A Case Study of the Functions Involved in Effectively Organizing and Administering the "Hospital-wide" Inservice Program in Four University-related Medical Centers in the City of Chicago, with a View Toward Developing an Original Model of Administering the "Hospital-wide" Inservice Program

M. Richard Wright Jr.
Loyola University Chicago

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A CASE STUDY OF THE FUNCTIONS INVOLVED IN EFFECTIVELY ORGANIZING AND ADMINISTERING THE "HOSPITAL-WIDE" INSERVICE PROGRAM IN FOUR UNIVERSITY-RELATED MEDICAL CENTERS IN THE CITY OF CHICAGO, WITH A VIEW TOWARD DEVELOPING AN ORIGINAL MODEL OF ADMINISTERING THE "HOSPITAL-WIDE" INSERVICE PROGRAM

by

M. Richard Wright, Jr., B.A.; M.Ed.

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

June

1976
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VITA

The author, M. Richard Wright, Jr., was born in Chicago, Illinois on September 8, 1942, the son of Marshall Richard Wright, Sr. and Helen (Luckritz) Wright.

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CHAPTER I

INTRODUCTION

Providing inservice for both professional and non-professional staff is recognized today as a crucial responsibility of all organizations.

What industry has discovered is equally applicable to every other institution - namely, that adult-education processes are basic tools of organizational growth and development. These processes are now used routinely for the orientation of new employees, for on-the-job training in technical skills, for the preparation of personnel for advancement, for executive development, for supervisory training, for the improvement of the institution's public relations.  

The provision of inservice training undertaken by an organization to achieve such "organizational growth and development" has become an ever increasing phenomenon, so much so that inservice may quite properly be called a distinct trend in the field of adult education.

Adult education has become a conscious and differentiated function in an increasing number of institutions. As more and more agencies have come to see that they are performing adult educational roles, they have tended to establish separate administrative units to operate this phase of their programs. . . . This development has led in turn to the emergence of training - both pre-service and in-service - as a major new aspect of the movement.  


The health care sector is no exception to this inservice trend. Hospital administrators, cognizant of the inservice approach adopted in the business sector, have begun to recognize and address the need to upgrade the skills of their employees, both professional and non-professional. These administrators have come to recognize that "organizational growth and development," one among several other ends, can be achieved through structured inservice programs.

We have found that continuing education and training are important in the health care field because of the contributions they can make to improved resource utilization, to staff development, to the quality of health care, to the stimulation of cooperative action among hospitals, and to prepare the consumer to cope with his broadened desires and interests. In all of these matters the hospital's role is central. The more effectively hospitals respond, the quicker the American people will be on the road to strengthening their complex and dynamic system of health care.¹

The first organized attempt at health care continuing education, excluding nursing and medical continuing education, was conducted on a nationwide basis. This attempt took the form of the Hospital Continuing Education Project. Initiated in 1964 through a grant from the W.K. Kellogg Foundation to the Hospital Research and Education Trust, the Project was coordinated with already existing graduate programs (programs typically in hospital administration) in seven colleges and

universities throughout the country.\(^1\)

During the nine years of the Project's existence, until 1972,\(^2\) many health care personnel attended one of these seven institutions for short term, not-for-credit seminars.

While the primary purpose of the project was "to help improve the knowledge and skills of presently employed hospital personnel,"\(^3\) the majority of seminars concentrated on either administrative or supervisory development.

However, the Project, while an excellent breakthrough, was far from adequate in servicing the varied inservice needs of hospital personnel. The locale of "continuing education"\(^4\) in order to adequately address the inservice needs of all hospital personnel had to and actually began to shift from the college setting to the actual place of employment, the hospital itself. Hospital administrators were coming to the realization that to achieve desired training outcomes, hospital administrators would have to exercise control over the training program itself.

\(\text{---}\)

\(^1\)Daniel Schechter and Thomas M. O'Farrell, Universities, Colleges and Hospitals: Partners in Continuing Education (Battle Creek, Mich.: Kellogg Foundation, 1972).

\(^2\)Schechter, Agenda, p. 1.

\(^3\)Schechter and O'Farrell, Universities, p. 4.

\(^4\)Schechter defined the term "continuing education" as "education for hospital-related personnel beyond the pre-service level and not leading to an academic degree," in Universities, p. 4. The author of this study accepts this term as synonymous with "inservice."
Training and development is increasingly recognized as a most important organizational activity. We cannot expect our schools and colleges to prepare people for specific tasks. This is the responsibility of the employer. Organizations without a directed training effort are merely asking employees to acquire job knowledge and skill in their individual ways on a haphazard and unorganized basis. Through directed training, the employer also has the opportunity to build mutually rewarding attitudes.1

The earliest attempts at inservice conducted within the hospital itself, and thus under the control of the hospital, took the form of inservice for the nursing staff. Since the end of World War II hospital nursing departments have been providing inservice training.2 Such inservice training has typically taken the form of specialized skills offerings to either upgrade or retrain nurses in skills deemed necessary for the nurses' specialized form of patient care.3

Nursing inservice programs, the most clearly differentiated form of inservice within the hospital, have in recent years expanded and developed to the point where today nursing inservice directors have become significant figures within the hospital.

Her title is director of in-service education or one of more than five dozen variants. . . . The position she occupies in the hospital power structure is strategic, and growing more so. One of her main sources of strength

---


3 Ibid.
is the open communications she maintains with every echelon in the institution. Her primary channel to large and influential groups is through the courses she teaches or administers, which cover over 100 different subjects. But teaching is not her only pipeline to the springs of power. She also sits on key management committees, often in a leadership role, where she wields influence on purchasing, policy and management decision-making.1

However, while nurses within the hospital today find their inservice needs addressed, the question can properly be asked, "Whose task is it to address the inservice needs of the other professionals and non-professionals within the hospital setting?"

Serious attention to this question has led to a rather recent development in the hospital setting, namely, a program, at first sporadic, of inservice education directed at the needs of hospital personnel other than nurses and physicians.

During the 1960's, a strategy relatively new to health care institutions was put into use to an increasing degree. That is the strategy of manpower development through training and continuing education.2

"Hospital-wide" inservice education, continuing through the 1960's and into the 1970's, was beginning to establish a foothold. A number of studies were documenting the establishment of the "hospital-wide" inservice program in the hospital.

---

1 Summary of a 1973 survey of 814 nursing directors of education conducted by Inservice--Training and Education and cited in Virginia Stopera and Donna Scully, "A Staff Development Model," Nursing Outlook, 22 No. 6 (June, 1974), 390-393.

Fisher, surveying Indiana hospitals, found that the majority had begun some form of management training since 1969.1

Sloan and Schrieber, in 1971, discovered that more and more hospitals had by that time begun to provide for the same need, namely, management development.

During the past decade, an increasing number of hospitals have attempted to increase the skills and abilities of their managerial personnel. Many hospitals have begun to develop their managers through university programs and courses, in-house training lectures, consulting services, and management book clubs.2

The "hospital-wide" inservice movement had begun. But its scope was at first limited to management development to the exclusion of other inservice needs. Hospitals, in the 1960's and early 1970's, were not fully committing resources to a total inservice program.

In the present context, all that one need specify is that the health care industry in general and the hospital in particular have, up to the present, tended to under-invest in the continuing education of their work force below the level of the physician.3

"Hospital-wide" inservice would have to be expanded to include projects which addressed needs in addition to management development needs. Lucier, in expressing the need for


2 Stanley Sloan and David E. Schrieber, Hospital Management, An Evaluation (Madison, Wis.: University of Wisconsin, Bureau of Business Research and Service, 1971).

what she termed a "well organized and well supervised in-service program" outlined several avenues inservice training ought to take. "Such training must include Orientation, Skill Training, Leadership and Management Development and Continuing Education." ¹

To address these varied inservice needs demanded the creation by the hospital of a centralized and organized unit which could devote itself to a total package of "hospital-wide" inservice training. Serious attention to providing such a total inservice package has led hospitals in the 1970's in the direction of establishing just such a centralized and organized inservice unit, a unit which is known as the "Hospitalwide Training and Education Department." ²

Ironically enough, such an overall inservice unit, which typically did not make its appearance until the 1970's, was strongly advocated by Hullerman as early as 1956:

A great deal of inservice training is being given in hospital departments but in few, if any, has there been established an over-all point of planning, goal setting, educational consultation, coordination and guidance. Hospitals spend millions of dollars to send their personnel to workshops, institutes and university courses. These are worthwhile, but they are not enough. More and more, it is being recognized that hospitals must find a way of providing complete inservice training within their own walls. Considering the importance of inservice training today, hospitals should create and staff a department of inservice training and give it responsibility for the


²Term apparently first utilized by Lucier, "Development," and taken up by Schechter in Agenda.
overall program. Until this is done, we can only guess at how adequately the hospital is meeting its inservice training needs.

The Problem

Although the current trend in hospitals in the mid 1970's has been to establish an overall inservice training unit which administers the "hospital-wide" inservice package, there was in existence no complete set of adequate, research-based guidelines which answered the question of how to effectively organize and administer the "hospital-wide" inservice unit.

Several authors have attempted to present guidelines which they considered to be the most important aspects of administering an inservice program, but none of these authors presented a comprehensive model of an effectively organized and administered "hospital-wide" inservice program.

Guidelines, to be most useful, ought to take the form of a model which would depict the answer to the question, "How can the 'hospital-wide' inservice program be effectively organized and administered?"

Therefore, the study attempted to fill this vacuum in a field which has been rapidly developing and clearly in need of such direction, by the creation of an original model for administering "hospital-wide" inservice programs.

1 Hugo V. Hullerman, M.D., "Seven Tests for an In-Service Program," Hospitals, 30 (November, 1956), 49-53.

2 The authors referred to are cited throughout Chapter II, "Review of the Related Literature."
Purpose of the Study

As indicated, there was a need for the development of a model depicting an effectively organized and administered "hospital-wide" inservice program. The development of such a model, however, demanded an in-depth case study of established "hospital-wide" inservice programs as well as a review of the literature on administering the inservice program.

Therefore, the purpose of the study was to develop an original model depicting an effectively organized and administered "hospital-wide" inservice program.

Framework of the Study

In order to make a thorough assessment of the organization and administration of the "hospital-wide" inservice program, the analysis utilized in this study was based on the seven "functional elements" of the process of administration advanced by Luther Gulick. The assumption underlying the study was that Gulick's framework included all the major elements of the process of administering an inservice program.

The elements of the process of administration advanced by Gulick were:¹

1. Planning

working out in broad outline the things that need to be done and the methods for doing them to accomplish the purpose set for the enterprise.

2. Organizing

establishment of the formal structure of authority through which work subdivisions are arranged, defined and coordinated for the defined objective.

3. Directing

the continuous task of making decisions and embodying them in specific and general orders and instructions and serving as the leader of the enterprise.

4. Staffing

the whole personnel function of bringing in and training the staff and maintaining favorable conditions of work.

5. Coordinating

the all important duty of interrelating the various parts of the work.

6. Reporting

keeping those to whom the chief executive is responsible informed as to what is going on, which thus includes keeping himself and his subordinates informed through records, research, and inspection.

7. Budgeting

all that goes with budgeting in the form of fiscal planning, accounting and control.

Gulick's theory was used in the study simply as a framework descriptive of the totality of the elements involved in organizing and administering an inservice program. It was assumed by the author that the inservice director, much like
the school administrator, "performs his job by applying these elements to specific administrative tasks."\textsuperscript{1}

The elements of effectively organizing and administering the "hospital-wide" inservice program came, not from Gulick, but from various guidelines suggested by inservice theorists from both the health care and the education sectors, as is elaborated upon in Chapter II of the study.

Areas to be Investigated

The "areas to be investigated" by means of the case study were:

1. Organizing
   a. The inservice director is clearly established as part of the formal authority structure of the institution.
   b. The inservice director should be clearly established as part of the formal authority structure of the institution.

2. Staffing
   a. The inservice director has authority to hire, train, and evaluate inservice staff.
   b. The inservice director should have authority to hire, train, and evaluate inservice staff.

3. Budgeting
   a. The inservice director has the authority to request and monitor a budget adequate to achieve inservice purposes.

\textsuperscript{1}Southern States Cooperative Program in Educational Administration, "Better Teaching in School Administration," in Robert E. Wilson (ed.) Educational Administration (Columbus, Ohio: Charles E. Merrill Books, Inc., 1966), p. 34.
b. The inservice director should have the authority to request and monitor a budget adequate to achieve inservice purposes.

4. Planning
   a. The inservice director determines what institutional needs are to be addressed through inservice projects.
   b. The inservice director should determine what institutional needs are to be addressed through inservice projects.

5. Coordinating
   a. The inservice director coordinates all inservice efforts within the institution.
   b. The inservice director should coordinate all inservice efforts within the institution.

6. Directing
   a. The inservice director has authority to decide what projects will be undertaken as well as how projects will be implemented.
   b. The inservice director should have authority to decide what projects will be undertaken as well as how projects will be implemented.

7. Reporting
   a. The inservice director evaluates and reports on the accomplishments of the inservice program.
   b. The inservice director should evaluate and report on the accomplishments of the inservice program.

**Design of the Study**

To achieve the purpose of the study, namely, to develop an original model depicting an effectively organized and administered "hospital-wide" inservice program, the following tasks were undertaken to collect the necessary data:
1. a careful review of the literature pertaining to the administration of the inservice program in both the health care and the education sectors, and

2. an in-depth case study of the organization and administration of the "hospital-wide" inservice program in four university-related Medical Centers in the city of Chicago.

To uncover as thoroughly as possible the literature related to the topic of this study, the author utilized the following source materials:

1. Search of Dissertation Abstracts International conducted through University Microfilms, Ann Arbor, Michigan

2. Medline Bibliographic Citation Search on "Inservice Training in Hospitals" through the National Library of Medicine's National Interactive Retrieval Service, Bethesda, Maryland

3. Abstracts of Hospital Management Studies. University of Michigan, Cooperative Information Center for Hospital Management Studies, Ann Arbor, Michigan

4. Dissertation Abstracts International. University Microfilms, Ann Arbor, Michigan:
   - Volume 3: Earth, Life Sciences
   - Volume 5: Social Sciences
   - Volume 7: Education

5. Education Index. New York: The H.W. Wilson Company

6. Hospital Literature Index. Chicago: American Hospital Association
The in-depth case study included an examination of the current administrative functions undertaken by the inservice directors at each of the four study institutions as well as the ideal functions these four directors felt they should be undertaking in administering their programs. In addition, several pertinent documents from each of the four institutions were scrutinized by the author to uncover additional data for analysis.

A detailed interview guide was administered by the author in person to the inservice director at each of the four institutions. The guide consisted of several questions which pursued from various angles the content of each of the seven "areas to be investigated."

The "hospital-wide" inservice programs chosen as the sample of the study were those located in the following four university-related Medical Centers:

1. Northwestern Memorial Hospital
2. Rush-Presbyterian St. Luke's Medical Center
3. University of Chicago Hospitals and Clinics
4. University of Illinois at the Medical Center

The rationale for the choice of these four institutions is fully explained in Chapter III.

Analysis of the Data

The research data were analyzed by means of a narrative, rather than a statistical, analysis.

The analysis reflected the following criteria:
1. **Consistency** in answers given to questions within each "area to be investigated."

2. **Compatibility** of answers given in one area to answers given in other areas.

3. **Comparison** for verification of answers given to data contained in relevant Medical Center documents.

4. **Conformity** of collected data with accepted theory regarding the functions of administration.

5. **Comprehensiveness** of answers given to questions.

6. **Variation** in administrative methods utilized.

The analysis of data consisted of two stages.

**Stage I**

The author, taking one "area to be investigated" at a time, summarized the administrative approach found in each of the four institutions. The author then made a comparative analysis of the summaries, noting similarities and dissimilarities in administrative approach. Relevant data from available documents at each of the four institutions were compared to the answers given by the inservice directors for verification as well as for supplementing answers to interview guide questions.

This stage of the analysis, referring to statement "a" under each of the seven "areas to be investigated," reflected the "current state of the art" of administering the "hospital-wide" inservice program.
Stage II

The author then analyzed the perceptions of the four inservice directors as to what they felt their administrative role under each of the seven "areas" should be. This stage reflected statement "b" under each of the seven "areas to be investigated."

The author accomplished the analysis by studying the answers given to the questions which asked whether the inservice director felt there should be any change in his current role in any of the seven "areas."

The author then compared the "ideal role" responses with the data gathered on the directors' "current role."

Development of the Model

The two stage analysis provided, together with the relevant literature on inservice program administration, the data from which the author formulated his model of an effectively organized and administered "hospital-wide" inservice program.

The process by which the author arrived at the formulation of the model is described in detail in Chapter III.

Validation of the Model

After the model was developed, the author submitted the model to seven practitioners in the inservice field. The author asked for the reactions of these practitioners to the content as well as the format of the model, and thus achieved
a form of both content and construct validation.

After receiving the comments from each of these seven practitioners, the author made appropriate revisions to the model. (The model is found in Chapter V.)

The seven practitioners who formed the jury to validate the model were those who assisted in the validation of the interview guide as well as the four inservice directors interviewed in the case study.

In addition to developing the original model, the author presented other conclusions and inferences made from the data and offered several recommendations.

**Definition of Terms**

The following terms are used throughout the study in the specific meaning assigned here. Clarification of the precise meaning of specific terms was necessary because much confusion existed in the inservice field as to the meaning intended by various authors.

**Functions**

The different elements which together constitute the administrative process as outlined by Gulick. These elements are: Planning, Organizing, Directing, Staffing, Coordinating, Reporting, and Budgeting.

**Hospitalwide**

An inservice program responsible for projects directed toward all levels of personnel within the hospital
(in actual practice, however, excluding medical doctors). The term connotes a centralized program.

Medical Center

That organizational component of a University devoted to the patient care aspect of the University's mission. This component consists of one or more hospitals and/or outpatient clinics and any combination of a Medical School, a Dental School and a School of Nursing.

Project

Any particular offering, such as a workshop, course, seminar or other session conducted by the inservice unit.

Unit

The office which is responsible for the "hospital-wide" inservice program. A unit is either a separate department in itself or a component of another department.

Training

Preservice. Based on Houle's definition\(^1\), the theoretical and/or practical training of students which is designed to provide background and competence in an area in which these students will some day be expected to perform.

Even though preservice training may be given in a work setting, such as a hospital clinical laboratory, the trainee is a student and not an employee and the emphasis is

primarily on teaching and learning rather than on actual service, such as patient care. A comprehensive listing of preservice programs in health care available throughout the country has been compiled in the volume, *Health Occupations Training Programs*.¹

**Induction.** Training given by an employer to an employee, to teach him to perform specific duties upon entering the institution (entry-level training) or to assist an employee to adjust to a different method of performing in the employee's field of competence (on-the-job training).²

**Inservice.** Several definitions of inservice have been proposed and each of the eight definitions cited here contains an important element to be incorporated into the definition the author proposes for the study.

1. "The education of a permanent employee in an attempt to improve his ability in doing a job and to improve his attitude toward his job and the organization."³

Emphasizes the goals of skill and attitude improvement but is incomplete.


²Houle, "Education," p. 118.

2. "The continuing education of the worker to keep his capacities at a high level, to equip him with new knowledge, or to enable him to meet new responsibilities."¹

Emphasizes the continuous nature of inservice but seems to exclude induction training. As defined in the study, inservice includes induction training.

3. "Planned experiences designed to improve the professional employee's effectiveness as a result of professional growth for individual and school."²

Emphasizes the planning necessary for good inservice and the end product, namely, increased employee effectiveness, but excludes the non-professional employee. This study includes the non-professional employee.

4. "Education for hospital-related personnel beyond the preservice level and not leading to an academic degree."³

Excludes preservice from the definition, an exclusion likewise made by this author.

5. "A program of planned learning experiences providing opportunities within a working situation to improve the quality of care provided for patients, by correcting information and skill deficiencies of personnel, by assisting the inexperienced to acquire needed skills and attitudes, by

¹ Houle, "Education," p. 118.
³ Schechter, Universities, p. 4.
keeping personnel abreast of changes in health care, and by stimulating the continuous development of occupational and personal abilities of each employee."¹

Refers specifically to nursing inservice, but can be applied to any health care inservice program.

6. "Broadly defined, inservice education must include all activities aimed at the improvement of staff members, including both professional and noninstructional staff."²

Includes both professional and nonprofessional employees in the definition.

7. "Training for personal development is generally directed toward providing learning experiences that will be useful to people in enhancing their long-range effectiveness in their organizations, thus serving useful objectives both for themselves and for their organizations."³

Properly points out both individual and organizational benefits of inservice, but limits definition to long-range effectiveness. Organizations must be interested both in the short range and long term effectiveness of their employees.


8. "Training now encompasses activities ranging from the acquisition of a simple motor skill up to the development of a complex technical knowledge, inculcation of elaborate administrative skills, and the development of attitudes toward intricate and controversial social issues."¹

Includes the inservice goals of knowledge, skill and attitude behavior change and also breaks down the distinction between "education" and "training."

The specific definition of inservice used in this study is the planned, organized, and ongoing development of its employees undertaken by an institution in the directions the institution has determined to be necessary.

Limitations of the Study

Sample Size

The primary limitation of the study was the limited sample size. Generalizations based on this kind of sample may, strictly speaking, be made only about the sample institutions themselves.²

However, the author accepted this limitation because of the nature and context of the study. The study by nature was an in-depth analysis rather than a survey of many institutions. And the context of the study was such that, because


of lack of previous research on the topic, the present study was designed to provide the first of what the author hoped would be a series of further studies by other researchers.

Engelhart, in addressing the problem of a limited sample, concedes:

... the researcher may provide other data which tend to characterize or define the population from which his principal data are drawn. This may justify application of the findings to other school systems or colleges" (and, by extension, to other similar institutions).

Some inferences could thus be made with a certain degree of probability about other similar inservice programs.

The author, in an attempt to uncover possible similarities between institutions in the Chicagoland area, conducted a telephone survey of directors of "hospital-wide" inservice programs located in twelve hospitals within the Chicagoland area as well as the four inservice programs comprising the study sample. Comparing the results of this survey (see Appendix A), there were found certain distinct similarities between the study sample and the other twelve hospitals. These similarities included hospital size, organizational location of the inservice unit, the rationale for instituting the inservice program, recipients of inservice training, and the relationship of the "hospital-wide" program to the Nurse Inservice Department.

These similarities have subsequently permitted the author to undertake limited generalizations beyond the study sample.

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1Ibid.
Methodology: Interview

The second limitation of the study was inherent in the methodology used, namely, the personal interview. The limitation centered around the degree of subjectivity that can enter into the interview process and into the analysis of the interview data.

The interviewer can be biased in the questions he asks and in the way he asks them. He can be selective in what he hears and in what he records; in fact, he may receive so much data that he may not be able to record all the data.

However, the author chose the personal interview as the most appropriate method to elicit a broad spectrum of data as well as to pursue specific question areas in depth in order to provide both a sufficient amount and depth of data for analysis. In the decision to use this interview method, the author followed Engelhart's observation that "in studying or surveying educational practices or conditions, questionnaire, interview, observational, and test data are the appropriate types of data collected."¹

The author made the determination that the advantages of the personal interview method outweighed the disadvantages. The author was able to define terminology utilized to the satisfaction of the respondent before the interview began; was able to clarify minor misunderstandings of question intent; and was able to identify and immediately probe vague

¹Ibid., p. 91.
and incomplete responses.

Further, the author took steps to counteract the limitations of the interview methodology. First he secured several kinds of documents from each of the study institutions which were used as a cross-check of respondent answers.

Second, each interview was audio tape recorded in its entirety so a complete record of responses was available to the author for analytical evaluation.

Third, the interview guide consisted of structured questions which were asked in a predetermined order. (Chapter III fully explains the manner in which the interview guide was devised and validated.)

Fourth, the analysis, while dependent upon the analytical skills of the author, was based on the six predetermined guidelines of consistency, compatibility, comparison, conformity, comprehensiveness, and variation as outlined earlier in this chapter.

Fifth, the author, as he undertook the study, was in an administrative position similar to that of each of the respondents, and was thus able to more easily establish rapport with the respondents as well as pursue areas of investigation with a degree of confidence and knowledgeability he would not have had were he not in such a similar position.

Lastly, the author, having been trained as an interviewer and counselor and having utilized this skill in the course of his professional career, has developed a sufficient background of interviewing skills which enabled him to keep the
Because of the above reasons, the limitation of subjectivity in interviewing has been adequately addressed in accordance with Engelhart's following criteria:

While some amount of subjectivity may be unavoidable in collecting data relevant to a problem, a researcher may be able to demonstrate that subjectivity is not a significant factor limiting the dependability of his findings and that his conclusions or generalizations are justified in spite of the faults in his data.¹

¹Ibid.
CHAPTER II

REVIEW OF THE RELATED LITERATURE

The purpose of the study was to develop an original model for effectively organizing and administering the "hospital-wide" inservice program.

In order to achieve that purpose, the author has relied on two sources of data:

1. an in-depth study of "hospital-wide" inservice programs in four university-related Medical Centers in the city of Chicago, and
2. a review of the related literature on inservice both in the health care sector as well as the educational sector.

Chapter I presented the overview of the study. The overview consisted of an introduction to the health care inservice movement, the problem, the purpose, the design and methodology of the study, and a definition of important terms.

The purpose of Chapter II is to present a review of the related literature and research relative to the administration of inservice programs in both the health care and the educational sectors.

In surveying the related literature the author was guided by two major concerns. The first concern was to seek
an answer to the question, "Is there a need for inservice in either the health care or the education sector?"

The second concern was to seek an answer to the question, "If there is a need for inservice, does there now exist, either in the health care sector or in the education sector as that sector relates to the health care sector, a set of guidelines or a model which depicts a well organized and well administered inservice program?"

The review of the related literature is thus divided into the following categories:

1. The health care sector
   a. Need for inservice programs
   b. Suggested guidelines on administering the inservice program

2. The education sector
   a. Need for inservice programs
   b. Suggested guidelines on administering the inservice program

3. Previous studies of inservice programs in the health care sector

4. Previous studies of inservice programs in the education sector.

**Health Care Sector**

**Need for Inservice**

As outlined in Chapter I, a current phenomenon in the health care sector was the recent introduction of the
"hospital-wide" inservice program. It was only within the last three decades, the 1950's through the 1970's, that this need for inservice had been acknowledged and addressed.

Throughout these three decades several writers have called attention to both the lack of and the need for such inservice programs.

In 1953 Morgan convincingly pointed to the ultimate reason for developing a program of inservice training--improved service to the hospital's client, the patient.

That such training is needed is evidenced every day in almost every department of the hospital. Observation of the patient from the time he is admitted...will reveal that much could be done to improve the service rendered the patient through proper training of the employee.1

Nine years after Morgan's study, in 1962, Brown, while addressing herself to the topic of nursing inservice, called for "orientation and a continuous program of staff education"2 to provide better care, the ultimate need addressed by Morgan. Brown later broadened the applicability of her statement beyond nursing inservice by adding that "no category or level of personnel should be left without a program in which it can participate readily or feel is its own."3

References:
3 Ibid., p. 129.
By 1963 a key element was introduced into the statement of need for hospital inservice—the need to coordinate or centralize the hospital's inservice efforts. Walter introduced the concept of coordination by calling for a "centralized approach to training," which he described as either one person or one department to be responsible for all inservice training within the hospital.¹

Lucier, five years later, reechoed the call for centralization of the inservice program, specifying, however, that the program encompass all levels of hospital personnel. In doing so, Lucier might very well have been the first author to use the phrase "hospital-wide inservice."

Although inservice training is given in some hospital departments, few hospitals have established an over-all center of planning, goal setting, coordination and guidance. Currently it is being recognized that it is essential that hospitals provide inservice training for all categories of personnel. Considering the importance of such training today, hospitals need to create and staff a center for this project and give it responsibility for the establishment of a Hospitalwide Inservice Training Program. Until this is accomplished, one can only guess how adequately the hospital is meeting its inservice needs.²

Later that same year, 1968, Hole discovered that some hospitals across the country were already attempting to


centralize the inservice program.\(^1\) So strongly did Hole feel that hospitals were beginning to recognize the need for a centralized inservice program that he based his study on two very significant assumptions:

1. Hospital education and training should be an integral part of the total responsibility of the hospital, and
2. Adequate administration of hospital education should be provided at the local hospital level.\(^2\)

Schutz looked into the future and determined that continuing education would continue to be administered by the local hospital.\(^3\) Based upon his study of the then current status of hospital inservice programs, Schutz predicted that "individual hospitals and other organizations of the hospital-oriented sector will continue to adopt and initiate continuing education courses for their employees."\(^4\)

In 1972 Miles, however, suggested that Schutz' prediction was more of a wish than a fact. Implying that hospitals apparently were not providing inservice for their employees, Miles, in a position paper outlining a proposed set of educational objectives for the health care sector, exhorted hospitals to be more concerned about providing

\(^1\)Floyd M. Hole, "Functions and Preparational Needs of Directors of Hospital Education" (unpublished dissertation, Arizona State University, 1968).

\(^2\)Ibid., pp. 6-7.


\(^4\)Ibid., p. 130.
continuing education for employees. "The hospital should provide more than curative services... Continuing education of personnel should be an important concern of hospitals."¹

Suggestions for Inservice Guidelines In The Health Care Sector

Some writers in the health care sector have made suggestions as to the general direction guidelines for administering the inservice program should take. These authors have talked about the need for sound planning, organization, coordination, supervision, and formalization of a philosophy and objectives for inservice programs.

Lovett, project director with the Hospital Research and Education Trust, pointed to the result of a lack of inservice guidelines. Speaking with this author in a personal interview about the data collected during a four-year survey the H.R.E.T. had been conducting on hospital inservice programs throughout the country, Lovett stated that there were currently in operation many de facto models of "hospital-wide" inservice programs. These "models" varied from the one extreme of loose control over inservice by one person who occasionally presented inservice seminars while individual departments were left to their own devices in developing on-the-job training, to the opposite extreme of an inservice

department exercising **total control** over all inservice efforts within the hospital.¹

Schechter emphasized the need for a coordinated approach to continuing education, thus opting for Lovett's "control" extreme, in any kind of health care continuing education program. "The time is rapidly passing when a series of unrelated, uncoordinated, discrete lectures can be offered as an educational program in the hospital field."²

Lucier reiterated the call for a well organized program and added a call for close supervision of the entire inservice effort. Lucier stated that her study "made it remarkably clear that without a well organized and well supervised inservice training program, a hospital cannot hope to achieve its basic goals successfully."³

Dorsett suggested the necessity for sound planning of the inservice program.⁴ The effects, Dorsett went on to say, of a well planned inservice program include:

- more adequate work on the part of all strata of personnel; improved morale; reduction of turnover; personal job satisfaction; professional growth; reduced

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¹Mark Lovett, private interview with author held at the Hospital Research and Education Trust offices, July 2, 1975.


⁴James V. Dorsett, "Role of In-Service Education Within a General Hospital" (unpublished thesis, Northwestern University, 1959), p. 42.
absenteeism; greater understanding of others and many other benefits.¹

Keyes and Miles, in their position paper, called for a "more formal codifying of hospital educational objectives." The means to achieve this formal codification was to be a department which would "plan, implement, and maintain a continuing education program for all staff--medical, allied, supportive, and volunteer."²

How does the inservice director outline what he wants to achieve through the inservice program? Clement answered this question by pointing out the necessity for developing a "comprehensive statement of philosophy" of the inservice program in order to be able to "develop a set of objectives and goals" from which would then logically follow inservice policies and operational procedures.³

One author has gone so far as to put together a set of general guidelines for conducting a successful inservice program. Froberg enunciated the characteristics of a good inservice program as follows:⁴

¹Dorsett, "Role of In-Service Education," p. 42.
²Lynford Keyes and Stanley Miles, "Educational and Communications Objectives for Hospitals" (mimeographed, 1970), p. 3.
1. Inservice education activities receive direction from and are related to work the personnel are doing. The activities are based on real and specific problems of the workers, the patients and the community.

2. All the personnel have a significant share in planning all inservice activities which stimulates a desireable attitude toward change.

3. Health care providers are intrinsically motivated to engage in meaningful activities. Real self-improvement originates from within. The inservice educator strives to develop the insights and thinking of others rather than imposing his own.

4. Sound principles of learning are utilized: learning is growth; growth is personal and gradual; growth takes place in a climate favoring the development of new perceptions that can be translated into actual practice.

5. Inservice activities are an integral part of the working program. It is realized that almost any activity that is added to the working load or workday, as an extra, is doomed to failure. Time and money are provided for the proper functioning of the inservice program.

6. The inservice education program is characterized by a variety of activities designed to serve specific purposes. Participation in, and cooperative relationships with community and state educational facilities are included in the activities.

7. Activities of the inservice program are carefully and intelligently evaluated, and continuously being improved.

The characteristics outlined by Froberg, however, were too general to apply to a model of effectively organizing and administering an inservice program. While the characteristics provided certain factors to be taken into account in organizing an inservice program, the inservice director is left with no specific direction to follow.

Because of the lack of a set of specific guidelines,
there was a real need for the development of a set of practical research-based guidelines in the form of a model depicting an effectively organized and administered "hospital-wide" inservice program.

Education Sector

Need for Inservice

In similar fashion to the health care sector, within the last three decades, the 1950's through the 1970's, authors in the field of school administration have consistently pointed to the need for inservice programs in the education sector.

Grieder in 1954 portrayed inservice as a means to assist school personnel to keep abreast of a constantly changing society.

Every agency in our society is faced with the challenge of studying and modifying its program to meet the changing times. The school is no exception; a changing society requires a changing school to meet the new demands. A school which is trying to meet the need of its constituency must establish some form of an inservice training program.1

This same call for continuous self renewal demanded by change was taken up by Brimm and Tollett who looked at change from a different perspective. The authors exhorted teachers to constantly strive to keep abreast of and effectively respond to the changing needs of the school's clientele--the student.

The professional preparation of teachers is a continuing process, and self-renewal must occur if teachers are to stay in tune with the changing needs of their students. Effective inservice programs should help the teacher meet these changing needs.¹

Kleiman dramatized the acuteness of the need for a continuous program of inservice, centering his comments on the fact that teachers, if not kept up to date on current teaching methodology, can easily become out of touch with new theories and methods.

There is a definite need for ongoing inservice education for personnel within a school. Many faculty members have not been a part of undergraduate education programs for a good number of years. They are out of touch with progressive teachers and training techniques being used on some campuses today. They are out of contact with the newer methods being stressed in education, or they are familiar with these new techniques but have never personally received first-hand training in utilizing them.²

Heath added weight to the issue of keeping teachers up to date in their field by citing statistics that portray the half-life of a teacher's education at five years.³ By this statement Heath meant that half of what a teacher learned in college would be obsolete five years after he completed the college program. From these statistics Heath concluded:


we must provide a continuous process of inservice training if today's teachers are to be prepared to teach today's children today, and tomorrow's children tomorrow.¹

Campbell likewise emphasized the need for continuous learning by teachers when he stated that "acquiring the knowledge necessary to become and to continue to be a good teacher or educational leader is a lifetime endeavor."²

Campbell, however, was quite reassured by the fact that at least the need for inservice was acknowledged by school administrators to the point that inservice was "practically taken for granted as an essential part of a staff personnel program."³

Cochran disagreed with Campbell's view that inservice was widely acknowledged as an essential aspect of a staff personnel program and examined the problem of why he felt inservice had typically been overlooked in the schools. Lack of emphasis on continued development, according to Cochran, centered in the fact that, typically, "teacher education has been preoccupied with its preservice function, the demands of which have, until recently, been beyond the capabilities of teacher preparation institutions."⁴

¹ Heath, "In-Service Training," p. 267.
³ Ibid.
Cochran went on to say, however, that an increased interest in inservice was slowly beginning to emerge in the schools for a number of reasons, predominantly "the preponderance of new methods, media, and processes resulting from or produced by technology."¹

Expanding on the theme of the necessity for teachers to keep abreast of teaching technology, Adams specified two approaches to be undertaken in school inservice programs. The first approach was "in-depth orientation for teachers to the uses and values of new programs and projects." And the second approach, following after the first, was to "expose teachers to practical demonstrations of the materials and to the methodologies underlying both the materials and programs."²

But why organize an inservice program? Who, if anyone, ultimately benefits from an effectively organized inservice program? DeVault identified the ultimate recipient of a good inservice program--the student himself.

It is true that a teacher's main responsibility is with his pupils; but there is evidence from research and much more evidence from common sense that children grow most in classes conducted by teachers who themselves are engaged in growing. The questions is not only which teacher knows most, but which teacher is continuing to learn. One reason, therefore, for inservice

¹Cochran, "In-Service Education," p. 6.
involvement of the teachers is that his pupils will benefit.¹

How widespread were existing inservice programs? And how effective were existing programs?

The editors of Theory into Practice felt that because of pressing, crisis-riddled problems in the schools, that inservice, typically viewed as a luxury, has not been widespread at all.

In-service education, in theory, has always sought such quality programs but because of the pressing problems associated with numerical growth and staff turnover, intellectual growth, professional development and staff development were talked about but seldom achieved. Worse yet, some persons even created situations which made staff development impossible.²

Nagle provided a pessimistic answer to the question of how effective inservice programs have been. Most inservice programs, according to Nagle, are "assumptive." That is, administrators assume they know what their staff needs, weave this assumption into a "theme of the year" and then invite a beginning-of-the-year speaker to address this theme. Inservice thus becomes in effect a "pep rally" for teachers taking place once, or possibly twice, each school year. Nagle lamented that with this approach no differentiation is made between the individual needs of different teachers, no follow-up takes place, and thus inservice has no lasting

¹M. V. DeVault, "Research and the Classroom Teacher," Teacher's College Record (December, 1965), p. 212.

effect on the teachers whatsoever. "Unfortunately, most of these [inservice] programs are incompetently conceived, planned and executed, and produce little or no change." 1

While all the above authors agreed that there has been a real need for school inservice, there have been differing suggestions on how to go about designing an effective inservice program.

Suggestions for Inservice Guidelines In The Education Sector

The need for inservice in the schools has been just as real as the need for inservice in the health care sector. And, just as in the latter sector, there has been to date no complete statement of adequately researched guidelines for administering an effective school inservice program.

Grieder in 1954 pointed out the need for such a set of inservice guidelines. Grieder observed that "teachers and administrators of a school system would profit by developing a set of principles to guide them in their in-service training program." 2

Again, as in the health care sector, some authors have suggested the general direction or shape these guidelines or principles should take. These authors have stressed the importance of adequately assessing inservice needs, developing objectives, planning, evaluating, differentiating between

2 Grieder and Rosenstengel, Administration, p. 239.
teachers in levels of experience and competence, organizing, and implementing the program based on adequately determined needs.

Dillon suggested that a good inservice program must be based on school district and individual teacher needs. Dillon pointed out that this "needs analysis" was very often neglected as a first step in implementing an inservice program. "Too often district-level activities are not tied either to district or to individual goals or needs, and are not based on solid learning theory."¹

Heath likewise pointed to the importance of sound "needs assessment" based on the differing needs of various groups of teachers. Heath wanted to address the differences between and within the various professional groups in the school as well as the differences arising from each group's particular specialty or area of responsibility.

"If inservice is to be at all viable, the assessed needs of all of the educators of the district become the most important element in preparing the program."²

Gregorc took up the theme of differentiating between the needs of various teachers by calling attention to the "developmental stages" of experience and competence through

²Heath, "In-Service," p. 272.
which each teacher passes.¹

Gregorc criticized the three primary sponsors of continuing education for teachers--colleges, school systems, and educational associations--for mutually reinforcing the attitude of the "finished" teacher. The effective inservice program, according to Gregorc, provided a continuing program of upgrading teacher competencies and took into account the developmental stages--"Becoming, Growing, Maturing, and the Fully Functioning Professional." Good inservice ought to provide differentiated programs for teachers in each of these stages based on the teachers' varying needs.

Brimm and Tollett broadened the concept of "needs assessment" by emphasizing that needs assessment, while very important, was only the first step in implementing an inservice program.

Determination of the needs of the teachers within the school system seems prerequisite to the planning of meaningful inservice education programs. Specific objectives should be developed and follow-up procedures established to determine if these objectives have been realized.²

That careful planning is an important step in implementing an inservice program has been emphasized by three other authors.

According to Nagle, "the most important factor in the


²Brimm and Tollett, "In-Service Education," p. 525.
development of a successful inservice program is planning."¹

Nagle went on to identify several steps in the planning process, including ascertaining the needs of the teachers, setting priorities, determining scheduling constraints, and identifying appropriate resource people."²

Kleiman similarly called for a "very well planned program of in-service education with specific goals to achieve improvement."³ Elaborating on his statement, Kleiman outlined several steps to be followed in planning a comprehensive inservice program:⁴

1. have as simple an organizational structure as possible
2. identify faculty needs
3. analyze these needs for the direction the program should take
4. select activities to meet these objectives
5. evaluate.

Corbally, Jensen and Staub emphasized planning, but shared planning by which they meant administrators and faculty working together to plan the inservice program.

Real leadership is required to engender the confidence that must underlie such a [inservice] program. Mutual agreement must exist about purposes and methods of a program of professional growth and evaluation. . . . There are many ways in which this can be done, but one of the most demonstrable and meaningful of them is

²Ibid., p. 126.
⁴Ibid.
to solicit the help of the staff on matters that are of concern to them.\(^1\)

Harris and Bessent, taking a negative approach, identified the three most serious mistakes commonly made in administering the inservice program in the school setting.\(^2\)

1. failure to relate in-service program plans to genuine needs of staff participants
2. failure to select appropriate activities for implementing program plans
3. failure to implement in-service program activities with sufficient staff and other resources to assure effectiveness.

These authors were quick to point out that the above three mistakes were their own speculation rather than the results of research on their part, but speculation based on their experience because "rigorous studies are rarely reported, forcing practitioners to speculate concerning the mistakes that others have made."\(^3\)

There have been several previous attempts to outline general guidelines for implementing effective inservice programs in the education sector.

The Southern Association's Cooperative Study in


\(^3\)Ibid.
Elementary Education offered the following guidelines.¹

1. Real problems existing in a local school unit should provide the starting point for study and action.
2. Responsibility for initiating and planning in-service education activities should rest primarily with local school personnel.
3. In-service education activities should be recognized as an integral part of the school program with respect to scheduling, teaching load, and budgeting funds.
4. In-service education activities which are planned should support the over-all philosophy and aims of the school.
5. In-service education activities should contribute to the unity of the total program of the school and to the optimum growth and development of children.
6. Provisions should be made for continuous evaluation of the total program.
7. Potential leaders should be discovered and developed.
8. Participants should be expected to strive for and to achieve high standards of quality in all work which is a part of the in-service teacher education program.

Along the same lines, the North Central Association of Colleges and Secondary Schools isolated five assumptions underlying a good inservice education program:²

1. In-service education can best take place in an environment which provides for the maintenance of that high degree of physical and emotional health which promotes the spontaneity, vitality, and enthusiasm essential to good teaching.
2. In-service education, if it is to be a significant experience, must be based upon a challenging

problem which has developed in the framework of the local situation.

3. In-service education can best take place in an environment which utilizes the intelligent and creative thought and action of the entire faculty.

4. Utilization of the creative energy of any group of teachers necessitates the development of effective techniques of democratic cooperation.

5. An effective in-service program must concern itself with the relations of specific school problems to the larger problems of education and to the larger community of which the school is a part.

Parker likewise developed a set of guidelines for conducting effective inservice programs at the request of the National Society for the Study of Education. ¹

1. People work as individuals and as members of groups on problems that are significant to them.
2. The same people who work on problems formulate goals and plan how they will work.
3. Many opportunities are developed for people to relate to each other.
4. Continuous attention is given to individual and to group problem-solving processes.
5. Atmosphere is created that is conducive to building mutual respect, support, permissiveness, and creativeness.
6. Multiple and rich resources are made available and are used.
7. The simplest possible means are developed to move through decisions to actions.
8. Constant encouragement is present to test and to try ideas and plans in real situations.
9. Appraisal is made an integral part of in-service activities.
10. Continuous attention is given to the inter-relationship of different groups.
11. The facts of individual differences among members of each group are accepted and utilized.
12. Activities are related to pertinent aspects of the current educational, cultural, political, and economic scene.

Cochran enumerated what he termed the components of a good inservice program. These components, Cochran asserted, if present, would prevent the inservice program from being administered in a haphazard manner. Thus, according to Cochran, the "well-established in-service program" should: ¹

1. be based on research, especially "action research"
2. be directed at practical problems and situations
3. be based on two-way communications
4. involve a "systematic approach," including planning and evaluation
5. establish a working partnership with various in-service agencies--universities and associations.

The shortcoming present in all of these sets of guidelines, however, was that the guidelines were too general.

While these various sets of guidelines were valuable in providing a general direction which inservice programs could follow, something more specific was needed. What was needed was a set of research-based practical guidelines in the form of a model which could provide specific direction for administering an effective inservice program.

Previous Studies of Inservice In The Health Care Sector

Several studies have addressed themselves to various aspects of hospital inservice programs.

Fisher surveyed supervisory training programs in 61 Indiana hospitals which were classified as acute general hospitals. His purpose was both to describe the first-line

¹Cochran, "In-Service Education," pp. 8-9.
supervisory training found in these hospitals as well as to investigate "whether there was a congruent relationship between the established policy of the hospital concerning management training for first-line supervisors and the execution of the policy."¹

Of the 61 hospitals, 25 conducted first-line supervisory training. Twenty-three of these hospitals responded to the author's questionnaire.

An interview schedule was designed to secure information in four areas: (1) general information about the hospitals; (2) education, work experience and organizational location of those conducting management training; (3) examination of the administrative and curriculum aspects of the programs; and (4) "the hospital-employee relations regarding management training."

The author made several conclusions, some of which were applicable to the present study:

3. The majority of hospitals with management training began management training since 1969.
7. The hospitals used commercially prepared educational materials; the majority of the hospitals used them exclusively.
9. There was no way of reporting the effects of management training because the hospitals had no uniform manner of evaluating management training.

Lesicko investigated the "type, content, organization and scope of in-service education programs in 45 short term,¹

general, non-profit Wisconsin hospitals." The author gathered her information by means of a questionnaire sent to hospital personnel in the 45 hospitals as well as a follow-up interview in six of the hospitals.

The most significant finding in Lesicko's study was that most hospitals in Wisconsin had inservice programs, but that most of these programs were under the direction of the Nursing Service Department and were not hospital-wide.

Walter studied all voluntary, not-for-profit hospitals in Illinois to determine the extent of their use of formal, organized inservice programs and found that hospital size directly affected the type of training program as well as the program's organization and scope. Larger hospitals tended to have larger and more varied training programs than did smaller hospitals.

Stein and Vernon evaluated the learning system for allied health personnel employed at one Michigan hospital. The authors concluded that the learning system at the study hospital was effective in developing needed manpower skills but was inefficient in its use of allocations.

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1Sister Anna Michael Lesicko, "A Comparative Study of Inservice Educational Programs in General Hospitals of Wisconsin," Abstracts of Hospital Management Studies, Volume VIII, p. 211.

2Walter, "Hospital Employee."

The authors specifically recommended that the hospital establish an "Office of Hospital-wide Education and Training" to manage the learning system in a manner consistent with the methods and philosophy of adult education.

Hoffman evaluated the supervisory training program at one Kansas hospital in order to recommend methods of improving the program's effectiveness. ¹

The objectives established for the study were: 1--to identify the requirements established for the training department; 2--to determine the effectiveness of the training department in attaining the hospital's goals; 3--to establish the major deficiencies within the training system; and 4--to recommend methods of improvement to assure training effectiveness and goal attainment. . . .

It was concluded that a more formalized program of management by objectives be established. This program would require formalized, periodic review of specific areas to allow accurate and appropriate judgments of what the hospital staff's objectives for training are when compared with the results furnished by the training department.

Leyasmeyer examined the development and effectiveness of training programs for hospital supervisors sponsored by the Office of Continuing Hospital Education at the University of Minnesota and discovered that in 1968 there was a discernible pattern in which hospitals turned their management development role over to colleges and universities rather than undertaking management development within the hospital

Hole surveyed Directors of Hospital Education Departments to identify their important functions, determine the competencies required for the position and identify the most pertinent problems encountered by hospital education directors.2

A questionnaire comprising forty-nine statement of functions and thirty-three competency statements was used in the attempt to identify the basic functions and to determine the competencies needed for their successful performance. The questionnaire was mailed to the one-hundred participants of the Institute on Hospital-Wide Education and Training, September 19-21, 1966, conducted under the auspices of the American Hospital Association. The results in this study are based upon the returns from eighty-one, or 81 percent, of the questionnaires mailed. . . .

The findings present a rather thorough description of the job of the director of hospital education and establishes a guide which comprises a broad range of critical functions in hospital education. The functions were ranked in order of importance in the following ten operational areas: organizational; program purposes; program development; instructional services; student personnel services; staff personnel; facilities; business management; program evaluation; and, research. . . .

Major problems facing directors of hospital education were identified in the following areas: financial support; staff problems; program; facilities; equipment; materials; student personnel services; organization; and, research.

While the above studies pertained to hospital inservice, none of the studies attempted to identify the functions involved in effectively organizing and administering

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1Edith Leyasmeyer, "A Study of Management Training and an Examination of the Supervisor Development Programs Sponsored Through the University of Minnesota" (unpublished dissertation, University of Minnesota, 1968).

2Hole, "Functions."
the "hospital-wide" inservice program. None of the above studies was a comparative case study of several institutions having established "hospital-wide" inservice programs.

Therein was the distinct contribution of the current study.

**Previous Studies of Inservice In The Education Sector**

Several studies have addressed themselves to various aspects of inservice in the education sector.

Carsetti studied whether inservice produced any effect on teacher behavior.¹ Her purpose was "to examine the effectiveness of a specifically designed in-service program in terms of change in teacher behavior."

An observational check list based on the behavioral objectives of the inservice program was utilized to record changes in the behavior of 60 elementary school teachers.

Carsetti drew the following conclusions from her observations:

1. The research hypothesis that one presentation of an in-service program changes teacher behavior is supported. An observable change of teacher behavior is demonstrated at the fourth week of the study.

2. The research hypothesis that two presentations of an in-service program change teacher behavior is supported. The data indicates that teachers participating in two presentations of the same inservice program, one live, one video-taped,

changed their behavior at the fourth week of observation.

3. The research hypothesis that two presentations of the same in-service program change teacher behavior more than does one presentation of an in-service program is not supported. Those teachers who received two presentations of the same in-service program demonstrated some observable change of behavior at the fourth week of observation, to the same degree that teachers receiving only one presentation demonstrated change in behavior.

5. The research hypothesis that regression of teacher behavior occurs after two presentations of the same in-service program is not supported. Teachers receiving two presentations of the same in-service program continued to demonstrate a change in behavior at the eighth week of observation. The behavior of six of these teachers remained changed at the eighth week of observation.

6. The research hypothesis that there is greater regression of teacher behavior after two presentations of the same in-service program is not supported. The behavior of those teachers who received two presentations of the same in-service program was changed to the same degree that the behavior of the teachers receiving only one presentation was changed.

Stanley studied four fifth-grade and four sixth-grade classes involving eight teachers in one public school system which used the author's original self-appraisal guide as the basis of discussion at five inservice meetings between October and December, 1966.1 His purpose was:

to determine the effectiveness of a self-appraisal guide in an in-service education program for elementary teachers as measured by pupil achievement on a standardized achievement test.

The "t" test was used to measure the level of significant difference that arose.

The "t" test calculations showed that seven of the eight experimental groups had gains, in the total test battery scores, that were greater than the control groups and that those gains were significant at the .05 level or beyond.

The general conclusion of Stanley's study was that the program of inservice education utilizing the self-study guide did increase the achievement of pupils in the experimental group.

Robinson studied six eighth-grade social studies teachers and their students as an experimental group and a similar number of teachers and students as a control group.¹

The purpose of his study was:

to determine whether a systematic year-long in-service program utilizing interaction analysis and micro-teaching would produce a change in the teaching patterns of teachers. A second purpose of the study was to discover if the year-long in-service program would result in improved student achievement and ability to do critical thinking. The final purpose of the study was to ascertain if there were any changes in the attitudes of students in the two groups.

The systematic in-service program was conducted in the 1968-69 school year under the leadership of consultants from the University of Nebraska.

Robinson's findings were as follows:

1. The control group teachers decreased significantly (at the .05 level) in indirectness during the school year.

¹Clifton Newkirk Robinson, Jr., "A Study of the Effectiveness of an Experimental Inservice Program Utilizing 'Interaction Analysis' and Micro-Teaching with Teachers in the Westside Community Schools," Dissertation Abstracts, Volume XXXI, p. 5279-A.
2. There was a significant difference (at the .05 level) in the indirect-direct ratio at the end of the school year between the two groups in favor of the experimental group.

3. Teachers in the experimental group asked significantly fewer questions (at the .01 level) at the conclusion of the school year than they did when the in-service project was initiated.

4. As the school year progressed the teachers in the experimental group asked significantly more analysis type questions.

5. Teachers in the control group increased significantly (at the .01 level) in the giving of directions during the year.

6. Teachers in the control group increased significantly the use of criticism throughout the year (at the .01 level).

7. There was a significant difference (at the .01 level) between the control and the experimental groups in analysis level student response in favor of the experimental group.

8. There was a significant difference (at the .05 level) between the control and the experimental group in extended direct influence in favor of the control group.

9. There were no observable changes in student achievement, attitude, or the ability to do critical thinking between the experimental and control groups.

Robinson suggested that the differences between the control and experimental groups were due not to the increased indirectness of the experimental group, but to the increased directness of teachers in the control group.

Lee studied 51 public elementary school teachers from three districts in Southern California, representing all elementary grade levels.¹

The purpose of the study was to compare the effectiveness of sensitivity training in an inservice teacher-training... 

program with two other methods of human relations training.

Lee's conclusions were as follows:

Comparing the effectiveness of sensitivity training with the control group it was found that teachers in sensitivity training improved their scores on the Minnesota Teacher Attitude Inventory significantly more than did those in the control group. Teachers in sensitivity training increased in self-esteem, or self-value, as measured by the Q-sort instrument, significantly more than did those in the control group . . . While there was no significant difference in teacher absenteeism rate between the two groups, the students of teachers who received sensitivity training were absent significantly less than were the students of teachers in the control group.

Comparing the effectiveness of sensitivity training with the conventional class in human relations, sensitivity training was found superior in reducing student absenteeism with near significant trends favoring sensitivity training in improving MTAI scores and teachers' self-esteem measures on the Q-sort instrument.

Breit compared preservice and inservice participants in the same teacher education program in terms of the development of certain teacher competencies. An experimental and control group of undergraduate students and an experimental and control group of elementary teachers were included in the study.

Breit reached the following conclusions:

The results of the study indicate that the program was successful in developing knowledge of the processes of science with both preservice participants and inservice participants. However, a greater increase was found for the inservice participants. The high correlation between pretest scores and change scores on the Science Process Measure for Teachers indicates that the greater change in knowledge in the inservice participants

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1Frank Delano Breit, "A Comparison of the Effectiveness of an Inservice Program and a Pre-Service Program in Developing Certain Teaching Competencies," Dissertation Abstracts, Volume XXX, p. 1446-A.
was related to their lower initial level of knowledge. This could indicate that the instruction given is more beneficial for those with a lower level of knowledge.

Both preservice participants and inservice participants made substantial change in their instructional decision behavior. The preservice participants began at a significantly higher level than the inservice participants and retained this difference at the end of the program. This seems to indicate that the aspects of the program which dealt with instructional decision behavior were of equal benefit to individuals at various levels of competence and with or without teaching experience.

Thompson submitted an original inservice kit to 25 teachers in five elementary schools and 25 teachers in five secondary schools.¹ His purpose in doing this was as follows:

to ascertain opinions of elementary and secondary school teachers regarding the effectiveness of inservice kits designed to develop certain competencies in the selection, creation, and utilization of instructional materials through self instruction.

Teachers were asked to use the kits and to complete a questionnaire which related their opinions regarding the effectiveness of the kit.

From the analysis of the results obtained from the questionnaires, Thompson reached the following conclusions:

1. Teachers feel they are more adept in the selection of instructional materials as a result of using the kits. Seventy-four percent of the teachers in the investigation were of the opinion that use of the kits increased their competency to select materials.

2. Teachers feel they have a greater ability to create simple instructional materials after using the kits. Eighty-two percent of the teachers in the investigation felt they increased their

¹Glenn J. Thompson, "An Investigation into the Effectiveness of an Inservice Education Program Dealing with the Selection, Creation, and Utilization of Instructional Materials," Dissertation Abstracts, Volume XXX, p. 4322-A.
competency to create simple materials because of their use of the kits.

3. Teachers feel they will utilize materials more effectively in the classroom because of their use of the kits. Eighty-two percent of the teachers indicated they felt more competent to utilize materials in the classroom after using the kits.

Clark surveyed 201 second-grade and 134 seventh-grade teachers in nine northeastern California counties.1

The purpose of this study was to (1) determine the effect of in-service training programs in modern mathematics on the knowledge of elementary school teachers; and (2) determine whether the degree of teacher knowledge of modern mathematics is reflected in the achievement level of pupil knowledge in the same subject.

Teachers were asked to indicate four items on the survey questionnaire: (1) the type of inservice they received in modern mathematics; (2) a rating of their readiness to teach modern mathematics; (3) the kind of inservice program that was of greatest help to them in learning modern mathematics; and (4) from a list of instructional and administrative personnel, the degree of help received in learning modern mathematics.

Clark's findings were as follows:

1. Of the 355 responding teachers 82% indicated that they were adequately or very well prepared in the knowledge of modern mathematics. Fourteen percent felt inadequate and four percent did not respond.

2. The sources of help checked most frequently as being important in learning the content of modern mathematics were, in rank order, county workshops, college extension courses, district workshops, college summer sessions, films, and T.V.

1John Ferguson Clark, "A Study of the Relative Effectiveness of Some In-Service Programs in Modern Mathematics on Second and Seventh Grade Teachers in Nine North-eastern California Counties," Dissertation Abstracts, Volume XXVIII, p. 2578-A.
3. College instructors, colleagues, and workshop leaders were most frequently checked as being of "some" or "great" help to the teachers in learning about modern mathematics.

4. The mean score of the seventh grade teachers was significantly higher than the mean score of the second grade teachers.

5. There was a significant difference at the .001 level of confidence between the total mean score and the mean of those teachers who attended an N.D.E.A. institute.

6. There was a significant difference at the .05 level of confidence between the total mean score and those teachers who had attended between 1-10 hours of county sponsored workshops.

7. Virtually no relationship was found to exist between teacher score and pupil achievement.

Williams studied the curricular implications of two programs, one inservice and the other preservice, based on the tasks undertaken by vocational directors and supervisors.¹

His purpose in the study was:

to analyze the roles of the various local vocational directors and supervisors in Ohio in order to discover implications which can be used in the design of future pre-service and in-service vocational leadership development programs.

A secondary purpose was to obtain background data on these local vocational leaders which can also be used in the design of future leadership development programs.

Williams sent a questionnaire containing a list of 84 tasks arranged in checklist format under two columns--importance and frequency. The questionnaire was sent to 33 joint vocational school directors, 40 non-joint vocational school directors and 146 supervisors.

¹Robert J. Williams, "A Survey and Analysis of the Professional Tasks of Ohio's Local Vocational Directors and Supervisors with Curricular Implications for Pre-Service and In-Service Training Programs," Dissertation Abstracts, Volume XXXIV, p. 4116-A.
The methods utilized to analyze the data received from the questionnaires included frequency distribution, chi square test, analysis of variances and "t" test.

Williams reached the following conclusions:

1. There was a high level of agreement between the various local leaders and the panels of authorities on both the importance and frequency of the professional tasks.

2. There were many more differences between the roles of the directors and the supervisors, than between the two directors' groups or among the three supervisors' groups. These differences existed both in regard to the importance placed upon the tasks and the frequency with which the tasks were performed.

3. The directors were deeply involved in tasks associated with general administration, pupil personnel, and personnel administration. The supervisors were more involved in those tasks dealing with curriculum and instruction. Both groups were involved to the same extent in the school-community relations tasks.

4. There were a great many tasks which were common to all of the leadership groups.

5. The scope of the director's role was extremely broad and included many tasks in all of the five categories. A program designed to prepare personnel for the position of vocational director must therefore be quite comprehensive.

Most of the above studies in the education sector dealt with the evaluation of the effectiveness of inservice programs and not with the functions involved in administering an inservice program.

The studies centered on the effectiveness of either programs designed to utilize different approaches to inservice or methodology involved in conducting an inservice project or of programs designed to teach a particular curricular content, such as mathematics. One study centered on implications for inservice programs based on tasks performed
by local vocational education directors and supervisors.

The methodology of the above studies typically involved utilization of one or more experimental and control groups and one or more statistical measurements.

The present study was distinctly different from the previous studies in two ways. First, the present study was concerned with the functions involved in the administration of an inservice program and not with the measurement of the effects of a particular inservice project. Second, the present study utilized the *case study* methodology rather than the experimental methodology.

**Summary**

The "Review of the Related Literature" revealed that in both the health care and the education sectors there has been a repeated call for more effectively administered inservice programs. In addition, authors in both of these sectors have attempted to present guidelines depicting a well run inservice program. But the authors either presented one administrative function, such as planning or evaluating, as the most important guideline or, in the case of those authors presenting a set of guidelines, proposed guidelines too general to be used as a model. In neither case were the guidelines based on research of any kind.

The current study has focused on addressing a need which was readily apparent from the review of the literature,
namely, developing a model depicting an effectively organized and administered "hospital-wide" inservice program.
CHAPTER III

THE RESEARCH PROCEDURE

The purpose of the study was to develop an original model for effectively organizing and administering the "hospital-wide" inservice program.

Chapter I presented the overview of the study, including the problem, the purpose, definition of terms, and limitations of the study.

Chapter II presented a review of the related literature and research relative to inservice programs, both in the health care and in the education sectors.

The review of the related literature and research provided one of two sources of data for the study. The other source of data was provided by an in-depth case study of the "hospital-wide" inservice program in four university-related Medical Centers in the city of Chicago.

The purpose of Chapter III is to present the procedure utilized by the author in preparation for and implementation of the in-depth case study of the four inservice programs.

Chapter IV presents the analysis of data and Chapter V presents the original model as well as other conclusions and recommendations.


Procedure of the Study

The study consisted of eight distinct stages: I. General plan and methodology; II. Review of the related literature; III. Development of the interview guide; IV. Field testing of the interview guide; V. Conducting the investigation; VI. Analyzing the data; VII. Development of the model, and VIII. Validation of the model.

I. General Plan and Methodology

The general plan for conducting the research included a case study of established "hospital-wide" inservice programs in university-related Medical Centers in the city of Chicago.

The case study method, rather than the survey approach, was utilized in the study in order to achieve an in-depth examination of the administration of existing inservice programs as well as the organizational context in which the inservice programs operated. The author wanted to uncover not only what procedures were utilized by the inservice directors in administering the inservice programs, but also the reasons behind the administrative procedures adopted. In addition, the author wanted to ascertain whether the inservice directors would change, if they could, any of the procedures they utilized and the reasons why the directors would or would not want to make procedural changes.

The inservice programs chosen as the basis of the case study were those located in the following four Medical Centers:
The four Medical Centers included in the study were selected for the following reasons:

1. All four Medical Centers housed established and functioning "hospital-wide" inservice programs which had been in existence at least five years and which had conducted ongoing training projects.¹

2. The national concentration of hospital-based inservice trainers was located in an urban setting. Schechter, after conducting a national survey of hospital-based trainers in 1972, stated that:

   . . . forty-five percent of the trainers surveyed work in cities classified by the 1970 census as the 100 largest cities in the United States. Inasmuch as only 19 percent of the nation's hospitals are located in these cities, trainers are highly concentrated in large urban centers.²

In order that the original model developed by the author have applicability to hospitals other than hospitals located in university-related Medical Centers, it was important to study inservice programs located in an urban setting. All four inservice programs studied were in fact located in an urban setting.

¹ascertained by the author through a telephone survey conducted in November, 1974 (See Appendix A).

setting, namely, the city of Chicago.

3. Each of the four Medical Centers employed at least 2,000 health care personnel and contained a total of at least 600 hospital beds. It was important to study large institutions since previous studies had demonstrated that large health care institutions were more apt to have an organized inservice program than smaller institutions. Walter concluded his study by stating, "... the training programs in the larger hospitals are better organized and more comprehensive than are the training programs in the smaller hospitals."2

4. University-related Medical Centers were chosen for two reasons. First, the four Medical Centers contained in the study constituted the total population of university-related Medical Centers in Chicago having an organized "hospital-wide" inservice program located on its premises. Second, the Medical Centers were organizationally complex, including one or more hospitals and clinics in addition to various combinations of a School of Dentistry, School of

1Schechter, Agenda, and James T. Walter, "Hospital Employee In-Service Training Programs: A Study of Training Programs and the Extent of their Use in Illinois Hospitals" (unpublished thesis, University of Iowa, 1963).

2Walter, "Hospital Employee," p. 46.

An assumption underlying the study was that application of the principles of administering an inservice program in a complex institution could be modified to apply to less complex institutions, but not vice-versa.

Yet, despite the above similarities, there was sufficient diversity within each of the Medical Centers to provide a broad spectrum for analysis. The number of training staff varied from one to five; each institution differed in the reasons for instituting an inservice program; there were differences in how each program was evaluated; and there were differences in statements of the objectives for each of the inservice programs.

II. Review of the Related Literature

The literature reviewed by the author consisted of books, journals, theses, dissertations, abstracts of both theses and dissertations, as well as the following types of documents obtained from the inservice directors:

1. institutional organization charts
2. historical summaries of the university and the Medical Center
3. job descriptions of inservice staff and inservice director

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1 See Chapter IV for a description of the components of each of the four study institutions.

2 Ascertained by the author through a telephone survey conducted in November, 1974 (see Appendix A).
4. inservice program annual reports
5. personnel department policy manuals
6. inservice program statements of purpose and objectives.

The literature provided two types of data which were included in the implementation of the case study: (1) the general directions that guidelines for administering the inservice program should take (these guidelines were explained in Chapter II); and (2) sources which the author utilized to develop questions for the interview guide (these sources are discussed in Section III of this chapter).

III. Development of the Interview Guide

After completing the review of the literature, the author developed the interview guide in a series of stages. The interview guide sought data which could be analyzed according to the fourteen statements included under the "areas to be investigated." The "areas to be investigated" were in turn based on the seven "functional elements" of the process of administration advanced by Luther Gulick. The seven "functional elements" as explained by Gulick were:

1. Planning

"working out in broad outline the things that need to be done and the methods for doing them to accomplish the purpose set for the enterprise."

2. Organizing

"establishment of the formal structure of authority through which work subdivisions are arranged, defined and coordinated for the defined objective."

3. Directing

"the continuous task of making decisions and embodying them in specific and general orders and instructions and serving as the leader of the enterprise."

4. Staffing

"the whole personnel function of bringing and training the staff and maintaining favorable conditions of work."

5. Coordinating

"the all important duty of interrelating the various parts of the work."

6. Reporting

"keeping those to whom the chief executive is responsible informed as to what is going on, which thus includes keeping himself and his subordinates informed through records, research, and inspection."

7. Budgeting

"all that goes with budgeting in the form of fiscal planning, accounting and control."

Gulick's outline of the administrative process was utilized by the author because the outline contained the most complete series of categories depicting the process of administration the author found in the literature. Other theorists of educational administration since Gulick have discussed the
elements of the administrative process.\textsuperscript{1} The other theorists, however, adhered very much to Gulick's original "elements," even though several theorists combined one or more of Gulick's "elements" into a category of broader scope.

The author decided that the "open ended" question was the appropriate primary methodology since his task was to acquire a broad range of data; to explore the reasons behind certain answers given by the respondents; and to identify the frame of reference from which each respondent spoke. The author was guided in this decision by Kahn and Cannell's directive:

The open ended question appears to be more appropriate when our objective is not only to discover the respondent's attitude toward some issue, but also to learn something about his level of information, the structure or basis on which he has formed his opinion, the frame of reference within which he answers the question, and the intensity of his feelings on the topic.\textsuperscript{2}


The author devised the first draft of the interview guide by comparing three previous surveys of health care in-service programs. The author closely examined the three surveys and chose questions from each which could be incorporated under the seven "functional elements" of the process of administration. The author then modified the questions selected to fit the specific statements included under the seven "areas to be investigated."

The three surveys utilized by the author were the following: first, Schechter sent a questionnaire to over 600 hospital-based trainers throughout the country. Besides seeking basic demographic data, Schechter asked for a list of the organizational needs uncovered by the trainers, the methods used to uncover these needs, and whether the needs uncovered were likely to change within the next two years. Schechter also asked what kinds of inservice projects, such as orientation, skills training, continuing education, management development, were offered and to what levels of personnel; what resource people were called upon to assist in developing or presenting projects; a list of the job components of the inservice director; and, the dollar amount of the

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1 Floyd M. Hole, "Functions and Preparational Needs of Directors of Hospital Education" (unpublished dissertation, Arizona State University, 1968); Hospital Research and Education Trust, "Interview Schedule: Hospitalwide Education and Training Project" (mimeographed, 1974); Schechter, *Agenda*.

inservice budget compared to a projected "ideal budget." Several of Schechter's question areas were adapted by the author for the interview guide of this study.

Second, the Hospital Research and Education Trust conducted a survey of selected hospital inservice directors throughout the country. The survey interview guide was divided into three parts: (1) inservice organization and development; (2) inservice costs, and (3) inservice needs and objectives.

Part 1 contained questions about how the inservice program was organized; how inservice policies were developed; to whom the inservice director reported; what levels of personnel received inservice training; whether all inservice was under the control of the inservice department; and how the inservice department was staffed.

Part 2 of the H.R.E.T. interview guide asked several questions about budget items: who approved and determined the budget; whether other departments had inservice budgets; how budget priorities were established; and how the inservice budget was justified.

Part 3 sought to determine the basic source of responsibility for determining inservice needs; how inservice needs were assessed; whether there was a statement of inservice objectives; how inservice projects were evaluated; and what

1Hospital Research and Education Trust, "Interview Schedule."
records were kept on inservice projects and recipients. Several of the H.R.E.T. questions were likewise adapted and modified for the interview guide of this study.

Third, Hole sent a questionnaire to 81 hospital inservice directors throughout the country. Under Part I of the instrument, "functions performed by the director," Hole asked several questions pertaining to the following areas of the inservice program:

1. organization of the department  
2. program purposes  
3. program development  
4. instructional services  
5. recordkeeping  
6. staff personnel  
7. facilities  
8. business management  
9. program evaluation  
10. research

The general direction of several of Hole's question areas, specifically areas 1, 2, 4, 6, 7, 8, and 9, were adapted for the interview guide of this study.

IV. Field Testing of the Interview Guide

After completing the first draft of the interview guide, the author presented the draft to a Ph.D. candidate in educational administration at Loyola University of Chicago. In this first of two steps in validating the interview guide, the author asked for critical review of question format and readability as well as for compatibility of the seven "areas to be investigated" with the several questions listed under

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^1Hole, "Functions," pp. 194-201.
each of the "areas." Additions, deletions, and modifications were made by the author after this initial critical review.

After this revision, the author entered into step two in validating the interview guide. The author submitted the revised draft of the interview guide in person and one at a time during the months of November and December, 1975 to three directors of inservice programs.

The purpose of this step in field testing the interview guide was to establish both content as well as construct validation. The author, through the process of field testing, sought the answers to two basic questions:

1. Did the vocabulary of the interview guide hold the same meaning for different respondents? and

2. Did the interview guide adequately measure what it was intended to measure?

The first question concerned **construct** validity. The jury members were asked to judge and refine, if necessary, the terminology or "constructs" utilized in the interview guide questions. Several changes in terminology were made by the author based upon the recommendations of the jury.

The second question concerned **content** validity. The jury was asked to compare the interview guide questions with the corresponding seven "areas to be investigated." The jury was then asked to judge the accuracy and adequacy of the interview guide questions as measures of the seven "areas to be investigated." Specifically, the jurors were asked to
comment upon whether the interview guide questions sufficiently, completely, and clearly covered the subject matter under each of the seven "areas." This procedure was undertaken with a view to developing as complete as possible a series of questions which would adequately cover the major aspects of each of the seven administrative "functional elements" of Gulick as expressed in the "areas to be investigated."

Appropriate changes, including additions, deletions, corrections, refinement of wording, as well as changes in the order in which the questions were asked were made by the author based on the recommendations of the three jury members.

Several specific recommendations were made by the jury members. In the demographic questionnaire, for instance, the author had not included any questions seeking information about the inservice director himself. Two jurors pointed out that a section should be included which sought the educational and work experience background and years of service of the inservice director at the Medical Center, specifying the length of tenure as inservice director as well as the provisions made by the director for his own professional development.

One juror suggested that a more logical order of presenting the question areas other than Gulick's "PODSCORB" order be followed. The author rearranged the order of presentation of questions to the sequence found in Chapter IV.

Another juror suggested that several important questions be included in more than one category to serve as
checkpoints for consistency of answers given by each inservice director in different segments of the interview. Several questions, most notably in the "planning," "directing" and "reporting" areas, were repeated with minor shading of emphasis.

The jurors modified the author's emphasis in the "organization" section by expanding the questions to include the relation of the inservice director to his peers as well as to include the specifics of how much time the inservice director's immediate superior spent with him and for what purpose.

The jurors pointed out that several questions lent themselves to including specific "checklist" items to which the directors could respond either "yes" or "no." Questions such as the criteria used in filling an inservice staff vacancy as well as in evaluating the accomplishments of the inservice program itself were expanded along these lines.

Questions on outside sources of funding and costing-out of inservice projects were added to the "budgeting" and "reporting" sections based on jury recommendations.

A question asking how priorities among inservice needs were determined as well as the phrasing "standardized reports" were both added to the "planning" section.

The addition of a question asking whether inservice efforts of other departments were integrated with "hospital-wide" inservice efforts was made at the strong request of one of the jurors with subsequent agreement by the other two jurors.
Several categories of inservice projects were deleted as irrelevant in the question asking what kinds of projects were conducted by the inservice program.

In summary, the interview guide was substantially strengthened as a result of the field testing procedure.

In the content validation process itself, the author adhered to the evaluation procedure described in Engelhart. "Content validity is evaluated by showing how well the content of the test samples the class of situations or subject matter about which conclusions are to be drawn."¹ In this study, "test" refers to the interview guide and "class of situations" refers to the seven "areas to be investigated."

Those selected to serve as jurors were the following:

1. Mary O. Castellanos
   Training Director - Science Research Associates
   Chicago, Illinois

2. Stephen Hulsh
   Training and Development Manager - Resurrection Hospital
   Chicago, Illinois

3. Albin Sikora
   Personnel Director - MacNeal Memorial Hospital
   Berwyn, Illinois

The three jurors were all directly involved in administering an inservice program and all three were quite familiar with the health care environment. Further, the jurors were representative of the directors interviewed in the study, both in educational and work background.

V. Conducting the Investigation

After validating the interview guide, the author then organized the procedure to collect the data. The author secured by letter the permission of each of the four in-service directors to conduct a study of their inservice programs. (The letter requesting permission to conduct the study is contained in Appendix B.)

Two types of data were collected for analysis:

1. The author wanted to obtain data which described the organizational context in which each inservice program operated as well as a brief history of each Medical Center. Certain detailed demographic data were therefore collected which provided a description of each of the four institutions as well as each of the four inservice directors. These data were in the form of selected historical and organizational information on the University, the Medical Center, the in-service program, and the inservice director. The data were obtained from various documents provided by the inservice directors as well as from the answers to demographic questions asked of the inservice directors.

2. Certain research data were collected in the form of answers to open-ended questions asked of the inservice director at each of the four institutions. The author asked for and received several kinds of documents from the directors which were used to obtain data supplementary to the responses of the inservice directors. In addition, the author toured the inservice program facilities.
The interviews with the four inservice directors were conducted in the following manner. The interview guide was administered by the author in person to the inservice director at each of the four study institutions during the months of February and March, 1976. Each interview was audio taped in its entirety as a means of preserving intact the interview data for the analysis stage of the procedure.

VI. Analyzing the Data

Chapter IV presents the detailed analysis of the data obtained through the methodology described above. The analysis of data was accomplished by utilizing the following guidelines:

1. **Consistency** in answers given to questions within each area.
2. **Compatibility** of answers given in one area to answers given in other areas.
3. **Comparison** for verification of answers given to data contained in available documents.
4. **Conformity** of collected data with accepted theory regarding functions of educational administration.
5. **Comprehensiveness** of answers given to interview guide questions.
6. **Variation** in administrative methods utilized.

The analysis of data consisted of two stages. In stage one, the author, taking one study "area" at a time, summarized the administrative approach found in each of the
four study institutions.

To preserve anonymity the four institutions were labelled "A", "B", "C", and "D".

The author made a comparative analysis of the four summaries, noting similarities and dissimilarities between the four institutions. This stage of the analysis, referring to statement "a" under each of the seven "areas," reflected the current administrative "state of the art," that is, current procedures adopted by the inservice directors in administering the inservice programs. Relevant data from available Medical Center organizational and inservice program documents were compared to the answers given by the four directors for verification and for elaboration upon the answers given to the interview guide.

The author then entered into the second stage of the analysis by comparing the perceptions of each of the four inservice directors as to what their administrative role in each of the seven "areas" should be. This stage of the analysis reflected statement "b" under each of the seven "areas." Statement "b" referred to the ideal role the inservice director should be playing. The author studied answers given to interview guide questions asking whether or not the inservice director felt there should be any change in his role, justification for felt change, and specifically what, if any, changes he would make if he could. The author compared the "ideal role" responses of each of the directors to the corresponding "current role" responses. The author made the
comparison to determine if the inservice directors felt that the procedures they were currently utilizing were the procedures the directors felt they ought to be utilizing.

VII. Development of the Model

The two stage analysis of data provided, together with guidelines drawn from the literature, the data from which the author formulated his original model of an effectively organized and administered "hospital-wide" inservice program.

The model (portrayed in Chapter V) was developed in a narrative and graphic format. The model took its basic format from statement "b" under each of the seven "areas" to be investigated. Statement "b" referred to the ideal role to be played by the inservice director in administering the inservice program. Elaboration upon each of the ideal role statements based on various responses to the interview guide was incorporated into the model itself.

VIII. Validation of the Model

After the author developed the model, he submitted the model to seven inservice directors for validation. These directors included the original jury which assisted in the validation of the interview guide as well as the four inservice directors interviewed in the study.

The author asked for the reactions of these directors to the content as well as the format of the model. The author asked the seven directors to comment upon the clarity or ambiguity of the narrative statement and the graphs; the
practicality of implementing any portion of the model in the hospital setting; the consistency of various model statements with each other; and the adaptability of the model to the directors' own institutional setting.

After receiving reactions from each of the seven directors, the author made appropriate revisions to the model.

The author then presented other conclusions of the study drawn from the analysis of data and provided general recommendations as well as recommendations for further study.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Introduction

The purpose of the study was to develop an original model depicting an effectively organized and administered "hospital-wide" inservice program.

To achieve the purpose the primary methodology utilized was an in-depth case study of four established "hospital-wide" inservice programs. Included in the case study were a detailed personal interview with the inservice director at each of the four study institutions, a tour by the author of the inservice facilities, and a review of available documents pertaining to the inservice program, the university, and the Medical Center.

Two types of data were collected:

1. Certain detailed demographic data were collected which provide for the reader background information on each of the four institutions as well as each of the four inservice directors. The demographic data also served as refer- ence information for the author in his analysis of the re- search data.

Demographic data were in the form of selected historical and organizational information on the university, the Medical Center, the inservice program, and the inservice director. The data were obtained from various documents
provided by the inservice directors as well as from the answers to the demographic questions asked of the inservice directors. (The demographic questionnaire along with the responses of the four inservice directors are found in Appendix C.)

2. Certain research data were collected in the form of answers to open-ended questions asked of the inservice director at each of the four institutions according to a structured interview guide as well as in the form of reference information obtained from various kinds of available documents.

Research data were analyzed with reference to the fourteen statements in the seven "areas to be investigated." The seven "areas to be investigated" each contained two types of statements. The first statement reflected the current state of the art of administering the inservice program while the second statement reflected the ideal state of the art from the perspective of each of the inservice directors.

Areas to be Investigated

The "areas to be investigated" by means of the case study were:

1. Organizing

   a. The inservice director is clearly established as part of the formal authority structure of the institution.

   b. The inservice director should be clearly established as part of the formal authority structure of the institution.
2. Staffing
   a. The inservice director has authority to hire, train, and evaluate inservice staff.
   b. The inservice director should have authority to hire, train, and evaluate inservice staff.

3. Budgeting
   a. The inservice director has the authority to request and monitor a budget adequate to achieve inservice purposes.
   b. The inservice director should have the authority to request and monitor a budget adequate to achieve inservice purposes.

4. Planning
   a. The inservice director determines what institutional needs are to be addressed through inservice projects.
   b. The inservice director should determine what institutional needs are to be addressed through inservice projects.

5. Coordinating
   a. The inservice director coordinates all inservice efforts within the institution.
   b. The inservice director should coordinate all inservice efforts within the institution.

6. Directing
   a. The inservice director has authority to decide what projects will be undertaken as well as how projects will be implemented.
   b. The inservice director should have authority to decide what projects will be undertaken as well as how projects will be implemented.

7. Reporting
   a. The inservice director evaluates and reports on the accomplishments of the inservice program.
b. The inservice director should evaluate and report on the accomplishments of the inservice program.

**Description of the Four Study Institutions**

The four university-related Medical Centers which formed the basis of the study were complex organizations. The following historical and organizational information provides for the reader background material on each university, Medical Center, and "hospital-wide" inservice program studied.

**Northwestern Memorial Hospital**

Northwestern University was chartered as an independent institution of higher education in 1851. Nondenominational and coeducational, the University had a total enrollment in 1974 of about 18,000 students.¹

The university consists of two campuses along Lake Michigan: 170 acres in Evanston, Illinois and 14 acres located twelve miles south, in Chicago. The Chicago campus contains the School of Law, the Medical School, the Dental School, and the Evening Divisions.²

The Chicago campus is the heart of the McGaw Medical Center of Northwestern University, which coordinates the research, educational, and service facilities of the Medical School, the Dental School, and member hospitals.³

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¹Northwestern University, "Undergraduate Catalogue, 1974-75" (Evanston, Illinois: Northwestern University Information, August, 1974), XLIII, 11, p. 7.

²Ibid., p. 9.

³Ibid.
The Medical School was founded in 1859 and the Dental School in 1891. The Medical Center itself was established in 1965 as the Northwestern University Medical Center and re­named the McGaw Medical Center in 1969. The Medical Center, otherwise known as Northwestern Memorial Hospital, consists of both University and member hospitals.

On the Chicago campus are Northwestern Memorial Hospital (Wesley Pavilion and Passavant Pavilion), Veterans Administration Research Hospital, the Rehabilitation Institute of Chicago, Prentice Women's Hospital and Maternity Center, and the Institute of Psychiatry. Two member hospitals in locations away from the campus are the Children's Memorial Hospital and Evanston Hospital.¹

The "hospital-wide" inservice unit is contained within the personnel department. The inservice unit, founded in 1970, is located in a building adjacent to one of the hospital pavilions.

Rush-Presbyterian St. Luke's Medical Center

The history of Rush-Presbyterian St. Luke's Medical Center is a history of mergers. Three separate charters were merged over the course of time: Rush Medical College, St. Luke's Hospital, and Presbyterian Hospital.

Rush Medical College, founded in 1837 through a charter from the Illinois legislature, held its first classes six years later in 1843 in Dr. Rush's own offices.²

¹Ibid., p. 10.

²"Rush-Presbyterian St. Luke's Medical Center, "Medical Center Perspectives" (Training and Development Department: slide presentation script, mimeographed and undated), pp. 1 & 2.
The necessity for more abundant health care led the Rush faculty in 1879 to build a hospital. Faculty efforts were joined to the efforts of a group of Presbyterian laymen in the completion of Presbyterian Hospital in 1883. Located on the city of Chicago's west side, the hospital was built on what is now the present site of Rush Medical Center.¹

St. Luke's Hospital was founded independently in 1863 as a place in which the sick poor could be cared for.²

In 1942 Rush Medical College suspended its operations. St. Luke's Hospital and Presbyterian Hospital, faced with similar needs and goals, formed an agreement of merger in 1956 in order to expand their services. The physical merger took place in 1959 when facilities were combined in the west side Medical Center.

On October 24, 1969 the Trustees of Rush Medical College signed an agreement of merger with Presbyterian St. Luke's Medical Center. The new Medical Center was created to reactivate the Rush charter and to re-establish the undergraduate medical education programs of Rush Medical College.³

Today Rush Medical Center consists of 18 buildings at the west side location. Included are Presbyterian-St. Luke's Hospital; Rush University, which includes the Medical College, Nursing College, College of Allied Health Sciences, and the Graduate College; the Bowman Health Park, a total center for elderly patient care; and the Research Center.⁴

The "hospital-wide" inservice unit, called the "Training and Development Department," is located in a separate building across the street from the hospital complex.

¹Ibid., p. 4. ³Ibid., p. 6.
²Ibid., p. 3. ⁴Ibid., pp. 8 & 9.
Established in 1964 as part of the personnel department, the inservice unit is today part of the College of Allied Health Sciences.

University of Chicago Hospitals and Clinics

The University of Chicago, founded by John D. Rockefeller, opened its doors for classes in 1892. Located on Chicago's south side, the University of Chicago, a private, nondenominational, and coeducational university, includes the undergraduate college, four graduate divisions, seven graduate professional schools, the University Extension, and, in addition, the University of Chicago Press.¹

Built in 1927, the Albert Merritt Billings Hospital is the nucleus of the University of Chicago Hospitals and Clinics. A total of eleven hospitals and clinics comprise the Medical Center complex.

Today the University of Chicago Hospitals and Clinics is one of the nation's largest private, nonprofit medical centers, comprising 11 interconnected buildings. The Hospitals and Clinics are operated by the University's Division of the Biological Sciences, which includes The Pritzker School of Medicine.²

The "hospital-wide" inservice unit is called the "Training and Education Department." Established in 1970 as a result of a wildcat strike among hospital service employees,

¹The University of Chicago, "Fact Book" (published by D.J.R. Bruckner, Vice-President for Public Affairs, undated) p. 3.

²The University of Chicago Hospitals and Clinics, "Map for Patients and Visitors" (Division of the Biological Sciences and the Pritzker School of Medicine, undated), p. 15.
the inservice unit was established to upgrade employee skills in order to assist employees in preparing for promotion. The inservice unit is located in a building separate from the various hospitals and clinics.

University of Illinois at the Medical Center

The University of Illinois is a state supported institution encompassing three campuses--Urbana-Champaign, Chicago Circle, and the Medical Center, Chicago. The university had a total student enrollment in 1974 of 63,041.  

Founded in 1867, the University of Illinois opened its Chicago campus in 1945 as the Chicago Undergraduate Division. In 1896 the College of Pharmacy, chartered earlier as an independent school, was annexed to the university and thus became the first component of what was later to develop into the Medical Center campus.  

Today, the Medical Center campus includes teaching, research, patient-care, and service units in the health sciences. The campus is part of the Medical Center District on Chicago's near west side, one of the largest medical center districts in the world. The College of Nursing, the College of Medicine, the College of Dentistry, the College of Pharmacy, the Graduate College, the School of Public Health, the University Hospital, clinics and other units are located in the 40 acre area.  

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1 University of Illinois, "Reference Folder 1974-75" (Offices of Public Information, revised to November 1, 1974), p. 7.

2 Ibid., p. 24.

3 Ibid., p. 22.
The University Hospital is a 600-bed institution. Hospital facilities include the General Hospital, the Eye and Ear Infirmary, the Neuropsychiatric Institute and Orthopedic Hospital, as well as 36 outpatient clinics.¹

The "hospital-wide" inservice unit, known as the "Training and Staff Development" section, is one of eight sections comprising the Personnel Services office. Like the other seven sections, the inservice section "operates within University-wide policies, rules, and procedures with regard to nonacademic personnel."²

Records on the establishment of the inservice unit are unclear, but sometime in 1966 Personnel Services established the inservice unit for the express purpose of administering the tuition waiver and reimbursement program.

Training and Staff Development presents the new Employee Orientation Program several times a month, counsels on and administers the educational benefits for employees, as well as implements new training techniques and programs for everyone as needed. In addition, many of the personnel publications are done in this office.³

Presentation and Analysis of Research Data

The purpose of Chapter IV is to present the data collected through the interview guide as well as to analyze...

¹Ibid., p. 23.


³Ibid., p. 19.
and interpret the data collected. The analysis presents the seven "areas to be investigated" one area at a time and compares and draws inferences from the responses of the four inservice directors.

In order to present a complete picture of the administration of the "hospital-wide" inservice program at each institution, the research data are presented on an institution by institution basis. However, to preserve anonymity the institutions as well as the directors are not referred to by name, but rather labelled "A", "B", "C", and "D". The reader is advised that the answers to each question in the interview guide are presented vertically with the responses of director "A" always first, "B" always second, "C" always third, and "D" always fourth throughout the entire chapter. Multifaceted questions, such as 11 and 13 under "organizing," are presented in groupings, again with the responses of director "A" always the first grouping, "B" the second grouping, and so on.

Each "area to be investigated" is presented as follows:

1. Interview questions
2. Responses of directors
3. Analysis of data

I. Organizing

Interview questions
1. Do you report directly to more than one superior?
2. What is the title of the person to whom you directly report?
3. In general, what is your reporting relationship to your superior?

4. What other programs report to your immediate superior?

5. How many levels is your immediate superior from the top administrator of the university?

6. Would you change your reporting relationship if you could?

7. What changes would you make?

8. Why or why would you not change your reporting relationship?

9. How does your superior view the inservice program?

10. What does your superior expect inservice to accomplish within the organization?

11. How does your superior facilitate or support your role:
   a. by personal participation in inservice projects
   b. by providing "public relations" on inservice to his peers
   c. by increasing your financial support
   d. other

12. How much time does your superior spend with you:
   a. individually
   b. together with others

13. What kind of discussion typically takes place when you meet with your superior:
   a. formulating plans
   b. giving information
   c. evaluating
   d. other

14. In general, how do your peers view your inservice role?

15. What do your peers expect the inservice program to accomplish?
Responses of directors

1. No
   No
   No
   No

2. Associate Administrator, Human Resources
   Director of University Hospitals and Clinics
   Personnel Director
   Vice President, Personnel Relations

3. highly informal; very open; inservice director very autonomous
   formal; inservice director autonomous
   formal
   very informal; inservice director very autonomous

4. director, employee relations; director, wage & salary administration: affirmative action coordinator
   4 Associate Directors (Finance, Nursing, Personnel, General Administration Service)
   seven other sections of the personnel department
   Personnel and Health Service

5. 3 levels from President
   2 levels from President
   4 levels from President
   2 levels from President

6. Yes
   No
   Yes
   Yes

7. access, but not accountability, to Vice-President level
   does not apply
   report to Vice Chancellor of Administrative & Related Services
   should be a training Vice-President

8. access to top decision makers/inservice unit to coordinate all training
   cannot be tied to representing personnel policies
   need a separate budget; more authority and easier project approval
   need status to be credible; training more viable outside personnel
9. as quite effective
promotes inservice; strong supporter & influencer;
more budget
he and his superior very supportive; views inservice favorably
views inservice as necessary but not a top priority

10. support his goals in solving corporate problems
as an educational resource: job enrichment; career and management development
upgrade skills; meet continuing education requirements
of allied health
produce more effective managers

11. No
No
Yes
leaves me on my own

Yes
Yes
Yes
speaks at inservice projects

No
Yes
Yes
acts as intermediary on inservice to his superior

No
Yes
No
No

12. 1 hour/week individually; 1 hour/month with my staff
2-3 hours/month with me; I'm not asked to attend
Admin. Staff meetings
very little individually; one time/month in a formal staff meeting
minimally with me; no staff meetings

13. No
Yes, very much
No
corporate problem discussion

Yes
Yes, mostly
Yes
exploration of where inservice is going
13. Continued

No
Yes, quite a lot
No
No
Yes
No
No

asks for my reactions to a given topic

14. those involved with us recognize us as a valuable resource; others do not understand us mixed reactions; we're interfering with them; but mostly, as a support service to them not as a key administrative position positively

15. they do not know varies: many want instant behavioral change; many look down on inservice staff, preferring outside "expert"
expect special training programs; management development; smoothly handled tuition waiver procedure expect us to train managers

Analysis of Data

The organization charts of each of the four institutions made it clear that the four inservice directors, while differing somewhat in title, were clearly established as part of the formal authority structure of the institutions, consistent with Gulick's theory of organizing. In fact, the inservice directors' superiors were located quite high on the organization charts, either two, three, or four levels from the president of the university! (Question 5.)

It was interesting to note, however, that three of the four directors wanted either to have access to, in the case of director "A", or to actually report to, in the cases of directors "C" and "D", an even higher level superior than they were currently reporting to (question 7). More credibility for the inservice program, more authority for the director, and more coordination of inservice within the institution were the reasons advanced by the directors for reporting to a higher level administrator (question 8). Perhaps the directors felt that the greater status they and their programs would achieve by reporting to a higher level administrator would in turn offset the mixed reactions of the directors' peers about the inservice program (question 14).

Two directors, in response to question 8, felt that inservice should be located outside the personnel department, while a third director implied a similar sentiment in expressing the wish for an inservice budget separate from the personnel budget (director "C"). It could be that the inservice directors have found that personnel directors have so many other crucial matters taking up their time—wage, salary and benefits administration, affirmative action, safety, disciplinary procedures and grievance procedures—that inservice thereby becomes a lower priority in the mind of the personnel directors.

There seemed to be two key factors about the reporting relationship of the inservice director to his superior
that are not directly tied to the formal organizational structure as such. First, is the person to whom the inservice director reports supportive of the inservice program and does the superior view inservice as a top priority? Together with the supportiveness shown by the superior seemed to come autonomy for the inservice director, viewed by three of the directors as necessary to their own role (question 3). Three of the four directors, in answer to question 9, felt that their superior was supportive of inservice, while director "D" felt, on the other hand, that his superior did not view inservice as a high priority. Consequently, it must be pointed out, both staffing and budgeting of the inservice program in institution "D" suffered. Director "D" had no inservice staff other than himself, nor did he have any input whatsoever into the budget preparation process (see section II, staffing, questions 12D and 13D, demographic question 13D, and section III, budgeting, question 5D).

The second key factor not directly related to the organizational structure as such was the nature of the relationship between the inservice director and his superior (question 3). Whether formal, as in institutions "A" and "D", or informal, as in institutions "B" and "C", the significant factor was that the relationship allowed the inservice director autonomy to make decisions on what the director felt was needed and how the director felt the needs were to be addressed (supported by the answers to questions
Peers of the inservice directors apparently held mixed reactions about the inservice programs. Peer reactions ranged from apathy and lack of understanding, through resentment that the inservice program was interfering with their own department, to a strong support of the inservice program as a valuable service (question 14). Likewise, peers of the inservice director either did not know what to expect from the inservice program (institution "A"), expected instant behavioral change from participants after completion of an inservice project (institution "B"), or were more realistic in their expectations (as it seems in institutions "C" and "D"), based on question 15.

The mixed reactions of peers of the inservice directors about the inservice program might perhaps be explained by a lack of thorough communication about the purpose and role of the inservice program by the inservice directors. It seemed a better job of communication had taken place in institutions "C" and "D" than in institutions "A" and "B". However, it must be noted in making this inference that institutions "C" and "D" offered fewer types of inservice projects than did institutions "A" and "B" (based on answers to question 13, section VI, directing). The possibility exists that it is easier to communicate more accurately one's objectives if one offers fewer inservice projects!
II. Staffing

Interview questions

1. What role do you play in hiring your inservice staff?

2. Is there a job description for each inservice staff position?

3. Is each inservice staff member responsible for a particular inservice area?

4. What criteria are used in filling an inservice staff vacancy:
   a. work experience
   b. educational background
   c. from inside or outside the institution
   d. previous hospital experience
   e. other

5. How and by whom are the above criteria determined?

6. What criteria are used in deciding to open a new inservice position?

7. How and by whom are criteria for adding a new position determined?

8. Are employees referred to you from other areas of the institution for consideration to fill an inservice vacancy?

9. Is moving into your program considered a promotion from within?

10. Who makes the final determination in hiring an inservice staff member?

11. Would you change the hiring process in any way if you could?

12. What changes would you make?

13. Why or why would you not change the process?

14. How and by whom are inservice staff oriented and trained on the job?

15. Is there an overall plan to develop inservice staff?
16. What role do you play in development of inservice staff?
17. What is the extent of the resources available to develop inservice staff?
18. How often do you meet with your staff:
   a. individually
   b. together as a group
19. In general, what is usually discussed in a meeting with your inservice staff?
20. What do you do to ensure that your staff works together as a team?
21. Would you change in any way your role in the development of your staff if you could?
22. What changes would you make?
23. Why or why would you not change your role?
24. In general, what type of evaluation of inservice staff takes place?
25. What role do you play in evaluating inservice staff?
26. What role do others play in evaluating inservice staff?
27. How often does evaluation of inservice staff take place?
28. Would you change in any way your role in evaluating your staff if you could?
29. What changes would you make?
30. Why or why would you not change your role?

Responses of directors

1. decide upon applications screened first by employment manager
does not apply

2. Yes
   Yes
   Yes
   Yes
3. Yes: 2 generalists and 3 specialists
   Yes
   Yes, basically
   does not apply

4. Yes
   Yes
   No
   No, prefer industrial experience
   training a detriment: want trainer using participatory techniques
   Yes
   No
   No, but would rather have outsider
   No, but helpful
   person with potential to develop
   Yes
   Yes
   No
   No
   No
   does not apply

5. inservice director
   inservice director, inservice staff, hospital director
   university Civil Service System
   does not apply

6. when work load of any trainer becomes 150%
   depends upon kinds and quantity of requests for inservice
   formal request to Civil Service Commission
   does not apply

7. inservice director
   inservice director and hospital administrator
   inservice director and personnel director
   does not apply

8. Yes
   Yes
   Yes
   does not apply

9. Yes
   Yes
   does not apply
10. inservice director

inservice director after consulting with hospital administrator
inservice director after consulting with employment office
does not apply

11. No
Yes
Yes

12. does not apply

involve representatives from other departments in hiring process
break away from Civil Service System
add staff (ideally 7 staff: 2 for management development and one each for research; admin. asst.; career ladders; community projects; and coordinator of technical inservice)

13. inservice director in best position to decide upon his staff
need more commitment and involvement from other departments
Civil Service System unwieldy
need to implement a comprehensive management development program

14. inservice director--meet individually one time/week
inservice director or assistant director and others with whom they'll be working
inservice director; personnel manuals; first experience in general orientation
does not apply

15. No--aim to hire trainers with developed skills
No
No, it is usually accidental
does not apply

16. solo and direct coaching with staff and awareness of outside conferences total
does not apply

17. consultations with inservice director; outside seminars limited coordination with University sources; outside conferences
free tuition at Ill. state schools; 100% reimbursement for job related courses elsewhere
does not apply
18. individually, one hour/week; as a group, very seldom individually, one time/week; weekly staff meetings individually, every day; as a group as needed, @ 2 times/week
does not apply

19. content and methodology of projects; other concerns in the training, instructing, learning process problem-solving; sharing information; budget decisions current projects; planning for future projects
does not apply

20. crossover in area of expertise to back up each other overlapping responsibilities; content of weekly meetings backup responsibility for each project; frequent and informal communication
does not apply

21. Yes
   Yes
   No
If I had staff, I would coach them, be available to help them, and involve them in planning and organization of the unit.

22. spend 2 hours/week in "train the trainer" workshop with staff; have not been able to hire polished trainers I'd like bring in outsiders to train staff in project development and assessment
does not apply
does not apply

23. to allow staff to become totally independent to provide for greater staff development want to keep communication with staff informal
does not apply
does not apply

24. written critique by project participants; formal yearly evaluation; using inservice director as sounding board for ideas group evaluation at weekly meetings; yearly formal evaluation; informal evaluation every three weeks evaluation 3 months after hiring and 6 months after hiring; then one time per year (departmental practice)
does not apply

25. total almost total almost total
does not apply
26. none
minimal
minimal
does not apply

27. performance evaluation 6 months after hire, then yearly;
informal evaluation, daily
every three months, informally
once a year, formally; daily, informally
does not apply

28. No
No
No
If I had a staff, I would support them highly at first,
preparing them to assume more responsibility
gradually.

29. does not apply
does not apply
does not apply
does not apply

30. it is working as is; adding class observation would
make trainers nervous
three month evaluation often enough
daily informal contact very workable
does not apply

Inservice director from institution "D" was asked, "Who
should hire, orient, train, and evaluate inservice
staff?" The answer was "the inservice director, who
might possibly delegate some or all of the functions
to others in the department."

Analysis of Data

The inservice directors interviewed had the authority
to hire, train, and evaluate their own inservice staff. (In-
service director "D" had no inservice staff, but when asked
"Who should hire, train, and evaluate inservice staff?"
responded, "the inservice director or his designee within the
department.")

Comparing questions 1 and 10 concerning who had the
authority to hire inservice staff, it was found that director "B" had a free hand in the hiring process, while directors "A" and "C" made the final decision, but only on referrals from the employment office.

Three directors wanted to change the current hiring process (question 11). Director "C", desiring more autonomy and flexibility in hiring, wanted to break away from the rigid civil service system (question 12). Director "B" expressed the wish to involve personnel from other departments in the hiring process in order to achieve increased commitment from other departments to inservice program efforts (questions 12 and 13). The desire for the participative approach was consistent with director "B's" wish to involve personnel from other departments in both needs assessment and in inservice project implementation (see section IV, planning, question 24B and section VI, directing, question 16B). Director "D" expressed the wish to have an inservice staff, and proceeded to list seven inservice positions that should be opened! (question 12D) The situation of director "D" seemed to be an example of the mistake pointed out by Harris and Bessent whereby an institution does not provide enough inservice staff to assure program effectiveness.1 Directors "A", "B", and "C" had, consistently enough, direct input into the

decision to open a new inservice staff position (question 7).

None of the directors felt that previous hospital experience, interestingly enough, was an important criteria for hiring staff, and in fact, director "A" preferred industrial experience (question 4). Director "A" was consistent in that he likewise preferred an industrial model for his entire inservice program, insisting, for example, that the inservice program be intimately linked with the corporate problem-solving process (section I, organizing, questions 10A and 13A, and section V, coordinating, question 19A). However, director "A's" inservice program was not, in fact, organized according to the industrial model. Director "A" admitted regretfully that "As a corporate problem-solver, we have not achieved our purpose." (section VII, reporting, question 14A)

While the inservice directors played a significant and, in two cases, a total role in training their own staff, it was interesting to note that in none of the four institutions was there a plan for developing inservice staff (question 15). The inference seemed to be that, in practice, the training of inservice staff was not a top priority of inservice directors. Yet director "A" admitted he could not hire the top-level trainers he would like to be able to hire (question 22A) and director "B" pointed out the need for staff to develop greater credibility with other departments (section I, organizing, question 15). Both of these situations might be improved through a more formalized and planned staff
training program. Even though directors "A" and "B" were not currently working with their staff in a formalized program of development, the same two directors expressed the desire to make staff development more of a priority. In answering question 22, director "A" expressed the wish to spend two hours per week with his staff in improving teaching methodology, and director "B" expressed the desire to bring in outsiders to help develop inservice staff in the areas of project development and assessment.

All four directors attended to their own professional development, either through reading, attending conferences, or attending specific credit courses, but even in the matter of their own development there seemed to be no formalized plan (demographic question 10).

While an approach taken by all four directors was to have each staff member be responsible for a particular inservice area (question 3), all inservice directors demanded a certain amount of overlapping responsibilities between staff. This overlapping of responsibilities allowed staff to fill in for one another, thus helping to build a spirit of teamwork within the department (question 20).

The combination of frequent, informal evaluations of staff coupled with a yearly formal evaluation of each staff member by the inservice director appeared to be an ideal approach (questions 24 and 27). Since that combination was utilized by all directors and since none of the directors
wanted to change their current approach to evaluation of staff (questions 28 and 30), the above conclusion may be drawn. Evaluation of staff seemed to be adequately addressed, but, as explained earlier in this section, the follow-up to evaluation, namely, staff development, was found somewhat lacking.

III. Budgeting

Interview questions

1. Do you have your own inservice budget?

2. Other than from a budget, where are funds for inservice obtained?

3. Does your program receive funding from outside sources?

4. Is there a cost charge-back to other departments for projects you run or develop for them?

5. What role do you play in preparing the inservice budget?

6. Do you have a lump sum or a categorical budget?

7. How do you determine how much money and into what categories inservice money is to be distributed?

8. Who is involved in approving the inservice budget?

9. What role do you play in the budget expenditure process?

10. Are there any limits imposed upon you in the budget expenditure process?

11. Would you make any changes in the current budget arrangement if you could?

12. What changes would you make?

13. Why or why would you not make changes in the arrangement?

14. Approximately, what proportion of the Medical Center operating budget is allocated to your inservice budget?

15. Do other departments have a budget for inservice?
16. Excluding salaries, approximately how much money have you spent on inservice projects within the past 12 months?

17. Excluding salaries, approximately how much money will you spend on inservice projects within the next 12 months?

18. Have you ever determined how much money a specific inservice project costs?

19. How do you make a determination of inservice project costs?

Responses of directors

1. Yes
   Yes
   No
   No

2. does not apply
   does not apply
   chancellor's account; some cost chargeback to departments; inservice is part of the personnel budget
   inservice is part of the personnel budget

3. No
   Yes: several contracts and grants
   No
   No

4. No
   No
   Yes
   No

5. total
   total, but involve inservice staff in process
   minimal--some estimation of financial needs for major programs
   none

6. categorical
   categorical
   categorical
   lump sum

7. using a grid, taking each project through each budget category
   assessing needs; projecting number of participants;
relying on past experience
submitting a request in all categories
no input

8. my superior; Admin. VP; Budget Committee; Management Committee
Hospital director; budget director; university board personnel director; Vice Chancellor for Admin. Service; University General Office
VP Personnel; Executive VP; Chief Executive Officer; Board

9. inservice director's signature only needed on form
either inservice director's or assistant director's signature on form
inservice director's signature and, in some cases, Personnel Director's signature
inservice director has no authority; VP Personnel signature only

10. No, am allowed to go over budget if justifiable
Yes, on capital expenditures; but can exceed budget
No
Yes, only up to amount budgeted for inservice

11. No
Yes
Yes
Yes

12. does not apply
budget savings should go into next fiscal year budget;
budget savings should go into capital equipment, if needed
take budget process out of the rigid system
definitely establish a separate inservice budget

13. present system very adequate
need incentive for fiscal responsibility
system unwieldy and complicated and too long a wait for payment
inservice director needs input into inservice budget

14. 0.0025 of corporate budget
unknown
very small
very, very little

15. Yes, for a department's clinical specialties; for continuing education
Yes, some departments
Yes, each college for continuing education; tuition
15. continued
refund money
Yes, clinical programs handled by specific departments

16. $125,000 including tuition reimbursement
$30,000 through inservice department; $80,000 through
grants and contracts
$5,000, excluding tuition reimbursement
$4,000, excluding tuition waiver

17. $150,000, including tuition reimbursement
$32,000, plus grant and contract money
$8,000, excluding tuition reimbursement
$60,000 (most of the money to come through Nursing
Inservice Department, which is coordinating an
expanded management development program)

18. Yes, every inservice project
Yes, some projects
Yes, some projects
Yes, some projects

19. actual compared with proposed costs; per participant
cost
teaching time; preparation time; materials; equipment;
use of facilities; food; books; tuition; released
time
instructor; equipment; supplies (have free use of
space)
facilities; materials; teachers; equipment rental;
food; printing; facilities (do not determine released
time cost)

Analysis of Data

In only two cases, institutions "A" and "B", did the
inservice director have authority to request and monitor a
budget adequate to achieve inservice purposes (questions 5
and 9).

Directors "A" and "B" possessed their own departmental
budget while directors "C" and "D" received their money through
the personnel department budget (questions 1 and 2). Because
of the budget arrangement, director "C" had to rely to some
extent either on cost charge-backs for inservice projects to other departments or on money obtained from the chancellor's account to supplement budget funds. Lack of adequate funding limited the ability of director "D" to offer varied kinds of inservice projects (see section VI, directing, question 13D) and to conduct projects in the fashion the inservice director deemed necessary (see section VI, directing, questions 16 and 17). Just as director "D" did not have what he considered adequate staffing (section II, staffing, question 12), so also did director "D" not have adequate budgeting, again hampered by the two major limitations to being able to conduct an effective inservice program pointed out by Harris and Bessent.

One result of the differences in approach between institutions to the inservice budgeting process was the vast difference in inservice expenditures in the four institutions. Institutions "A" and "B", which provided a separate budget for the inservice department, spent over $100,000 last year on inservice (including tuition reimbursement and waiver monies in institution "A" and outside grants and contracts in institution "B"). Institutions "C" and "D", which placed the inservice budget within the personnel department budget, spent $5,000 and $4,000 respectively on inservice in the past year (question 16).

The inference seemed to be that with his own budget, the inservice director can expect to spend a significantly
greater sum of money on inservice projects, a very tangible indication of institutional support of the inservice program. In support of this inference, director "D" stated that inservice was in fact not a top priority in the mind of his superior (section I, organizing, question 9D). Although director "C" stated that his superior and his superior's superior were supportive of the inservice program (section I, organizing, question 9C), it is possible that the hands of director "C's" superior were tied when it came to ability to appropriate more money for inservice, similarly indicating the relatively lesser degree of support by the institution for the inservice program.

Three directors wished to make a change in the current budget process (question 11). It was significant that director "A", who administered the largest budget of the four directors, was the only director who did not wish to change the current budget process! Directors "C" and "D", who did not have their own budget, expressed the wish to have a separate budget for their inservice program (question 12). Although director "C" stated in question 12 that the budget process should be taken out of the rigid civil service system procedure, director "C" had earlier stated explicitly the need for a separate inservice program budget (section I, organizing, question 8).

Apparently, projecting the exact cost of each inservice project was not expected by inservice directors' superiors as part of the budget procedure. While all four
directors had in fact costed-out some inservice projects (question 18), only director "A" had costed-out all of his inservice projects by formally linking that procedure to the process of budget preparation and administration (questions 7A and 19A). That the process of costing-out every project was not required of any of the directors, including director "A", was confirmed by the answers to question 3, section VII, reporting, in which the four directors stated they were not required to cost-out their inservice projects.

It was significant that two of the directors, "A" and "B", both of whom had their own budgets, had the authority to exceed their budgeted dollar amount (question 10). Director "C" was likewise able to exceed the budgeted dollar amount, but director "D" was not allowed to exceed the figure budgeted for inservice (question 10). The disparity may be an indication of a weaker overall budgeting process in institutions "A", "B", and "C" in that expenditures were allowed to exceed budget predictions. It is also possible that the disparity, on the other hand, may have indicated a higher demonstrated priority of the inservice program in the minds of inservice director superiors in institutions "A", "B", and "C" than that of the inservice director superior in institution "D". Or the disparity may have reflected a greater flexibility in the first three institutions which allowed the inservice program to respond to unanticipated inservice needs, possibly based on new legislation or new accreditation standards which
IV. Planning

Interview questions

1. Do you have a statement of overall inservice objectives?
2. What are your overall inservice program objectives?
3. What part did you play in designing inservice objectives?
4. In general, how do you decide upon inservice projects for the coming year?
5. What methods are used to identify needs for inservice:
   a. interviews with top administrators
   b. interviews with department heads
   c. interviews with supervisors
   d. interviews with employees
   e. surveys of employee attitudes
   f. work studies of employee performance
   g. informal conversations
   h. other
6. How often are needs identification methods utilized?
7. Are standardized reports utilized in the process of assessing inservice needs?
8. What kinds of standardized reports are utilized:
   a. turnover reports
   b. grievances
   c. formal complaints
   d. requests for transfer
   e. other
9. What is your role in the needs identification process?
10. Are personnel from other departments involved in identifying inservice needs?
11. Is there a formal inservice advisory committee?
    Inservice can be viewed as being both proactive and reactive. With this in mind,
12. Have you initiated any new projects within the past 12 months?
13. Taking one project as an example, what were the factors entering into the decision to offer the project?

14. Have you responded to any requests to offer inservice projects within the past 12 months?

15. Taking one project as an example, what factors entered into the decision to offer the project?

16. What role do you play in decisions to offer inservice projects?

17. How do you determine the priority of what projects to offer?

18. Are inservice projects planned to tie into identified career ladders?

19. Do you have a planning calendar to keep a record of inservice projects?

20. When will you decide what inservice projects will be offered in the future?

21. How will you reach decisions about projects to be offered?

22. In general, what kinds of inservice needs have you identified within the past 12 months?

23. Would you change in any way your role in the needs identification process if you could?

24. What changes would you make?

25. Why or why would you not change your role?

Responses of directors

1. No, want flexibility of objectives
   Yes
   No
   We are working on a statement

2. training/development/education; to provide projects to assist employees acquire knowledge, skills, attitudes which will improve patient care career mobility; skill development; management and organizational development management development; special courses; administer tuition waiver
2. Continued

management development; informal, vague objectives because we have not been required to spell out objectives

3. does not apply
inservice director and inservice staff arrive at specific project objectives with department heads involved
does not apply
sent out written survey to managers and conducted informal survey with managers

4. mostly, our impression of what is needed and requests from top administrators primarily, requests from other departments employee attitude survey; requests from other departments could talk to top management and supervisors; written surveys; keep abreast of current legislation

5. Yes
Yes
Yes
Yes
No
No
Yes
top administrator's decisions; skills inventories

Yes
Yes
Yes
Yes
Yes
Yes
No
Yes, mostly
advisory committees to various projects

No
Yes
Yes
Yes
Yes
No
Yes
No
5. Continued

Yes
Yes
Yes
No
Yes
No
Yes
top management requests

6. frequently—all methods are ongoing
had one formal attitude survey; ongoing interviews with
department heads and supervisors; written surveys do not always serve purpose: outdated and ambiguous
had one formal attitude survey; termination questionnaires; informal assessment is ongoing
written survey every two years; informal assessment, which is very valuable, is ongoing

7. No
Yes
Yes
No

8. does not apply

Yes, in some areas
No
Yes
No
No
Yes
No
Yes
No
No
does not apply

9. design survey technique and receive data uncovered
securing commitment from superior; explaining procedure
to managers; analyzing data (need a researcher)
direct entire process
plan, collect data, prioritize data, take to Personnel
Vice President who makes decisions on data

10. Yes, line supervisors administer skills inventory
Yes
Yes
Yes, informally
11. No, I disbanded committee because it would not take action
   No, but there used to be
   No
   No, but informal advisory committee to nurse inservice on which I act as coordinator and resource person

12. Yes
   Yes
   Yes
   No

13. based on top administrator and department head complaints we developed a project for a high patient contact department
    a department requested a specialized management development project, which we wanted to offer anyway--we developed the project
    need for a continuing and fully developed management development project does not apply

14. Yes
   Yes
   Yes
   Yes

15. reorganized and restructured into a more thorough package a project hastily put together by a department head
    at request of one department we offered a model program in human relations training
    poor morale, undefined reporting relationships in an area
    requests for conversational Spanish

16. usually, I hand down corporate dictum that a project will be offered
    coaching inservice staff in determining what they can handle and the parameters of the project
    curriculum development; instruction; coordination
    surveyed interest; arranged for course to be offered

17. #1 priority: requirements of federal and state legislation; #2 priority, specific, immediate need
    our perception of needs and what employees want--we determine what projects will be offered
    based on available resources, whatever will keep accreditation
    determine priorities based on written surveys
18. No, but we are developing a manpower planning program
   Yes
   No, but we counsel employees
   No

19. Yes
   Yes
   Yes
   Yes

20. some projects cyclical; some introduced as needed; some rejected
    during 3 month performance appraisal meetings with inservice staff
    during the summer quarter
    projects have already been decided upon (by others)

21. based upon corporate needs, inservice department capabilities, and political gains for inservice department
    together with inservice staff, our perceptions of institutional needs
    retain successful projects; respond to new requests
    decision made by Vice Presidents that all managers be trained--inservice director told to develop a 12-month plan

22. #1--interpersonal relations; #2--skills required of lay people in specialized areas; #3 knowledge required to become more corporate minded
    nursing career mobility; human relations
    upgrading clerical skills; supervisory skills series; performance evaluation
    grievances; wage and salary administration training; increased information seminars for employees

23. Yes
   Yes
   Yes
   No

24. involve more managers in needs analysis
    deal more with top administrators and involve more people in needs assessment
    inaugurate a workable inservice advisory committee
    does not apply
25. managers have prime responsibility to develop employees
to achieve more accurate feedback on needs
cannot uncover needs in isolation
inservice director has staff and resource role to
gather information and present information meaning­
fully to top management and abide by direction
given in survey

Analysis of Data

It appeared that the inservice directors had a decided
role in uncovering institutional inservice needs and in deter­
mining which of the needs were to be addressed through the
inservice program.

While all four directors planned the needs assessment
process, collected and analyzed data, only director "C"
stated he directed the entire needs assessment process (ques­
tion 9). Directors "A", "B", and "D", however, were very much
involved in the process from beginning to end and seemed to
come very close to directing the entire process.

Requests for inservice projects originating from
other departments were the primary rationale for developing
inservice projects in institutions "A", "B", and "C", although
some initiative was also taken by the inservice directors in
these institutions to offer projects either the director or
his staff felt to be necessary (questions 12 and 13).

What methods were utilized to uncover inservice needs?
Interviewing top administrators, department heads, super­
visors, and, sometimes, employees were the most utilized
methods in all four institutions (question 5). Indications
were, however, that the interview process utilized was
typically handled on an informal, rather than a formal, basis. Director "B" stated, for example, that informal conversations comprised the greatest source of needs assessment data (question 5B), while all four directors mentioned the "ongoing" nature of the interview process in question 6, seeming to imply the use of the informal interview rather than the formal, structured interview.

Standardized reports were typically not utilized in assessing inservice needs. Two directors, "A" and "D", made use of no formal reports whatsoever, while directors "B" and "C" made use only of turnover reports (in some employee areas) as well as formal complaints in the needs assessment process (questions 7 and 8).

Only one of the four inservice units, "B", had a written statement of inservice program objectives, although director "D" was helping put together such a statement (which statement, however, was to emanate from the Nursing Inservice Department) (question 1). While director "A" defended not having such a statement of objectives on the grounds of seeking to preserve flexibility in program objectives, it appeared that the lack of such a statement disseminated within the institution might very well have been indicative of a lack of communication about the inservice program, the effect of which was discernible in the "mixed" reactions of inservice director peers, an effect pointed out by the author earlier in the discussion in section I, organizing, questions 14 and 15. The lack of a statement of inservice program objectives
directly contradicted the approach advocated by Clement.\textsuperscript{1}

While none of the inservice programs had a formal advisory committee on inservice (question 11), all four directors involved personnel from other departments in identifying inservice needs (question 10). However, three directors, "A", "B", and "C", wanted to change their own role in the needs identification process by encouraging more involvement of personnel from other departments, especially top administrators and department heads. Director "C" wished to establish an inservice advisory committee! (questions 23 and 24)

The reasons advanced for involving other personnel differed somewhat (question 24), but two directors, "B" and "C", expressed concern that the inservice program could not accurately identify the real inservice needs of the institution in isolation from other departments. In retrospect, the decision of director "A" to disband his inservice advisory committee (question 11A) because the committee could not make needed decisions, may have been, at least from the aspect of communication between the inservice program and other departments, a mistake! Certainly, involving others in the needs assessment process would be consistent with the approach strongly advocated by Froberg as well as by Corbally, Jensen,

The very specific answers given to question 22, describing the inservice needs the directors identified within the past twelve months, provided an indication that apparently adequate needs assessment had taken place in all four institutions, in spite of the fact that the assessment methods utilized were more informal than formal. Adequate needs assessment was consistent with the approach to inservice advanced by Dorsett as well as by Dillon and by Heath.

The inservice needs identified in question 22 were directly related to the stated objectives of each of the four inservice programs (question 2). There was thus present a consistency between the areas of need addressed by the four programs and the overall directions which the four inservice programs had, in fact, taken. Furthermore, there was consistency between the needs identified and the specific projects implemented by the directors to address the needs (see section VI, directing, question 13 and compare with

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question 22 of this section). Apparently, once the inservice director was convinced of an inservice need, the director took steps to see that the need was somehow addressed!

V. Coordinating

Interview questions

1. To what levels of personnel do you provide inservice?

2. Are there any levels of personnel for which you are not allowed to provide inservice?

3. Are there any levels of personnel for which you do not provide inservice even though you are allowed to?

4. Does anyone else provide inservice for these levels?

5. Do you have any involvement either by assisting with, advising on, or coordinating inservice projects offered by other departments?

6. Are other inservice projects integrated in any way into your overall inservice efforts?

7. Does lack of integration affect your inservice efforts in any way?

8. What role do you play in determining what educational projects offered outside the Medical Center are beneficial to Medical Center personnel?

9. What role do you play in determining what Medical Center personnel are sent to outside educational projects?

10. Is there a tuition refund, waiver, or reimbursement program?

11. If so, what is your role in regard to this program?

12. If you have no role, who is responsible for coordinating this program?

13. How are participants selected for inservice projects?

14. What role do you play in the selection process?

15. Are records kept on employees who participated in your inservice projects?
16. Who keeps the records?
17. What use is made of the records?
18. Would you change in any way the role you play in coordinating inservice efforts in the institution if you could?
19. What changes would you make?
20. Why or why would you not change your role?

Responses of directors

1. staff employees; first level managers; middle managers
   staff employees; first line supervisors; department
   heads
   employees; first level supervisors; top management
   top administrators; department heads; first line
   supervisors; recently, employees

2. Yes, top level management and professional training
   No
   No
   No

3. Excluding levels in question #2, No
   Yes, trustees
   Yes, Nurse Inservice; Medical Education; middle
   managers (but beginning)
   Yes, top administration

4. Yes, Medical and Nursing School Deans and Nursing
   Inservice
   Yes, Nursing Inservice; inservice for ward clerks
   Yes, Nursing Inservice; College of Medicine (continuing
   education)
   Yes, Nursing Inservice; Medical Education; various
   inservice projects in departments)

5. No
   No, sometimes we do, but it is by exception
   No, we are just beginning at integration efforts
   Yes, I am used as a resource person for advice on
   inservice committees

6. Some, but they are exceptions
   Yes, dietary upgrading; overlapping areas, yes;
   technical, no
   No
   No, but we should be integrated
7. No, but hinders progress of institution: duplication of equipment and efforts
   No, but duplication of efforts; however, difficult to have all inservice report to one director--technical inservice should be separate
   No, but there is lack of coordination
   No, but duplication of efforts affects organization; I know what else is happening and schedule around other projects

8. None
   None, formally; sometimes we provide advice on programs
   None, unless we advertise an outside program
   None, formally; but informally give advice

9. only with employees taking academic courses for credit
   None--solely up to each department head
   None--departments fund outside conferences and determine employee eligibility
   None

10. Yes
    No, employees may only audit courses here
    Yes
    Yes

11. sole administrator of program, monies, and decision on employee eligibility
    does not apply
    full administration: recordkeeping and issuing waivers none

12. does not apply
    does not apply
    does not apply
    another person, in personnel area

13. selected by their department head, sometimes through supervisor recommendation; requirements of outside cooperating institution; demonstration of needed skills
    we interview to determine usefulness of course to employee
    various methods--depends on current top administration's attitude to inservice

14. only in management training: one-to-one interview with selected managers
    I formulate policy; inservice staff select participants for their own programs
14. continued

inservice staff interview employees for projects
inservice staff coordinate
I offer program; department head selects participants

15. Yes
Yes
Yes
Yes

16. inservice department
inservice department plus a copy to personnel and to
participants' supervisor
inservice secretary records notation on official
personnel file
inservice director

17. promotability; affirmative action; where inservice
money is going and what payoff we are receiving
career mobility; performance appraisal
promotability; when we try to identify management skills
already possessed; but really looked at very little
should be put in employee's official file

18. Yes
Yes
No
Yes

19. tie inservice efforts with manpower development; keep
track of an individual's progress; control Nursing
Quality Assurance
more centralization of efforts; more cooperation with
other inservice units
does not apply
one coordinator of all inservice, however, not necessary
to have all inservice staff "under one roof"; need a
written statement on inservice.

20. to develop a plan for competent staffing at all manageri-
ial levels
overcome duplication of staff and resources; to develop
a sound educational philosophy; to provide greater
inservice impact
inservice unit coordinates most inservice within insti-
tution; we need no coordination over Nurse Inservice
or Medical Education
to erase duplication of efforts and facilities and
audio-visuals; we need to be proactive, not reactive;
the institution is rambling in different training
directions
Analysis of Data

The data presented in this section displayed the fact that none of the four inservice directors coordinated all inservice efforts within their institutions.

Separating an institution's personnel into four distinct levels, based on question 1, the following categories resulted: employees; first line supervisors; department heads; and, top administrators. It was interesting to note that all four inservice programs provided inservice projects to both the employee and first line supervisory levels; three of the four programs provided inservice to department heads; and only two of the programs provided inservice to top administrators (question 3). In fact, inservice director "A" was not allowed to provide inservice to top administrators! It may be concluded that either administration wanted only lower level inservice needs addressed but was not quite willing to have its own needs addressed, or it may simply have been that there were in fact more pressing inservice needs found at lower personnel levels in the organizations than at the top. The author surmised that the typical situation may have been a combination of both of the above conclusions! Thus, the inservice programs had not reached the ideal of encompassing all employee levels as advocated by Brown.¹

In addition to the existence of the "hospital-wide" inservice program, all four institutions housed a separate Nursing Inservice Department which provided technical skill training and on-the-job orientation to nurses, as well as a Medical Education Department, typically located in the School of Medicine, which provided inservice to physicians (question 4).

At institutions "B" and "D" there was to be found some coordination between "hospital-wide" inservice program efforts and the Nurse Inservice Department, while in institutions "A" and "C" there appeared to be no coordination between the "hospital-wide" inservice program and Nurse Inservice (question 5). However, none of the four "hospital-wide" inservice programs were coordinated in any formal way with the Medical Education Department (question 5).

Similarly, there was to be found some, but very little, integration of efforts between the "hospital-wide" inservice program and either the Nurse Inservice Department or the Medical Education Department in institutions "A" and "B", while there appeared to be no integration of efforts among the three departments in institutions "C" and "D" (question 6). It may be that the large number of personnel employed by each of the study institutions as well as the rather scattered physical location of the various buildings comprising each Medical Center were both factors which tended to inhibit any efforts toward integration or coordination between the three major inservice departments.
While the four "hospital-wide" inservice directors felt that the almost complete absence of either coordination or integration of efforts between the three inservice departments had no effect on the "hospital-wide" inservice program as such (question 7), all four directors felt strongly that the consequent duplication of efforts had an adverse effect upon the institution itself. It may thus be concluded that more integration of efforts between the three major inservice departments--"hospital-wide," Nursing, and Medical--is, for the well-being of the institution, a necessity! This conclusion was supported by three of the inservice directors who specifically called for more coordination of efforts (question 6D and question 20B, C, and D). Coordination of inservice efforts was also proposed and strongly advocated by Walter, by Lucier, and by Keyes and Miles.¹

But should it fall upon the shoulders of the "hospital-wide" inservice director to coordinate all inservice efforts? The answer to that question varied. Three of the directors, "A", "B", and "D", felt that there should be a change in the role they currently played in coordinating institutional inservice efforts (question 18). However, none of the four

directors proposed that the "hospital-wide" inservice director should be the person responsible for the coordination! While director "A" wished to exercise control over Nursing Quality Assurance (which was handled by the Nurse Inservice Department), he wanted to exercise no control over Medical Education (question 19). Director "B" called for more centralization of inservice efforts as well as more cooperation between all inservice programs within the institution (question 19). While director "D" stated there should be one person responsible for coordinating inservice efforts, he distinguished coordination from control by stating that, "it is not necessary to locate all inservice staff under one roof" (question 19). Director "C" did not want to change the current role of the "hospital-wide" inservice director because the director in institution "C" did coordinate "most of the inservice" provided in the institution, and continued, "we need no coordination over nurse inservice or medical education" (question 20).

It thus seemed that in a complex organization such as a university-related Medical Center, control over all inservice efforts is not and apparently should not be a function of the "hospital-wide" inservice director, the exhortations contained in the literature notwithstanding! Rather, a more workable system or procedure of coordination of efforts between the three major inservice departments--"hospital-wide" nursing, and medical--must be found!
VI. Directing

**Interview questions**

1. Is there a statement on inservice in the overall institutional objectives?

2. Is inservice implied as an institution objective?

3. Are there institutional policy statements on inservice?

4. Who determined the inservice policies?

5. What role did the inservice director play in determining inservice policies?

6. Does the presence or absence of inservice policies have any affect on your program?

7. Assume you have decided on the need for a particular inservice project. What must you now do before determining how to implement that project?

8. Do you have any role in determining whether attendance at your inservice projects is voluntary or mandatory?

9. What is your role in determining the logistics of time, place, participant mix, content, methodology, materials, and announcement of inservice projects?

10. Are others outside the inservice program involved in the determination of logistics?

11. Do you bring in outsiders to develop or conduct projects:

   a. people outside the institution
   b. people within the institution but outside your program

12. Why or why do you not bring in people outside your program?

13. What kinds of inservice projects have been or are being conducted under your control:

   a. new employee general orientation
   b. new employee departmental orientation
   c. entry level skills training
   d. basic supervisory development
   e. basic managerial development
13. Continued
   
f. continuing education  
g. refresher training  
h. safety training  
i. G.E.D. classes  
j. basic education other than G.E.D. classes  
k. english as a second language  
l. other  

14. For any of the projects you have developed or have knowledge of, how was the necessity for the projects determined?

15. Would you change in any way your role in deciding upon and implementing inservice projects if you could?

16. What changes would you make?

17. Why or why would you not change your role?

Responses of directors

1. No  
   No  
   No  
   No  
   No

2. No, lip service from above, but informally recognized  
   Yes, based on "teaching" mission of the University  
   Yes, since we are an educational institution  
   Yes, general statement on "education" as a mission of the hospital

3. No  
   Yes  
   Yes  
   Yes, on tuition reimbursement only (Nursing Inservice and Management Development have policies, however)

4. does not apply  
   inservice advisory committee (no longer exists)  
   university trustees and president  
   vice-presidential level

5. does not apply  
   inservice director set up advisory committee  
   none  
   none
6. **none at all**
   it is helpful to have the guidelines we have
   it is helpful to us that we have top level backing
   without written policies, inservice unit lacks
   credibility and visibility

7. **discuss with department head the project idea; write**
   a detailed, formal proposal; negotiate proposal
   with involved decision makers; then we determine
   logistics
   inservice director meets with hospital administrator
   and then confers with department heads who are to
   be affected
   need permission of hospital director for new programs
   for a project for one department, inservice director
   has total control; for hospital-wide needs, per-
   mission of superior needed

8. **Yes, we determine who enters our classes**
   Yes, some projects mandatory, others voluntary; but
   decision on participants is that of each department
   head
   No, all projects are voluntary
   No, decision made by top management

9. **total**
   in conjunction with other department heads involved
   everything is coordinated by inservice unit
   on decisions of "how" I have had almost total role;
   now there is a new committee (I have lesser role)

10. **Yes--minimal, i.e., person who schedules classrooms**
    Yes--with department head affected
    Yes--supervisor and department head permission needed
        and clearance from room scheduler
    Yes--Organizational Development Committee

11. **Yes**
    Yes
    No
    Yes
    Yes
    Yes, all the time
    Yes
    Yes
12. need for specialized expertise; relieves inservice staff of responsibility to conduct all sessions of a project needed expertise; less expensive; insiders who are skilled and enjoy teaching thereby become backers of inservice unit could not engage in breadth of projects without outsiders outsiders seem to be more credible; have a fresh approach; can talk about sensitive areas

13. Yes No No Yes Yes, middle management on a one-to-one basis Yes No Yes Yes No Yes Yes several others

Yes Yes, by advising departments Yes Yes Yes Yes Yes Yes Yes Yes Yes career mobility projects

Yes No, but we issue a checklist No Yes No, but we are beginning Yes Yes Yes No Yes Yes Yes No
13. Continued

Yes  No  No  Yes  Yes  Yes  No  No  Yes  No  Yes  Yes, a few others

14. some basic to a hospital; some by request
union demands; requests by others
subjective judgment, usually made by inservice unit
staff
some are obvious needs; others arise as situation
changes

15. No  Yes  Yes  Yes

16. does not apply
more internal public relations by involving all depart-
ments other than the four or five we usually work with
advisory committee to inservice unit
strengthen role of inservice director in implementing
management development projects

17. use of detailed project proposal is best way of
obtaining basic parameters of a project
we need to ferret out other needs
cannot accurately uncover needs and implement projects
in isolation
need to make inservice projects more educationally
sound

Analysis of Data

The data gathered indicated that the inservice direc-
tors had the authority to undertake inservice projects as well
as to decide how inservice projects were to be implemented.
Directors "A", "B", and "D" conferred with other department heads involved in a proposed inservice project on the actual implementation of the project, while directors "B" and "D" also conferred with their superiors in initiating new projects (question 7). Director "C" needed permission of the hospital director, who was not director "C's" immediate superior, in order to implement new inservice projects.

In determining inservice project logistics, three directors, "A", "C", and "D", exercised almost total or, in fact, total control, while director "B" determined project logistics in conjunction with the department heads involved in the proposed project (question 9). The fact that inservice project logistics were in all four cases, no matter what the approach, well thought out in advance was consistent with the principles advocated by Nagle.\(^1\)

Again, just as the directors involved personnel from other departments in the process of determining inservice needs (section IV, planning, question 10), three of the four directors, "B", "C", and "D", utilized fairly extensively the participative approach to inservice project implementation (question 10). So strong was the desire of the three directors to involve personnel from other departments as much as was feasible that two directors, "B" and "C", wished to involve even more personnel in the project implementation.

process, "B" by consulting personnel in departments other than the four or five departments typically affected by current inservice projects, and "C" by initiating an advisory committee to the inservice program (question 16).

It was noteworthy that director "B", who typically was the most participatory of the four directors, as well as director "C", who together with inservice staff, completely determined project logistics, in effect, the least participatory of the four directors, both felt the need for increased participation of personnel from other departments in project implementation! Again, the reason for desiring more participation from outsiders in project implementation was important. The more isolated the inservice program was from personnel in other departments, the less accurate and the fewer the number of inservice needs uncovered or properly addressed (question 17).

None of the four institutions had propounded an overall statement on inservice (question 1), although three of the four inservice directors, "B", "C", and "D", felt that inservice was implied in the context of the general statement on the "teaching mission" of the university (question 2). However, the interpretation that the "teaching mission" statement implied the need for inservice was quite likely a meaningful and valid interpretation only for the director and staff of the inservice program! Since university mission statements are, in general, at least in interpretation, as
old as the university itself and since none of the inservice programs studied was older than twelve years, it seemed to be highly questionable to insist that those who currently promulgate the "mission statement," that is, the university trustees, hold the same interpretation of the meaning of the word "teaching" as did the inservice directors! In fact, director "A" felt that inservice was not only not implied as an institutional objective, but that inservice was merely paid lip service by top administration. Yet institution "A" had promulgated a general mission statement on "teaching"!

On the other hand, the same three directors who felt that inservice was implied as an institutional objective, namely, directors "B", "C", and "D", pointed to the fact that there were in existence institutional policy statements on inservice (question 3,) although, interestingly enough, only one institution, "B", solicited inservice staff involvement in the process of determining policy statements on inservice (question 4). It is possible that because institutions "B", "C", and "D" had promulgated policy statements on inservice (even though the policies in institution "D" dealt simply with tuition reimbursement), the inservice directors in these three institutions felt that inservice must therefore be implied as an institutional objective.

Director "A" claimed that the absence of inservice policies had no effect upon the inservice program, while director "D", on the other hand, lamented the fact that lack of
inservice policies on items other than tuition reimbursement was a major factor in the lack of credibility and visibility of the inservice program itself (question 6). The two directors whose institutions promulgated extended policy statements on inservice, institutions "B" and "C", insisted that the presence of inservice policies was very helpful to their inservice efforts (question 6). It was apparent that, like staff and budget, and notwithstanding the insistence of director "A" that the absence of inservice policies had no effect on his efforts, inservice policies were another tangible indication of an institution's true commitment to inservice.

It was noteworthy that all four directors brought in outsiders to assist in implementation of inservice projects (although director "B" utilized only "outsiders" who were however, within the institution itself) (question 11). The reasons for utilizing outsiders varied: the need for specialized expertise ("A", "B", and "C"); the fact that outsiders seemed to hold more credibility than those from inside, tended to bring with them a newer approach to a question, and were able to more comfortably address sensitive issues ("D"); and, again, displaying the advantages of the participatory approach, the fact that personnel from other areas of the institution who assisted in inservice projects soon became ardent supporters of the inservice program itself ("B")! (question 12)
VII. Reporting

Interview questions

1. Do you account to your superior on the time, money, and effort you expend on inservice?

2. How do you prepare this accounting?

3. Must you and do you cost out individual inservice projects?

4. By what means do you accomplish the costing out of projects?

5. What criteria do you use to make a judgment on whether your overall inservice program is successful:
   a. fewer accidents
   b. fewer grievances
   c. savings in money
   d. savings in time
   e. fewer absences
   f. less turnover
   g. fewer complaints
   h. fewer transfer requests
   i. better morale
   j. more requests for inservice projects
   k. less use of sick time
   l. other

6. Do you evaluate each of your inservice projects?

7. In evaluating your projects, what do you look for:
   a. participant reaction to the project and the instructor
   b. conceptual learning by the participant
   c. changes in participant behavior in the classroom
   d. on-the-job changes in participant behavior

8. In evaluating your inservice projects, what methods do you utilize:
   a. testing
   b. written survey of participants at completion of the project
   c. interviews with participants
   d. interviews with participants' superiors
   e. interviews with participants' subordinates
   f. other
9. How are project evaluations compiled?

10. Are the summaries of project evaluations disseminated within the institution?

11. To whom are project evaluations disseminated?

12. Why was the "hospital-wide" inservice program begun?

13. Has the inservice program accomplished the original purpose?

14. On what do you base your answer?

15. Would you change in any way the role you play in evaluating your inservice program or projects if you could?

16. What changes would you make?

17. Why or why would you not change your role?

Responses of directors

1. No, except for expenditures over budgeted amount
   Yes
   Yes
   Yes

2. a verbal explanation
   verbally, usually; a written proposal when more money needed
   formalized monthly report; after every project, a written copy of evaluations
   check with superior on large expenditures on projects

3. No
   Yes, all

   No
   Yes, some

   No
   Yes, some

   No
   Yes
4. matrixing inservice projects against all budget categories
   materials; salaries; facilities
   materials; salaries; software
   facilities; equipment; supplies

5. No
   No
   No
   No
   No
   No
   No
   No
   No
   No, hard to measure
   Yes
   No
   subjective judgments by department heads on increased productivity of project participants
   (it is too premature to use statistical criteria because of lack of accountability of department heads to top management)
   No
   Yes
   Yes, for example, it costs less to upgrade nurses than to hire new nurses
   No
   Yes, in some
   Yes
   Yes
   No
   Yes, it has been reported
   Yes
   No
   No
   No
   No
   No
   No
   No
   Yes
   Yes
   Yes
   Yes
   Yes, biggest factor
   No
   No
5. Continued

No
No
No
No
No
No
No
Yes
No
No
(we have not been asked by top management to evaluate on-the-job effects)

6. Yes
Yes
Yes
Yes

7. Yes
No
No
No

Yes
Yes
Yes
Yes
Yes
Yes
Yes
No

Yes
Yes
Yes
No

8. No, in very few projects do we test
Yes
Yes, only with random sample after orientation
No
No
reactions of instructor to project
8. Continued

Yes
Yes
Yes
Yes
Yes
instructor's own evaluation

Yes
Yes
Yes, by telephone
No
No
No

Yes, some
Yes
No
No
No
No

9. summarized statistically and narratively
in a summarized format
hand tabulated by project instructor
all summarized, usually at end of project, but,
recently, after each session

10. Yes
Yes
Yes
Yes

11. confidential report to those intimately involved with
project, i.e., those who have a need to know
only to the person who asked for the project
instructors; chancellor
participants; Vice President of Personnel; Executive
Vice President; Chief Executive Officer

12. evolved because other corporations had inservice units
result of a wildcat strike--demand to upgrade skills
to administer tuition waiver program
as a result of a unionization attempt and general
criticism of hospitals for not training employees

13. Yes
Yes
Yes
No
14. originally, a narrow purview of rationale for existence of inservice unit (but as a corporate problem-solver we have not achieved purpose) has addressed career mobility (we are not entering more heavily into job enrichment and management development) an ongoing effort; number of employees involved in tuition waiver program keeps increasing we have a long way to go in entering new areas of need

15. Yes
Yes
Yes
Yes

16. quadruple evaluation procedures and project validation coach staff more closely on when and how to evaluate measure on-the-job results of projects organization-wide setting of objectives with inservice unit as coordinator

17. to upgrade quality of projects and tie into corporate problem-solving to be able to make needed changes in projects to achieve more accurate project evaluation beyond paper response for more systematic tie-in of inservice unit with running of corporation

Analysis of Data

It was apparent from the data gathered that the inservice directors both evaluated and reported on the accomplishments of the inservice programs. This effort at program appraisal was consistent with the principles advocated by Parker.¹

Three directors, "B", "C", and "D", made an accounting to their superiors on the time, money, and effort expended on

the inservice program (question 1). Director "A" accounted to his superior only when the director found he had to exceed his budget (question 1A).

The accounting was verbal and informal in the cases of directors "A", "B", and "D", and took the form of a written monthly report in the case of director "C" (question 2). Again, confirming question 18, section III, budgeting, none of the inservice directors were required to cost-out their inservice projects (question 3).

It would appear that evaluation of the inservice program itself was not a top priority in the minds of the superiors of the four inservice directors, first, because evaluation itself was typically informal and second, because in response to question 13, section I, organizing, "what kind of discussion typically takes place when you meet with your superior?", three of the directors, "A", "C", and "D", responded "No" to the statement, "evaluating"!

In addition, very few specific, measurable criteria were used by the inservice directors themselves in judging the overall effectiveness of their inservice programs (question 5). The only criterion that all four directors used as an indicator of inservice program success was "more requests for inservice projects," perhaps in the short run and given only informal evaluation requirements by their superiors, a very important criterion! However, the use of limited criteria in evaluating the inservice program itself fell short
of Froberg's principle of "careful and continuous evaluation."\(^1\)

There was much more evaluation at the inservice program level, however, of individual inservice projects. All four directors said they evaluated each of their inservice projects (question 6). There was wide variation, though, in the methods used to evaluate the projects (question 8). All four directors made use of a written evaluation form completed by project participants at the completion of the project. Three directors used testing of participant retention of content, and three directors interviewed participants after completion of the project. However, only one director, "B", interviewed both superiors and subordinates of project participants after completion of a project. It was quite possible that the amount of time and effort required to hold follow-up evaluations, especially through the interview technique, was the reason that such interviews typically were not included in the evaluation procedure of three of the four directors.

All four directors saw to it that project evaluations were summarized and disseminated within the institution to those who had a "need to know" (questions 9, 10, and 11). It was noteworthy that evaluation summaries were treated as confidential and privileged material, presumably as a safeguard to both participants and instructors. As a result, the

\(^1\) Froberg, Guide, p. 7.
dissemination of project evaluations was quite limited, another instance of limited communication, albeit for a reason, about the inservice program within the institution, the effects of which were outlined in Section I, organizing, questions 14 and 15. It may have been advantageous for inservice directors to consider publicizing a general summary after the completion of an inservice project about the project itself, the number of participants, and the like, simply as an internal "public relations" device!

It can be safely concluded that evaluation of inservice projects was typically handled in a somewhat limited fashion (question 7). The major thrust of the evaluation process centered on what happened within the confines of the classroom. All four directors, for instance, sought written participant reactions to the project. Three directors, "B", "C", and "D", looked for participant learning and behavioral change within the classroom.

However, the wider issue of whether inservice had any effect on participant behavior back on the job was not addressed at all in three of the institutions, "A", "C", and "D". Only director "B" said that "on-the-job change in participant behavior" was looked at in evaluating an inservice project. It may be inferred that because it is relatively easier to assess participant reaction to a project as well as to assess learning and behavioral change in the classroom, and because it was much more difficult to assess what happens back at the
work station, inservice directors tended to lean toward assessing the former to the almost complete neglect of the latter. Indeed, the two primary means of ascertaining the on-the-job effects of an inservice project, as mentioned earlier in this section, were the very means that three of the four directors did not, in fact, utilize, namely, interviews after the completion of a project with either the superior or the subordinates of project participants (question 8)!

All four directors, alluding to the need for greater efforts in evaluation, wished to change their role in project evaluation (question 15). Director "A" wanted to "quadruple" evaluation and project validation procedures; director "B" wanted to achieve greater depth in evaluation; and director "C" explicitly stated that on-the-job results of inservice projects ought to be ascertained (question 16). Director "D" wanted a change to effect a more systematic linking of the inservice program with the administration of the Medical Center, with the inservice director coordinating an organization-wide process of setting objectives! (questions 16D and 17D) The more in-depth approach which the inservice directors seemed to want would have brought the inservice programs closer to the kind of evaluation process advocated by Brimm and Tollett.¹

It was interesting to note that all four inservice programs were originally established to achieve what the four directors felt was a limited purpose, which purpose, however, the directors felt had been accomplished (questions 12 and 14). All four directors stated that more inservice needs than those originally seen at the inception of the inservice program had since been uncovered and were currently either being addressed or in the process of being addressed. This seemed to imply that once the inservice program was established, the program, under the thoughtful leadership of the inservice director, began to take to itself greater and wider responsibilities.

Summary

The purpose of Chapter IV was to present, analyze, and interpret the data collected by means of the case study involving four "hospital-wide" inservice programs located in university-related Medical Centers. The data, obtained primarily by means of a detailed interview guide administered by the author to the four "hospital-wide" inservice directors, were analyzed by comparing the current role the directors played in administering their inservice programs with the directors' perceptions of changes they would have liked to make in their current role.

The data presented in Chapter IV, together with the review of the related literature in Chapter II, was assembled in order to achieve the purpose of the study, namely, to
present an original model depicting a well organized and administered "hospital-wide" inservice program. The original model, together with other conclusions and recommendations, is presented in Chapter V.
CHAPTER V
CONCLUSIONS, RECOMMENDATIONS, AND
PRESENTATION OF MODEL

Introduction

While the trend in hospitals in the 1970's has been to establish a "hospital-wide" inservice program, there has appeared in the literature no set of research-based guidelines which adequately depicts how to effectively organize and administer the "hospital-wide" inservice program.

Guidelines, to be most useful to inservice directors attempting to develop a "hospital-wide" inservice program, ought to take the form of a model.

In response to the need for such a model, the purpose of the study was, in fact, to develop an original model depicting an effectively organized and administered "hospital-wide" inservice program. In order to achieve the purpose of the study, the author reviewed the related literature on inservice, both in the health care and the education sectors, as well as conducted an in-depth case study of four established "hospital-wide" inservice programs located in university related Medical Centers.

The full procedure followed by the author in conducting the study consisted of eight distinct stages:
I. General plan and methodology
II. Review of the related literature
III. Development of the interview guide
IV. Field testing of the interview guide
V. Conducting the investigation
VI. Analyzing the data
VII. Development of the model
VIII. Validation of the model

Major Conclusions of the Study

A number of conclusions were drawn by the author under each of the seven "areas to be investigated" in Chapter IV. Of those conclusions reached by the author, several conclusions, explained more fully in chapter IV, are highlighted here as especially important.

1. Inservice directors felt that the inservice program, while a "personnel-related" function, should be separated from the personnel department itself. In their view, the inservice director should report to an administrator other than the personnel director.

2. Inservice directors felt that it was extremely important that they report to a high level administrator, typically an administrator no less than three levels from the president of the university.

3. Inservice directors preferred a relationship with their superior which would allow the director the autonomy and the authority necessary to make decisions on inservice
needs and project implementation within the institution.

4. Inservice directors felt it essential that they have the authority to make the final decision on hiring inservice staff and felt the director himself should take the major responsibility for both training and evaluating inservice staff.

5. Inservice directors expressed the wish to have a separate budget for their inservice program. This budget arrangement would provide the director with needed control over both budget preparation and budget expenditures.

6. The major responsibility for uncovering inservice needs rested with the inservice director, although typically the directors felt the need to involve personnel from other departments in the needs assessment process.

7. The needs assessment process seemed to be conducted more on an informal, rather than a formal, basis, typically by relying almost completely on the use of the unstructured interview.

8. The term "hospital-wide" seemed to carry the meaning, "cross-departmental." All four institutions housed not only a Nursing Inservice Department and a Medical Education Department, but also various other pockets of inservice activity in addition to the "hospital-wide" inservice program. What typically differentiated the "hospital-wide" inservice program from all other inservice programs and activities was the fact that the "hospital-wide" inservice program was the
only program responsible for conducting inservice projects which crossed departmental lines! Personnel from many hospital areas were participants in the various "hospital-wide" inservice projects.

9. There was found to be very little coordination or integration of "hospital-wide" inservice efforts with inservice projects undertaken by either the Nursing Inservice or the Medical Education Departments. Inservice directors unanimously felt that such lack of coordination of efforts adversely affected the institution.

10. Inservice directors felt that there should be a concerted attempt made to achieve more coordination of inservice efforts between the three major inservice programs.

11. The lower the level of the employee in the four institutions, the more likely was he to be the recipient of "hospital-wide" inservice efforts. Conversely, the higher the level of the employee, especially a department head or a top administrator, the less likely was he to be a recipient of "hospital-wide" inservice efforts.

12. While the final responsibility for the implementation of inservice projects rested with the inservice directors, the directors typically felt that there should be involvement of personnel from other departments in helping to determine some of the logistics of implementing inservice projects.

13. It was found to be quite helpful to the efforts
of the inservice directors to have institutional policy statements on different aspects of the inservice program.

14. The evaluation of the inservice program expected by the superior of the inservice director typically was informal and verbal. As a result it seemed that evaluation procedures utilized by inservice directors themselves were typically informal and limited in scope!

15. Evaluation of inservice projects typically centered around what took place in the "classroom" itself. There was minimal attempt to address the wider question, "What were the results of inservice projects on the behavior of project participants when they returned to the job?"

16. There was found to be a distinct trend whereby inservice programs, after having been in existence over a period of time, tended to take to themselves ever greater and wider inservice responsibilities.

17. The literature reviewed stressed the necessity for the establishment of an organized inservice function both in the educational as well as the health care sectors, and usually in terms of better service to the institution's clientele, namely, the student or the patient.

18. The literature on health care inservice stressed the necessity of establishing an "over-all" inservice function, whether in the form of one person or one department, which would be responsible for coordinating inservice efforts within the institution.
19. The need for thorough planning in the form of needs assessment as the first step in implementing an effective inservice program was emphasized by a majority of the authors writing on inservice.

20. A repeated exhortation in the literature, especially in the literature on inservice in the education sector, was the involvement of others, especially those who would be affected by inservice efforts, in the planning, implementation, and evaluation of inservice projects.

The Model

Introduction

The original model presented here was devised by the author after comparing the related literature (summarized in Chapter II) with the data collected and analyzed in Chapter IV under each of the seven "areas to be investigated." The model reflects both the current state of the art of administering the "hospital-wide" inservice program and particularly the perceptions of the four directors on the ideal state of the art.

The first draft of the model was sent to seven inservice directors for validation. The directors included the original jury which assisted in the validation of the interview guide as well as the four inservice directors interviewed in the study.

The author sought the reactions of the directors to the content as well as the format of the model: the clarity
or ambiguity of the model; the scope of the model; the practicality of implementing any portion of the model; the consistency of various statements with one another; and the adaptability of the model to each director's particular institution.

Appropriate changes in the form of additions, clarifications, and deletions were made by the author after receiving the reactions of the directors.

The model is offered as a guide to be utilized in either establishing or in expanding the "hospital-wide" inservice program. The author realizes that because of circumstances within a given institution the model may not be able to be adapted intact. Rather, the sound judgment of the inservice director must pervade the selective and judicious application of the model to his particular inservice program and institutional circumstances.

"Hospital-wide" Inservice Director: Role and Responsibilities

As a necessary prerequisite, the "hospital-wide" inservice program to be effective must have genuine commitment from top administration. The commitment must be verbal in the form of institutional policy statements on inservice as well as tangible in the provision of adequate facilities, budget and staff which allow the "hospital-wide" inservice director to accomplish the purposes of the inservice program. In addition, top administrators must realize that the
"hospital-wide" inservice program in its efforts to address institutional needs will and should expect to be able to include under its purview all personnel within the institution, including top administrators themselves!

It is necessary that one person, namely, the "hospital-wide" inservice director, be invested with the responsibility for directing the "hospital-wide" inservice program. Without one person clearly designated as the director of the program, inservice will be little more than a "series of unrelated, uncoordinated, discrete lectures," the situation deplored by Schechter and O'Farrell.¹

Organizing²

The "hospital-wide" inservice program performs a "personnel-related" function in that it addresses the area of human resources development. However, it is crucial to the autonomy necessary for the inservice director to function effectively that he report not to the personnel director but rather to a higher level administrator. This higher level administrator should be at least at the Vice-Presidential level in the case of a university-related Medical Center (for example, Vice-President of Human Resources) or the Assistant


²In the context of the model, "Organizing" addresses the organizational structure in which the "hospital-wide" inservice director operates.
Hospital Director level in the case of a non-university
related hospital. The "hospital-wide" inservice director
himself should be located at no less an administrative level
than that of the personnel director. The "hospital-wide"
inservice director should be at least on a peer level with
both the Medical Education Director and the Nursing Inservice
Director.

Staffing

The "hospital-wide" inservice director must have full
authority to make the final decision on hiring his own in­
service staff, even though others may be involved in the
interview process.

In organizing his own department, the inservice di­
rector should assign specific duties to each inservice staff
member, taking care to provide some overlapping of responsi­
bilities in order to achieve a team approach within the
department.

In addition, the inservice director should devise and
see to the implementation of a plan for continuous development
of his inservice staff, especially in the areas of classroom
techniques and methodology as well as methods of both project
and participant evaluation. This plan for staff development
should combine on-the-job training as well as attendance at
outside workshops and courses.

The inservice director must also frequently evaluate
his staff, utilizing both formal and informal procedures.
IDEAL ORGANIZATIONAL RELATIONSHIP OF THE
"HOSPITAL-WIDE" INSERVICE DIRECTOR
TO OTHER ADMINISTRATORS

Vice-President, Human Relations or Assistant Hospital Director

Personnel Director

"Hospital-wide" Inservice Director

Director, Medical Education

"Hospital-wide" Inservice Staff

Other department heads

Director, Nursing Inservice

Key: --- peer relationship
     --- superior-subordinate relationship
Ideally the "hospital-wide" inservice director should have a separate budget which he submits directly to the budget director. However, in order to prevent a proliferation of smaller budgets within the institution, the ideal budget situation may be neither feasible nor desirable. Thus, even though the inservice budget may be contained within a broader budget, for instance, the Vice-President or Hospital Administrator's budget, it is essential that the inservice director have direct input in determining the specific dollar amount allocated to the "hospital-wide" inservice program. The dollar amount designated for the inservice program must be so situated that it cannot be touched by the director of any other program contained within the broader budget.

Likewise, should there be a need to cut the dollar amount budgeted for the inservice program, the inservice director should alone make the decision on what specific categories should be cut and by what amount.

It is also essential that the "hospital-wide" inservice director have sole authority to monitor and disburse the funds allotted to the "hospital-wide" inservice program.

The "hospital-wide" inservice director should also explore the feasibility of securing outside funding, in the form of grants or contracts, for his inservice program.
Planning

The "hospital-wide" inservice director must assume final responsibility for uncovering inservice needs as well as deciding upon what inservice needs are to be addressed. It is crucial, however, that the inservice director seek out ways of involving as wide a cross-section of personnel from other departments in the needs assessment process as possible in order to achieve more accurate and thorough assessment.

In assessing needs, the inservice director must be careful to distinguish inservice needs from either systems needs (inefficient procedures or operations) or administrative needs (ineffective managers), neither of which can be effectively addressed by inservice projects alone.

Coordinating

Ideally, the "hospital-wide" inservice director ought to exercise control over all inservice efforts undertaken within the institution. Such control would make the coordination and integration of inservice efforts, an enviable ideal, a more likely reality than would the absence of such control.

However, because of the organizational structure within a given institution, the existence of a separate Nursing Inservice Department and a Medical Education Department, it may be a long time before the ideal situation outlined above becomes a reality (if, indeed the ideal situation ever becomes a reality!) Given the situation of the existence of
three separate inservice departments, "hospital-wide", Nursing Inservice, and Medical Education, the following arrangements ought to be present.

As a means of ensuring coordination of all the various inservice efforts necessary to the smooth functioning of the institution, the "hospital-wide" inservice director must be given a direct, peer relationship to those responsible for various "department specific" inservice programs within the institution, especially Nursing Inservice and Medical Education. This relationship must allow the "hospital-wide" inservice director to act as an inside "consultant" to other intra-institutional inservice programs.

It is crucial, however, that the "hospital-wide" inservice director exercise direct control over all the facets of "cross-departmental" inservice projects, including such areas as management and supervisory development, human relations training, and the like. To put this concept another way, if the inservice project is to affect personnel from more than one department, the "hospital-wide" inservice director should be directly responsible for that project.

Directing

The inservice director must exercise final control over all the logistics of implementing "hospital-wide" inservice projects. This control includes not only the determination of the time and place of the project and the
levels of personnel to be included in the project, but also selection of the person to present the project, whether an inservice staff member, a speaker from outside the institution, or a speaker from another department, as well as determination of the manner in which the project is to be presented.

The inservice director is well advised to involve personnel from departments affected by the inservice project in such matters as scheduling and selection of project participants, but not in determining how a project will be presented nor by whom. If the inservice director does not have final authority to decide how a project is to be presented as well as by whom, there is little justification for the presence of a professional inservice director. Any administrator can contract with an outside consultant to conduct a particular project!

**Reporting**

Suitable methods must be utilized to evaluate the on-the-job results of inservice projects, since the primary reason for the existence of the "hospital-wide" inservice program is the effect, albeit in some cases simply an attitudinal effect, the program has on the employee at the work station itself. Inservice directors must be prepared for the

---

1The focus in "Reporting" is not upon the person to whom the "hospital-wide" inservice director reports, but rather upon what the director reports, i.e., what the inservice director is accountable for.
day when they are asked, and quite properly so, to point to on-the-job results of their inservice projects.

Inservice directors also must develop procedures for costing-out all inservice projects. This costing-out process is valuable not only in project planning and budgeting but also in providing one means for evaluating the entire inservice program itself by providing an answer to the question, "Where did we spend our inservice money and what were the results of our investment?"

Likewise, the matter of internal "public relations" must be considered a top priority in the mind of the inservice director. Methods to insure ongoing communication of the role and accomplishments of the inservice program must be identified and utilized by the inservice director. Such methods could include an inservice newsletter, an inservice library of printed and media materials on topics such as leadership, decision-making, performance appraisal and the like, as well as periodic reports on particular inservice projects.

Summary

In summary, the author offers the above model as a guide to be utilized by the "hospital-wide" inservice director according to his own best judgment. The author realizes that for an inservice director to accept the model intact might not be at all appropriate because of particular circumstances within a given institution. The author, rather,
The author presents the above diagram purposefully not assigning priorities to the seven responsibilities. Each "hospital-wide" inservice director, based on his own background and current situation, must decide upon the priority of the seven responsibilities as they apply to the administration of his particular inservice program.
INGREDIENTS OF AN EFFECTIVE
"HOSPITAL-WIDE" INSERVICE PROGRAM

Organizational Relationship (ORGANIZING)

- adequate facilities
- institutional inservice policies
- adequate budget (BUDGETING)
- adequate staff (STAFFING)

Coordination of all inservice efforts (COORDINATING)

sound inservice needs assessment (PLANNING)
sound inservice project implementation (DIRECTING)
sound inservice project evaluation (REPORTING)

Prerequisites for "Hospital-wide" Inservice Program Effectiveness

Prerequisite for Institutional Efficiency

"Hospital-wide" Inservice Program Cycle
urges the selective and judicious adaptation of the model to the "hospital-wide" inservice director's particular situation.

**Other Recommendations**

The original model advanced by the author is, of course, the major recommendation of the study. However, in addition to the model, several other directions, tangential to the purpose of the study itself but nonetheless important, became significant to the author as he ventured further into the study. These other directions are presented here in the form of several recommendations.

**General Recommendations**

1. Administrators of health care institutions are well advised to take a careful look at the need for and the role a "hospital-wide" inservice program can play in the institution. Inservice is especially crucial in the light of recent legislation which has extended Taft-Hartley requirements to the not-for-profit health care institutions as well as from the point of view of the growing concern for health care human resources development.

2. Inservice directors ought to be ready to assume full responsibility for the directions their inservice programs should be taking. The inservice director should not only outline the training plan for the institution, but should also be prepared to assume significant responsibility in the wider effort of both human resources and organizational
development within the institution.

3. Inservice directors should keep up to date on the approaches to inservice taken in other sectors, education as well as business and industry, with the view to incorporating other approaches into their own programs.

4. Inservice directors should take a more careful look at all phases of the administration of their inservice program. The director's role in development of particular inservice projects, while important, is secondary to his role in planning, organizing, and evaluating the inservice program itself!

5. It is essential that inservice directors develop more formalized and sophisticated approaches to both the needs assessment process as well as to the evaluation process, especially the follow-up evaluation of on-the-job results of inservice projects.

Recommendations for Further Study

1. There is need for a broader data base on "hospital-wide" inservice programs at other university-related Medical Centers throughout the country. A study might be undertaken which would replicate the procedures used in this study but as applied to such inservice programs in other geographical locations.

2. To further refine the model proposed in the study, a follow-up study should be undertaken of the "hospital-wide" inservice program located in hospitals and extended care
facilities not situated in university-related Medical Centers.

3. A study might be undertaken to test the feasibility of adapting the inservice program model presented in this study to the primary or secondary education sectors as well as to the higher education sector.

4. A study should be undertaken to evaluate the effectiveness of inservice programs in the health care sector, especially as effectiveness might be related to differences in the administration of various inservice programs.
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APPENDICES
APPENDIX A

RESULTS OF THE TELEPHONE SURVEY
CONDUCTED BY THE AUTHOR
IN NOVEMBER, 1974

I. HOSPITALS
II. MEDICAL CENTERS
I. HOSPITALS

Questions

1. Number of hospital beds (indicated as above or below the median of 423 beds)

2. Is the Inservice Program located within the Personnel or Employee Relations Department?

3. Number of professional trainers.

4. How old is the Inservice Program?

5. Why was the Inservice Program started?

6. Do you have a written statement of the Program's training objectives?

7. Who are the recipients of your training?
   a. top management
   b. department heads
   c. first-line supervisors
   d. trustees
   e. clerical/secretarial

8. Is Nurse In-Service separate from your Program?

9. Do you have programs to make employees promotable?

10. How do you obtain participants for your programs?

11. How do you evaluate your programs?
    a. written evaluation by participants after completion of course
    b. written evaluation by participants after each session
    c. personal interview with participant
    d. follow-up with supervisor or department head after a period of time
    e. tests during sessions and attitude surveys every six months
    f. final quiz
    g. none
    h. evaluation by an ongoing training committee

12. Does the hospital pay for seminar attendance of your employees elsewhere?
13. Does the hospital have a tuition refund program?

a. yes, 100%

b. yes, 50%

c. yes, 50% toward bachelor's degree; 75% toward master's degree

d. yes, 100% if job-related; 50% if not job-related

e. No
### Table

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<th>C</th>
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<td>2</td>
<td>1</td>
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<td>1 1/2 yrs.</td>
<td>2 yrs.</td>
<td>10 yrs.</td>
</tr>
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</tr>
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</tr>
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</tr>
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<td>Yes</td>
</tr>
<tr>
<td>c</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>d</td>
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<td>No</td>
<td>No</td>
</tr>
<tr>
<td>e</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td>9</td>
<td>No-but encouraged to take courses elsewhere</td>
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<td></td>
<td></td>
<td></td>
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<td>d</td>
<td>a</td>
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<td>d</td>
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1. The Director approves nurse in-service capital budget.

2. Trainers also have some personnel functions.
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<td>0</td>
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<td>1 year</td>
<td>1 1/2 yrs.</td>
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<td></td>
<td>needs analysis</td>
<td>as result of union</td>
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<td></td>
<td></td>
<td>with department heads</td>
<td>attempt</td>
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<td>7a</td>
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<td>b</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>c</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>d</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>e</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
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<td>8</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, but works with tng.</td>
</tr>
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<td>9</td>
<td></td>
<td>Yes</td>
<td>Yes (LPNs)</td>
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<td></td>
<td>some voluntary</td>
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<td>13</td>
<td>e</td>
<td>e</td>
<td>a, maximum of 2 courses per semester</td>
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1 The Director approves nurse in-service capital budget.

2 Trainers also have some personnel functions.
### PART B - HOSPITALS OVER 1,325 EMPLOYEES

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<td>4</td>
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<td>3 yrs.</td>
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<td>5</td>
<td>need seen for tng.</td>
<td>need seen for supervisory tng.</td>
<td>need for employee &amp; supervisory tng.</td>
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<td>Yes</td>
<td>Yes (dietary &amp; housekeeping)</td>
<td>(G.E.D.; typing/shorthand)</td>
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<td>participants are assigned employees assigned thru dept. heads; supervisors &amp; managers strongly urged</td>
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<td>13</td>
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<sup>1</sup> However, cassettes for trustees are available to them.

<sup>2</sup> Evaluation will begin this year

<sup>3</sup> One trainer does some personnel work
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<td>need for employee &amp; supervisory tng.</td>
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<td>b</td>
<td>Yes</td>
<td>Yes</td>
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</tr>
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<td>c</td>
<td>Yes</td>
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<td>No, included with tng. dept.</td>
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<td>a,b,f</td>
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<td>13</td>
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<td>a, up to $250 per year</td>
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1. However, cassettes for trustees are available to them.

2. Evaluation will begin this year.

3. One trainer does some personnel work.
II. MEDICAL CENTERS

Questions

1a. Number of employees (mean = 3,300)

1b. Number of beds (mean - 759)

2. Is the inservice program located within the Personnel or Employee Relations Department?

3. Number of professional trainers.

4. How old is the inservice program?

5. Why was the inservice program started?

6. Do you have a written statement of the training objectives?

7. Who are the recipients of your training?
   a. top management
   b. department heads
   c. first-line supervisors
   d. trustees
   e. clerical/secretarial

8. Is Nurse In-Service separate from your program?

9. Do you have programs to make employees promotable?

10. How do you obtain participants for your programs?

11. How do you evaluate your programs?
   a. written evaluation by participants after completion of course
   b. written evaluation by participants after each session
   c. personal interview with participant
   d. follow-up with supervisor or department head after a period of time
   e. tests during sessions and attitude surveys every six months
   f. final quiz
   g. none
   h. evaluation by an ongoing training committee

12. Does the Medical Center pay for seminar attendance of your employees elsewhere?

13. Does the Medical Center have a tuition reimbursement or waiver program?
### MEDICAL CENTERS

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<td>over 3,300</td>
<td>over 3,300</td>
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<td>1b</td>
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<td>over 759</td>
<td>over 759</td>
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<td>2</td>
<td>Yes</td>
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<td>Yes</td>
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<td>5</td>
<td>4</td>
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<td>5 years</td>
<td>5 years</td>
<td>8 years</td>
<td>6 years</td>
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<td>admin. saw</td>
<td>repeated</td>
<td>unknown to</td>
<td>initially, to organize tuition</td>
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<td></td>
<td>need</td>
<td>complaint</td>
<td>respondent</td>
<td>waiver pgm.</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7b</td>
<td>Yes</td>
<td>Yes</td>
<td>No (in process)</td>
<td>Yes</td>
</tr>
<tr>
<td>7c</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No (in process)</td>
</tr>
<tr>
<td>7d</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>7e</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>8</td>
<td>Yes, but</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>close informal relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>9</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>many ways, depending on Dept. Chairman</td>
<td>voluntary</td>
<td>some voluntary</td>
<td>voluntary, supvr. prgm. will be condition of employment</td>
</tr>
<tr>
<td>11</td>
<td>b, both rating scale &amp; open-ended</td>
<td>a &amp; h</td>
<td>a</td>
<td>a, b &amp; d</td>
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<tr>
<td>Questions</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
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</tr>
<tr>
<td>12</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Waiver</td>
<td>Waiver, 100% nurses for BS, 50% for others</td>
<td>Reimbursement, 100% for degree, cert., or job-required courses; 75% for self-employment</td>
<td>Waiver &amp; Refund - 100% if job-related courses</td>
</tr>
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APPENDIX B

LETTER TO THE "HOSPITAL-WIDE" INSERVICE DIRECTORS
REQUESTING PERMISSION TO CONDUCT
THE CASE STUDY
Dear Inservice Director,

I am writing to ask if you would be willing to allow me to undertake a case study of your inservice program.

My purpose in undertaking the study is not to evaluate the quality of your program nor to accept or reject your program as a model for other inservice programs. Rather, I intend to look at your program from the point of view of the administration of the program.

I intend to examine the administration of the inservice program located at the university-related Medical Centers in the city of Chicago. My purpose is to establish guidelines in the form of a model for the administration of inservice programs in the health care sector.

I propose to interview you in a structured interview which I would judge would take from two to two-and-one-half hours; tour your inservice facility; and have access to certain inservice documents from which I would make notes. In order to preserve the interview intact for my analysis, I propose to audio tape the entire interview. However, rest assured that no information identifying the institution will be included in the recording and that the analysis will not identify you or your program specifically.

The study I am undertaking is comparative, but only in the sense that answers to individual interview questions will be compared. I will not be comparing the programs of each institution with one another.

I would like to conduct the interview sometime in February or early March, 1976. Could I ask you to set aside either a morning or an afternoon within that time period? I will contact you next week to make a specific appointment.

Thank you for your interest and cooperation in this project.

Sincerely yours,

M. Richard Wright, Acting Director
Office of Internal Education
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
AND
RESPONSES OF THE INSERVICE DIRECTORS
DEMOGRAPHIC QUESTIONNAIRE*

Institutional Characteristics

1. How many hospitals and clinics comprise the Medical Center?
2. What is the total number of hospital beds?
3. Excluding medical staff, what is the total number of employees at the Medical Center?
4. Through whom is the Medical Center related to the University?
5. Can you provide documents describing the history of the university as well as its initial involvement in health care activity?
6. Can you provide an organization chart of the Medical Center?

Inservice Director and Program

7. For how long have you worked at the Medical Center?
8. For how long have you been inservice director?
9. Briefly, what is your educational and work background?
10. What provisions do you make for your own professional development?
11. In what year was the inservice program established?
12. How and why was the inservice program established?
13. What is the number of professional trainers, including yourself, in your program?
14. What is the number of clerical staff in your program?
15. Are you or your staff involved in activities other than inservice?

*The Questionnaire answers in the following section are presented so the Director A's response is always 1st, B's second, etc. Multiple faceted Questions 25 and 26 are also grouped accordingly.
16. What are these other activities?

17. What proportion of time is devoted by you and your staff to the inservice program?

18. Do you currently have adequate inservice staff positions?

19. Are you involved in conducting degree or certificate courses with other educational institutions?

20. Are you involved in cooperative or shared inservice projects with other hospitals or health care institutions?

21. In general, what kinds of equipment for conducting inservice projects does your program own?

22. Is your unit in charge of audio-visual equipment?

23. Is there a separate audiovisual department in the institution?

24. Who controls audiovisual software used in your inservice projects?

25. What facilities are available to your inservice program:

   a. number of classrooms
   b. number of offices
   c. number of conference rooms
   d. number of laboratories
   e. auditorium
   f. library
   g. other

What facilities are controlled by your inservice program:

   a. number of classrooms
   b. number of offices
   c. number of conference rooms
   d. number of laboratories
   e. auditorium
   f. library
   g. other
RESPONSES OF THE INSERVICE DIRECTORS

1. One hospital which contains six Ambulatory Care clinics
Eleven hospitals and clinics
Five hospitals and 32 clinics
Three hospitals

2. 864
   650
   650
   1200

3. 4200
   3000
   4500
   3600

4. Executive VP's (3) to President of Med Center
   Hospital Administrator to Dean of Biol. Sciences
   to University President
   Hospital Administrator and 5 College Deans to
   Chancellors of Medical Center to President
   of University
   Chief Executive Officer (2--Hospital and Medical
School) to President of University

5. Yes
   Yes
   Yes
   Yes

6. No
   Yes
   No
   Yes

7. 2 years
   6 years
   3 years
   6 1/2 years

8. 2 years
   1 1/2 years
   3 years
   6 1/2 years
9. M.A. Psych/15 years technical-management training
   (10 industry/5 health care)
M.A. Counseling/H.S. teacher/Asst. to Director
Allied Health, Chicago City Colleges
B.A. Theatre-Speech/H.S. teacher/8 years Personnel, mostly training
M.A. Adult Ed/Dir. of Volunteers/Center for Continuing Education

10. reading/national conferences/contact with key training directors
begin Ph.D. program/prof. organizations/conferences
seminars/evening courses/reading/professional organizations
seminars/prof. organizations/reading

11. 1964
1969
1966
1970

12. as adjunct of Personnel dept--later reorganized under Allied Sci.
wildcat strike: demands for education to advance as well as better supervision
unknown
threatened strike of service personnel/JCHA demanded management development

13. 6
5
3
1

14 3
2
1
1

15. Yes, director -- No, inservice staff
No, both director and staff
No, both director and staff (with very rare exception)
Yes, director

16. counseling with supervisors on goal setting
does not apply
does not apply
several institutional committees/high school acreer programs

17. 75% director -- 100% staff
100%
100%
70%
18. Yes, based on current inservice scope
   No, cannot keep pace with requests for more inservice
   No, cannot provide adequate programs for all employees
   No, not enough visibility; cannot handle all needed
   programs

19. Yes, U of I Circle; Northern Ill. U; Central YMCA
   Yes, Central YMCA; Chicago City Colleges
   No
   No

20. No
   Yes--LPN training; LPN to RN training; starting allied
   health certificate training
   No
   Yes--Conversational Spanish through Chicago City
   Colleges

21. none
   typewriters; lab equipment; basic AV equipment; basic
   nursing props
   tape recorders; overhead projectors; teaching machines
   none

22. No
   No
   No
   No

23. Yes, Office of Educational Resources
   Yes, services both Medical School and Hospital
   Yes, university-wide Office of Educational Resources
   No, but some delivery of available equipment now
   provided

24. inservice unit, but stored in Office of Educational
    Resources
    inservice unit; AV department; other departments
    cooperative film purchases with Health Science Library,
    stored there
    inservice unit

25. 30 available; none controlled
    6 controlled
    1 available; none controlled
    none available; none controlled
    one available; none controlled
    Medical College library available
    Animal Care labs
25. Continued

3 available; 3 controlled
5 controlled
1 controlled
1 controlled
one available; none controlled
University & Medical College library available;
also inservice library
hospital conference rooms
several available; none controlled
3 controlled
several available; none controlled
none available or controlled
several available
University library available
none
several available; none controlled
1 controlled
1 controlled
none available; none controlled
2 available; none controlled
University library available
off site conference rooms rented from other
organizations
The dissertation submitted by M. Richard Wright, Jr. has been read and approved by the following committee:

Dr. Melvin P. Heller, Director
Professor and Chairman,
Administration and Supervision, Loyola

Dr. Robert L. Monks
Assistant Professor,
Administration and Supervision, Loyola

Dr. Jasper J. Valenti
Professor, Administration and Supervision and
Associate Dean, School of Education, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

[Director's Signature]

[Date: May 17, 1976]