, that is unique to them alone, and is not used commonly

Please
leave
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by administrators in other management fields.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(7)
-------------------	-------	-----------	----------	----------------------	-----

5. Hospital Administrators have definite and distinct work skills that differentiate them from administrators in other types of organizations.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(8)
-------------------	-------	-----------	----------	----------------------	-----

6. The work of the Hospital Administrator holds special challenges.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(9)
-------------------	-------	-----------	----------	----------------------	-----

7. Hospital Administrators should perform their managerial duties without having to adhere to a set of standards that are laid down by a professional association.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(10)
-------------------	-------	-----------	----------	----------------------	------

8. When there is a difference, it is more important that Hospital Administrators adhere to their occupational code of ethics than that they follow the instructions of the Board of Trustees.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(11)
-------------------	-------	-----------	----------	----------------------	------

9. Even though Hospital Administrators are employees, they should have the freedom to use their professional judgment in order to carry out their duties and responsibilities.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(12)
-------------------	-------	-----------	----------	----------------------	------

10. Hospital Administrators should delegate some of their less important duties to other personnel.

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	(13)
-------------------	-------	-----------	----------	----------------------	------

Please
leave
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11. Hospital Administrators should work hard to share with Hospital Administrators in other organizations, all of their work information concerning new ideas, solutions and experiences.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(14)
Agree				Disagree	

12. The job of the Hospital Administrator can be done effectively only by people who have undergone training in Hospital Administration at the level of: (indicate opinion for each level)

<u>Strongly</u>				<u>Strongly</u>
<u>Agree</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Disagree</u>

-No Additional Training:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(15)
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-Diploma:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(16)
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-Undergraduate Degree:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(17)
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-Masters Degree:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(18)
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-Doctoral Degree:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(19)
-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	------

13. Satisfactory completion of a prescribed course should be a mandatory requirement for anyone who is hired as a Hospital Administrator.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(20)
Agree				Disagree	

14. Hospital Administrators should undertake the responsibility of providing students who are preparing for careers in Hospital Administration with practical experiences by acting as preceptors.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(21)
Agree				Disagree	

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15. In a university setting, Hospital Administration should:
(indicate opinion for each setting)

Strongly				Strongly
Agree	Agree	Uncertain	Disagree	Disagree

-Establish its own faculty or school:

(22)

-Be placed under the faculty of Medicine:

(23)

-Be placed under the faculty of Commerce/Administration:

(24)

-Be jointly under Medicine and Commerce/Administration:

(25)

16. Research on the Administration of health care should be promoted in order to raise the status of the occupation of Hospital Administration.

Strongly	Agree	Uncertain	Disagree	Strongly
Agree				Disagree

(26)

17. An association membership, which is limited to qualified Hospital Administrators, is necessary in order to further the cause of Hospital Administration.

Strongly	Agree	Uncertain	Disagree	Strongly
Agree				Disagree

(27)

18. An association of Hospital Administrators should be able to control how membership within the Hospital Administration field is maintained.

Strongly	Agree	Uncertain	Disagree	Strongly
Agree				Disagree

(28)

19. There should be a restriction of, or quota on, the number of people who can enter the field of Hospital Administration.

Strongly	Agree	Uncertain	Disagree	Strongly
Agree				Disagree

(29)

20. Proof of continuing education should be required to

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maintain membership within an association of Hospital Administrators.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(30)
Agree				Disagree	

21. An association of Hospital Administrators should speak on behalf of Hospital Administrators' interest.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(31)
Agree				Disagree	

22. Responsibility for raising standards and quality within the occupation of Hospital Administration should be held by: (indicate opinion for each group)

<u>Strongly</u>				<u>Strongly</u>	
Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	Disagree	

-The Universities:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(32)
-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	------

-The Preceptors:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(33)
-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	------

-The Occupational Association:

<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	(34)
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23. The occupational association as well as the Hospital Trustees, should have disciplinary and expulsory powers over Hospital Administrators.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(35)
Agree				Disagree	

24. The occupational association should protect its members against Trustees' disciplinary actions when matters of moral conduct are involved.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(36)
Agree				Disagree	

25. The judging and disciplining of members by an occupational association, is only appropriate when the members are employed on a fee-for-service basis.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(37)
Agree				Disagree	

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26. It should be compulsory for all Hospital Administrators to be licensed under government legislation.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(38)
Agree				Disagree	

27. Hospital Administration is a satisfying career.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(39)
Agree				Disagree	

28. Hospital Administrators should spend the majority of their time exercising the skills that are distinct to their occupation rather than everyday administrative skills.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(40)
Agree				Disagree	

29. Hospital Administrators should give priority to their clients' (patients and public) needs before their own personal needs.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(41)
Agree				Disagree	

30. The Hospital Administrator should be oriented towards service as opposed to seeking monetary rewards.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(42)
Agree				Disagree	

31. It is important that clients (patients) and the general community recognize the special expertise of the Hospital Administrator.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(43)
Agree				Disagree	

32. It is important that patients and the public accept the authority of Hospital Administrators because of their special expertise.

<u>Strongly</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u>	(44)
Agree				Disagree	

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33. A government Act is required to close the field of Hospital Administration to members only, before the state of the occupation can improve.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(45)
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34. It is important for the occupation of Hospital Administration to undergo a name change to further its professionalization process.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(46)
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35. Most legislation concerned with the occupation of Hospital Administration should be shaped by Hospital Administrators as a body acting through their occupational association rather than through political decision-making.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(47)
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36. Hospital Administration now constitutes a profession.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(48)
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37. Developing the professional status of Hospital Administration is important to me.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(49)
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38. During the past year my opinions have changed a great deal as to how Hospital Administration can become more professionalized.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(50)
--------------------------	--------------	------------------	-----------------	-----------------------------	------

39. The professionalization of Hospital Administration has gone too far and interferes with the daily functional role of the Hospital Administrator.

<u>Strongly</u> Agree	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	<u>Strongly</u> Disagree	(51)
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40. What do you feel is the most major change, or requirement, that Hospital Administrators must undergo in order to enhance their future position?

Do you wish to receive the findings of this study?

☐ yes ☐ no

A.3 Coding System Utilized

The professionalization questionnaire items were scored on a five point Likert's scale, with a range from one to five. For each item a score of one represented strong disagreement with the item statement; two--disagreement; three--uncertainty as to whether the respondent agreed or disagreed; four--agreement; and five--strong agreement with the item statement.

For questions where negative answers were expected, the coding system was reversed, i.e., a score of one represented strong agreement and a score of five represented strong disagreement. The questions or parts of questions which were coded in the reverse manner were: Questions 1, 7, 12a, 12b, 15b, 15d, 22a, and 39. The open-ended question number 40 was not used in the analysis.

A.4 Letters for Distribution

See the following eight pages for the research letters.

CANADIAN HOSPITAL ASSOCIATION

Dear Student,

The Canadian Hospital Association has requested that I undertake a study of students regarding the H.O.M. course and Hospital Administration.

In order to complete this work, I require your assistance. Will you please fill in the enclosed questionnaire and return it to me promptly. It is very important to obtain this information from you so that I may do an adequate study. The information will be handled in a confidential manner and only seen by the researcher.

I am working out of the above address. A return envelope is enclosed for your convenience. I would like to have the material returned in one week's time so that it may be computed in early February. However, I can add in late replies by hand as I realize that some of you may be in a position where you are unable to meet this time requirement.

I would like to thank you for your co-operation. I anticipate that the project will be completed for the Canadian Hospital Association by late summer.

Sincerely,

(Sgnd.) Carol A. Bortnick

(Mrs.) Carol A. Bortnick
Research Assistant
Department of Health Care
and Epidemiology
University of British Columbia

CAB:ehj

CANADIAN HOSPITAL ASSOCIATION

M E M O

Date: January 19, 1976

To: First-Year H.O.M. Students

From: Erwin Waschnig, Ph.D.
Head

Reference: Research Project

Education Department

In order to get research support for the H.O.M. program, the Canadian Hospital Association was very fortunate in getting the co-operation of the University of British Columbia to undertake a study on the effectiveness and level of standard of the H.O.M. course.

Mrs. Carol Bortnick, Research Assistant, Department of Health Care and Epidemiology, Faculty of Medicine, U.B.C. has very kindly agreed to undertake this project under the supervision of Doctor Anne Crichton.

The results of this study will help us tremendously in our continuous effort to improve the quality and effectiveness of the program which, in turn, will benefit the graduates having participated in a nationally recognized program of high standard.

Your Assignment 10 has been selected to be the main resource for analysis. Together with other necessary data we hope to bring this project to a conclusion by September 1976.

Please find enclosed a letter and a questionnaire developed by Mrs. Bortnick. Also, for your convenience, a stamped return envelope for the completed questionnaire.

Your kind assistance will be very much appreciated.

(Sgnd.) Erwin Waschnig

CANADIAN HOSPITAL ASSOCIATION

M E M O

Date: August, 1976

To: Second-Year H.O.M. Students
1976/77

From: Erwin Waschnig, Ph.D.
Head
Education Department

Reference: Research Project

We are still involved in the research study undertaken by the University of British Columbia.

To complete the project, please be kind enough to fill out the enclosed questionnaire. It is important to have the full co-operation of all the students.

Please use the enclosed stamped addressed envelope for the return of the questionnaire to Mrs. Carol Bortnick.

Thank you very much for your assistance.

Sincerely,

(Sgnd.) Erwin Waschnig

Dear Student:

In order to complete a study for the Canadian Hospital Association I require your assistance. It is important to obtain information from you so that an adequate study can be undertaken. It is anticipated that the study findings will prove to be useful to the future of the profession of Hospital Administration and the H.O.M. programme.

Only students of the Canadian Hospital Association have been chosen for this survey. The study has received complete approval of the Canadian Hospital Association. All information will be treated with the strictest confidence necessary to ensure total anonymity.

I am working from the above address. A return envelope is enclosed for your convenience. I would like to have the material returned in one week's time so that it may be computed by the end of the month. However, if you are unable to meet this time requirement, please return the questionnaire as soon as possible. The study should be completed by Fall.

I would like to thank you, in advance, for your participation and co-operation.

Sincerely,

C. A. Bortnick
Research Assistant
Department of Health Care and
Epidemiology
University of British Columbia

Dear Student:

Thank you for your participation in the Canadian Hospital research project. I appreciate your interest and promptness in supplying the requested information.

While compiling the data I noticed that your questionnaire had two pages stuck together so consequently the third page was not completed. As I value your opinions I am enclosing that page so that it can be filled out and returned for compilation. In this manner the results of the study will reflect your feelings towards all of the subject matter. I believe it is important that your views are included to add the strength of your opinions.

Thank you, once again, for your participation and co-operation.

Sincerely,

C. Bortnick
Research Assistant
U.B.C.

Dear Student:

Recently a questionnaire(s) and a request for your assistance in helping with a study of the occupation of Hospital Administration was sent to you. As there is an overlap in mailing time, if you have already returned the questionnaire(s), thank you. If not, I am enclosing another copy of the same questionnaire(s), with a return envelope for your convenience, so that your opinions can be reflected by the study.

You can make a valuable contribution to this research by taking a few minutes to complete the enclosed questionnaire(s). Your answers will give an inside view of Hospital Administration and perceptions of characteristics of this occupation. With a complete class sample the answers will then establish a more definite occupational profile for the Canadian Hospital Association.

Let me emphasize that your answers will be kept strictly confidential. Should you require further information or assistance, please do not hesitate to write, using the enclosed envelope.

As the information which you can provide is very valuable, I look forward to receiving your completed questionnaire soon. Thank you for helping future students and the Canadian Hospital Association.

Sincerely,

(Sgnd.) C. Bortnick

C. A. Bortnick
Research Assistant
U.B.C.

Dear Student:

While compiling the data I found that your name appears on the list of both H.O.M. classes that are under study. Therefore I assume material of the H.O.M. teaching programme was received by you during the 1975-1976 course year. Consequently, could you please tell me if since that time, of receiving the material, if you read the Lesson material before completing the questionnaire on Hospital Administration, of the August 1976 study.

Knowing if you had read the material before completing the questionnaire would help clarify the study populations. In order for the study to correctly reflect your opinions could you please fill out the bottom portion of this letter and return it to me. Thank you for your participation and co-operation.

Sincerely,

(Sgnd.) C. Bortnick

C. A. Bortnick
Research Assistant
U.B.C.

NAME _____

PRIOR TO COMPLETION OF THE QUESTIONNAIRE I READ THE LESSON MATERIAL:

[] yes [] no

CANADIAN HOSPITAL ASSOCIATION

M E M O

Date: September 27, 1976

To: H.O.M. Students

From: Erwin Waschnig, Ph.D.
Head
Education Department

We have received another request from our researcher, Mrs. Bortnick, to follow up on previous mailings.

For the completion of the study we would be grateful if you could fill out the enclosed at your earliest convenience.

Should you have already done so, please ignore this memo.

Thank you for your cooperation.

APPENDIX B.O

CROSSTABULATION TABLES OF SECOND YEAR (1975-76) ,
FIRST YEAR (1976-77) .

- B.1 By Higher Education
- B.2 By Degree Obtained through Education
- B.3 By Level of Position Group within the
Organization
- B.4 By Type of Organization Structure

B.1 Second Year (1975-76), First Year (1976-77)
 Compared by Higher Education

Year	Non- Professional	Nurses	B.A./ B.Comm.	Professional	Para- Professional	Row Total
1975-76	n= 18	11	18	18	9	74
	11.5%	7.1	11.5	11.5	5.8	
1976-77	n= 27	15	13	17	10	82
	17.3%	9.6	8.3	10.9	6.4	
Column	n= 45	26	31	35	19	156
Total	28.8%	16.7	19.9	22.4	12.2	100%

Chi-square = 2.90 with 4 Degrees of Freedom

Significance Level = 0.57

Number of Missing Observations = 7

B.2 Second Year (1975-76), First Year (1976-77)
 Compared by Degree Obtained through Education

Year	Minimal Training	Certificate	Degree	Row Total
1975-76	n= 12	25	37	74
	7.7%	16.1	23.9	
1976-77	n= 17	33	31	81
	11.0%	21.3	20.0	
Column	n= 29	58	68	155
Total	18.7%	37.4	43.9	100%

Chi-square = 2.18 with 2 Degrees of Freedom

Significance Level = 0.34

Number of Missing Observations = 8

B.3 Second Year (1975-76), First Year (1976-77)
 Compared by Level of Position Group within
 the Organization

Year	Top Third	Middle Third	Bottom Third	Row Total
1975-76	n= 14 9.4%	44 29.5	15 10.1	73
1976-77	n= 10 6.7%	48 32.2	18 12.1	76
Column Total	n= 24 16.1%	92 61.7	33 22.1	149 100%

Chi-square = 1.05 with 2 Degrees of Freedom

Significance Level = 0.59

Number of Missing Observations = 14

B.4 Second Year (1975-76), First Year (1976-77)
 Compared by Type of Organization Structure

Year	Flat	Intermediate	Tall	Row Total
1975-76	n= 15 10.0%	44 29.3	15 10.0	74
1976-77	n= 14 9.3%	41 27.3	21 14.0	76
Column Total	n= 29 19.3%	85 56.7	36 24.0	150 100%

Chi-square = 1.11 with 2 Degrees of Freedom

Significance Level = 0.57

Number of Missing Observations = 13

APPENDIX C.O

QUESTION 12

C.1 Restructuring of Question 12

c.1 Restructuring of Question 12

Q.12. The job of the Hospital Administrator can be done effectively only by people who have undergone training in Hospital Administration at the level of: (indicate opinion for each level)

Strongly <u>Agree</u>	<u>Agree</u>	<u>Uncertain</u>	<u>Disagree</u>	Strongly <u>Disagree</u>
<i>-No Additional Training:</i>				
_____	_____	_____	_____	_____
<i>-Diploma:</i>				
_____	_____	_____	_____	_____
<i>-Undergraduate Degree:</i>				
_____	_____	_____	_____	_____
<i>-Masters Degree:</i>				
_____	_____	_____	_____	_____
<i>-Doctoral Degree:</i>				
_____	_____	_____	_____	_____

The assigned new code for this question had one representing No Additional Training; two--Diploma; three--Undergraduate Degree; four--Masters Degree; and five represented a Doctoral Degree. Five indicating the highest professionalization score.

The following coding rules were established:

1. Where various levels were marked indicating agreement then the level that had the highest numerical value that was marked as *Agree* was utilized. An example would be: No Additional Training--*Disagree*; Diploma--*Agree*; Undergraduate--*Agree*; Masters--*Agree*; and Doctoral--*Uncertain*. The scoring would be 4 or Masters Degree.
2. Utilization of the strongest opinion. When *Strongly Agree* was scored the highest level of education indicated by this score

was then used as the new question value.

3. If all parts of the question were marked *Disagree* or *Strongly Disagree* then code one, No Additional Training, was scored.
4. If No Additional Training was marked either *Disagree* or *Strongly Disagree*, and the student had not indicated an opinion for any of the other parts of the question, then a value of nine or Missing Value was assigned.
5. In the case where a student marked *Agree* or *Strongly Agree* for the level of No Additional Training and did not indicate any opinion for the other parts of the question then the composite answer would be coded as one, indicating No Additional Training was required.
6. Nine, the Missing Value code was also used when students only chose *Uncertain* as their opinion towards all the various parts of the question.

APPENDIX D.O

RESULTS OF HOTELLING'S T-SQUARE TESTS

- D.1 Professionalization Orientation of Students
in the Two Classes, 1975-76 and 1976-77
- D.2 Dimension of Realism of Students with Nur-
sing and Accounting Backgrounds

D.1 Hotelling's T-square Test for Professionalization
Orientation of Students in the Two Classes,
1975-76 and 1976-77

Factor	Question	1975-76 Mean	1976-77 Mean	Left Limit	Right Limit	Differences Between Means
1	16	3.86	3.91	-1.04	1.13	-0.04
	17	3.30	3.28	-1.30	1.26	0.02
	18	3.52	3.29	-1.41	0.96	0.23
	19	2.27	2.39	-1.08	1.33	-0.13
	26	2.82	2.82	-1.27	1.26	0.00
	33	2.32	2.24	-1.19	1.04	0.08
	34	2.30	2.37	-0.88	1.00	-0.06
2	1	3.58	3.21	-1.82	1.09	0.37
	6	4.30	4.23	-0.75	0.60	0.08
	7	3.79	3.63	-1.33	1.02	0.15
	22c	4.24	4.04	-0.96	0.55	0.20
	23	3.28	3.08	-1.60	1.21	0.19
	37	3.75	3.73	-1.21	1.17	0.02
	39	3.79	3.64	-1.03	0.74	0.15
3	9	4.25	4.38	-0.57	0.83	-0.13
	10	4.52	4.48	-0.77	0.68	0.04
	11	4.42	4.24	-1.04	0.68	0.18
	14	4.27	4.27	-0.72	0.73	-0.01
4	5	3.14	2.95	-1.59	1.21	0.19
	21	3.86	3.71	-1.13	0.84	0.15
	27	4.29	4.19	-0.88	0.68	0.10
	28	3.33	2.68	-2.03	0.72	0.65
	29	3.72	3.99	-0.89	1.42	-0.27
	30	3.86	3.77	-1.24	1.06	0.09
5	25	3.64	3.43	-1.34	0.91	0.21
	31	4.01	3.98	-0.98	0.91	0.04
	32	3.84	3.54	-1.40	0.80	0.30
6	12	3.24	3.17	-1.80	1.67	0.07
	20	3.66	3.55	-1.36	1.13	0.11
	38	3.18	3.00	-1.38	1.02	0.18
7	3	3.32	3.42	-1.02	1.22	-0.10
	22a	2.64	2.71	-1.17	1.31	-0.07
	22b	3.26	3.36	-1.14	1.35	-0.10

(The figures above have been rounded.)

T-square Value = 71.27

Associated F-value = 1.72

Significance Level = 0.02

Degrees of Freedom = 33/126

F-value used in Determination = 1.53

D.2 Hotelling's T-square Test for the Dimension
of Realism of Students with Nursing and
Accounting Backgrounds

Factor	Question	Means Nurses	Means Accountants	Left Limit	Right Limit	Differences Between Means
7	3	3.62	3.25	-1.09	0.36	0.37
	22a	3.67	2.91	-1.59	0.07	0.76
	22b	4.27	4.13	-0.58	0.29	0.14

(The figures above have been rounded.)

T-square Value = 11.60

Associated F-value = 3.70

Significance Level = 0.02

Degrees of Freedom = 3/44

F-value used in Determination = 2.80