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THE INFLUENCE OF
MANDATORY CONTINUING EDUCATION ON
PERCEIVED EFFECTIVENESS OF HOSPITAL ADMINISTRATORS

DISSERTATION

Presented in Partial Fulfillment of the
Requirements for the Degree Doctor of Philosophy
in the Graduate School of The Ohio State University

By

Robert Boissoneau, B.A., M.A.

The Ohio State University
1974

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To
The People
Who Made This Study Possible
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and Dr. John A. Prior. All were helpful and supportive.

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FIELDS OF STUDY

Major Field: Education

Studies in Educational Development. Professors Donald P. Sanders and William W. Wayson


Studies in Adult Education. Professor John Ohliger
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CHAPTER I
THE PROBLEM

Continuing education is increasingly recognized as a major component in the sustaining effort of professionals to maintain their effectiveness. Continuing education is even viewed by many as a necessity. Houle states that the practicing professional has to keep up with new knowledge.\textsuperscript{1} Blakely declares that continuing education is needed to keep abreast of change and to do a better job.\textsuperscript{2} Brown and Uhl write that quality medical care and medical excellence in general rest upon continuing education and further development of the physical, biological, social and behavioral sciences.\textsuperscript{3} Even the public recognizes that physicians must be aware of new medical knowledge.\textsuperscript{4}

\textsuperscript{1}Cyril O. Houle, "The Lengthened Line of Education," Reprinted with permission by the American College of Hospital Administrators, 1969, from Perspectives in Biology and Medicine, 11:43, Autumn, 1967.


Despite the apparent need, a question in the minds of many is whether professionals actually engage in any continuing education activities at all. In the past, responsibility for his own continuing education resided with the individual on a voluntary basis. Professionals pursued education after completion of formal degree requirements, only as each felt the need.

The voluntary approach has been questioned recently. Vollan reports that the physician has not pursued voluntary continuing education because of (1) the lack of another qualified individual to care for patients while he attends programs, (2) the costs of attendance, and (3) the large number of hospital and medical society meetings that he feels compelled to attend.  

While 181,636 physicians participated in continuing education courses at medical schools in 1969-1970, an increase of 315 percent over 1960-61, as many as one-third of the nation's physicians did not engage in formal continuing education programs.6


In 1960, the National Opinion Research Center studied the question of whether dentists engaged in continuing education activities following graduation from dental school. The report indicated that 45.6 percent of the dentists in the United States had participated.\(^7\)

Ness states that success of voluntary continuing education for pharmacists has been minimal,\(^8\) and Shalinsky reports that only thirty-six percent of the active pharmacists in Kansas attended one or more continuing education meetings in 1967-68.\(^9\)

Disclosures such as these have led some to think that individuals must be required to engage in continuing education. They maintain that the voluntary approach has proved ineffective. Leading the way toward mandatory continuing education in the health professions are the proponents of Senator Edward M. Kennedy's bill for


national health insurance, "Health Security for America," the National Advisory Commission on Health Manpower, and the Secretary's Commission on Medical Malpractice. The Kennedy bill would charge the Health Security Board with establishing requirements for continuing education of health personnel. The Manpower Commission declares:

Professional societies and state governments should explore the possibility of periodic relicensure of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty.

The recommendations of the Commission on Medical Malpractice are similar to those of the Manpower Commission. Many professionals in the health field now are forced to complete continuing education requirements in order to maintain licensure or to retain membership in a professional

---


13 Kennedy, op.cit., p. 8.

14 Report of the Secretary's Commission on Medical Malpractice, op. cit., p. 42.
society. Professionals involved in mandatory continuing education include: physicians, nurses, dentists, dietitians, pharmacists and nursing home administrators.

Another of the emerging allied health disciplines which will be confronted with the mandatory issue is hospital administration. The growth of this emerging profession parallels the developing institutionalization of hospital care which began in the 1930's. Physicians and nurses had served previously in the chief administrative capacity, but increasingly complex financial arrangements created the need for business-oriented executive officers, and academic programs to qualify professionals for these positions in management.15

The University of Chicago initiated the first enduring program in 1934.16 By 1972, thirty-eight graduate programs had become full or associate members of the Association of University Programs in Health Administration, and almost 9,000 men and women had graduated from these programs.17

---


16Michael M. Davis, "Development of the First Graduate Program in Hospital Administration," Graduate Education for Hospital Administration (Chicago, Graduate Program for Hospital Administration, 1959), R.E. Brown (Ed.) p. 6.

17Graduate Education for Hospital and Health Administration (Washington, D.C.: Association of University Programs in Health Administration, January, 1973).
Until now, hospital administration has not been faced with the prospect of mandatory continuing education. Only one state, Minnesota, requires that hospital administrators be licensed, although a closely related field, nursing home administration, had been forced to license its practitioners under the Social Security Amendments of 1967 in order for states to qualify for Medicaid reimbursement. Now, however, the American College of Hospital Administrators, the Association of University Programs in Hospital Administration and the American Hospital Association are reviewing the licensure question.\(^{18}\)

While hospital administrators do not have personal responsibility for direct patient care, their decisions do influence the quality of care given by physicians, nurses and other personnel who render care directly to patients. A major role of the hospital administrator is that of creating an environment in which positive patient care can be given at reasonable cost. In reaching this objective, the administrator needs to insure wise and efficient use of financial resources and personnel. Whether hospital administrators perceive that they would better fulfill their role if forced to engage in continuing education is a major question in this dissertation.

Purpose of the Study

The purpose of the study is to determine whether knowledgeable people believe mandatory continuing education could be expected to increase the effectiveness of hospital administrators in managing the hospital to achieve its goal of quality patient care at reasonable cost. To be effective in the pursuit of the hospital's goal is the objective of the hospital administrator. While others have more specific objectives in the organization, the very nature of the administrator's position as the chief executive officer dictates that his role be that of a generalist, responsible for the management of the total institution. "Effectiveness," as used in this study, includes: (1) productivity, (2) flexibility in adjusting to change, and (3) capability of maintaining cooperation between groups. "Productivity" is the total of the accomplishments of the hospital administrator in moving the hospital toward its goal, while the other components of effectiveness serve the need for organizational stability in the presence of external and internal change.¹⁹

to be evaluated in terms of whether the administrator enables the hospital staff to provide quality patient care at reasonable cost. While the effectiveness of physicians, nurses, and others involved in direct patient care is usually a measurement of their contribution to patient care, the effectiveness of the hospital administrator is seldom reviewed to ascertain patient outcomes. Indeed, the effectiveness of the administrator, the chief executive officer of the organization whose goal is to provide quality patient care, should be measured on patient outcomes.

Little doubt exists about the responsibility of the hospital administrator in the hospital's mission of providing quality patient care. Standard V of the Joint Commission on Accreditation of Hospitals' Accreditation Manual for Hospitals declares:

The governing body, through the chief executive officer, shall provide appropriate physical resources and personnel required to meet the needs of the patients, and shall participate in planning to meet the health needs of the community.20

The administrator's responsibility to the patient is vital and second only in importance to the relationship of the physician to the patient. The patient places

himself in the care of the hospital, as personified by the administrator, with implicit faith that his health and safety will be guarded and that proper treatment will be given. The administrator is obligated to physicians and other personnel to maintain facilities, equipment, and other resources so that the patient's condition may be improved or stabilized.21

Significance of the Study

A major goal of society is to make quality health care a right of all people.22 If this goal is to be reached, hospital care must be improved. One of the avenues for improvement is through the hospital's chief executive officer, the hospital administrator. Although considerable doubt exists as to whether improvement of hospital care can be reached through general education, through voluntary continuing education, or through mandatory continuing education, hospital administration education has reached a level of sophistication which indicates that a study of the effects of mandatory continuing education is needed. Certainly, if such a study


were to conclude that required education would result in improved patient care, the profession could accept the finding as a mandate to address the question of how best to establish requirements.

Because of the relative youth of the discipline and a paucity of studies of the field, sufficient data about hospital administrators are lacking. This dissertation assesses only one aspect of the field, mandatory continuing education. Such a study could help administrators, related professionals and other interested parties to better understand hospital administration and the mandatory continuing education issue. Also, the study could assist in opening the field to inquiry in other areas. Too, a demonstration by the profession of willingness to open itself to study could have an effect upon those who will be recruited into the field.

Besides the benefits to hospital administration, results of the study may afford insights to others concerned with the mandatory education question, both in and out of the health field.
Approach to the Problem

The following assumptions provide the background for the approach to the problem:

1. Quality patient care in hospitals is a goal of society.

2. Effectiveness of hospital administrators affects the quality of patient care in hospitals.

3. Hospital administrators must keep abreast of new knowledge in the field in order to maintain effectiveness.

4. To allow hospital administrators to engage in continuing education as each determines his or her individual need has come to be questioned.

5. Mandatory continuing education has had sufficient impact upon health professionals to warrant a closer look at implications for the field of hospital administration.


7. Hospital administrators themselves could be expected to evaluate the impact of mandatory continuing education on quality of patient care in hospitals. Chairmen of boards of trustees, chiefs of medical staffs and executives of hospital-related health associations are also in a position to evaluate because of their close working relationships with administrators.

8. Questioning a sample of these groups is an efficient method of securing answers to pertinent concerns.

9. Responses elicited by means of a questionnaire can be used as expert opinion to determine whether mandatory continuing education for hospital administrators would affect quality of patient care in hospitals.
The plan for carrying out the study was to question a sample of hospital administrators, chiefs of medical staffs, chairmen of boards of trustees and executives in hospital-related areas of the health field who interact with hospital administrators, and, consequently, could be expected to give answers based upon knowledge and experience about the group being studied.

A sample of hospitals was taken from The 1973 American Hospital Association Guide to the Health Care Field (referred to hereafter as The 1973 Guide). This document is considered the primary source of statistical information about hospitals in this country.

Stratifying a random sample of hospitals was planned. Stratified sampling requires that a given population be divided into parts with the sample taken in proportion to the numerical size of the parts. Stratification was achieved in this study by dividing hospitals into two groups, hospitals with 100 beds or more and hospitals with less than 100 beds. Approximately fifty percent of the hospitals in this country have fewer than 100 beds.

Hospital size is of particular importance, for available information indicates that substantial differences


exist in the amount and kind of education completed by administrators who work in hospitals with 100 beds or more and those who are employed by hospitals with fewer than 100 beds. The management consulting firm of A.T. Kearney surveyed a group of hospital administrators and found that twenty percent reported having less than an undergraduate degree, and that sixty-eight percent of that group were managing hospitals with fewer than 100 beds.25

In this study, ten percent (706) of the 7,061 hospitals listed in The 1973 Guide were sampled. Three hundred and fifty-three hospitals under 100 beds were sent questionnaires as were 353 hospitals with 100 or more beds.

Within each of the two groups of hospitals, a sample selection was made at random. Val Dalen states that the use of a random sample reduces the possibility of bias because choice of subjects is left to chance.26 A table of random numbers was employed to select specific hospitals to be included in the sample.

Separate questionnaires were sent to the administrator,


chairman of the board of trustees and the chief of the medical staff in each hospital included in the sample. In addition, a fourth type of questionnaire was sent to executives in hospital-related agencies of the health field. Data were collected during April, 1974.

An IBM 370/165 computer was used to analyze data. Data were analyzed by using the Chi Square, Wilcoxon Rank Sum and Friedman Two-Way Analysis of Variance by Ranks statistical tests. They are reported in descriptive and summary as well as statistical form. A complete presentation of the data analysis is contained in Chapter III, Design and Methodology.

**Hypotheses**

The objective of the survey was to collect data related to the influence of mandatory continuing education on perceived effectiveness of hospital administrators. Several hypotheses have been developed to test the data.

**Hypothesis I.** A difference exists between response of administrators of 100-bed hospitals and larger and administrators of 99-bed hospitals and smaller (dependent variables) relative to the following variables (independent variables):
1. Administrator's effectiveness \(H^{(1)}\)
2. Administrator's pursuit of continuing education activities \(H^{(2)}\)
3. Effectiveness of continuing education \(H^{(3)}\)
4. Adequate quality of continuing education programs \(H^{(4)}\)
5. Need for more continuing education programs \(H^{(5)}\)
6. Need for off-campus study \(H^{(6)}\)
7. Need for required continuing education \(H^{(7)}\)
8. Impact of mandatory continuing education \(H^{(8)}\)
9. Organization to administer programs \(H^{(9)}\)
10. Support for review mechanism \(H^{(10)}\)

**Null Hypotheses.** No difference exists between responses of administrators of 100-bed hospitals and larger and administrators of 99-bed hospitals and smaller (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \(H_0^{(1)}\)
2. Administrator's pursuit of continuing education activities \(H_0^{(2)}\)
3. Effectiveness of continuing education \(H_0^{(3)}\)
4. Adequate quality of continuing education programs \(H_0^{(4)}\)
5. Need for more continuing education programs \(H_0^{(5)}\)
6. Need for off-campus study \(H_0^{(6)}\)
7. Need for required continuing education \(H_0^{(7)}\)
8. Impact of mandatory continuing education \(H_0^{(8)}\)
9. Organization to administer programs \(H_0^{(9)}\)
10. Support for review mechanism \(H_0^{(10)}\)
Alternative Hypotheses. There is a difference between responses of administrators of 100-bed hospitals and larger and administrators of 99-bed hospitals and smaller (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H_A^{(1)}]\]
2. Administrator's pursuit of continuing education activities \([H_A^{(2)}]\]
3. Effectiveness of continuing education \([H_A^{(3)}]\]
4. Adequate quality of continuing education programs \([H_A^{(4)}]\]
5. Need for more continuing education programs \([H_A^{(5)}]\]
6. Need for off-campus study \([H_A^{(6)}]\]
7. Need for required continuing education \([H_A^{(7)}]\]
8. Impact of mandatory continuing education \([H_A^{(8)}]\]
9. Organization to administer programs \([H_A^{(9)}]\]
10. Support for review mechanism \([H_A^{(10)}]\]

Hypothesis II. A difference exists between responses of administrators with five years or more experience as a hospital chief executive officer and responses of administrators with less than five years experience (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H^{(11)}]\]
2. Administrator's pursuit of continuing education activities \([H^{(12)}]\]
3. Effectiveness of continuing education \([H^{(13)}]\]
4. Adequate quality of continuing education programs \([H^{(14)}]\]
5. Need for more continuing education programs \( [H_{15}] \)
6. Need for off-campus study \( [H_{16}] \)
7. Need for required continuing education \( [H_{17}] \)
8. Impact of mandatory continuing education \( [H_{18}] \)
9. Organization to administer programs \( [H_{19}] \)
10. Support for review mechanism \( [H_{20}] \)

**Null Hypotheses.** No difference exists between responses of administrators with five years or more experience as a hospital chief executive officer and responses of administrators with less than five years experience (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \( [H_{0}^{11}] \)
2. Administrator's pursuit of continuing education activities \( [H_{0}^{12}] \)
3. Effectiveness of continuing education \( [H_{0}^{13}] \)
4. Adequate quality of continuing education programs \( [H_{0}^{14}] \)
5. Need for more continuing education programs \( [H_{0}^{15}] \)
6. Need for off-campus study \( [H_{0}^{16}] \)
7. Need for required continuing education \( [H_{0}^{17}] \)
8. Impact of mandatory continuing education \( [H_{0}^{18}] \)
9. Organization to administer programs \( [H_{0}^{19}] \)
10. Support for review mechanism \( [H_{0}^{20}] \)

**Alternative Hypotheses.** There is a difference between responses of administrators with five years or more experience as a hospital chief executive officer and responses of administrators with less than five years experience
Hypothesis III. A difference exists between response of administrators who have graduated from a school of hospital and health services administration and of those who have not (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H_A^{(11)}]\)
2. Administrator's pursuit of continuing education activities \([H_A^{(12)}]\)
3. Effectiveness of continuing education \([H_A^{(13)}]\)
4. Adequate quality of continuing education programs \([H_A^{(14)}]\)
5. Need for more continuing education programs \([H_A^{(15)}]\)
6. Need for off-campus study \([H_A^{(16)}]\)
7. Need for required continuing education \([H_A^{(17)}]\)
8. Impact of mandatory continuing education \([H_A^{(18)}]\)
9. Organization to administer programs \([H_A^{(19)}]\)
10. Support for review mechanism \([H_A^{(20)}]\)
Null Hypotheses. No difference exists between responses of administrators who have graduated from a school of hospital and health services administration and of those who have not (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H_0^{(21)}]\)
2. Administrator's pursuit of continuing education activities \([H_0^{(22)}]\)
3. Effectiveness of continuing education \([H_0^{(23)}]\)
4. Adequate quality of continuing education programs \([H_0^{(24)}]\)
5. Need for more continuing education programs \([H_0^{(25)}]\)
6. Need for off-campus study \([H_0^{(26)}]\)
7. Need for required continuing education \([H_0^{(27)}]\)
8. Impact of mandatory continuing education \([H_0^{(28)}]\)
9. Organization to administer programs \([H_0^{(29)}]\)
10. Support for review mechanism \([H_0^{(30)}]\)

Alternative Hypotheses. There is a difference between responses of administrators who have graduated from a school of hospital and health services administration and of those who have not (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H_A^{(21)}]\)
2. Administrator's pursuit of continuing education activities \([H_A^{(22)}]\)
3. Effectiveness of continuing education \([H_A^{(23)}]\)
4. Adequate quality of continuing education programs \([H_A^{(24)}]\)
5. Need for more continuing education programs \([H_A^{(25)}]\)
6. Need for off-campus study \([H_A(26)]\)

7. Need for required continuing education \([H_A(27)]\)

8. Impact of mandatory continuing education \([H_A(28)]\)

9. Organization to administer programs \([H_A(29)]\)

10. Support for review mechanism \([H_A(30)]\)

**Hypothesis IV.** A difference exists between responses of administrators with a date of birth of January 1, 1923, and after, and responses of administrators born before that date (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H(31)]\)

2. Administrator's pursuit of continuing education activities \([H(32)]\)

3. Effectiveness of continuing education \([H(33)]\)

4. Adequate quality of continuing education programs \([H(34)]\)

5. Need for more continuing education programs \([H(35)]\)

6. Need for off-campus study \([H(36)]\)

7. Need for required continuing education \([H(37)]\)

8. Impact of mandatory continuing education \([H(38)]\)

9. Organization to administer programs \([H(39)]\)

10. Support for review mechanism \([H(40)]\)

**Null Hypotheses.** No difference exists between responses of administrators with a date of birth of January 1, 1923, and after, and responses of administrators born before that date (dependent variables) relative to the following variables (independent variables):
1. Administrator's effectiveness \( [H_0(31)] \)
2. Administrator's pursuit of continuing education activities \( [H_0(32)] \)
3. Effectiveness of continuing education \( [H_0(33)] \)
4. Adequate quality of continuing education programs \( [H_0(34)] \)
5. Need for more continuing education programs \( [H_0(35)] \)
6. Need for off-campus study \( [H_0(36)] \)
7. Need for required continuing education \( [H_0(37)] \)
8. Impact of mandatory continuing education \( [H_0(38)] \)
9. Organization to administer programs \( [H_0(39)] \)
10. Support for review mechanism \( [H_0(40)] \)

**Alternative Hypotheses.** There is a difference between responses of administrators with a date of birth of January 1, 1923, and after, and responses of administrators born before that date (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \( [H_A(31)] \)
2. Administrator's pursuit of continuing education activities \( [H_A(32)] \)
3. Effectiveness of continuing education \( [H_A(33)] \)
4. Adequate quality of continuing education programs \( [H_A(34)] \)
5. Need for more continuing education programs \( [H_A(35)] \)
6. Need for off-campus study \( [H_A(36)] \)
7. Need for required continuing education \( [H_A(37)] \)
8. Impact of mandatory continuing education \( [H_A(38)] \)
9. Organization to administer programs \( [H_A(39)] \)
10. Support for review mechanism \( [H_A(40)] \)
Hypothesis V. A difference exists between responses of the administrator, the board chairman and the chief of the medical staff in the same hospital (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \( [H(41)] \)
2. Administrator's pursuit of continuing education activities \( [H(42)] \)
3. Effectiveness of continuing education \( [H(43)] \)
4. Need for more continuing education programs \( [H(44)] \)
5. Need for off-campus study \( [H(45)] \)
6. Need for required continuing education \( [H(46)] \)
7. Impact of mandatory continuing education \( [H(47)] \)
8. Organization to administer programs \( [H(48)] \)
9. Support for review mechanism \( [H(49)] \)

Null Hypotheses. No difference exists between responses of the administrator, the board chairman and the chief of the medical staff in the same hospital (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \( [H_0(41)] \)
2. Administrator's pursuit of continuing education activities \( [H_0(42)] \)
3. Effectiveness of continuing education \( [H_0(43)] \)
4. Need for more continuing education programs \( [H_0(44)] \)
5. Need for off-campus study \( [H_0(45)] \)
6. Need for required continuing education \( [H_0(46)] \)
7. Impact of mandatory continuing education \( [H_0(47)] \)
8. Organization to administer programs \( [H_0(48)] \)
9. Support for review mechanism \( [H_0(49)] \)
Alternative Hypotheses. There is a difference between responses of the administrator, the board chairman and the chief of the medical staff in the same hospital (dependent variables) relative to the following variables (independent variables):

1. Administrator's effectiveness \([H_A(41)]\)
2. Administrator's pursuit of continuing education activities \([H_A(42)]\)
3. Effectiveness of continuing education \([H_A(43)]\)
4. Need for more continuing education programs \([H_A(44)]\)
5. Need for off-campus study \([H_A(45)]\)
6. Need for required continuing education \([H_A(46)]\)
7. Impact of mandatory continuing education \([H_A(47)]\)
8. Organization to administer programs \([H_A(48)]\)
9. Support for review mechanism \([H_A(49)]\)

Limitations of the Study

The study is limited to a sample of hospital administrators, chairmen of boards of trustees and chiefs of medical staffs. Also, executives of hospital-related health organizations considered knowledgeable about the field of hospital administration, are questioned. These groups are considered competent to answer the research questions. Only hospitals with a board of trustees and organizations within the United States which are listed
in The 1973 Guide $^{27}$ will be used in the study.

It should be emphasized that this is a study of perceptions of effectiveness. Effectiveness has an elusive quality that is widely understood at an abstract level as "power to bring about a result." $^{28}$ However, great difficulty is encountered when one attempts to operationalize the concept because of the large number of variables involved in a live setting. Ultimately, each person making judgments about effectiveness relies upon his own value system with a consequent lack of standardization among raters. $^{29}$ In this study, it is assumed that respondents, who are in positions which require frequent judgments about hospital administrators, have used their own perceptions in answering the questions. A study designed to establish criteria for measuring effectiveness of hospital administrators would be of assistance to the development of the field, however, that objective is beyond the scope of this study.

As in any study made solely through the use of questionnaires, results of this study are bound by the

$^{27}$American Hospital Association Guide to the Health Care Field, op. cit.


candidness of respondents. These limitations have been accepted as inherent to such a study, and the design and sampling method devised so that the validity of findings after analysis of all data has not been appreciably impaired.

Organization of the Study

This study is organized in five chapters. In Chapter I, the study is described, the problem stated, purpose identified, limitations cited and the organization outlined. Chapter II contains a review of literature. Chapter III contains an analysis of the study design, including sample selection, instrument development, and methods and procedures used in collection and analysis of data. Chapter IV presents and analyzes findings. Chapter V contains a summary, conclusions and recommendations.
CHAPTER II
RELATED LITERATURE

The purpose of this chapter is to analyze and summarize the literature that is related to the study. While the literature search revealed no analytical studies in this subject area, descriptive information was available. The first section of the chapter pertains to literature about effectiveness. The second section deals with the role of the hospital administrator in the management of patient care. Final sections are concerned with continuing education in the health field.

Effectiveness

The elusiveness of any conclusive means of measuring effectiveness is pointed out repeatedly in the literature. While the importance of identifying perceptions of effectiveness was not cited explicitly, it became clear that many were describing perceptions of effectiveness. An important aspect of this study is that it deals with perceptions and does not establish criteria for measuring effectiveness.

Referring to managerial effectiveness, Reddin\(^1\) states that it is the extent to which a manager achieves the

output requirements of his position. Effectiveness has to be related to achievements rather than functions.

Although the words "effectiveness" and "efficiency" are often used interchangeably, they have different meanings. Effectiveness is a measure of production of a desired result while efficiency is a measure of the proper use and allocation of resources. Whereas effectiveness connotes measurement of a total structure, efficiency is a measurement of parts of the structure.²

While Lopez³ implies that unusual ability is required if one is to be effective, Drucker⁴ believes little correlation exists between effectiveness and intelligence, imagination and knowledge. Drucker indicates that effectiveness is a series of habits that become part of the manager's personality when repeated frequently. He lists five practices that have to be achieved in order to become an effective manager:

1. Knowing how time is spent. Output limits are set by the most scarce resource which is time, in the manager's case.


2. Directing effort at results rather than work in general.

3. Building on strengths. The manager must rely on his own strengths and those of his superiors, peers, subordinates and the organization.

4. Concentrating on a few projects where superior performance will produce outstanding results.

5. Making sound decisions. This becomes a system in which proper steps occur in the correct sequence.

Another perspective is that the key to effectiveness is balance in the manager's operation. Needed is a capable system that functions routinely and signals approaching trouble. A reporting sub-system has to be developed to afford the manager the opportunity of maintaining balance.5

In order to become effective, the manager needs to establish standards and state objectives.6 These standards and objectives serve to evaluate the performance of the manager rather than to justify executive compensation programs or to set territorial limits.7

An example of the difficulty encountered in establishing criteria for determining effectiveness is reflected


6 Reddin, op. cit., p. 288.

7 Lopez, op. cit., p. 64.
in the work of Campbell.\textsuperscript{8} He writes that effective management behavior is: (1) a function of complex interactions between individual characteristics, (2) a result of demands and expectations placed upon people by the physical, administrative and social environment of the organization, and, (3) a reliance upon feedback incentives and reward systems developed by organizational policies and practices.

A view reflecting the thinking of many authors seems to be that the life expectancy of a business can be traced directly to the level of managerial effectiveness in the organization. However, in government, education, church and health administration, the relationship is not as direct, though the result is the same. Every year an unspecified but substantial loss is suffered in sales volume, profits, client services, cost effectiveness and budget performance. A high price is paid by these institutions and their investors, taxpayers and customers, a price represented by the difference between that which is actually realized and that which could have been realized by greater effectiveness.\textsuperscript{9}


\textsuperscript{9}Lopez, \textit{op.cit.}, p. 4.
Concern for the performance of hospitals and their top-level management has been developing for twenty years, both in government and outside of it. The lack of criteria for measuring effectiveness is a major problem in the hospital field.¹⁰

Role of the Hospital Administrator in the Management of Patient Care

Management effectiveness in the hospital results in the successful delivery of care to each patient. Management of the hospital and delivery of acceptable patient care are synonymous in hospital operations.¹¹

The management position of hospital administrator has developed more rapidly than any other in the American hospital.¹² Early in the twentieth century, many administrators were physicians. In the dual role of physician-administrator, they performed the patient care quality control function. They were considered to be the most knowledgeable physicians and served as arbitrators when


¹¹Frazier, op. cit., p. 53.

disputes arose.13

The role of hospital administrator became increas­ingly complex as medical discoveries were made which rap­idly created medical specialties in such numbers that hos­pitals became as complex as the most intricate industrial plants. New equipment, practices and use of resources changed hospital departments, imposing added demands on the administrator.14 The need for a management-oriented administrator became evident in the complex hospital or­ganization.

The transition from the physician to the specializing manager as hospital administrator has been occurring over a number of years and even now is not complete. Large numbers of management-educated hospital administrators did not become available until the 1950's. Writing in support of the movement from physicians to managers in the admin­istrator position, Douglas R. Brown15 stated that while an inference could be made that only people with a knowledge of medicine could provide unified professional direction of hospitals, medical education alone does not prepare a

14Ibid., p. 5.
person for employment in administration. Finance and personnel management are usually not covered in medical education. Also, a proliferation of occupational specialties in the hospital field requires a more objective administrator, not one already aligned with the most powerful group in the institution. Since the number of physicians serving as administrators is decreasing, the responsibility of providing trained administrative manpower would appear to rest with schools of hospital and health services administration.

The administrator's duties have changed over the years. Now, he primarily coordinates diverse interest groups, develops long-range plans, determines capital fund needs and sources, and controls the functions of the hospital. All of these activities relate to quality of care.¹⁶

In addition to the need of maintaining competence among practitioners and those who assist in direct patient care, many other needs contribute to that end. Physical facilities and their maintenance can have a major influence on patient care. Equipment availability, laboratory service and even food temperature are factors to be considered in quality care. Hospital management is responsible

¹⁶Ibid.
for these support functions.\textsuperscript{17}

Traditionally, quality care has been the total responsibility of physicians. The situation seems to be changing, however, as recent legal decisions place greater responsibility with the governing board and its administrator.\textsuperscript{18} Increasing involvement of government in the health care industry is one reason for the change. The trend toward government financing of health care has brought demand for greater accountability of the institution.\textsuperscript{19}

Evaluation of patient care in hospitals has become a national issue. A physician, Lowell E. Bellin,\textsuperscript{20} has stated that a permanent administrative method of quality control must be established within the hospital hierarchy under the clear direction of the hospital administrator. He believes that the industrial model, in which all professional as well as non-professional personnel are the responsibility of the chief executive officer, must be applied to hospitals. Referring to quality control in industry,

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{17}J.E. Smits, "Strong Management and Quality Control," \textit{Hospital Progress,} 50:56, February, 1969.
\item \textsuperscript{18}Letourneau, \textit{op.cit.}, p. 85.
\item \textsuperscript{19}Lowell E. Bellin, "If We Know What Quality Care Is, Why Don't We Get It?" \textit{Modern Hospital} 119:87, December, 1972.
\item \textsuperscript{20}Ibid.
\end{itemize}
\end{footnotesize}
Bellin points out that the quality control engineer does not report to a manager at the operating level whose performance is being evaluated, as is the case in the hospital with physicians reviewing physicians who may be depended upon for patient referrals. Brown expands on the role of the administrator in the management of patient care by asserting that management-oriented administrators can be as responsible for quality of hospital care as they are for financial affairs. While most administrators do not have the personal skills and knowledge to perform many specialized activities in the institution, these managers can insure that programs receive the attention they deserve from both medical and non-medical specialists by the development of measuring instruments and reporting systems.

Administrators of the nation's health care institutions will be able to maintain the competence needed to meet demands placed upon them by the communities they serve only through continuing education, constant examination and renewal and updating of management techniques.22

21Brown, op.cit., p. 16.

The Voluntary Method of Continuing Education in the Health Field

The method of continuing education is of particular importance to hospital administrators and other health professionals. Many claim that the choice of whether or not to participate must reside with the individual. Referring to physicians, Darley\(^2^3\) states that the doctor's personal standards of excellence provide the only force which can motivate him to keep abreast of medicine's advances. Evidence of his success can be found in the often unexpressed judgment of his conscience, his peers and individual patients.

Dryer\(^2^4\) writes that continuing education activities must have the following highly personalized goals:

1. **Personal Satisfaction.** Physicians must be motivated to advance with the leading intellectuals of medicine. They must be well-trained and be given the opportunity to earn a greater amount of money. Physicians have to retain the respect and fellowship of their colleagues and, to meet the rising expectations of patients and physicians, they must feel a sense of productive satisfaction.

Educational programs must make sense to each physician on his own terms. There is no need to harass him about being interested only in new skills, new drugs


and new techniques. Criticism will not help to enlarge his abilities to make decisions, solve patient's problems and enrich his sense of personal and professional responsibility. He is trained to look for both subtle and obvious evidence of illness and will be looking for constant proof that education genuinely serves his needs.

2. Freedom of Choice. Great pressure exists at the national level for the careful allocation of resources. Under these circumstances, the freedom of individuals to make choices often appears to be an expensive social luxury. Regardless of whether the individual physician agrees with that possibility, he must consider that point of view in his decisions regarding continuing education.

3. Continuity. A need exists for cohesive programming. Even in many hospitals that have regularly scheduled time periods for continuing education, intermittent subject matter is presented which is indicative of improper planning. Programs are sometimes conflicting. Multiplicity may have value but scheduling becomes a problem. If a national body could combine the benefits of continuity with freedom of choice, then the physician could choose the combination most beneficial to him.

4. Accessibility. Distance from continuing education programs and time involved participating in them are important negative factors. The use of name speakers, improved instructional methods, better parking facilities and social hours are not adequate compensation for the losses. A study of general practice in North Carolina revealed that the character and frequency of meetings attended was often determined by availability rather than desirability. The physicians wanted regular programming and believed that being away from their patients was a greater problem than distance.
5. **Convenience.** Convenience is giving what the professional wants at the time and in the location he wants it. The opportunity for continuing education should be available to each person in both individual and group situations. Also, an individual should have the right to choose any or all of a particular curriculum.

To bolster voluntary continuing education, the House of Delegates of the American Medical Association passed a resolution in 1968 calling for the creation of an award to recognize physicians who participate in continuing medical education programs. In addition to providing a means of recognition for thousands of physicians who regularly participate in continuing medical education, the Physician Recognition Award encourages each physician to keep up to date and provides assurance to the public that American physicians are maintaining competency by regular participation.25

A Physician Recognition Award can be earned by completing 150 hours of continuing education in three years. Sixty hours or more must come from a required list while the remainder may come from electives. Required continuing education includes accredited continuing education courses, papers, publications and teaching. Recent

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medical school graduates may count internships and residencies. Education for advanced degrees and research activities qualify as required activities. Electives include attendance at scientific meetings of other national professional societies, local and regional scientific meetings, presentation of scientific exhibits and additional teaching responsibilities.26

The Physician Recognition Award is likely to be well received because of its positive rather than punitive nature and its sponsorship by a national medical organization. The approach assumes that the great majority of practicing physicians are highly motivated to continue learning throughout their careers. However, the program cannot guarantee full participation because of its voluntary nature.27 The Physician Recognition Award has been criticized as merely "hours spent rather than anything learned." The critics claim that course attendance has never been shown to result in better care. When continuing education was voluntary, the physicians who found courses helpful could attend and others could learn as


they desired. If a display of erudition, new research findings, stimulation and enrichment of practicing physicians is the goal, then present methods should continue. However, if the purpose is to improve the level of practice and patient care, then the starting point should be the assessment of care.28

An editorial in the Journal of the American Medical Association noted the following trends that support voluntary continuing education:29

1. The support of the A.M.A. House of Delegates for such ideas as periodic recertification by specialty boards, and documentation of continuing medical education activities as a condition for continued membership in state medical associations.

2. The establishment of the A.M.A. Physician's Recognition Award and its use cooperatively with similar programs by state medical associations as a means of documenting the continuing medical education activities of practicing physicians.

3. The greater availability of relevant continuing medical education activities and the steadily increasing number of these programs listed annually in The Journal and state medical journals.


4. The increasing numbers of state medical associations that have adopted continuing medical education programs of high quality.

5. The increasing popularity and use of self-assessment examinations.

6. The increasing use of peer review, utilization review and medical audits as an educational tool for continuing medical education activities.

7. The increasing number of directors of medical education in hospitals who are concerning themselves with continuing medical education as a service to the practicing physicians in their area.

8. The increasing level of knowledge and skills that is developing in continuing medical education.

9. The increasing availability and better utilization of electronic devices for continuing medical education, such as video tapes, radio networks and computers.

10. Improved techniques for evaluating continuing medical education in terms of physician performance.

11. Serious consideration by state medical associations of making continuing medical education a condition for membership.

12. The outstanding program of the American Academy of Family Physicians as the only specialty organization requiring continuing medical education as a condition of membership.

13. The standard of the Joint Commission on Accreditation of Hospitals, which states the medical staff should provide a continuing education program and show evidence of member participation.
Dalton found in surveying members of the American Association of Dental Examiners that they were interested in the effectiveness of voluntary continuing education. Responses to questions were varied and it was apparent the voluntary method was not perfect. However, greater than two-thirds of the respondents felt continuing education should be voluntary.

Panelists who favored voluntary continuing education at a March 1969 Philadelphia County Dental Society conference stated that responsibility for continuing education lies with the profession as well as the individual. These individuals felt that dentists could be motivated to involve themselves in continuing education without the use of force. They cited the need for quality programming as an incentive to attract greater numbers. The voluntary supporters cited the educational offerings of the Academy of General Dentistry as an example of sound programming. An increasing number of dentists were taking courses at dental schools and hospitals. The organization had grown to 5,000 members in the eighteen years preceding 1969 and was expected to double within a few years. A desire for self-improvement accounted

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for the progress. The voluntary advocates cautioned that forced attendance might result in an attitude of rebellion which would hamper meaningful learning. Desire for intellectual growth must come from within the individual. The value of continuing education is in the ability to transfer knowledge into performance. The ultimate in the health field is for better patient care to ensue.31

The voluntary sector is concerned that no positive proof exists to show that a portion of the dentists are less than adequate because they have not updated skills. Data are lacking which demonstrate how much or how little the dentist reads on his own, how many scientific meetings he attends and how often he improves his knowledge through consultation with peers.32

Voluntary methods were favored by 70.6 percent of the sample in a Pharmacy Times survey. Questionnaires were sent to 200 retail pharmacists on a random basis asking about the issue of mandatory continuing education. At press time, the journal had received fifty-one replies, a return of 25.5 percent.33


32Ibid.

These same pharmacists in favor of voluntary continuing education offered suggestions for improving current programming:

1. A pharmacist would not have to leave his place of business in order to keep up-to-date if correspondence courses were offered. Both printed and tape-recorded lessons should be utilized. In addition, lists of recommended readings should be used.

2. Programs should include methods of operating a business more profitably in addition to teaching professional aspects of pharmacy.

Ness states that most workers in continuing education believe that voluntary education is the most beneficial arrangement but success to date has been minimal. Many will support voluntary continuing education and will favor that position until individualized education is attainable in a manner that is convenient for self-learning.

Regardless of the particular stand on the mandatory-voluntary axis, most writers would seem to agree with Darley who said, "Unless the total profession shows

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34Ibid.


more active concern for its own self-renewal, the ques-
tions of relicensure and recertification will change from 
handwriting on the wall to reality much sooner than most 
of us think."

Evidence of Voluntary Engagement

of Health Professionals in Continuing Education

Darley's words reverberate when evidence of partici-
pation in continuing education is reviewed. Total enroll-
ment in continuing education has increased for physicians.
In 1960-61, 57,500 people registered for continuing edu-
cation courses at medical schools. Attendance figures for
1969-70 indicate that 181,636 participated, an increase of
315 percent. During that period of time the total number 
of physicians had increased by twenty-five percent. How-
ever, in 1968, perhaps as many as one-third of the nation's 
physicians did not engage in formal continuing medical edu-
cation programs.38

Many dentists do not engage in continuing education 
activities. In 1960, the National Opinion Research Center 
studied the problem, which was reported in Survey of Den-
tistry. This report indicated that less than half of the 
dentists in the United States (45.6 percent) engaged in

38Ibid. p. 1241.
advanced education following graduation from dental school. The point was made that a movement in the direction of compulsory continuing education would encourage practitioners to pursue such study. Some see the result to be an elevation of the dentist's image and improvement in the quality of dental services.\textsuperscript{39}

While over 1800 hospital pharmacists participated in continuing education programs sponsored by the American Society of Hospital Pharmacists during 1968,\textsuperscript{40} only about ten percent of participating pharmacists regularly attend meetings.\textsuperscript{41} In Kansas, Shalinsky\textsuperscript{42} reports that 618 pharmacists participated in eleven seminars throughout the state in 1967-68. The actual number of different people was 479 since several individuals attended more than one seminar. The 479 figure is an increase from 350 in 1965-66 and 456 in 1966-67 and indicates that thirty-six


\textsuperscript{40}Grover C. Bowles, "Continuing Education May Be Required for Pharmacist License," \textit{Modern Hospital} 113:130, October, 1969.

\textsuperscript{41}Kenneth F. Fingers, "Mandatory Continuing Education as a Requirement for Licensure from the Standpoint of the Educator," \textit{Proceedings of the Third District, Wrightsville Beach, North Carolina}, August 24-26, 1969, p. 44.

percent of the active pharmacists in the state attended one of the meetings. He estimates that three percent of all pharmacists in the country and ten percent of the pharmacists in California participate in continuing education meetings each year. During the second year of the mandatory provision, 1968-69, 670 pharmacists registered for seminars and 32 for correspondence courses which amounted to a total of 702 registrations and 549 different individuals. Approximately 1,000 pharmacists were active in the state that year.

Another claim is that only fifty-eight percent of California pharmacists have participated in any form of continuing education under voluntary conditions. Lawrence states that pharmacists have not sufficiently engaged in continuing education, and the profession has not met the objective of providing the optimum level of health care services.


Quality of Continuing Education in the Health Field

A criticism of the present system of continuing education is that the programming is passive, content-oriented and categorical. Some members of the medical profession do little reading, attend no rounds and travel to no scientific meetings. 45

Brown and Uhl 46 charge that continuing medical education has lacked a conceptual scheme which would relate education programs directly to an identified physician and his needs. They state further that almost everybody is dissatisfied with the present continuing education product and its lack of effectiveness in not achieving needed changes in the practice of medicine.

The National Advisory Commission on Health Manpower stated that some existing programs of continuing education are inadequate in both content and geographic distribution. New programs have to be developed and presented in ways that are tailored to the location and


time requirements of practitioners.\textsuperscript{47}

Respondents to a Florida Board of Pharmacy survey indicate in 890 of 1,000 queries that programs were sufficient. Personal areas of interest were covered according to 796 respondents. However, sixty-two people felt retail pharmacy had not been covered adequately. Florida pharmacists believed programs and faculty were not as professional as they should be. Criticism was made of physical facilities, communications and planning. It was also pointed out that materials need to be sent in advance to participants and repeat programs should be available because of the shifts pharmacists work.\textsuperscript{48}

\textbf{Attitudes toward Mandatory Continuing Education in the Health Field}

A sample of physicians in Oregon, Washington and Idaho was asked about voluntary and mandatory continuing education for physicians. Thirty-five respondents said

\begin{itemize}
\item \textsuperscript{48}Hinton F. Bevis, "Continuing Education as a Requirement for Extended Licensure," Proceedings of the Annual Meeting of District Four, Oshkosh, Wisconsin, November 9-11, 1969, p. 60.
\end{itemize}
that maintenance of competence should be voluntary and thirty-seven answered in favor of the mandatory approach.49

In another survey, dentists were questioned by the Pierre Fauchard Academy Poll of Professional Opinion. The study revealed that forty-eight percent responded favorably and fifty-two percent negatively to the query: "Should State Boards require dentists to take a prescribed number of postgraduate courses or attend a specified number of dental meetings?" Support for mandatory continuing education increased by age groups up to the category of dentists who had practiced from eleven to twenty years and then declined for individuals with over twenty years of practice. Table I shows the breakdown by years of practice.50

Speakers were selected to discuss voluntary and mandatory issues at the Philadelphia County Dental Society meeting. The Society surveyed participants' attitudes before and after the program. Fifty-eight percent of the respondents favored mandatory continuing education at the beginning of the program and fifty-six percent at the conclusion.51

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### TABLE 1

Percentage Comparison of Responses to Question Asking whether Continuing Education Should Be Required for Relicensure

<table>
<thead>
<tr>
<th>Years of Practice</th>
<th>YES</th>
<th>Percentage of</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 Years</td>
<td>42</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>5 to 10</td>
<td>49</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>11 to 20</td>
<td>58</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>21 to 30</td>
<td>46</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>31 to 40</td>
<td>43</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>More than 40</td>
<td>25</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>44</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>

The National Advisory Commission on Health Manpower stated that relicensure of physicians and other health professionals should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in
the practitioners specialty. The Commission declared that simply making educational opportunities available will not assure their utilization unless incentives are provided.

Dr. Melvin Breese, Chairman of the Oregon Medical Association's Council of Medical Education, has written that their mandatory program has made each physician's continuing education efforts more easy and effective. They can keep up-to-date in all areas of their practice and minimize the gap between available knowledge and application.

In New Mexico, the state medical society sponsored a bill requiring physicians to engage in continuing medical education, although a dissident group feared compulsion and the consequent power of the Board of Examiners. After the bill was enacted into law, a county medical society delegation tried to prevent its implementation. The attempt was unsuccessful but hard feelings were evident as the attackers charged the Board secretary

52Report of the National Advisory Commission on Health Manpower, op.cit.

53Ibid., p. 40.

54"Keep Up to Date or Else, Medics Told," Dayton Daily News, Dayton, Ohio, Jul. 11, 1968, p. 23.
In 1969, the American Dietetics Association adopted an amendment to its constitution authorizing a category of membership called "Registered Dietitian" or "R.D." The change was made for the purpose of self-improvement through continuing education. A special meeting of members had been held to report results of the balloting on Constitutional Amendments. The vote revealed eighty percent of the membership had cast a ballot, with 12,596 in favor and 4,494 opposed to "Registered Dietitian" category.

With reference to the pharmacy profession, Lawrence maintains that compulsory continuing education is essential to the achievement of professional objectives.

Replies in the Pharmacy Times survey brought the following criticisms of mandatory continuing education:

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55L.A. Healy, op.cit.


58Lawrence, op.cit.

59"Continuing Education: Voluntary Compulsory," op.cit.
1. Higher wages would be forced because pharmacists would have more direct and indirect expenses for additional education.

2. Older pharmacists would forfeit licenses rather than take educational courses.

3. It would cause a problem for the retail pharmacist in a small store because he would have no coverage in his pharmacy while attending courses.

Compulsory continuing education was favored by 29.4 percent of respondents in the survey. These people favored forced continuing education for the following reasons:

1. Drastic changes are taking place in laws, medications and pharmaceutical procedures.

2. Unless mandatory, fewer pharmacists would engage in continuing education courses.

3. Pharmacists who have been out of school for several years would not be able to pass the state board examination without continuing education.

4. Older pharmacists, many of whom have had little classroom training, would benefit from additional formal education.

5. Periodic recertification would be required because the pharmacist's work is vital to the public's health and safety.

6. The profession of Pharmacy would be upgraded by compulsory methods.

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Ibid., p. 41.
These supporters of mandatory continuing education favor the following means of improving such education: ¹

1. Close retail and hospital pharmacies at different times on a staggered basis to allow pharmacists to attend classes.

2. Administer mandatory continuing education on a national basis.

Required continuing education offers an environment unequaled by prior measures for the conduct of educational programs. It can provide the means to reach every professional rather than the ten percent who regularly attend meetings. ² K.F. Fingers, ³ Dean of the College of Pharmacy at the University of Florida, has stated that a mandatory provision will enable colleges of pharmacy to begin meaningful continuing education programming.

Reflecting on the first year of mandatory continuing education for pharmacists in Florida, Hinton F. Bevis, ⁴ Executive Secretary of the Florida Board of Pharmacy, stated that 5,601 pharmacists renewed licenses in 1969 compared to 6,003 the previous year. He considers the

¹Ibid.
²Fingers, op.cit.
³Ibid.
⁴Bevis, op.cit., p. 59.
closeness of the two figures amazing in view of the prediction that many would not renew because of the requirement to complete fifteen hours of continuing professional education during the year. Many pharmacists who did not renew had gone into the military, had retired or moved into another field. Bevis concluded that the mandatory provision did not have a significant effect upon license renewals.

The California Nurses' Association has sponsored a measure in the state legislature that would establish continuing education requirements for Registered Nurses and Licensed Vocational Nurses as a condition for relicensure.65

Many nursing home administrators have welcomed licensure and mandatory continuing education in an attempt to achieve professional development.66

Continuing education is the method used by the American College of Hospital Administrators in meeting its objectives. However, participation is voluntary and below optimum standards. An ACHA Task Force has suggested a continuing education requirement to retain membership


eligibility.  

In favoring mandatory continuing education, the Commission on Medical Malpractice declared:

Here it is enough to point out that the weakness of such voluntary programs is the age old one of human nature: it is the most thoughtful and conscientious individuals who take the courses; the less motivated and careless, who may need them more, are less likely to do so, even though their ignorance may increase the likelihood of malpractice suits against them. The rationalization that they are overworked and "can't spare the time" deters many, and the threat of being dropped from membership in a medical society may not provide a strong enough impetus for such people to maintain their proficiency; a stronger prod is needed. Moreover, those who presently do take the courses are rated only for attendance, not for substantive knowledge.

Consequently, the Commission recommends that control mechanisms be imposed upon the present system of self-regulated continuing education which will require continuing medical education and evidence of proficiency.

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Attitudes toward a Professional Association's Having Responsibility for Enforcement of Mandatory Continuing Education

The American Medical Association's Board of Trustees and Council on Health Manpower made several recommendations for the involvement of professional societies in continuing education. It was recommended that:

1. Medical specialty boards be encouraged by the A.M.A. to consider periodic recertification, which would be granted on the basis of participation by the member in continuing education, involvement in self-assessment programs or other appropriate conditions.

2. Recognized medical specialty societies be encouraged by the A.M.A. to explore the desirability of establishing similar requirements for continued society membership.

3. Medical societies, medical specialty organizations and other appropriate groups increase efforts to use self-assessment evaluation programs for physicians.

4. Constituent medical associations be encouraged to investigate the desirability of requiring members to participate in continuing education as a condition of continued medical society membership and to furnish periodic documentation.

Brown and Uhl state that despite the fact that professional organizations are fostering mandatory continuing education, continued involvement of professional societies in continuing education is necessary.

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education, a wholesale move in that direction would frustrate innovative educators from exploring new avenues.\textsuperscript{71} Needed is a system that places a premium on maintaining excellence. Without that ingredient, continuing education will never reach its potential, never be much more than a frill and never reach a large proportion of practitioners.\textsuperscript{72}

The Oregon Medical Association is an organization of physicians which has sought mandatory continuing education standards for its members. The OMA has been credited with pioneering developments in the field of mandatory continuing education for physicians. In September 1968, the OMA authorized a voluntary continuing education pilot program for its members to be conducted during 1969 which was to be followed by a compulsory program in 1970. The organization's policy-making body, the House of Delegates, unanimously approved a detailed plan which went into effect on January 1, 1970. The Council on Medical Education had recommended earlier that minimum continuing education requirements be established for association members and that an evaluation mechanism

\textsuperscript{71}Brown and Uhl, \textit{op.cit.}, p. 1662.

\textsuperscript{72}Charles A. McCallum, "What is the Attitude of the American Association of Dental Schools on Continuing Education as a Requirement for Relicensure?" \textit{The Journal of the American College of Dentists}, 36:189, July, 1969.
be established to monitor program quality.\textsuperscript{73}

Particular program requirements are developed by each specialty section within the OMA. The specialty section submits lists of acceptable study opportunities to the Council on Medical Education whose staff members compare individual physician reports of continuing education activities completed with the approved lists. If reports are not acceptable, the appropriate specialty section reviews the report either to concur with the staff decision or refer the report to an arbitration committee. Each specialty group follows up delinquent reports of its own members, and non-physician staff members handle routine operations. The reporting mechanism is designed to be simple, taking physicians only a few minutes each year to report their continuing education activities. The OMA completes the process by sending a letter of approval and a decal to display before the public.\textsuperscript{74}

The Oregon program was not designed to be difficult. Instead, it was developed to provide a realistic guideline for minimal standards as determined by physicians themselves. The OMA plan is a method of differentiating


\textsuperscript{74}Ibid., p. 1659.
the acceptable from the unacceptable. It is considered a mechanism for allowing physicians to compare their continuing education activities with other physicians and then to seek improvement on their own initiative.75

Pennington76 relates that the primary goal of mandatory continuing education in Oregon is to improve the quality of health care to the people of that state by upgrading knowledge and competence of the members of the OMA. However, he does not contend that physicians will become better practitioners simply because of the mandatory provision. Pennington points out, however, that the program does make clear the importance of keeping abreast of the latest developments in medicine. Further, he declares that if the mandatory continuing education venture is successful, association membership will be more prestigious and, consequently, more physicians will want to become members. As a result of the latter, Oregon citizens would receive better care.

The mandatory provision is intended to be helpful, not punitive, despite the fact that if the approximately 2,100 physician members do not continue their medical education on a regular basis they face stiff penalties,

75 Ibid.
76 Ibid.
including expulsion. Breese states that this first such policy decision by a state medical society has not been designed to force physicians against their will. He says that the mandatory program makes each physician's continuing education efforts more easy and effective. They can keep up-to-date in all areas of their practice and minimize the gap between available knowledge and application.\(^77\)

Although critics of mandatory continuing education in Oregon say the OMA will lose members because of its compulsory nature, Pennington\(^78\) states that this is only remotely possible because the program was designed with the knowledge that the majority of physicians in the state already surpass the requirements and they are really only reporting facts. He declares that the physicians who choose not to cooperate will do little damage to the organization. In his opinion, the most important consideration is that physicians who do not meet the requirements for reasons other than by choice, will be isolated and then assisted in complying with the provisions. In further response to critics who have declared the program too easy and too late, Pennington cites the numerous requests received from throughout the country and world

\(^77\)"Keep Up to Date or Else, Medics Told," op.cit.
\(^78\)Pennington, op.cit., p. 1660.
for information about the Oregon experience. He interprets these requests to mean that the program is timely and that others also realize public responsibility of professionals to maintain competence.

Whether physicians can accommodate a plan for re-examination is not the issue. The public is demanding that determinations be made about a physician's clinical competence, character, physical health and mental health. Further, such determinations need to be made throughout professional life and not only at one point in time. 79

The American Academy of Family Practice (formerly American Academy of General Practice) has required members to complete continuing education requirements since its founding in 1948. 80 This is the only medical board requiring periodic recertification, although the American Board of Internal Medicine is now investigating that possibility. 81 The Internal Medicine Long Range Planning Committee reported to the board that periodic recertification of members should be undertaken. The recommendation

79 "Continuing Education: Option or Obligation," op. cit., p. 1241.


was accepted in principle.  

The American Medical Association approved the American Board of Family Practice in 1969. This specialty requires recertification every six years, a stipulation which compels the family physician to keep up-to-date with new knowledge and techniques. This examination is so rigorous that 800 of the first 4,000 practicing physicians taking the test did not pass. Individuals not passing the examination are given another opportunity, with many being among the 4,000 members who have been certified. Starting in 1978, only physicians completing the three-year postgraduate educational program and passing the examinations will be certified as family physicians. Members are required to complete 150 hours of approved continuing education every three years.  

The California Medical Association has taken a different approach to the mandatory question. The chief of the medical staff in all California hospitals received a letter suggesting that their medical staff members annually submit a list of continuing medical education activities. Participation in organized activities would

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83 "Family Physician is Replacing Old 'GP',' The Columbia Daily Tribune, Columbia, Missouri, September 18, 1972, p. 4.
constitute a requirement for a hospital staff appointment.\textsuperscript{84}

Reaction to the suggestion has been mixed. Some medical staffs are waiting to see the reaction of other staffs before making a decision. Others have asked that a CMA representative attend a hospital medical staff meeting in order to discuss the recommendation. About ten percent of the state's hospitals have decided to implement the suggestion. At least one hospital is concerned about the legal implications of enforcing such a policy. That hospital will seek legal advice before implementation because its officials fear contention of the policy in court would bring a negative verdict.\textsuperscript{85}

The California plan is viewed as one of the increasing number of ways to force physicians to maintain competence. It is no longer acceptable to say that most doctors are interested enough in their work to maintain competence or to state that the hospital and medical society conduct continuing education programs and will discipline those few physicians who do not keep up-to-date and endanger patients. Further, many people are extremely concerned about the physician who works alone

\begin{flushright}
84"Continuing Education: Option or Obligation?" op. cit.
85ibid.
\end{flushright}
and, consequently, does not receive the scrutiny of his peers. The isolated physician does not have the educational opportunities that accrue to doctors who work in close proximity to other professionals.86

Some physicians do not practice in hospitals at all. Others practice at hospitals not accredited by the Joint Commission on Accreditation of Hospitals, an estimated twenty percent of all hospital beds.87

In the previously cited survey of physicians in Oregon, Washington and Idaho, most felt continuing education requirements should be enforced by the state medical association with the specialty board organization, specialty society and American Medical Association close behind.88

The Tennessee Medical Association indicated its interest in the field of continuing education by adopting a resolution in 1969 instructing its committee in this field to seek the cooperation of the Regional Medical Program to assist in the promotion of continuing education. The continuing education council of the Medical Society of Virginia resolved that consideration be given

86Ibid.
to the formulation of a plan of continuing education for its members as a highly desirable credential for membership. The Pennsylvania Medical Society approved in principle a membership requirement of 150 hours of continuing education every three years. The Arizona Medical Association appointed a study committee to work with the Board of Medical Examiners to determine the mechanics of periodic relicensure to include a continuing education provision.89

By 1973, six state medical societies had made continuing education a requirement for continued membership. Thirteen other state associations have enacted measures for voluntary participation in continuing education by society members.90

Standards set by a professional society as a condition for specialty board certification, hospital affiliation or medical society membership can be established at higher levels because the basic ability of a practitioner to earn a living is not affected as strongly. Also, standards can be continuously refined and tailored


to a particular field without having to change status. 91

A segment of the American Dental Association mem-
bership argues that efforts to develop continuing edu-
cation should be removed from laws and legal restrictions
of state regulatory bodies, including state dental ex-
aming boards. These people state that the organized
dental profession should establish standards of profes-
sional competence. Such an obligation, they contend,
should not be relinquished to a governmental agency. 92

Other members of the American Dental Association
are concerned about licensed dentists who are not mem-
bers of a constituent society. Thirteen percent of den-
tists fall in this category. Further complications arise
with the knowledge that some dentists are not engaged in
active practice while others hold direct membership in
the Association without belonging to a constituent soci-
ety. Many of these dentists support a voluntary pro-
gram based upon peer review and current methods of disci-
pline against dentists who do not provide acceptable
care. 93

91"Continuing Competence of Physicians," op. cit.
p. 1541.

92Reginald H. Sullens, "Dental Licensure and Con-
tinuing Education," Journal of the Missouri Dental Asso-

93Ibid., p.7.
In nursing, the Utah Nurses Association has established a voluntary certification program with inclusion of continuing education requirements. A task force has been appointed by the American Nurses Association to study the question of including continuing education as a requirement for license renewal.

The Commission on Medical Malpractice recognizes that the competence of American medical specialists is certified by various specialty boards. The Commission recommends that the boards periodically re-evaluate and recertify physicians it has certified. It claims that peers can evaluate continuing competence by a simple assessment.

The Commission on Medical Malpractice takes note of a trend toward mandatory continuing education programs with both the American Academy of Family Physicians and American Osteopathic Association requiring continuing education of its members. The state medical associations of Arizona, Massachusetts, New Jersey, New Mexico, Oregon


and Pennsylvania require a stipulated number of continuing education hours to maintain membership. However, expulsion from membership in the medical association does not eliminate the doctor's privilege of practicing medicine.97

**Attitudes toward**

*a Governmental Agency's Having Responsibility for Enforcement of Mandatory Continuing Education*

Sponsors of the Kennedy proposal for national health insurance have included a section pertaining to government's role in mandatory continuing education of health personnel. As reported in the January 25, 1971 issue of the *Congressional Record*, Senator Edward M. Kennedy's bill, "Health Security for America," would charge the Health Security Board, organized in the Department of Health, Education and Welfare, with establishing requirements for continuing education of health personnel.98

The National Advisory Commission on Health Manpower recommended that state governments and professional

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societies explore the possibility of periodic relicensure of physicians and other health professionals. In citing potential problem areas, the Commission stated that licensure can only be granted by a governmental agency. It concluded by declaring that governmental jurisdiction over professional activity should be pursued only after careful planning for prevention of abuse.\footnote{Report of the National Advisory Commission on Health Manpower, op.cit.}

In order to secure background information about the question of mandatory continuing education, Dalton\footnote{Dalton, op.cit.} polled affiliates of the American Association of Dental Examiners, who are members of governmental dental boards, and received responses from forty-two of the fifty-three agencies within a three-week period. He learned that none of the states had any continuing education requirements for relicensure but that twenty-five percent indicated probable inclusion within the foreseeable future. Eighty-five percent expected considerable difficulty with administration if a program were developed. Most boards stated they would set their own standards of continuing education but that they would review guidelines established elsewhere.

The American Dental Association's House of Delegates
in 1968 passed a resolution stating that determination of qualifications of the individual dentist participating in publicly funded health programs should be made by governing bodies of component and constituent dental examining boards. This statement had come in response to questions raised by health agency officials in the State of New York about continuing education requirements for dentists who treat Medicaid patients.101

The American Dental Association Council on Dental Education in 1967 had presented a "Statement on Dental and Dental Hygiene Licensure" which declared that constituent dental societies, working with state boards of dentistry, should develop methods to insure the continuing competence of all dentists licensed in their jurisdiction.102 The Council stated that boards and constituent societies should determine the amount of continuing education needed in their states. They would be responsible for deciding whether continuing education should be required for licensure renewal. In succeeding years, other committees have reaffirmed the responsible role of boards and constituent societies. They said that the nature and extent of continuing education and

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102 Ibid.
administrative procedures would have to be developed by these groups. A "grandfather" clause and distant effective date were considered essential so that undue hardship would not be faced by any member.103

At the conference of the Philadelphia County Dental Society in March 1969, twenty-six percent of the respondents at the beginning of the program and forty-three percent at the conclusion believed the state board of dental examiners should assure that dental practitioners engage in continuing education. At 10:00 a.m., thirty-three percent disclosed that the individual dentist should assure involvement in continuing education compared with twenty-two percent at 3:00 p.m.104

In California, proposed legislation, Bill AB 449,105 would require that a Council on Continuing Education for the Health Professions be established in the Department of Consumer Affairs. The departmental director of this state agency would serve as Council Chairman and appoint four additional members as follows:

1. One administrator of a licensed hospital
2. One registered nurse

103 Ibid., p. 15.
105 "Continuing Education Bill Nears Approval," op. cit.
3. One licensed vocational nurse
4. One public member

The Council would establish standards for continuing education in each field which would assume reasonable currency of knowledge as a basis for safe practice by licensees in each field. Standards would be established in a manner to assure a variety of alternatives is available to licensees in order to comply with requirements. Alternatives include, but are not limited to, academic studies, inservice education, institutes, seminars, lectures, conferences, workshops, extension studies and home study programs. Committees may formulate proposed standards in each occupational field and invite recommendations from licensing agencies and boards. The following provisions would be included:

1. The licensure board shall require that each holder submit proof, from the preceding two-year period, of continuing education courses acceptable to it. Instead of completing continuing education requirements, the license holder may elect to take an examination developed by the board.

2. A license may be reinstated after it has lapsed by successful completion of a refresher course or by other means considered to be equivalent by the board. Payment of fees is required.

3. The board may temporarily suspend requirements for licensees serving in overseas

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106 Ibid.
military service and in special cases where unreasonable hardship would occur.

4. Continuing education requirements will not be enforced for licensees the first two years following graduation from nursing school.

The bill was drafted in cooperation with the Licensed Vocational Nurses' League of California, the California Licensed Vocational Nurses' Association and the California Hospital Association. All of these organizations are listed as co-sponsors.107

Speakers in favor of the mandatory provision at the Philadelphia County Dental Society meeting stated that enforcement should be instigated by individual state board supervision. One of these supporters believed that members of the state board should not be political appointees. All agreed that standards should be established by state boards and that dental societies, dental schools and hospitals should provide courses.108

Bevis109 related that over 4,600 evaluations were received by the Florida Pharmacy Board during the first year of that state's mandatory continuing education law.

107 Ibid.
He uses this fact as evidence that pharmacists in Florida are displaying a positive attitude toward the role of government in required continuing education.

Payment of a renewal fee by a person holding the certificate of pharmacy registration in Kansas authorizes renewal of his certificate if evidence is furnished that some form of continuing education, as required and approved by the Kansas Board of Pharmacy, had been completed in the previous year. The requirement cannot exceed two days of education each year and must be developed by a major institution.110

In California, Assembly Bill 977 was enacted into law which required pharmacists to engage in continuing education for license renewal in 1973. The State Board of Pharmacy is responsible for the selection of a Committee for the Continuing Education of Pharmacists whose membership will be appointed with equal representation from the State Board of Pharmacy, faculty of colleges of pharmacy in the State of California and practicing pharmacists within the State. The law stipulates that on and after January 1, 1973 the board will not issue any renewal certificate unless the applicant submits proof that he has completed not less than thirty clock hours of

110Joseph G. Shalinsky, op. cit.
approved courses of continuing pharmaceutical education during the two preceding years. The clock-hour requirements do not apply to licensees during the first two years immediately following graduation from a college of pharmacy or department of pharmacy of a university recognized by the board.111

The Ohio State Board of Pharmacy was responsible for developing minimum standards of continuing education which became effective September 15, 1973. The objective of the mandatory feature is to assure and certify that every person licensed to practice pharmacy will be "fit to practice" as determined at the original time of licensure by examination. A second objective is to establish minimum requirements to attain the basic objective by reasonable, practical and productive procedures. Also considered important is the avoidance of burdensome and meaningless demands on the registered pharmacist and the State Board of Pharmacy.112

The Kansas legislature passed a law which would have related continuing education to relicensure. However, a provision was incorporated that required the Board of Medical Examiners to unanimously recommend it.

111Terry Dozier, op. cit.
Literature indicates the Board has not acted.113

States receiving funds under Title XIX (Medicaid) of the Social Security Act were required to have a program for the licensure of nursing home administrators by July 1, 1970. This legislation forced states to develop, impose and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator. The individual must be qualified in institutional administration by education or experience. Because of the large number of nursing home administrators who would not qualify under the new standards, a waiver provision was written into the legislation allowing each state two years, or until July 1, 1972, to update its nursing home administrators who had been in such a position for the calendar year preceding the effective date.114

Training grants were made available by the Federal government to enable states to educate the provisionally licensed administrators. These grants could not exceed seventy-five percent of the cost of educational programs and each program had to include approximately 100

113Healy, op.cit.

classroom hours of instruction and be taught through an affiliation with an accredited university. Subject matter had to include a core of knowledge consisting of nine areas:\textsuperscript{115}

1. Applicable standards of environmental health and safety
2. Local health and safety regulations
3. General administration
4. Psychology of patient care
5. Principles of medical care
6. Personal and social care
7. Therapeutic and supportive care and services in long-term care
8. Departmental organization and management
9. Community interrelationships

The State of Missouri requires nursing home administrators to renew their license each year. Every person seeking licensure must complete a minimum of twenty-four hours of continuing education which have been approved by the Missouri Board of Nursing Home Administrators, an eight-member board appointed by the Governor.\textsuperscript{116}

By 1973, three state legislatures had enacted laws

\textsuperscript{115}Ibid., p. 3969.

\textsuperscript{116}Licensure of Nursing Home Administrators, State of Missouri, p. 7.
to make formal participation in continuing medical education a requirement for periodic relicensure. One state medical society proposed legislation in cooperation with the state board of medical examiners and supported its passage.117

The Commission on Medical Malpractice found that two states have enacted a relicensure law for physicians, which includes requirements for compulsory continuing education and proof of proficiency. Another fifteen to twenty states are considering such legislation. In states that have separate licensing boards for M.D.'s and D.O.'s, doctors of osteopathy must meet continuing education provisions. Optometrists, dentists, dental hygienists and nurses have to show evidence of continuing qualifications as a condition of license renewal. In California, starting in 1975, registered nurses and licensed vocational nurses will be required to keep current in their fields, either by taking approved courses or by equivalent means.118 Also, the Commission recommends "that the states revise their licensure laws, as appropriate, to enable their licensing Boards to require periodic


re-registration of physicians, dentists, nurses and other health professionals based upon proof of participation in approved continuing medical education programs."119

Evaluation of the Effectiveness of Health Professionals Participating in Continuing Education

The continuing education program's effect upon the clinical competence of the medical practitioner is a major concern. Lack of an appropriate evaluation mechanism was cited as the reason for difficulty in precisely determining whether attendance at an individual course maintains competence. Such assessment is also difficult when attempting to evaluate the effectiveness of reading professional journals.120

An important approach to maintaining competence is through medical care evaluation and peer review of performance. Peer review activities have been based in the medical care institution as a responsibility of the medical staff. A movement toward strengthening and enhancing the educational component of reviewing the professional work of colleagues has taken place during the last few

119 Ibid.
120 "Pursuit of Excellence Through Continuing Education," op. cit.
years. In 1970, the Joint Commission on Accreditation of Hospitals approved revised standards for accreditation of hospitals to include continuing review of each staff member's clinical activities by his peers and continued participation by all staff members in evaluation of the clinical practice that exists within the hospital. Also, the JCAH's revised standards require that the medical staff provide a continuing program of professional education or give evidence of participation in such a program.121

Worthy of note are self-assessment tests being developed or being used by several of the medical specialty societies. In 1968, over thirty percent of the internists practicing in this country participated in a test consisting of 700 questions taken from nine categories of special knowledge in internal medicine. These self-assessment measures allow each physician to determine his own educational needs and to inform the specialty society about areas of knowledge which require emphasis in planning society-sponsored continuing education programs. However, a major problem in working with specialty boards is that they do not apply to all physicians.122 It is not mandatory that every physician be a member of some


122Ibid.
specialty board.

The self-assessment test offered by the American College of Physicians at a cost of $15 for members and $25 for non-members has been called the best bargain in medical education to correct an apparent knowledge deficiency. Some of the advocates of self-assessment do not like re-examination for licensure. They believe that passing a factual examination may give false reassurance because it means only that raw materials for professional practice are present. Critics claim that quality and actual value of efforts are not measured. If continuing education is to be related to re-evaluation of the physician, they state that it must measure the physician's effect upon the patient rather than his competency in an examination which tests his retention of facts and skills. Licensure examinations are written to test broad competence in unspecialized practice and would not be appropriate to medical specialists many years out of medical school. 123

Examinations that involve simulated patient situations, simulated problem solving, computer-based examinations, multiple-choice questions and oral or written tests are not appropriate for continued assessment of a doctor in practice. Performance at work rather than performance in

123 "Continuing Education: Option or Obligation?" op. cit., p. 1242.
examination is the important aspect. The initial certifying examination tests the nominee's knowledge, his information interrelations, the process of information use and his attitude. Performance at work is generally excluded.\textsuperscript{124}

Little consensus is evident about the degree to which participation in continuing education is conducive to improved clinical ability, or the degree to which performance on any examination truly measures ability. Inclusion of continuing education requirements in a law regulating an individual's right to earn a living by practicing a profession in which he is lawfully engaged would necessitate that standards of performance be set at a minimal level because a higher level would be continually subject to successful appeal by physicians negatively affected. The result would be little improvement in the ability of state medical boards to ensure physician competence.\textsuperscript{125}

Frequently discussed methods of re-examination and recertification are inappropriate. A series of continuing education courses followed by simulated patient situations,\textsuperscript{124}


\textsuperscript{125}"Continuing Competence of Physicians," \textit{op.cit.}, p. 1541.
simulated problem solving, a computer-based examination, a number of multiple-choice questions and written or oral examinations do not assess continuing physician performance in the line of duty. An examination system for the practicing professional should focus on results of productive activity and not information used. Important are the processes of patient management and results of patients managed.\footnote{126}{Mueller, op.cit., p. 1379.}

Such a system would require evaluation of office records, hospital admissions, operative records, tissue reports, medical audits, patients' hospital stay, complications, diagnoses, deaths and other areas of physician activity. The doctor's management process may be reviewed by observing what he is doing, if he has abandoned obsolete practices and adopted new ones, and if he is carrying out patient care activities in an up-to-date acceptable fashion. Mueller states that peer review has not guaranteed high standards of physician performance by exclusion of the inadequate or undesirable. Consequently, he claims lay examiners acquainted with medical practices should be used.\footnote{127}{Ibid.}

Peer review is a control technique in which professionals impose standards upon professionals which have been determined by the professionals themselves. Society has
allowed freedom of control as long as the profession has remained responsive to society's needs. Hardyment\textsuperscript{128} believes that peer review is essential whether society as a whole operating through government, or the organized profession through voluntary self-discipline, is the particular mechanism selected.

Dr. William G. Anlyan,\textsuperscript{129} former Chairman of the Association of American Medical Colleges, has written in favor of mandatory recertification of physicians every five years. The recertification decision should be based upon performance and determined by peer review of the problem-oriented patient record. Dr. Anlyan emphasizes that board specialty examinations should not be taken every five years. The object of basing recertification on past performance of the physician is to look objectively at the quality of work in the field of his choice.

Another observer, Dr. Russell A. Nelson, President of Johns Hopkins Hospital and a member of the National Advisory Commission on Health Manpower, believes that health professionals should have periodic testing of capacity by examination or observation by peers or, on

\textsuperscript{128}Hardyment, \textit{op.cit.}

the other hand, comply with continuing education require-
ments for both initial licensure and specialist qualifi-
cation. He believes that such a national system would
be difficult and would take a long time. In requiring
licensure, the ability of a person to earn a livelihood
is placed in jeopardy. A poor method could cause great
personal injury and essentially break a contract between
society and the individual which is implicit in the
granting of a license to a professional for his lifetime
unless he gets into trouble. Dr. Nelson proposes that
physicians lacking competence because of isolation from
peers be helped to obtain hospital appointments or urged
to work under supervision rather than imposing re-examina-
tion requirements. The physicians would probably respond
to the new environment and show improvement.130

Nursing home administrators believe that the nursing
home industry should regulate itself. In a survey, 116
administrators favored peer review and thirty-two decided
an outside agency should be responsible. Fifty-three
said there is a peer review program for nursing home
administrators in their state while eighty-five responded
negatively. In response to the question, "Do you think
self-regulation within the field would eliminate serious

130"Continuing Education: Option or Obligation?" op.cit., p. 1244.
instances of poor care and unsafe conditions?" ninety-seven answered "Yes" and forty-nine said "No". However, it is interesting to note that nearly half of the respondents felt that someone from state or local government should be assigned to safeguard the rights of patients.131

In the hospital field, the Colorado Hospital Association has developed a peer review mechanism for evaluating the quality of hospital management. In this voluntary program, the CHA maintains a list of administrators who agree to participate in review activities. Three listed administrators visit the facility of the requesting administrator on a particular day to focus on problems, discuss accomplishments and ideas, and to perhaps meet with the medical staff or trustees. Twenty-five of ninety-six CHA members have participated in seven reviews during the twelve months of the program's existence.132

Besides offering a learning situation to both reviewers and reviewed, the CHA program meets the demand of an increasingly health-conscious public. A Colorado Hospital Association official states that physicians, nurses and consumers want methods to determine the


effectiveness of people responsible for patient care. He declares that the system shows the interest of hospital administrators in continuing education. 133

The Management Effectiveness Program of the California Hospital Association is a voluntary service offered to hospital chief executive officers in that state. The final report goes to the individual and he has the option of sharing it with his board of trustees or maintaining privacy. The ACHA Task Force supports the concept of outside appraisal. 134

The Educational Testing Service is developing and administering, "Self-Assessment and Continuing Education in Dentistry," a program which will allow practicing dentists to evaluate their own professional knowledge and competence. Dentists will be able to measure their own continuing education progress and compare it with knowledge of their peers. This program is being developed under a contract with the American College of Dentists and is reportedly made available to an entire profession. Emphasis will be on evaluation of task-oriented skills and knowledge of current topics rather than of academic abilities. 135

133Ibid.


The participant will pay an annual fee of $40 for a series of four self-administered examinations mailed on a quarterly basis. Test results will be sent only to the participant who will receive an analysis of his performance, data indicating his relative standing in comparison with his peers and a list of references indicating where information may be found on questions answered incorrectly.136

By 1973, major growth in the development of self-assessment tests had been made by medical specialty societies. Fourteen national medical specialty societies had self-assessment programs in operation.137

The Commission on Medical Malpractice has stated:

As a man practices a specialty, his interests tend to focus more sharply; his abilities both narrow in scope and increase in depth. As he forgets more and more of what he does not need to know, it is to be hoped that he gets better and better at what he does. His peers, by a reasonably simple assessment, perhaps an oral examination, can well evaluate his continuing competence. They should be encouraged to do so at regular intervals. An impressive certificate hanging on the doctor's office wall leads the patient to think that the physician is highly competent. We believe that he should maintain that competence to retain that certificate. The Commission recommends that specialty boards periodically re-evaluate and recertify physicians they have certified.138

136Ibid.


Summary

A review of literature shows that effectiveness of hospital administrators is an elusive concept that lacks specificity. A growing body of literature indicates that the hospital administrator's effectiveness is beginning to be evaluated on the basis of patient care given in the hospital. While mandatory continuing education has had an impact on the health field, it has not been accepted as necessary by all. The major issue is stated by the Commission on Medical Malpractice:

The ultimate goal of all continuing education efforts should be the elevation of standards of care. The evidence thus far suggests that effective means for evaluating the impact of continuing education on the health care system as a whole have not been developed. The mere fact that someone has sat through a course is no evidence that he has profited from it. While almost every educational program undoubtedly has some benefits, we know very little about precisely how great those benefits are or about the relative effectiveness of these programs in improving the quality of care. We believe that this deficiency must be corrected. The Commission finds that medical education, at all stages of a health professional's career, has an impact on standards of care, and there is a compelling need for continuous evaluation of its direction, performance, and results.139

139Ibid., p. 58.
CHAPTER III
DESIGN AND METHODOLOGY

The purpose of this chapter is to describe the design, methodology and techniques used to conduct the study.

This study employs the descriptive method of research. Descriptive studies present facts concerning the nature and status of a group of persons or any other kind of phenomena.\(^1\) Descriptive research is one of the non-experimental strategies that assesses prevailing conditions, practices and attitudes.\(^2\)

In order to assess perceptions of the relationship between mandatory continuing education and effectiveness of hospital administrators, the decision was made to question hospital administrators, chairmen of boards of trustees, chiefs of medical staffs and hospital-related health executives by means of a questionnaire. These groups are considered knowledgeable about the practice of hospital administration.

Questionnaires are intended to collect data from


large, diverse and dispersed groups of individuals. They are employed to gather quantitative and qualitative data. Most questions in this study are structured, meaning that they are predetermined, definite and concrete.3

Sample

A stratified random sample of hospitals was taken from The 1973 Guide. The stratification decision was made on the basis of bed size. Hospitals were divided into two groups: institutions with fewer than 100 beds, and those with 100 or more beds. Hospitals in this country are divided equally between these two categories.

The 1973 Guide lists a total of 7,061 hospitals. It was decided that a sample of ten percent would be taken, with the result that 706 hospitals were included in the study. Three hundred and fifty-three selected hospitals had fewer than 100 beds, 353 had more than 100 beds.

After numbering hospitals in The 1973 Guide, a table of random numbers was used to select the institutions in the sample. All hospitals were given a number with the exception of the following organizations which do not have a board of trustees:

1. Federal prison hospitals
2. Mental health centers
3. Military hospitals
4. Public Health Service hospitals
5. State-owned psychiatric, tuberculosis, cancer and prison hospitals
6. Veterans Administration hospitals

The total number of excluded institutions amounted to 601. Numbers were assigned to 6,460 hospitals, the universe from which the sample was drawn.

The chairman of the board of trustees, chief of the medical staff and administrator of each hospital in the sample were sent a questionnaire. Also, questionnaires were sent to 436 hospital-related executives in the health field listed in The 1973 Guide. This group consisted of representatives of national associations and state organizations. Government officials and leaders of voluntary health agencies were included in the study. The following list includes the types of executives sent questionnaires:

1. Directors of national hospital associations
2. Directors of regional hospital associations
3. Directors of state hospital associations
4. Directors of metropolitan hospital associations
5. Directors of state health planning agencies
6. Directors of local health planning agencies
7. Directors of state health departments
8. Directors of Blue Cross plans
Data collected in this study could have been gathered by several different techniques currently used with the descriptive methodology. Questionnaires, interviews and observation were possibilities. However, the mailed questionnaire was selected because of its efficiency in reaching a large number of people. A strategic decision was made that fundamental information from a large number of knowledgeable people about the relationship between perceived effectiveness of hospital administrators and mandatory continuing education was needed at this time because of the newness of both mandatory continuing education and the field of hospital administration. Detailed studies should follow the important findings of this basic investigation.

While the questionnaires used in this study are eclectic, several questions utilize the Likert-type scale, which ranges from "Strongly Agree" to "Strongly Disagree," although particular words have been changed to fit the design. Further, the decision was made to use the forced choice type of question rather than to allow respondents to answer "No Opinion." The "No Opinion" option was not

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included because of the controversial nature of mandatory continuing education and the controversy surrounding evaluation of hospital administrators and other health professionals. It was felt that many respondents would answer "No Opinion" simply to remove themselves from the controversy. However, a provision has been made in the data analysis for a "No Response" category. Data were collected by using color-coded questionnaires to easily identify the four different groups who were considered knowledgeable about hospital administrators. Consequently, separate data collection instruments were needed for each group. Most of the questions were suggested by the review of literature as needing further exploration. The four questionnaires used in this study are the following, which can be found in Appendix A:

1. Questionnaire for Administrators
2. Questionnaire for Chairmen of Boards of Trustees
3. Questionnaire for Chiefs of Medical Staffs
4. Questionnaire for Hospital-Related Executives

**Questionnaire for Administrators**

Question 1 asks the administrator to enter the number of beds in the hospital. The answer was used to categorize administrator response by bed size. A hypothesis was developed claiming answers of administrators of hospitals
100 beds and larger would differ from administrators of hospitals under 100 beds.

Question 2 seeks an answer to the location of the organization. The respondent was asked the state in which the organization was located. This information then was placed in the districting scheme of the American College of Hospital Administrators. The A.C.H.A. has eight districts, one in Canada which is not included in this study. Assignment of states in the seven U.S. districts is shown in Appendix B.

Question 3 asks the administrator to list the number of years of experience as a hospital chief executive officer. A hypothesis was developed to claim a difference between administrators with five years experience and longer and people with less than five years experience.

Question 4 is included to obtain information about graduation from a Master's degree program in hospital and health care administration. A hypothesis was made that program graduates would differ in their answers from non-program graduates.

Question 5 seeks information about age. It was hypothesized that administrators born on January 1, 1923,
and later would answer differently than those born before that date. In Question 6, the administrator is asked directly to categorize the level of his effectiveness in performing his function. How the administrator feels about his own performance has serious implications for continuing education. For example, if the administrator feels he is operating at a "very effective" level, he may feel little need for continuing education and no need for mandatory continuing education. On the other hand, the administrator rating himself "usually ineffective" may welcome continuing education as a method of improving effectiveness, and mandatory continuing education as the ultimate solution because of a need to be forced into learning about the field being practiced.

Question 7 asks whether administrators feel they have taken advantage of opportunities in continuing education. If the answer is affirmative, perhaps only minor changes in existing methods are needed. Further, a positive answer may indicate the voluntary approach is appropriate. On the other hand, a negative reply could indicate that voluntary continuing education has not solved the problem.

The administrator is asked in Question 8 to assess the effectiveness of continuing education. Sometimes courses in continuing education seem to increase rapidly
without adequate evaluation of their usefulness. While asking the participant about the effectiveness of continuing education will not achieve a complete evaluation, it is an important aspect and germane to this study.

Question 9 seeks a direct answer to the quality of existing programs in continuing education. It is believed that the answer to this question has a bearing on the mandatory continuing education question. If programming is reported to be of "poor" or "average" quality, improved programs with voluntary attendance could possibly improve the effectiveness of hospital administrators. However, if programs are "excellent" or "good", perhaps voluntary attendance may never draw sufficient numbers of administrators.

Question 10 asks about greater involvement by graduate programs in continuing education. While concentrating on resident graduate education, Master's degree programs have not been extensively involved in continuing education. The Commission on Education for Health Administration, a task force developed to study the present condition of health care administration education and to make recommendations for its improvement, has stated its interest in receiving information about the continuing education role of graduate programs.6

Question 11 is the only open-end question in the questionnaire. Its intent is to find what respondents would suggest as content for continuing education programs offered by schools of hospital and health services administration. This question has high practical value because the data could be used immediately for development of continuing education programs.

Question 12 seeks information about the advisability of schools of hospital and health services offering non-resident degree opportunities for practicing hospital administrators without a degree in the field. Many hospital administrators do not have a degree in hospital administration. The question is included in this study to determine whether the sample would be in favor of schools developing such opportunities.

Question 13 asks whether the administrator should be required to engage in continuing education. This question allows administrators to state an opinion about the mandatory continuing education issue for hospital administrators. While many would make the assumption that hospital administrators would not select mandatory continuing education when faced with a choice, it is

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interesting to note that fifty-eight percent of the respondents favored the mandatory approach at a 1969 meeting of the Philadelphia County Dental Society.®

Question 14 concerns the impact of mandatory continuing education on effectiveness of administrators. This question is the most important in the study. An answer indicating that improvement in effectiveness would occur with a mandatory provision could give impetus to greater regulation of the field by requiring continuing education. A response indicating no change or reduced effectiveness would seem to indicate little change from present policy.

Question 15 seeks response about organizations which should administer a mandatory continuing education plan, if one were adopted. Based upon the experience of other disciplines in the health field, the choice would be made between a governmental agency and a professional organization.

The final question, number 16, asks for a reaction to a review mechanism for evaluating hospital administrators. A review of literature reveals considerable concern about the usual method of counting credit for mandatory continuing education. Requiring an individual to complete a certain number of hours of instruction

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does not insure effectiveness. The practitioner needs to be evaluated in the environment within which he practices under realistic conditions in order to assess effectiveness.

**Questionnaires for Board Chairmen and Chiefs of Medical Staffs**

Separate questionnaires were sent to chairmen of boards of trustees and chiefs of medical staffs. While the intent of questions was the same as the questionnaire for administrators, wording has been changed to address this group of respondents. The question about length of service as an administrator was eliminated as was the question about graduation from a program in hospital and health services administration. Also, the question about rating quality of continuing education programs was excluded because it is assumed most of the respondents had no first-hand knowledge. However, it seems reasonable to ask these groups about continuing education activities of hospital administrators.

**Questionnaire for Hospital-Related Executives**

A questionnaire was prepared for health executives in positions enabling them to make judgements about effectiveness of hospital administrators and continuing
education activities. This questionnaire is similar to that for administrators with only minor word changes to accommodate this group of respondents. The questions asking about the number of beds and experience as a hospital chief executive officer were eliminated because they do not apply to this group. However, the question about program education was retained because many of these health executives have graduated from a school of hospital and health services administration. These executives also attend continuing education programs with hospital administrators, so the question about quality of continuing education programs has been retained.

Pilot Study

Using methods contemplated for this study, a pilot study was conducted in the State of Missouri during January, 1974. A questionnaire was sent to the hospital administrator, the chairman of the board of trustees and the chief of the medical staff in each of the 170 Missouri hospitals listed in The 1973 Guide. A total of 522 questionnaires were mailed.

Each person was mailed a questionnaire along with a letter of explanation. A request was made to return the completed questionnaire in a stamped, self-addressed envelope which was included in the packet.

The pilot study elicited a return rate of forty-three
percent without follow-up. No follow-up activity was conducted because of the pre-test nature of the study.

A review of the pilot study indicated that the questionnaires were understandable and provided useful information. While an analysis of substantive findings in the pilot study would not be appropriate, information about improvements to be made in the larger study seems important. Results of the pilot study indicated that the study questionnaire should be revised to:

1. Ask for an entry of the hospital or other organization number on each questionnaire. This entry would make coding easier and eliminate any problems associated with not having the identification number on the instrument.

2. Include a "No Response" category in the computer analysis.

3. Include a question about geographic location to determine the relationship between this variable and perceptions of mandatory continuing education.

4. Ask respondents to select an organization to administer mandatory continuing education activities rather than to rank order a list of possibilities, which seemed to confuse some respondents. Question 15 on the Questionnaire for Administrators in Appendix A includes this revision.

5. Use answers given by respondents to the open-end question, Number 11 on the Questionnaire for Administrators, as categories in the larger study. Twenty-six content categories plus a miscellaneous entry were identified.
Data Analysis

The pilot study did fulfill the pre-test objective of securing information that would improve the larger study.

On April 1, 1974, a total of 2,534 questionnaires were mailed in the national study. The number of questionnaires sent to each group consisted of the following:

- Administrators: 706
- Board Chairmen: 706
- Chiefs of Staff: 706
- Hospital-Related Executives: 436

Questionnaires were mailed with a stamped, pre-addressed return envelope and a letter of explanation. (See Appendix C.)

Three weeks later a follow-up questionnaire was sent to each member of the sample who had not responded to the initial mailing. Appropriate notation was made on the questionnaires to identify the follow-up responses.

After receiving questionnaires from respondents, the instruments were coded on statistical coding records from which cards were key punched. A separate record of each return was made on IBM punch cards.

Results of the study are reported in Chapter IV. Descriptive, statistical and summary methods are used to show results.
A composite statistic has been compiled for each question in the study. The total response to each question is considered extremely important in a study of this fundamental nature. Data are displayed in both frequency and percentage form.

Two kinds of data are used in this study, ordinal and nominal. While both types of data fall in the category of nonparametric statistics, which make no assumptions about the population or claims about normal distribution, different statistical tests are used.

In this study, ordinal data consisted of respondents' answers to four questions which asked that one choice be made from a list of ranked variables. The answers were ordered and each individual responded on the basis of his own perceptions. The Wilcoxon Rank Sum procedure was used to test these ordinal data. The Wilcoxon Rank Sum is able to show direction of the differences between two groups. Because of the large sample sizes in this study, the normal approximation to Wilcoxon statistics was used.

The Wilcoxon Rank Sum has greater power than the Chi Square procedure, which was used on the five "Yes-No" questions and the one question in which respondents were

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asked to select from an unordered field. The Chi Square
test\textsuperscript{10} determines significance of differences between
groups.

The Friedman Two-Way Analysis of Variance by Ranks
test was used on the data gathered when all three respon­
dents from the same hospital returned a questionnaire.
In this procedure, "no response" answers had to be dis­
carded and data manipulated only on the other responses.
The Friedman Two-Way Analysis of Variance by Ranks pro­
cedure\textsuperscript{11} tests whether samples have been drawn from the
same population.

The level of significance has been set at .01 in this
study.

Data manipulation has been undertaken using the frame­
work provided by two packages of statistical programs,
the Statistical Package for the Social Sciences\textsuperscript{12} and
the Statistical Analysis System.\textsuperscript{13} These are integrated
systems of programs for analysis of data. SPSS was used

\textsuperscript{10}Ibid., p. 104.
\textsuperscript{11}Ibid., p. 166.
\textsuperscript{12}Norman H. Nie, Dale H. Bent and C. Hadlai Hull,
Statistical Package for the Social Sciences (New York:
\textsuperscript{13}Jolayne Service, A User's Guide to the Statistical
Analysis System (Raleigh, North Carolina: Student Supply
Stores, 1972).
for the Chi Square and SAS for the other two procedures.

The hypotheses stated in Chapter I have been tested with results found in Chapter IV. Sets of hypotheses have been developed on four dependent variables concerned with administrators: (1) number of hospital beds, (2) experience, (3) graduation from a school of hospital and health services administration, and (4) age. A fifth set was developed to analyze responses from the same hospital. These dependent variables were measured by manipulating ten independent variables on all but the last set, which had nine. The designation, $H_0$, was used to specify a null hypothesis and, $H_A$, to specify an alternative hypothesis.
CHAPTER IV
PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

The purpose of this chapter is to report the results of the study. Conclusions will be presented in Chapter V.

A total of 1,231 completed questionnaires were returned. The number of completed questionnaires in each group is shown in Table 2.

The rate of return for the study was 48.3 percent. Administrators responded at a rate of 57.9 percent, while chiefs of medical staffs, chairmen of boards of trustees and hospital-related health executives responded at a rate of 47.4, 35.1 and 55.6 percent respectively.

As seen in Table 2, the follow-up questionnaire added 8.6 percentage points to the study. Completed follow-up questionnaires numbered 220.

A total of eighty-eight questionnaires were returned but not completed. These questionnaires were not completed for one of the following reasons, according to available information:

1. Individual stated he did not have knowledge necessary to answer questions.

2. Individual stated he did not agree with intent of study.

3. Individual stated an appropriate hospital association had not endorsed the study.
<table>
<thead>
<tr>
<th>Category</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairmen</th>
<th>Executives</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Initial Mailing</td>
<td>706</td>
<td>706</td>
<td>706</td>
<td>436</td>
<td>2,554</td>
</tr>
<tr>
<td>Questionnaires Not Deliverable by Mail</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Net Initial Mailing</td>
<td>706</td>
<td>706</td>
<td>706</td>
<td>430</td>
<td>2,548</td>
</tr>
<tr>
<td>Questionnaires Returned But Not Completed</td>
<td>19</td>
<td>13</td>
<td>16</td>
<td>40</td>
<td>88</td>
</tr>
<tr>
<td>Number of Completed Questionnaires after Initial Mailing</td>
<td>345</td>
<td>271</td>
<td>192</td>
<td>203</td>
<td>1,011</td>
</tr>
<tr>
<td>Rate of Return by Category after Initial Mailing</td>
<td>48.9</td>
<td>38.4</td>
<td>27.1</td>
<td>47.2</td>
<td>39.7</td>
</tr>
<tr>
<td>Number of Follow-up Questionnaires Completed</td>
<td>64</td>
<td>64</td>
<td>56</td>
<td>36</td>
<td>220</td>
</tr>
<tr>
<td>Total Number of Completed Questionnaires</td>
<td>409</td>
<td>339</td>
<td>248</td>
<td>239</td>
<td>1,231</td>
</tr>
<tr>
<td>Rate of Return by Category on Completed Study</td>
<td>57.9</td>
<td>47.4</td>
<td>35.1</td>
<td>55.6</td>
<td>48.3</td>
</tr>
</tbody>
</table>
4. Position in the organization to which the questionnaire was directed was temporarily unfilled.

Noteworthy is the finding that forty of the eighty-eight questionnaires returned but not completed were from hospital-related health executives.

**Analysis of Responses by Category**

A summary of responses to the study is shown in Table 3. Data are displayed by administrators, chiefs of staff and chairmen of board of trustees. These data are combined into a total frequency and percentage distribution category, because the questions were asked about a specific administrator. Finally, data about hospital-related health executives are shown. These data are not included in the total because this group was questioned about hospital administrators in general.

**Administrator's effectiveness.** Data reveal that 92.3 percent of hospital respondents who answered the question believed that the administrator is either "Very Effective" or "Moderately Effective" in managing the hospital. Interestingly, while 66.5 percent of the board chairmen felt the administrator was "Very Effective," only 41.6 percent of the administrators themselves selected that answer. Even a larger percentage of chiefs of medical staffs than administrators decided that the administrator was "Very Effective." However, only 9.6 percent of the hospital
related health executives rated the administrator "Very Effective," although 60.3 percent answered "Moderately Effective." Also, 19.2 percent of health executives said administrators were "Somewhat Ineffective," contrasted with the total hospital group response of 4.2 percent.

Pursuing opportunities in continuing education. When asked if the administrator had taken advantage of continuing education opportunities, 80.8 percent of the hospital respondents stated "Yes." While 82.4, 77.0 and 83.5 percent of administrators, chiefs of staff, board chairmen, respectively, gave an affirmative answer, only 60.3 percent of the hospital-related health executives gave that answer.

Effectiveness of continuing education. Answers to the question about the effectiveness of continuing education in helping the administrator to manage the hospital show that 70.2 percent of the respondents describe the level as being "Very Effective" or "Moderately Effective."

While the answers were given by 68.2 percent of the administrators, 66.3 percent of the chiefs of staff and 78.6 percent of the board chairmen, only 56.0 percent were given by the health executives. In addition, 26.4 percent of the latter group said hospital administration continuing education was "Somewhat Ineffective." Nearly 25 percent of the chiefs of staff did not respond to the question.
TABLE 3
FREQUENCY AND PERCENTAGE DISTRIBUTION
OF RESPONSES BY CATEGORY

<table>
<thead>
<tr>
<th>Questions</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairman</th>
<th>Total Hospital Responses</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N = 409) (N = 335) (N = 248) (N = 992) (N = 239)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. How effective is the administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>170 (41.6)</td>
<td>156 (46.6)</td>
<td>165 (66.5)</td>
<td>491 (49.5)</td>
<td>23 (9.6)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>218 (53.3)</td>
<td>135 (40.3)</td>
<td>72 (29.0)</td>
<td>425 (42.8)</td>
<td>144 (60.3)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>11 (2.7)</td>
<td>28 (8.4)</td>
<td>3 (1.2)</td>
<td>42 (4.2)</td>
<td>46 (19.2)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>1 (0.2)</td>
<td>6 (1.8)</td>
<td>3 (1.2)</td>
<td>10 (1.0)</td>
<td>10 (4.2)</td>
</tr>
<tr>
<td>No Response</td>
<td>9 (2.2)</td>
<td>10 (3.0)</td>
<td>5 (2.0)</td>
<td>24 (2.4)</td>
<td>16 (6.7)</td>
</tr>
<tr>
<td>2. Has the administrator taken advantage of continuing education opportunities in hospital administration?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>337 (82.4)</td>
<td>258 (77.0)</td>
<td>207 (83.5)</td>
<td>802 (80.0)</td>
<td>144 (60.3)</td>
</tr>
<tr>
<td>No</td>
<td>65 (15.9)</td>
<td>52 (15.5)</td>
<td>32 (12.9)</td>
<td>149 (15.0)</td>
<td>56 (23.4)</td>
</tr>
<tr>
<td>No Response</td>
<td>7 (1.7)</td>
<td>25 (7.5)</td>
<td>9 (3.6)</td>
<td>41 (4.1)</td>
<td>39 (16.3)</td>
</tr>
</tbody>
</table>
### TABLE 3 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairmen</th>
<th>Total Hospital Responses</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. How would you describe the effectiveness of hospital administration continuing education in helping the administrator to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>74 (18.1)</td>
<td>100 (29.9)</td>
<td>77 (31.0)</td>
<td>251 (25.3)</td>
<td>23 (9.6)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>205 (50.1)</td>
<td>122 (36.4)</td>
<td>118 (47.6)</td>
<td>445 (44.9)</td>
<td>111 (46.4)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>47 (11.5)</td>
<td>25 (7.5)</td>
<td>9 (3.6)</td>
<td>81 (8.2)</td>
<td>63 (26.4)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>13 (3.2)</td>
<td>6 (1.8)</td>
<td>3 (1.2)</td>
<td>22 (2.2)</td>
<td>11 (4.6)</td>
</tr>
<tr>
<td>No Response</td>
<td>70 (17.1)</td>
<td>82 (24.5)</td>
<td>41 (16.5)</td>
<td>193 (19.5)</td>
<td>31 (13.0)</td>
</tr>
<tr>
<td>4. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>315 (77.0)</td>
<td>276 (82.4)</td>
<td>207 (83.5)</td>
<td>798 (80.4)</td>
<td>185 (77.4)</td>
</tr>
<tr>
<td>No</td>
<td>69 (16.9)</td>
<td>26 (7.8)</td>
<td>27 (10.9)</td>
<td>122 (12.3)</td>
<td>39 (16.3)</td>
</tr>
<tr>
<td>No Response</td>
<td>25 (6.1)</td>
<td>33 (9.9)</td>
<td>14 (5.6)</td>
<td>72 (7.3)</td>
<td>15 (6.3)</td>
</tr>
</tbody>
</table>
### Question

#### Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?

<table>
<thead>
<tr>
<th>Question</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairmen</th>
<th>Total Hospital Responses</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?</td>
<td>Yes 337 (82.4)</td>
<td>262 (78.2)</td>
<td>204 (82.3)</td>
<td>803 (80.9)</td>
<td>184 (77.0)</td>
</tr>
<tr>
<td></td>
<td>No 56 (13.7)</td>
<td>56 (16.7)</td>
<td>31 (12.5)</td>
<td>143 (14.4)</td>
<td>44 (18.4)</td>
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<tr>
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<td>No Response</td>
<td>16 (3.9)</td>
<td>17 (5.1)</td>
<td>46 (4.6)</td>
<td>11 (4.6)</td>
</tr>
</tbody>
</table>

#### Should the administrator be required to engage in hospital administration continuing education?

<table>
<thead>
<tr>
<th>Question</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairmen</th>
<th>Total Hospital Responses</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should the administrator be required to engage in hospital administration continuing education?</td>
<td>Yes 264 (64.5)</td>
<td>246 (73.4)</td>
<td>161 (64.9)</td>
<td>671 (67.6)</td>
<td>165 (69.0)</td>
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<tr>
<td></td>
<td>No 122 (29.8)</td>
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<td>65 (27.2)</td>
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<td>10 (3.0)</td>
<td>43 (4.3)</td>
<td>9 (3.8)</td>
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</table>
7. What impact would mandatory continuing education in hospital administration have on the administrator's effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

<table>
<thead>
<tr>
<th>Question</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairman</th>
<th>Total Hospital Responses</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Increase in Effectiveness</td>
<td>55 (13.4)</td>
<td>43 (12.8)</td>
<td>27 (10.9)</td>
<td>125 (12.6)</td>
<td>31 (13.0)</td>
</tr>
<tr>
<td>Moderate Increase in Effectiveness</td>
<td>198 (48.4)</td>
<td>152 (45.4)</td>
<td>128 (51.6)</td>
<td>478 (48.2)</td>
<td>144 (60.3)</td>
</tr>
<tr>
<td>No Change in Effectiveness</td>
<td>112 (27.4)</td>
<td>88 (26.3)</td>
<td>63 (25.4)</td>
<td>263 (26.5)</td>
<td>47 (19.7)</td>
</tr>
<tr>
<td>Moderate Decrease in Effectiveness</td>
<td>12 (2.9)</td>
<td>11 (3.3)</td>
<td>5 (2.0)</td>
<td>28 (2.8)</td>
<td>2 (0.8)</td>
</tr>
<tr>
<td>Great Decrease in Effectiveness</td>
<td>7 (1.7)</td>
<td>4 (1.2)</td>
<td>4 (1.6)</td>
<td>15 (1.5)</td>
<td>0 (6.3)</td>
</tr>
<tr>
<td>No Response</td>
<td>25 (6.1)</td>
<td>37 (11.0)</td>
<td>21 (8.5)</td>
<td>83 (8.4)</td>
<td>15 (6.3)</td>
</tr>
<tr>
<td>Question</td>
<td>Administrators</td>
<td>Chiefs of Staff</td>
<td>Board Chairmen</td>
<td>Total Hospital Responses</td>
<td>Executives</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
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<td>------------</td>
</tr>
<tr>
<td>8. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?</td>
<td>269 (65.8)</td>
<td>209 (62.4)</td>
<td>151 (60.9)</td>
<td>629 (63.4)</td>
<td>152 (63.6)</td>
</tr>
<tr>
<td>American College of Hospital Administrators</td>
<td>152 (37.2)</td>
<td>134 (40.0)</td>
<td>76 (30.6)</td>
<td>362 (36.5)</td>
<td>72 (30.1)</td>
</tr>
<tr>
<td>American Hospital Association</td>
<td>46 (11.2)</td>
<td>51 (15.2)</td>
<td>45 (18.1)</td>
<td>142 (14.3)</td>
<td>30 (12.6)</td>
</tr>
<tr>
<td>Association of University</td>
<td>46 (11.2)</td>
<td>31 (9.3)</td>
<td>28 (11.3)</td>
<td>105 (10.6)</td>
<td>35 (14.6)</td>
</tr>
<tr>
<td>Programs in Health Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Health Department</td>
<td>16 (3.9)</td>
<td>5 (1.5)</td>
<td>14 (5.6)</td>
<td>35 (3.5)</td>
<td>14 (5.9)</td>
</tr>
<tr>
<td>State Hospital Association</td>
<td>63 (15.4)</td>
<td>23 (6.9)</td>
<td>28 (11.3)</td>
<td>114 (11.5)</td>
<td>28 (11.7)</td>
</tr>
<tr>
<td>U.S. Department of Health, Education and Welfare</td>
<td>10 (2.4)</td>
<td>5 (1.5)</td>
<td>10 (4.0)</td>
<td>25 (2.5)</td>
<td>9 (3.8)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (3.2)</td>
<td>10 (3.0)</td>
<td>5 (2.0)</td>
<td>28 (2.8)</td>
<td>13 (5.4)</td>
</tr>
<tr>
<td>No Response</td>
<td>63 (15.4)</td>
<td>76 (22.7)</td>
<td>42 (16.9)</td>
<td>181 (18.2)</td>
<td>38 (15.9)</td>
</tr>
</tbody>
</table>

9. Would you support a review mechanism in which a team of hospital administrators would visit the administrator in his institution to evaluate the administrator's effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

| Yes | 269 (65.8) | 209 (62.4) | 151 (60.9) | 629 (63.4) | 152 (63.6) |
| No  | 120 (29.3) | 112 (33.4) | 85 (34.3)  | 317 (32.0) | 74 (31.0)  |
| No Response | 20 (4.9) | 14 (4.2) | 12 (4.8) | 46 (4.6) | 13 (5.4) |
Involvement of schools of hospital and health services administration in continuing education programs. Schools should offer more continuing education programs according to 80.4 percent of the hospital respondents.

Schools offering a degree program without full-time study on campus. It was stated by 80.9 percent of the respondents that schools of hospital and health services administration should offer degree opportunities without requiring full-time study on campus.

Required continuing education. Administrators should be required to engage in continuing education according to 67.6 percent of the hospital respondents.

Impact of required continuing education on administrator's effectiveness. Either "Moderate Increase in Effectiveness" or "No Change in Effectiveness" was the choice of 74.7 percent of those responding to this question. While 60.3 percent of the hospital-related health executives forecast "Moderate Increase in Effectiveness," only 48.4 percent of administrators, 45.4 percent of chiefs of staff and 51.6 percent of board chairmen responding to that question indicated that answer.

Administration of mandatory continuing education. The American College of Hospital Administrators was cited by 36.3 percent of the hospital respondents as the preferred organization to administer a mandatory continuing
education program.

Review mechanism. A review mechanism in which a team of hospital administrators would evaluate an administrator's effectiveness was supported by 63.4 percent of the hospital respondents.

Analysis of Responses by Hospital-Size Group

Table 4 shows a frequency and percentage distribution of responses by hospital-size groups. Administrators from 100-bed hospitals and larger amounted to 51.8 percent of the respondents, chiefs of staff 52.2 percent and board chairman 55.6 percent. Variation between the two groups was 3.6 percentage points for administrators, 6.8 percentage points for chiefs of staff and 12.1 percentage points for board chairmen.

Analysis of Responses by Age Group

A frequency and percentage distribution of responses by age groups is reported in Table 5. Born before January 1, 1923 were 32.3 percent of the administrators, 42.1 percent of the chiefs of staff, 50.0 percent of board chairmen and 30.1 percent of hospital-related health executives respectively.
<table>
<thead>
<tr>
<th>Group</th>
<th>Administrators (N = 409)</th>
<th>Chiefs of Staff (N = 335)</th>
<th>Board Chairmen (N = 248)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 - bed hospitals and larger</td>
<td>212 (51.8)</td>
<td>175 (52.2)</td>
<td>138 (55.6)</td>
</tr>
<tr>
<td>99 - bed hospitals and smaller</td>
<td>197 (48.2)</td>
<td>152 (45.4)</td>
<td>108 (43.5)</td>
</tr>
<tr>
<td>No Response</td>
<td>0</td>
<td>8 (2.4)</td>
<td>2 (0.8)</td>
</tr>
</tbody>
</table>
### TABLE 5
**FREQUENCY AND PERCENTAGE DISTRIBUTION OF RESPONSES BY AGE GROUP**

<table>
<thead>
<tr>
<th>Group</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairmen</th>
<th>Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 409)</td>
<td>(N = 335)</td>
<td>(N = 248)</td>
<td>(N = 239)</td>
</tr>
<tr>
<td>Born January 1, 1923 and after</td>
<td>270 (66.0)</td>
<td>181 (54.0)</td>
<td>98 (39.5)</td>
<td>158 (66.1)</td>
</tr>
<tr>
<td>Born before January 1, 1923</td>
<td>132 (32.3)</td>
<td>141 (42.1)</td>
<td>124 (50.0)</td>
<td>72 (30.1)</td>
</tr>
<tr>
<td>No Response</td>
<td>7 (1.7)</td>
<td>13 (3.9)</td>
<td>26 (10.5)</td>
<td>9 (3.8)</td>
</tr>
</tbody>
</table>
Analysis of Responses by Region

Table 6 displays a frequency and percentage distribution of responses by geographic region. Marked differences are not evident.

Analysis of Administrators' Responses by Region

Table 7 shows a number and percentage distribution of administrator's responses by region. "Very Effective" in managing the hospital was the response of only 27.5 percent of respondents in Region 2 compared with 38.3 percent of respondents in Region 5 and 52.5 percent in Region 4.

When asked to rate quality of continuing education programs, only 36.7 percent of respondents in Region 7 and 40.0 percent in Region 1 answered "Good" while 51.6 percent of respondents in Region 3 and 67.1 percent in Region 5 selected that answer.

"Moderate Increase in Effectiveness" was the answer of 76.9 percent of respondents in Region 2, 56.8 percent in Region 5, and 39.5 percent in Region 1 to the question about the impact of mandatory continuing education on the administrator's effectiveness. "No Change" was forecast by 15.4 percent of respondents in Region 2 and 36.8 percent in Region 1.
<table>
<thead>
<tr>
<th>Region</th>
<th>Administrators (N = 409)</th>
<th>Chiefs of Staff (N = 335)</th>
<th>Board Chairmen (N = 248)</th>
<th>Executives (N = 239)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>41 (10.0)</td>
<td>33 (9.9)</td>
<td>23 (9.3)</td>
<td>36 (15.1)</td>
</tr>
<tr>
<td>Region 2</td>
<td>41 (10.0)</td>
<td>29 (8.7)</td>
<td>20 (8.1)</td>
<td>33 (13.8)</td>
</tr>
<tr>
<td>Region 3</td>
<td>78 (19.1)</td>
<td>70 (20.9)</td>
<td>49 (19.8)</td>
<td>46 (19.2)</td>
</tr>
<tr>
<td>Region 4</td>
<td>60 (14.7)</td>
<td>49 (14.6)</td>
<td>42 (16.9)</td>
<td>23 (9.6)</td>
</tr>
<tr>
<td>Region 5</td>
<td>83 (20.3)</td>
<td>61 (18.2)</td>
<td>58 (23.4)</td>
<td>38 (15.9)</td>
</tr>
<tr>
<td>Region 6</td>
<td>52 (12.7)</td>
<td>43 (12.8)</td>
<td>24 (9.7)</td>
<td>25 (10.5)</td>
</tr>
<tr>
<td>Region 7</td>
<td>54 (13.2)</td>
<td>49 (14.6)</td>
<td>32 (12.9)</td>
<td>37 (15.5)</td>
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<tr>
<td>No Response</td>
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<td>0</td>
<td>1 (0.4)</td>
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<tr>
<td>Question</td>
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<td>4</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>1. How effective is the administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td>Very Effective</td>
<td>19 (47.5)</td>
<td>11 (27.5)</td>
<td>35 (46.1)</td>
</tr>
<tr>
<td></td>
<td>Moderately Effective</td>
<td>20 (50.0)</td>
<td>27 (67.5)</td>
<td>41 (53.9)</td>
</tr>
<tr>
<td></td>
<td>Somewhat Ineffective</td>
<td>1 (2.5)</td>
<td>2 (5.0)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Usually Ineffective</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Totals</td>
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<td>40</td>
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<td>76</td>
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<tr>
<td>No Response = 9</td>
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2. Has the administrator taken advantage of continuing education opportunities in hospital administration?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Totals</th>
<th>No Response = 7</th>
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<tr>
<td>Yes</td>
<td>36 (87.8)</td>
<td>30 (73.2)</td>
<td>62 (80.5)</td>
<td>50 (84.7)</td>
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<tr>
<td>No</td>
<td>5 (12.2)</td>
<td>11 (26.8)</td>
<td>15 (19.5)</td>
<td>9 (15.3)</td>
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<tr>
<td>Totals</td>
<td>41</td>
<td>41</td>
<td>77</td>
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TABLE 7 (continued)

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<th>6</th>
<th>7</th>
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<tr>
<td>3. How would you describe the effectiveness of hospital administration continuing education in helping the administrator to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>4 (11.4)</td>
<td>4 (12.9)</td>
<td>18 (29.0)</td>
<td>11 (21.6)</td>
<td>16 (21.9)</td>
<td>10 (26.3)</td>
<td>11 (22.4)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>24 (68.6)</td>
<td>19 (61.3)</td>
<td>33 (53.2)</td>
<td>31 (60.3)</td>
<td>51 (69.9)</td>
<td>25 (65.8)</td>
<td>22 (44.9)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>6 (17.1)</td>
<td>5 (16.1)</td>
<td>10 (16.1)</td>
<td>8 (15.7)</td>
<td>5 (6.8)</td>
<td>2 (5.3)</td>
<td>11 (22.4)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>1 (2.9)</td>
<td>3 (9.7)</td>
<td>1 (1.6)</td>
<td>1 (2.0)</td>
<td>1 (1.4)</td>
<td>1 (2.6)</td>
<td>5 (10.2)</td>
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<td>31</td>
<td>62</td>
<td>51</td>
<td>73</td>
<td>38</td>
<td>49</td>
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4. How do you rate the quality of continuing education programs in hospital administration?

<table>
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<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Excellent</td>
<td>8 (22.9)</td>
<td>1 (3.2)</td>
<td>8 (12.9)</td>
<td>9 (17.6)</td>
<td>6 (8.2)</td>
<td>9 (23.1)</td>
<td>7 (14.3)</td>
</tr>
<tr>
<td>Good</td>
<td>14 (40.0)</td>
<td>19 (61.3)</td>
<td>32 (51.6)</td>
<td>28 (54.9)</td>
<td>49 (67.1)</td>
<td>22 (56.4)</td>
<td>18 (36.7)</td>
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<tr>
<td>Average</td>
<td>9 (25.7)</td>
<td>8 (25.8)</td>
<td>20 (32.3)</td>
<td>12 (23.5)</td>
<td>18 (24.7)</td>
<td>7 (17.9)</td>
<td>20 (40.8)</td>
</tr>
<tr>
<td>Poor</td>
<td>4 (11.4)</td>
<td>3 (9.7)</td>
<td>2 (3.2)</td>
<td>2 (3.9)</td>
<td>0</td>
<td>1 (2.6)</td>
<td>4 (8.2)</td>
</tr>
<tr>
<td>Totals</td>
<td>35</td>
<td>31</td>
<td>62</td>
<td>51</td>
<td>73</td>
<td>39</td>
<td>49</td>
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TABLE 7 (continued)

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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>5. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26  (70.3)</td>
<td>35  (89.7)</td>
<td>61  (84.7)</td>
<td>47  (81.0)</td>
<td>64  (82.1)</td>
<td>40  (85.1)</td>
<td>42  (79.2)</td>
</tr>
<tr>
<td>No</td>
<td>11  (29.7)</td>
<td>4    (10.3)</td>
<td>11  (15.3)</td>
<td>11  (19.0)</td>
<td>14  (17.9)</td>
<td>7   (14.9)</td>
<td>11  (20.8)</td>
</tr>
<tr>
<td>Totals</td>
<td>37</td>
<td>39</td>
<td>72</td>
<td>58</td>
<td>78</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>No Response = 25</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>6. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31  (86.1)</td>
<td>31  (79.5)</td>
<td>58  (76.3)</td>
<td>54  (91.5)</td>
<td>70  (87.5)</td>
<td>45  (91.8)</td>
<td>48  (88.9)</td>
</tr>
<tr>
<td>No</td>
<td>5   (13.9)</td>
<td>8    (20.5)</td>
<td>18  (23.7)</td>
<td>5   (8.5)</td>
<td>10  (12.5)</td>
<td>4   (8.2)</td>
<td>6   (11.1)</td>
</tr>
<tr>
<td>Totals</td>
<td>36</td>
<td>39</td>
<td>76</td>
<td>59</td>
<td>80</td>
<td>49</td>
<td>54</td>
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<td>No Response = 16</td>
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### TABLE 7 (continued)

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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<tbody>
<tr>
<td>7. Should you be required to engage in hospital administration continuing education?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24 (64.9)</td>
<td>33 (80.5)</td>
<td>49 (66.2)</td>
<td>42 (76.4)</td>
<td>53 (67.9)</td>
<td>29 (59.2)</td>
<td>34 (65.4)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13 (35.1)</td>
<td>8 (19.5)</td>
<td>25 (33.8)</td>
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<td>25 (32.1)</td>
<td>20 (40.8)</td>
<td>18 (34.6)</td>
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<tr>
<td>Totals</td>
<td>37</td>
<td>41</td>
<td>74</td>
<td>55</td>
<td>78</td>
<td>49</td>
<td>52</td>
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<tr>
<td>No Response</td>
<td>23</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>8. What impact would mandatory continuing education in hospital administration have on the administrator's effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Great Increase in Effectiveness</td>
<td>6 (15.8)</td>
<td>3 (7.7)</td>
<td>8 (11.3)</td>
<td>12 (21.1)</td>
<td>11 (13.6)</td>
<td>8 (16.3)</td>
<td>7 (14.3)</td>
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<tr>
<td>Moderate Increase in Effectiveness</td>
<td>15 (39.5)</td>
<td>30 (76.9)</td>
<td>34 (47.9)</td>
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<td>46 (56.8)</td>
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<tr>
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<tr>
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<td>6 (8.5)</td>
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<td>1 (2.0)</td>
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<tr>
<td>Great Decrease in Effectiveness</td>
<td>1 (2.6)</td>
<td>0</td>
<td>1 (1.4)</td>
<td>0</td>
<td>1 (1.2)</td>
<td>2 (4.1)</td>
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<tr>
<td>Totals</td>
<td>38</td>
<td>39</td>
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<td>57</td>
<td>81</td>
<td>49</td>
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<td></td>
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</tr>
</tbody>
</table>
9. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

<table>
<thead>
<tr>
<th>Organization</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>American College of Hospital Administrators</td>
<td>21 (61.8)</td>
<td>18 (54.5)</td>
<td>24 (51.9)</td>
<td>28 (51.9)</td>
<td>21 (29.6)</td>
<td>20 (45.5)</td>
<td>20 (46.5)</td>
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<td>American Hospital Association</td>
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<td>11 (16.4)</td>
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<td>7 (9.9)</td>
<td>7 (15.9)</td>
<td>8 (18.6)</td>
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<tr>
<td>Association of University Programs in Health Admin</td>
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<td>7 (21.2)</td>
<td>9 (13.4)</td>
<td>7 (13.0)</td>
<td>13 (18.3)</td>
<td>3 (6.8)</td>
<td>4 (9.3)</td>
</tr>
<tr>
<td>State Health Department</td>
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<td>1 (3.0)</td>
<td>4 (6.0)</td>
<td>3 (5.6)</td>
<td>4 (5.6)</td>
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<td>0</td>
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<tr>
<td>State Hospital Association</td>
<td>2 (5.9)</td>
<td>2 (6.1)</td>
<td>12 (17.9)</td>
<td>5 (9.3)</td>
<td>23 (32.4)</td>
<td>11 (25.0)</td>
<td>8 (18.6)</td>
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<tr>
<td>U.S. Department of Health, Education and Welfare</td>
<td>1 (2.9)</td>
<td>2 (6.1)</td>
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<td>1 (2.3)</td>
<td>2 (4.7)</td>
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<tr>
<td>Other</td>
<td>0</td>
<td>1 (3.0)</td>
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<td>1 (2.3)</td>
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<td>54</td>
<td>71</td>
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</tbody>
</table>

No Response = 63

10. Would you support a review mechanism in which a team of hospital administrators would visit the administrator in his institution to evaluate the administrator's effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

<table>
<thead>
<tr>
<th>Response</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 (66.7)</td>
<td>13 (33.3)</td>
</tr>
<tr>
<td>46 (62.2)</td>
<td>28 (37.8)</td>
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</tr>
<tr>
<td>41 (70.7)</td>
<td>17 (19.3)</td>
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</tr>
<tr>
<td>56 (72.7)</td>
<td>21 (27.3)</td>
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<tr>
<td>32 (66.7)</td>
<td>16 (33.3)</td>
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<tr>
<td>38 (73.1)</td>
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<tr>
<td>Totals</td>
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<td>41</td>
</tr>
<tr>
<td>No Response = 20</td>
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</tbody>
</table>

127
Analysis of Data about Content Suggestions

Financial Management ranked first when respondents were asked to suggest content for continuing education programs offered by schools of hospital and health services administration. Administrators, chiefs of staff, board chairmen and hospital-related health executives all listed Financial Management more often than other subject matter in this open-ended question. Financial Management received more than twice as many responses as the second ranked item, Governmental Regulations. Nearly one-third of the administrators, board chairmen and health executives listed Financial Management.

Governmental Regulations was ranked second by administrators and board chairmen and third by chiefs of staff and hospital-related health executives.

Ranked third was Personnel Management. While it ranked third among administrators and board chairmen, chiefs of staff and hospital-related health executives listed it fourth. Data are shown in Table 8.

Analysis of Data by Number of Beds in Administrator's Hospital

Table 9 includes data about administrators in the two groups of hospitals. In the smaller group, 35.6 percent stated "Very Effective" and 59.7 percent "Moderately
<table>
<thead>
<tr>
<th>Category</th>
<th>Administrators</th>
<th>Chiefs of Staff</th>
<th>Board Chairmen</th>
<th>Executives</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Financial Management</td>
<td>128 1</td>
<td>45 1</td>
<td>74 1</td>
<td>82 1</td>
<td>329 1</td>
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<td>2. Governmental Regulations</td>
<td>66 2</td>
<td>31 3</td>
<td>41 2</td>
<td>18 3</td>
<td>156 2</td>
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<tr>
<td>3. Personnel Management</td>
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<td>23 4</td>
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<td>11 4</td>
<td>100 3</td>
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<tr>
<td>4. Administrator - Physician Relationship</td>
<td>21 7</td>
<td>41 2</td>
<td>22 4</td>
<td>10 5</td>
<td>94 5</td>
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<tr>
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<td>12 5</td>
<td>17 6</td>
<td>9 7</td>
<td>49 8</td>
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<td>6. Planning</td>
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<td>5 12</td>
<td>13 9</td>
<td>60 2</td>
<td>96 4</td>
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<td>7. Legal Affairs</td>
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<td>10 6</td>
<td>22 4</td>
<td>10 5</td>
<td>80 6</td>
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<td>8. Budgeting</td>
<td>24 6</td>
<td>6 9</td>
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<td>9. Computer Science</td>
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<td>8 8</td>
<td>1 18</td>
<td>2 20</td>
<td>17 16</td>
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<td>10. Current Issues in Hospital Administration</td>
<td>11 11</td>
<td>6 9</td>
<td>6 11</td>
<td>1 22</td>
<td>24 11</td>
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<tr>
<td>11. Management Theory</td>
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<td>0 21</td>
<td>0 22</td>
<td>3 16</td>
<td>13 17</td>
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<tr>
<td>12. Management by Objectives</td>
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<td>1 15</td>
<td>2 15</td>
<td>8 10</td>
<td>19 15</td>
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<td>Category</td>
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<td>Chiefs of Staff</td>
<td>Board Chairmen</td>
<td>Executives</td>
<td>Frequency Rank</td>
</tr>
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<td>-----------------------------------------------</td>
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<td>----------------</td>
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<td>----------------</td>
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<tr>
<td>13. Professional Standard Review Organizations</td>
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<td>6</td>
<td>9</td>
<td>3</td>
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<td>15</td>
<td>14</td>
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<td>16. Systems Approach</td>
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<td>0</td>
<td>21</td>
<td>1</td>
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<td>17. Construction Management</td>
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<td>14</td>
<td>2</td>
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<td>18. Shared Services</td>
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<td>1</td>
<td>15</td>
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<td>15</td>
<td>1</td>
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<td>21</td>
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<td>2</td>
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<td>22. Organizational Theory</td>
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<td>1</td>
<td>15</td>
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<td>23. Education for Boards of Trustees</td>
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<td>1</td>
<td>15</td>
<td>4</td>
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<td>24. Marketing</td>
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<td>0</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Category</td>
<td>Administrators</td>
<td>Chiefs of Staff</td>
<td>Board Chairmen</td>
<td>Executives</td>
<td>Frequency</td>
</tr>
<tr>
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<td>----------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>25. Decision-Making</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27. Miscellaneous</td>
<td>140</td>
<td>112</td>
<td>84</td>
<td>116</td>
<td>452</td>
</tr>
</tbody>
</table>
Effective" compared with 48.8 percent and 49.8 percent, respectively, in the larger group when asked about their own effectiveness. However, $H_0^{(1)}$ could not be rejected.

Among administrators of hospitals with fewer than 100 beds, 78.1 percent of the respondents said they had taken advantage of continuing education opportunities. Respondents among administrators with 100 or more beds stated that 89.0 percent had taken advantage of opportunities in continuing education. $H_0^{(2)}$ was rejected, which allowed $H_A^{(2)}$ to be accepted.

The null hypotheses, $H_0^{(3)}$, $H_0^{(4)}$, and $H_0^{(5)}$ could not be rejected. The alternatives then could not be accepted.

The percentage of respondents among administrators in the smaller hospitals was greater than administrators in the larger hospitals by a margin 92.7 to 79.1 to the question of whether schools of hospital and health services administration should develop opportunities without requiring full-time study on campus. $H_A^{(6)}$ was accepted by the rejection of $H_0^{(6)}$ with a "p" value of 0.0002.

$H_0^{(7)}$ and $H_0^{(8)}$ could not be rejected as indicated in Table 9.

The American College of Hospital Administrators was favored by 33.1 percent of administrators of the smaller
### TABLE 9
RESPONSES OF ADMINISTRATORS
BY NUMBER OF BEDS
IN HOSPITAL

<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 100 beds</th>
<th>100 or more beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How effective are you in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>68 (35.6)</td>
<td>102 (48.8)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>114 (59.7)</td>
<td>104 (49.8)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>8 (4.2)</td>
<td>3 (1.4)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>1 (0.5)</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>191</td>
<td>209</td>
</tr>
<tr>
<td>No Response</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Z = 2.9110; P = 0.0038</td>
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</tr>
<tr>
<td>2. Have you taken advantage of continuing education opportunities in hospital administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>150 (78.1)</td>
<td>187 (89.0)</td>
</tr>
<tr>
<td>No</td>
<td>42 (21.9)</td>
<td>23 (11.0)</td>
</tr>
<tr>
<td>Totals</td>
<td>192</td>
<td>210</td>
</tr>
<tr>
<td>No Response</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 8.0405; 1 D.F.; P = 0.0046</td>
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</tr>
<tr>
<td>3. How would you describe the effectiveness of hospital administration continuing education in helping you to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>40 (26.3)</td>
<td>34 (18.2)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>90 (59.2)</td>
<td>115 (61.5)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>17 (11.2)</td>
<td>30 (16.0)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>5 (3.3)</td>
<td>8 (4.3)</td>
</tr>
<tr>
<td>Totals</td>
<td>152</td>
<td>187</td>
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<tr>
<td>No Response</td>
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</tr>
<tr>
<td>Z = -2.0354; P = 0.0400</td>
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TABLE 9 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 100 beds</th>
<th>100 or more beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. How do you rate the quality of continuing education programs in hospital administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>27 (17.8)</td>
<td>21 (11.2)</td>
</tr>
<tr>
<td>Good</td>
<td>80 (52.6)</td>
<td>102 (54.3)</td>
</tr>
<tr>
<td>Average</td>
<td>41 (27.0)</td>
<td>53 (28.2)</td>
</tr>
<tr>
<td>Poor</td>
<td>4 (2.6)</td>
<td>12 (6.4)</td>
</tr>
<tr>
<td>Totals</td>
<td>152</td>
<td>188</td>
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</tr>
<tr>
<td>Z = -1.6242; P = 0.1000</td>
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</tr>
</tbody>
</table>

5. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?

| Yes                                                                      | 162 (87.1)        | 153 (77.3)       |
| No                                                                       | 24 (12.9)         | 45 (22.7)        |
| Totals                                                                   | 186               | 198              |
| No Response                                                              | 25                |                  |
| Corrected Chi Square = 5.6308; 1 D.F.; P = 0.0177                        |                   |                  |

6. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?

<p>| Yes                                                                      | 178 (92.7)        | 159 (79.1)       |
| No                                                                       | 14 (7.3)          | 42 (20.9)        |
| Totals                                                                   | 192               | 201              |
| No Response                                                              | 16                |                  |
| Corrected Chi Square = 13.7804; 1 D.F.; P = 0.0002                       |                   |                  |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 100 beds</th>
<th>100 or more beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Should you be required to engage in hospital administration continuing education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>127 (68.6)</td>
<td>137 (68.2)</td>
</tr>
<tr>
<td>No</td>
<td>58 (31.4)</td>
<td>64 (31.8)</td>
</tr>
<tr>
<td>Totals</td>
<td>185</td>
<td>201</td>
</tr>
<tr>
<td>Corrected Chi Square = 0.00004; 1 D.F.; P = 0.9950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. What impact would mandatory continuing education in hospital administration have on your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Increase in Effectiveness</td>
<td>30 (16.3)</td>
<td>25 (12.5)</td>
</tr>
<tr>
<td>Moderate Increase in Effectiveness</td>
<td>94 (51.1)</td>
<td>104 (52.0)</td>
</tr>
<tr>
<td>No Change in Effectiveness</td>
<td>51 (27.7)</td>
<td>61 (30.5)</td>
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<tr>
<td>Moderate Decrease in Effectiveness</td>
<td>3 (1.6)</td>
<td>9 (4.5)</td>
</tr>
<tr>
<td>Great Decrease in Effectiveness</td>
<td>6 (3.3)</td>
<td>1 (0.5)</td>
</tr>
<tr>
<td>Totals</td>
<td>184</td>
<td>200</td>
</tr>
<tr>
<td>Z = -1.0028; P = .2960</td>
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<tr>
<td>9. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American College of Hospital Administrators</td>
<td>55 (33.1)</td>
<td>97 (53.9)</td>
</tr>
<tr>
<td>American Hospital Association</td>
<td>26 (15.7)</td>
<td>20 (11.1)</td>
</tr>
<tr>
<td>Association of University Programs in Health Administration</td>
<td>20 (12.0)</td>
<td>26 (14.4)</td>
</tr>
<tr>
<td>State Health Department</td>
<td>8 (4.8)</td>
<td>8 (4.4)</td>
</tr>
<tr>
<td>State Hospital Association</td>
<td>44 (26.5)</td>
<td>19 (10.6)</td>
</tr>
<tr>
<td>U.S. Department of Health, Education and Welfare</td>
<td>4 (2.4)</td>
<td>6 (3.3)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (5.4)</td>
<td>4 (2.2)</td>
</tr>
<tr>
<td>Totals</td>
<td>166</td>
<td>180</td>
</tr>
<tr>
<td>Chi Square = 24.8884; 6 D.F.; P = 0.0004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Less than 100 beds</td>
<td>100 or more beds</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>10. Would you support a review mechanism in which a team of hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>administrators would visit you in your institution to evaluate your</td>
<td></td>
<td></td>
</tr>
<tr>
<td>effectiveness in managing the hospital to achieve its objective of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>131 (70.1)</td>
<td>138 (68.3)</td>
</tr>
<tr>
<td>No</td>
<td>56 (29.9)</td>
<td>64 (31.7)</td>
</tr>
<tr>
<td>Totals</td>
<td>187</td>
<td>202</td>
</tr>
</tbody>
</table>

No Response = 20
Corrected Chi Square = 0.6795; 1 D.F.; P = 0.7944
hospitals and 53.9 percent of administrators of the larger hospitals when they were asked about an organization to administer mandatory continuing education. The state hospital association was favored by 26.5 percent of the former and 10.6 percent of the latter. \( H_0^{(9)} \) was rejected with a consequent acceptance of \( H_A^{(9)} \) indicating a significant difference between the two groups regarding this question.

\( H_0^{(10)} \) could not be rejected.

**Analysis of Data by Administrators' Experience**

Few marked differences appear between categories. Administrators with less than five years experience who considered themselves "Very Effective" numbered 35.3 percent of the respondents. The same level of effectiveness was cited by 47.8 percent of the administrators with five or more years of experience. A rating of "Moderately Effective" was given by 60.6 percent of the less experienced and 50.0 percent of the more experienced groups. Data are shown in Table 10. \( H_0^{(11)} \) was rejected and \( H_A^{(11)} \) accepted.

Administrators with more experience stated that they had taken advantage of continuing education to a greater extent than stated administrators with less experience by a margin of 88.2 to 77.8 percent. \( H_A^{(12)} \) was accepted
### TABLE 10
RESPONSES OF ADMINISTRATORS
BY YEARS OF EXPERIENCE

<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 5 years experience</th>
<th>Greater than or equal to 5 years experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How effective are you in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>60 (35.3)</td>
<td>109 (47.8)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>103 (60.6)</td>
<td>114 (50.0)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>6 (3.5)</td>
<td>5 (2.2)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>1 (0.6)</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>170</td>
<td>228</td>
</tr>
<tr>
<td>No Response</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Z = 2.6044; P = 0.0094</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you taken advantage of continuing education opportunities in hospital administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>133 (77.8)</td>
<td>201 (88.2)</td>
</tr>
<tr>
<td>No</td>
<td>38 (22.2)</td>
<td>27 (11.8)</td>
</tr>
<tr>
<td>Totals</td>
<td>171</td>
<td>228</td>
</tr>
<tr>
<td>No Response</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 6.9781; 1 D.F.; P = 0.0083</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How would you describe the effectiveness of hospital administration continuing education in helping you to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>22 (16.4)</td>
<td>50 (24.8)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>85 (63.4)</td>
<td>119 (58.9)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>24 (17.9)</td>
<td>23 (11.4)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>3 (2.2)</td>
<td>10 (5.0)</td>
</tr>
<tr>
<td>Totals</td>
<td>134</td>
<td>202</td>
</tr>
<tr>
<td>No Response</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Z = 1.7584; P = 0.0802</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## TABLE 10 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 5 years</th>
<th>Greater than or equal to 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. How do you rate the quality of continuing education programs in hospital administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>17 (12.6)</td>
<td>30 (14.9)</td>
</tr>
<tr>
<td>Good</td>
<td>75 (55.6)</td>
<td>105 (52.0)</td>
</tr>
<tr>
<td>Average</td>
<td>35 (25.9)</td>
<td>59 (29.2)</td>
</tr>
<tr>
<td>Poor</td>
<td>8 (5.9)</td>
<td>8 (4.0)</td>
</tr>
<tr>
<td>Totals</td>
<td>135</td>
<td>202</td>
</tr>
<tr>
<td>No Response = 72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z = 0.3772, P = 0.2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>142 (86.6)</td>
<td>171 (78.8)</td>
</tr>
<tr>
<td>No</td>
<td>22 (13.4)</td>
<td>46 (21.2)</td>
</tr>
<tr>
<td>Totals</td>
<td>164</td>
<td>217</td>
</tr>
<tr>
<td>No Response = 28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 3.3469, 1 D.F., P = 0.0673</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Should schools of hospital and health services administration develop opportunities for practicing administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>139 (83.7)</td>
<td>195 (87.1)</td>
</tr>
<tr>
<td>No</td>
<td>27 (16.3)</td>
<td>29 (12.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>166</td>
<td>224</td>
</tr>
<tr>
<td>No Response = 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 0.6054, 1 D.F., P = 0.4365</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 10 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 5 years experience</th>
<th>Greater than or equal to 5 years experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Should you be required to engage in hospital administration continuing education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>116 (71.6)</td>
<td>146 (66.1)</td>
</tr>
<tr>
<td>No</td>
<td>46 (28.4)</td>
<td>75 (33.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>162</td>
<td>221</td>
</tr>
<tr>
<td>No Response</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square</td>
<td>1.0842; 1 D.F.; P = 0.2978</td>
<td></td>
</tr>
</tbody>
</table>

8. What impact would mandatory continuing education in hospital administration have on your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

<table>
<thead>
<tr>
<th></th>
<th>Less than 5 years experience</th>
<th>Greater than or equal to 5 years experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Increase in Effectiveness</td>
<td>22 (13.3)</td>
<td>33 (15.3)</td>
</tr>
<tr>
<td>Moderate Increase in Effectiveness</td>
<td>95 (57.2)</td>
<td>100 (46.5)</td>
</tr>
<tr>
<td>No Change in Effectiveness</td>
<td>43 (25.9)</td>
<td>69 (32.1)</td>
</tr>
<tr>
<td>Moderate Decrease in Effectiveness</td>
<td>4 (2.4)</td>
<td>8 (3.7)</td>
</tr>
<tr>
<td>Great Decrease in Effectiveness</td>
<td>2 (1.2)</td>
<td>5 (2.3)</td>
</tr>
<tr>
<td>Totals</td>
<td>166</td>
<td>215</td>
</tr>
<tr>
<td>No Response</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Z = -1.2573; P = 0.2300</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

<table>
<thead>
<tr>
<th>Organization</th>
<th>Less than 5 years experience</th>
<th>Greater than or equal to 5 years experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Hospital Administrators</td>
<td>68 (45.6)</td>
<td>83 (42.6)</td>
</tr>
<tr>
<td>American Hospital Association</td>
<td>19 (12.8)</td>
<td>27 (13.8)</td>
</tr>
<tr>
<td>Association of University Programs in Health Administration</td>
<td>20 (13.4)</td>
<td>26 (13.3)</td>
</tr>
<tr>
<td>State Health Department</td>
<td>9 (6.0)</td>
<td>7 (3.6)</td>
</tr>
<tr>
<td>State Hospital Association</td>
<td>25 (16.8)</td>
<td>37 (19.0)</td>
</tr>
<tr>
<td>U.S. Department of Health, Education and Welfare</td>
<td>3 (2.0)</td>
<td>7 (3.6)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (3.4)</td>
<td>8 (4.1)</td>
</tr>
<tr>
<td>Totals</td>
<td>149</td>
<td>195</td>
</tr>
<tr>
<td>No Response</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Chi Square</td>
<td>2.4210; 6 D.F.; P = 0.8772</td>
<td></td>
</tr>
</tbody>
</table>
10. Would you support a review mechanism in which a team of hospital administrators would visit you in your institution to evaluate your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

<table>
<thead>
<tr>
<th>Question</th>
<th>Less than 5 years</th>
<th>Greater than or equal to 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>118 (71.5)</td>
<td>151 (68.3)</td>
</tr>
<tr>
<td>No</td>
<td>47 (28.5)</td>
<td>70 (31.7)</td>
</tr>
<tr>
<td>Totals</td>
<td>165</td>
<td>221</td>
</tr>
</tbody>
</table>

No Response = 23
Corrected Chi Square = 0.3164; 1 D.F.; P = 0.5737
after rejecting $H_0(12)$.

Applying separate statistical tests, $H_0(13)$, $H_0(14)$, $H_0(15)$, $H_0(16)$, $H_0(17)$, $H_0(18)$, $H_0(19)$ and $H_0(20)$ could not be rejected. Thus, corresponding alternative hypotheses could not be accepted.

**Analysis of Data by whether Administrator Graduated from a School of Hospital and Health Services Administration**

Table 11 displays data about hospital administrators who are program graduates and those who are not. When asked about their own effectiveness, "Very Effective" was the response of 49.6 percent of program graduates but of only 33.1 percent of the other group. $H_0(21)$ was not rejected and $H_A(21)$ was not accepted.

While only 78.7 percent of administrators who had not graduated from a program stated they had taken advantage of opportunities in continuing education, 92.3 percent of the program graduates gave an affirmative answer. This finding proved to be significant in this study with the null hypothesis, $H_0(22)$, being rejected and the alternative hypothesis, $H_A(22)$, accepted.

However, regarding the effectiveness of hospital administration continuing education, 26.5 percent of the non-program administrators rated it "Very Effective"
### TABLE 11
RESPONSES OF ADMINISTRATORS BY GRADUATION FROM A SCHOOL
OF HEALTH AND HOSPITAL ADMINISTRATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Program Graduate</th>
<th>Not Program Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How effective are you in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>70 (49.6)</td>
<td>98 (38.1)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>69 (48.9)</td>
<td>149 (58.0)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>2 (1.4)</td>
<td>9 (3.5)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>0</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>Totals</td>
<td>141</td>
<td>257</td>
</tr>
<tr>
<td>No Response</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Z = -2.0952; P = 0.0360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you taken advantage of continuing education opportunities in hospital administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>132 (92.3)</td>
<td>203 (78.7)</td>
</tr>
<tr>
<td>No</td>
<td>11 (7.7)</td>
<td>55 (21.3)</td>
</tr>
<tr>
<td>Totals</td>
<td>143</td>
<td>258</td>
</tr>
<tr>
<td>No Response</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 11.4515; 1 D.F.; P = 0.0007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How would you describe the effectiveness of hospital administration continuing education in helping you to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>18 (13.6)</td>
<td>54 (26.5)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>83 (62.9)</td>
<td>121 (59.3)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>24 (18.2)</td>
<td>23 (11.3)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>7 (5.3)</td>
<td>6 (2.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>132</td>
<td>204</td>
</tr>
<tr>
<td>No Response</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Z = 2.7134; P = 0.0070</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 11 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Program Graduate</th>
<th>Not Program Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. How do you rate the quality of continuing education programs in hospital administration?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>15 (11.3)</td>
<td>30 (14.6)</td>
</tr>
<tr>
<td>Good</td>
<td>70 (52.6)</td>
<td>113 (55.1)</td>
</tr>
<tr>
<td>Average</td>
<td>36 (28.6)</td>
<td>56 (27.3)</td>
</tr>
<tr>
<td>Poor</td>
<td>10 (7.5)</td>
<td>6 (2.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>133</td>
<td>205</td>
</tr>
<tr>
<td>No Response = 71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z = 1.4690; P = 0.1336</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>107 (78.1)</td>
<td>206 (84.1)</td>
</tr>
<tr>
<td>No</td>
<td>30 (21.9)</td>
<td>39 (15.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>137</td>
<td>245</td>
</tr>
<tr>
<td>No Response = 27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 1.7379; 1 D.F.; P = 0.1874</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>94 (68.6)</td>
<td>241 (94.9)</td>
</tr>
<tr>
<td>No</td>
<td>43 (31.4)</td>
<td>13 (5.1)</td>
</tr>
<tr>
<td>Totals</td>
<td>137</td>
<td>254</td>
</tr>
<tr>
<td>No Response = 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 47.9291; 1 D.F.; P = 0.0000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE IX (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Program Graduate</th>
<th>Not Program Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Should you be required to engage in hospital administration continuing education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>95 (68.3)</td>
<td>168 (68.6)</td>
</tr>
<tr>
<td>No</td>
<td>44 (31.7)</td>
<td>77 (31.4)</td>
</tr>
<tr>
<td>Totals</td>
<td>139</td>
<td>245</td>
</tr>
<tr>
<td>No Response</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square</td>
<td>0.0047</td>
<td>1 D.F.; P = 0.9454</td>
</tr>
</tbody>
</table>

8. What impact would mandatory continuing education in hospital administration have on your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

<table>
<thead>
<tr>
<th>Impact</th>
<th>Program Graduate</th>
<th>Not Program Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Increase in Effectiveness</td>
<td>11 (7.9)</td>
<td>43 (17.7)</td>
</tr>
<tr>
<td>Moderate Increase in Effectiveness</td>
<td>78 (56.1)</td>
<td>120 (49.4)</td>
</tr>
<tr>
<td>No Change in Effectiveness</td>
<td>45 (32.4)</td>
<td>67 (27.6)</td>
</tr>
<tr>
<td>Moderate Decrease in Effectiveness</td>
<td>5 (3.6)</td>
<td>7 (2.9)</td>
</tr>
<tr>
<td>Great Decrease in Effectiveness</td>
<td>0</td>
<td>6 (2.5)</td>
</tr>
<tr>
<td>Totals</td>
<td>139</td>
<td>243</td>
</tr>
<tr>
<td>No Response</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Z = 1.4657; P = 0.1470</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program Graduate</th>
<th>Not Program Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Hospital Administrators</td>
<td>80 (64.5)</td>
<td>71 (32.1)</td>
</tr>
<tr>
<td>American Hospital Association</td>
<td>7 (5.6)</td>
<td>39 (17.6)</td>
</tr>
<tr>
<td>Association of University Programs in Health Administration</td>
<td>18 (14.5)</td>
<td>28 (12.7)</td>
</tr>
<tr>
<td>State Health Department</td>
<td>6 (4.8)</td>
<td>10 (4.5)</td>
</tr>
<tr>
<td>State Hospital Association</td>
<td>6 (4.8)</td>
<td>57 (25.8)</td>
</tr>
<tr>
<td>U.S. Department of Health, Education and Welfare</td>
<td>3 (2.4)</td>
<td>7 (3.2)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (3.2)</td>
<td>9 (4.1)</td>
</tr>
<tr>
<td>Totals</td>
<td>124</td>
<td>221</td>
</tr>
<tr>
<td>No Response</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Chi Square = 47.2419; 6 D.F.; P = 0.0000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. Would you support a review mechanism in which a team of hospital administrators would visit you in your institution to evaluate your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

<table>
<thead>
<tr>
<th>Question</th>
<th>Program Graduate</th>
<th>Not Program Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>87 (63.0)</td>
<td>180 (72.3)</td>
</tr>
<tr>
<td>No</td>
<td>51 (37.0)</td>
<td>69 (27.7)</td>
</tr>
<tr>
<td>Totals</td>
<td>138</td>
<td>249</td>
</tr>
</tbody>
</table>

No Response = 22
Corrected Chi Square = 3.1289; 1 D.F.; P = 0.0769
but only 13.6 percent of the other group gave that response. This result also proved significant with $H_0^{(23)}$ being rejected and $H_A^{(23)}$ accepted.

$H_0^{(24)}$ and $H_0^{(25)}$ were not rejected and $H_A^{(24)}$ and $H_A^{(25)}$ were not accepted.

It was stated by 68.6 percent of the program graduates and 94.9 percent of administrators who had not graduated from a school that schools of hospital and health services administration should develop opportunities without requiring full-time study on campus. $H_0^{(26)}$ was rejected and the alternative accepted.

$H_A^{(27)}$ and $H_A^{(28)}$ were not accepted as the corresponding null hypotheses could not be rejected.

The American College of Hospital Administrators should administer continuing education if it were to become mandatory, according to the answers of 64.5 percent and 32.1 percent of program and non-program graduates respectively. The American Hospital Association was favored by only 5.6 percent of the graduates, but by 17.6 percent of administrators who had not graduated from a program. Similarly, the state hospital association was favored by 4.8 percent of the graduates and 25.8 percent of the others. $H_0^{(29)}$ was rejected and $H_A^{(29)}$ accepted.
$H_0^{(30)}$ was not rejected and, consequently $H_A^{(30)}$ not accepted.

**Analysis of Data by Administrators' Age**

Notable differences are not evident when examining data between administrators born before January 1, 1923 and those born on and after January 1, 1923. Data are displayed in Table 12.

Statistically, $H_0^{(31)}$, $H_0^{(32)}$, $H_0^{(35)}$, $H_0^{(36)}$, $H_0^{(37)}$, $H_0^{(38)}$, $H_0^{(39)}$ and $H_0^{(40)}$ were not rejected and the alternatives were not accepted. However, $H_0^{(33)}$ and $H_0^{(34)}$ were rejected and $H_A^{(33)}$ and $H_A^{(34)}$ accepted.

**Analysis of Data by Three Responses from the Same Hospital**

Analysis, through the use of a separate statistical test on each set of data, indicates that the hypotheses, $H_0^{(41)}$, $H_0^{(42)}$, $H_0^{(43)}$, $H_0^{(44)}$, $H_0^{(45)}$, $H_0^{(46)}$, $H_0^{(47)}$, $H_0^{(48)}$ and $H_0^{(49)}$ could not be rejected. Correspondingly, the alternative hypotheses could not be accepted. Statistics are shown in Table 13.

The three respondents from the same institution answered differently on 66.7 percent of the responses to the question asking about the effectiveness of the administrator.
### TABLE 12
RESPONSES OF ADMINISTRATORS BY AGE

<table>
<thead>
<tr>
<th>Question</th>
<th>Born before Jan. 1, 1923</th>
<th>Born on or after Jan. 1, 1923</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How effective are you in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>68 (48.6)</td>
<td>102 (39.2)</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>68 (48.6)</td>
<td>150 (57.7)</td>
</tr>
<tr>
<td>Somewhat Ineffective</td>
<td>4 (2.9)</td>
<td>7 (2.7)</td>
</tr>
<tr>
<td>Usually Ineffective</td>
<td>0</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>Totals</td>
<td>140</td>
<td>260</td>
</tr>
<tr>
<td>No Response = 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z = -1.8316; P = .0660</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Have you taken advantage of continuing education opportunities in hospital administration?

| Yes                                                                     | 123 (87.2)               | 214 (82.0)                    |
| No                                                                     | 18 (12.8)                | 47 (18.0)                     |
| Totals                                                                 | 141                      | 261                           |
| No Response = 7                                                        |                          |                               |
| Corrected Chi Square = 1.4891; 1 D.F.; P = 0.2224                       |                          |                               |

3. How would you describe the effectiveness of hospital administration continuing education in helping you to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?

| Very Effective                                                          | 34 (27.6)                | 40 (18.5)                     |
| Moderately Effective                                                   | 76 (61.8)                | 129 (59.7)                    |
| Somewhat Ineffective                                                   | 11 (8.9)                 | 36 (16.7)                     |
| Usually Ineffective                                                    | 2 (1.6)                  | 11 (5.1)                      |
| Totals                                                                 | 123                      | 216                           |
| No Response = 7                                                         |                          |                               |
| Z = -3.5249; P < 0.0010                                                 |                          |                               |
TABLE 12 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Born before Jan. 1, 1923</th>
<th>Born on or after Jan. 1, 1923</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. How do you rate the quality of continuing education programs in hospital administration?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>22 (17.7)</td>
<td>26 (12.0)</td>
</tr>
<tr>
<td>Good</td>
<td>70 (56.5)</td>
<td>112 (51.9)</td>
</tr>
<tr>
<td>Average</td>
<td>29 (23.4)</td>
<td>65 (30.1)</td>
</tr>
<tr>
<td>Poor</td>
<td>3 (2.4)</td>
<td>13 (6.0)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>124</td>
<td>216</td>
</tr>
<tr>
<td><strong>No Response = 69</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Z = -3.1230; P = 0.0020</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**5. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?**

| Yes                                                                      | 103 (77.4)               | 212 (84.5)                     |
| No                                                                       | 30 (22.6)                | 39 (15.5)                      |
| **Totals**                                                               | 133                      | 251                            |
| **No Response = 25**                                                     |                          |                                |
| Corrected Chi Square = 2.4487; 1 D.F.; P = 0.1176                        |                          |                                |

**6. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?**

<p>| Yes                                                                      | 120 (88.2)               | 217 (84.4)                     |
| No                                                                       | 16 (11.8)                | 40 (15.6)                      |
| <strong>Totals</strong>                                                               | 136                      | 257                            |
| <strong>No Response = 16</strong>                                                     |                          |                                |
| Corrected Chi Square = 0.7628; 1 D.F.; P = 0.3825                        |                          |                                |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Born before Jan 1, 1923</th>
<th>Born on or after Jan 1, 1923</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Should you be required to engage in hospital administration continuing education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>95 (70.9)</td>
<td>169 (67.1)</td>
</tr>
<tr>
<td>No</td>
<td>39 (29.1)</td>
<td>83 (32.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>134</td>
<td>252</td>
</tr>
<tr>
<td>No Response = 23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Chi Square = 0.4302; 1 D.F.; P = 0.5119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. What impact would mandatory continuing education in hospital administration have on your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Increase in Effectiveness</td>
<td>22 (16.5)</td>
<td>33 (13.1)</td>
</tr>
<tr>
<td>Moderate Increase in Effectiveness</td>
<td>69 (51.9)</td>
<td>129 (51.4)</td>
</tr>
<tr>
<td>No Change in Effectiveness</td>
<td>32 (24.1)</td>
<td>80 (31.9)</td>
</tr>
<tr>
<td>Moderate Decrease in Effectiveness</td>
<td>5 (3.8)</td>
<td>7 (2.8)</td>
</tr>
<tr>
<td>Great Decrease in Effectiveness</td>
<td>5 (3.8)</td>
<td>2 (0.8)</td>
</tr>
<tr>
<td>Totals</td>
<td>133</td>
<td>251</td>
</tr>
<tr>
<td>No Response = 25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Z = -0.8555; P = 0.3700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American College of Hospital Administrators</td>
<td>48 (42.1)</td>
<td>104 (44.8)</td>
</tr>
<tr>
<td>American Hospital Association</td>
<td>14 (12.3)</td>
<td>32 (13.8)</td>
</tr>
<tr>
<td>Association of University Programs in Health Administration</td>
<td>14 (12.3)</td>
<td>32 (13.8)</td>
</tr>
<tr>
<td>State Health Department</td>
<td>6 (5.3)</td>
<td>10 (4.3)</td>
</tr>
<tr>
<td>State Hospital Association</td>
<td>26 (22.8)</td>
<td>37 (15.9)</td>
</tr>
<tr>
<td>U.S. Department of Health, Education and Welfare</td>
<td>2 (1.8)</td>
<td>8 (3.4)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (3.5)</td>
<td>9 (3.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>114</td>
<td>232</td>
</tr>
<tr>
<td>No Response = 63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chi Square = 3.3037; 6 D.F.; P = 0.7699</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE 12 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Born before Jan. 1, 1923</th>
<th>Born on or after Jan. 1, 1923</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Would you support a review mechanism in which a team of hospital administrators would visit you in your institution to evaluate your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td><strong>Yes</strong></td>
<td>107 (76.4)</td>
</tr>
<tr>
<td></td>
<td><strong>No</strong></td>
<td>33 (23.6)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td>140</td>
</tr>
<tr>
<td><strong>No Response</strong></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td><strong>Chi Square</strong></td>
<td></td>
<td>5.8002; 2 D.F.; P = 0.0550</td>
</tr>
</tbody>
</table>
TABLE 13
RESPONSES OF THE ADMINISTRATOR, BOARD CHAIRMAN
AND CHIEF OF STAFF FROM THE SAME HOSPITAL

<table>
<thead>
<tr>
<th>Question</th>
<th>Same Answer Selected</th>
<th>Different Answer Selected</th>
<th>No Response by at least One Respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How effective is the administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td>36 (30.0)</td>
<td>80 (66.7)</td>
<td>4 (3.3)</td>
</tr>
<tr>
<td></td>
<td>Chi Square = 7.8938; 2 D.F.; .01 &lt; P &lt; .02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has the administrator taken advantage of continuing education opportunities in hospital administration?</td>
<td>72 (60.0)</td>
<td>36 (30.0)</td>
<td>12 (10.0)</td>
</tr>
<tr>
<td></td>
<td>Chi Square = 0.3750; 2 D.F.; .80 &lt; P &lt; .90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How would you describe the effectiveness of hospital administration continuing education in helping the administrator to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td>18 (15.0)</td>
<td>50 (41.7)</td>
<td>52 (43.3)</td>
</tr>
<tr>
<td></td>
<td>Chi Square = 8.0368; 2 D.F.; .01 &lt; P &lt; .02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?</td>
<td>66 (55.0)</td>
<td>31 (25.8)</td>
<td>23 (19.2)</td>
</tr>
<tr>
<td></td>
<td>Chi Square = 1.7165; 2 D.F.; .30 &lt; P &lt; .50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Same Answer Selected</td>
<td>Different Answer Selected</td>
<td>No Response by at least One Respondent</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>5. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?</td>
<td>75 (62.5)</td>
<td>30 (25.0)</td>
<td>15 (12.5)</td>
</tr>
<tr>
<td>Chi Square = 0.5286; 2 D.F.; .70 &lt; P &lt; .80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Should the administrator be required to engage in hospital administration continuing education?</td>
<td>56 (46.7)</td>
<td>50 (41.7)</td>
<td>14 (11.7)</td>
</tr>
<tr>
<td>Chi Square = 0.3248; 2 D.F.; .80 &lt; P &lt; .90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. What impact would mandatory continuing education in hospital administration have on the administrator's effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td>23 (19.2)</td>
<td>72 (60.0)</td>
<td>25 (20.8)</td>
</tr>
<tr>
<td>Chi Square = 0.9053; 2 D.F.; .50 &lt; P &lt; .70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. If continuing education were to become mandatory for hospital administrators, which organization should be responsible for its administration?</td>
<td>22 (18.3)</td>
<td>52 (43.3)</td>
<td>46 (38.3)</td>
</tr>
<tr>
<td>Chi Square = 3.4662; 2 D.F.; .10 &lt; P &lt; .20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE 13 (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Same Answer Selected</th>
<th>Different Answer Selected</th>
<th>No Response by at least One Respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Would you support a review mechanism in which a team of hospital administrators would visit the administrator in his institution to evaluate his effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?</td>
<td>51 (42.5)</td>
<td>57 (47.5)</td>
<td>12 (10.0)</td>
</tr>
</tbody>
</table>

Chi Square = 1.8472; 2 D.F.; .30 < P < .50
The triad gave the same answer on 60.0 percent of the responses to the question about taking advantage of continuing education opportunities.

The administrator, board chairman and chief of staff gave the same answer in 55.0 percent and 62.5 percent of the responses to the questions asking whether schools of hospital and health services administration should offer more continuing education programs and opportunities to earn a degree without requiring full-time study on campus, respectively.

Regarding the impact of mandatory continuing education, 60.0 percent of the groups had at least one different answer.

**No Return Analysis**

Despite the fact that a follow-up questionnaire was sent to the portion of the sample not responding to the initial mailing, 51.7 percent of the total sample did not return a questionnaire.

Consequently, age, experience and education data could not be collected on the group not returning questionnaires. However, Appendix D displays a Frequency and Percentage Distribution of No Returns by Hospital Size Group. The data show that slightly more administrators, chiefs of staff and board chairmen from smaller hospitals than larger hospitals did not return questionnaires.
CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this chapter is to summarize the study. The first part presents a summary of the most important aspects of the study. The second part lists major conclusions drawn from the findings. The last part presents recommendations for further study.

Summary of the Study

The purpose of the study was to determine whether knowledgeable people believe mandatory continuing education could be expected to increase the effectiveness of hospital administrators in managing the hospital.

Continuing education has been considered an important aspect of professional development in hospital administration but, according to the literature, has seldom been related directly to administrator effectiveness. Until the last few years, continuing education has been almost completely a voluntary activity in the health field. Professionals engaged in it only if and when they felt a need. However, the voluntary method has been criticized because a considerable number of health professionals supposedly have not chosen to pursue continuing education.
Some physicians, nurses, pharmacists, dietitians, dentists and others now are required to complete continuing education activities for the purpose of providing improved patient care.

While administrators have the responsibility of managing the hospital to achieve quality patient care, little data exist about these professionals and their continuing education perceptions. In addition to soliciting information from administrators, chairmen of boards of trustees, chiefs of medical staffs and hospital-related health executives were questioned.

A stratified random sample of 706 hospitals was taken from The 1973 Guide, half with under 100 beds and half with 100 and more beds. Hospitals were limited to those having a board of trustees.

Separate questionnaires were sent to the administrator, chairman of the board of trustees and chief of the medical staff in each hospital sampled. Also, a fourth type of questionnaire was sent to executives in hospital-related agencies of the health field. While a literature search uncovered no analytical studies, its findings served as a frame of reference for the development of questions used in the questionnaire.

A pilot study was conducted in the State of Missouri during January, 1974 and the final national study in April, 1974.
Results of the national study were analyzed by computer using parts of two packages of statistical programs, which utilized the Chi Square, Wilcoxon Rank Sum and Friedman Two-Way Analysis of Variance by Ranks statistical tests.

Analysis of data revealed the following findings:

**Administrator's Effectiveness.** Nine out of every ten respondents among administrators, board chairmen and chiefs of staff stated that the administrator was "Very Effective" or "Moderately Effective" in managing the hospital.

While only four out of every ten administrators and chiefs of staff said the administrator was "Very Effective," six of every ten board chairmen gave that answer. However, only one of every ten hospital-related health executives responded that the administrator was "Very Effective." In fact, two of every ten said that administrators were "Somewhat Ineffective."

More than three in every ten administrators with less experience but almost five in every ten with more experience considered themselves "Very Effective." However, six in every ten of the less experienced group and five in every ten of the more experienced group stated they were "Moderately Effective." The Wilcoxon Rank Sum statistical test revealed a significant difference.
Less than three of every ten administrators in Region 2 stated that they were "Very Effective." More than five in every ten administrators in Region 4 gave that answer with responses in the other regions falling between the extremes.

A large majority in the top level of hospital management, administrators, board chairmen and chiefs of staff, in assessing administrator effectiveness as either "Very Effective" or "Moderately Effective," indicated satisfaction with perceived effectiveness. Any proposal, therefore, by these groups that continuing education be made mandatory seems unlikely. Pressure for change because of ineffectiveness appears minimal. No need seems to exist for changes in continuing education. It appears that mandatory continuing education is not needed because administrators now function at a high level, according to top management in the hospital.

However, perceptions of executives in the health field, associated with hospitals but not working in one, are markedly different. These executives do not perceive hospital administrators as being as effective as do the hospital triad of board chairman, chief of the medical staff and administrator. It is important to state that the hospital representatives were asked about a specific administrator while the hospital-related health
executives were questioned about hospital administrators in general.

Administrator's Pursuit of Continuing Education Activities. Nearly eight out of every ten hospital respondents stated that the administrator had taken advantage of continuing education opportunities. Specifically, eight out of every ten administrators and board chairmen and nearly that many chiefs of staff answered affirmatively. However, as was the case with administrator's effectiveness, fewer hospital-related health executives were as positive about pursuit of continuing education, with six of every ten executives stating that administrators had taken advantage of continuing education opportunities.

While eight out of every ten administrators of larger hospitals stated they had pursued continuing education activities, only seven of every ten administrators of smaller hospitals gave that answer. In this study, a significant difference was found between these groups on this variable.

Nearly nine of every ten administrators with greater experience said they had taken advantage of opportunities. Among less experienced administrators, almost eight of ten answered "Yes." The Corrected Chi Square statistical test indicated a significant difference between groups on this question.
Only slightly more than one of every ten graduates of schools of hospital and health services administration rated continuing education as "Very Effective" contrasted with nearly three of every ten non-school graduate administrators.

It appeared that the effectiveness of continuing education in hospital administration was not rated either very high or very low. The level of effectiveness seemed to fall between the extremes. Evidence attaching great importance to the effectiveness of continuing education was not found in this study.

Quality of Continuing Education. The quality of continuing education was most often rated as "Good" on the scale used in the study.

While fewer than four out of every ten respondents in Region 7 marked that the quality of continuing education programs was "Good," more than six in every ten in Region 5 gave that answer. Other responses fell between these extremes.

Need for improvement of the quality of continuing education programs in hospital administration was shown, although criticism appeared minimal. The question remains whether quality improvement of continuing education programs would attract appreciable more administrators without a mandatory provision.
While more than nine out of every ten graduates of schools of hospital and health services administration had taken advantage of opportunities in continuing education, fewer than eight of ten administrators in the other group gave that reply. Again in this case, the null hypothesis was rejected and the alternative accepted, indicating a significant difference between groups in the study.

Overall results indicated that administrators have taken advantage of opportunities in continuing education. Such information tends to support the continuation of the voluntary concept. However, differences appeared upon statistical analysis. More experienced administrators from larger hospitals who had graduated from a school of hospital and health administration seemed to take greater advantage of opportunities in hospital administration continuing education.

**Effectiveness of Continuing Education.** Seven out of every ten hospital respondents answered "Very Effective" or "Moderately Effective" when asked about the effectiveness of continuing education in helping the administrator to manage the hospital. Nearly seven of every ten administrators and chiefs of staff and eight of every ten board chairmen gave these answers. However, only six of every ten hospital-related health executives indicated "Very Effective" or "Moderately Effective."
Need for More Continuing Education by Schools in Field. Approximately eight out of every ten respondents indicated that schools of hospital and health services administration should offer more continuing education programs. Each of the four groups of respondents supported the development of additional educational offerings.

Content of Continuing Education Programs Offered by School in Field. All four groups of respondents ranked Financial Management first among suggested topics for continuing education programs. Governmental Regulations and Personnel Management followed Financial Management. These subjects are perceived as important for practitioners working in the health care system at this time.

Need for Opportunities to Attain A Degree without Full-Time Study on Campus. Eight of every ten respondents were in favor of the need for schools of hospital and health services administration to develop degree opportunities without the requirement for full-time study on campus. Such programs would be for practicing administrators who had not graduated from one of the schools in the field.

While over nine of every ten administrator-respondents from the smaller hospitals favored this concept, only eight of ten administrators from larger hospitals responded positively. A significant difference was found in this dichotomy.
Over nine of ten administrators who had not graduated from a program, but less than seven of ten who had, supported the development of this non-traditional concept. This finding, too, was statistically significant in the study.

Administrators who would seem to be eligible to enroll in such a program, responded overwhelmingly in favor of the idea. Administrators with the degree were not as positive about opportunities.

**Need for Required Continuing Education.** Slightly fewer than seven out of every ten respondents stated that continuing education should be required of hospital administrators. Differences were not notable across categories. Measurement of dependent variables found no significance at the .01 level, which was established in this study.

A conclusion of the study is that a majority of respondents, including hospital administrators themselves, believe that administrators should be required to engage in continuing education.

Important is the finding that others closely associated with the administrator also believed that he should be required to involve himself in continuing education.

Enforcement of a requirement for continuing education would include the limited number who do not engage in continuing education. Whether mandating the requirement
for all in order to force a few to become active remains an important issue.

**Impact of Mandatory Continuing Education on Administrator's Effectiveness.** More than seven out of every ten respondents stated that the impact of mandatory continuing education on the administrator's effectiveness would bring a moderate increase or make no change. The health executives forecast a moderate increase in effectiveness more often than did the hospital-based respondents.

Four of every ten administrators responding in Region 1 and more than seven of every ten in Region 2 predicted a moderate increase. The forecast of "no change" was made by fewer than two of every ten respondents in Region 2 and fewer than four of every ten in Region 1. Answers in other regions varied between these extremes.

While the study disclosed that the great majority of respondents forecast no decrease in effectiveness, neither did they see a great increase in effectiveness.

The implications for mandatory continuing education remain unclear. While respondents felt that a limited increase in effectiveness would result for most administrators, the opportunity of including those administrators who had not been involved previously in continuing education is an important consideration. If a decision were made to include those who do not engage in continuing education on a voluntary basis by mandating a requirement
for all, this study indicated that most administrators and their closest associates would agree.

Organization to Administer Programs. The American College of Hospital Administrators was cited most often as the organization that should be responsible for the administration of mandatory continuing education. However, a majority of respondents, including hospital administrators themselves, did not select the ACHA.

Although the professional society was selected by fewer than four of every ten respondents as the organization to administer programs, the study indicated support for voluntary associations rather than government agencies for the purpose of administering mandatory continuing education activities. Support for governmental involvement amounted to approximately one person in ten.

While five of every ten administrators of larger hospitals supported the ACHA, only three of ten administrators in the smaller institutions indicated that choice. More of the latter group than the former favored the state hospital association. The difference seemed significant.

Six of ten graduates of schools of hospital and health services administration favored the ACHA but only half of that number of non-school graduates selected the ACHA. Administrators without the degree in the field
selected the American Hospital Association and state hospital association more often than graduates. These findings proved significant in the study.

**Support for Review Mechanism.** Six out of every ten hospital respondents favored a review mechanism in which a team of hospital administrators would evaluate an administrator's effectiveness. The same was found among health executives.

Peer review seems to be assuming a greater role in maintaining the effectiveness of health professionals. Perhaps the peer review mechanism suggested in this study would help hospital administrators focus on the important aspects of effectiveness. Appropriate continuing education programs could then be developed.

**Hypothesis Testing.** A summary of the results of hypothesis testing is shown in Table 14.

**Conclusions of the Study**

The following are major conclusions drawn from the study:

1. Most respondents perceive that hospital administrators perform effectively.

2. Respondents associated with a hospital perceive that hospital administrators perform at a higher level of effectiveness than do respondents in the health field but not associated with a hospital.
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<td>There is a difference between responses of administrators with five years or more experience as a hospital chief executive officer and responses of administrators with less than five years experience relative to administrator's pursuit of continuing education activities.</td>
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3. Administrators with more experience perceive that they have a higher level of effectiveness than administrators with less experience perceive themselves as having.

4. Most respondents indicate that administrators have taken advantage of opportunities in continuing education.

5. Respondents associated with a hospital indicate that hospital administrators have taken advantage of opportunities in continuing education to a greater extent than hospital-related health executives indicate that administrators have.

6. Administrators of larger hospitals believe they have taken advantage of opportunities in continuing education to a greater extent than administrators of smaller hospitals think themselves to have taken.

7. Administrators with more experience believe they have taken advantage of continuing education opportunities to a greater extent than less experienced administrators believe themselves to have taken.

8. Graduates of schools of hospital and health services administration feel they have taken advantage of opportunities in continuing education to a greater extent than non-graduate administrators feel themselves to have taken.

9. Hospital administration continuing education is effective in helping the administrator manage his hospital.

10. Non-school graduate administrators think that hospital administration continuing education is more effective than do school graduate administrators.

11. Most respondents rate the quality of continuing education programs in hospital administration as "Good."
12. Most respondents indicate that schools of hospital and health services administration need to offer more continuing education programs.

13. More respondents suggested Financial Management as a subject above any other for continuing education in programs offered by schools of hospital and health services administration.

14. Most respondents stated that they were in favor of the development of degree opportunities for non-graduate administrators to pursue a degree without requiring full-time study on campus.

15. More administrators of smaller hospitals than administrators of larger hospitals concurred with the development of degree opportunities without requiring full-time study on campus.

16. More administrators who had not graduated from a school in the field than those who had, concurred with the development of degree opportunities without requiring full-time study on campus.

17. Most respondents stated that hospital administrators should be required to engage in continuing education.

18. Most respondents stated that the impact of mandatory continuing education on the administrator would be to bring a moderate increase in effectiveness or to result in no change.

19. More hospital-related health executives than administrators, board chairmen and chiefs of staff predicted that mandatory continuing education would bring a moderate increase in effectiveness.

20. More respondents stated that the American College of Hospital Administrators, rather than any other organization, should be responsible for administration of mandatory continuing education programs.
21. More respondents selected a voluntary association than a government agency as the organization to administer mandatory continuing education.

22. More administrators of larger hospitals than administrators of smaller hospitals favored the American College of Hospital Administrators as the organization to administer mandatory continuing education.

23. More administrators who had graduated from a school of hospital and health services administration than administrators who had not, favored the American College of Hospital Administrators as the organization to administer mandatory continuing education.

24. More administrators who had not graduated from a school in the field than those who had, indicated a preference for the state hospital association as the organization to administer continuing education.

25. More administrators who had not graduated from a school in the field than those who had, indicated a preference for the American Hospital Association to administer continuing education.

26. Most respondents would support a review mechanism in which a team of hospital administrators would evaluate an administrator's effectiveness in his own institution.

27. Important differences between responses of administrators in the geographic regions were not found.

28. Differences were not found when analyzing the set of data from each hospital when all three respondents returned questionnaires.
Implications of the Study

This study indicates that the administrator, the chief of the medical staff and the chairman of the board of trustees are satisfied with the administrator's level of effectiveness. Consequently, concern over present approaches to continuing education does not seem to exist within institutions at the top management level. This means that top level management probably will not initiate policies that favor mandatory continuing education for hospital administrators or favor a requirement that hospital administrators be graduates of schools of hospital and health services administration. The feeling seems to be that the administrator is performing well under prevailing conditions.

Health field executives outside of the hospital do not seem to believe that hospitals are managed as effectively as do the managers themselves. While the study did not produce reasons for this varying assessment of effectiveness, possible reasons are the social distance of the health executive from the hospital and the protective position within which hospital triads find themselves. Health executives are removed from the day-to-day hospital activities and despite their responses, really may not be close enough to the institution to know if the administrator does perform well. On the other hand, because of
the diffuse structure of the hospital top management, members of the triad may feel that they would be faulting themselves if they were to report that the administrator is not managing effectively. Another possibility is simply that the outsiders have established different objectives for the hospital than those set by management. Whereas health executives may view cost containment as the primary objective, the hospital management may believe that purchasing of needed equipment is more important.

An unusual finding was that most respondents, while they favor mandatory continuing education for hospital administrators, do not feel that requiring continuing education would produce more highly effective administrators.

Some respondents may feel that hospital administrators should be required to engage in continuing education only because many other health professionals must meet continuing education requirements.

Others may feel the heavy pressure of government regulation in certain aspects of health care, and see application of this regulatory tendency to continuing education as being inevitable.

Some respondents may not see the need for a direct relationship between continuing education and effectiveness. Still others may accept the linkage between continuing
education and effectiveness but not agree that continuing education activities need be related to effectiveness.

Many respondents probably are concerned with the absence of quantitative measures to determine effectiveness, and, when confronted with the questionnaire, first felt that required continuing education would be acceptable, but later when asked to subjectively measure the extent of effectiveness, determined that mandatory continuing education has an unmeasurable effect.

The study reveals several differences between groups in hospital administration. Important differences are found between graduates of schools in the field and those who are not graduates. School graduates seem to be involved in continuing education to a greater extent than others. They are also more critical of current offerings. School-educated administrators seem to have more interest in education because of their previous experience with it, but, on the other hand, less awed by the process.

Some graduates could be accused of being self-serving by not supporting external degree opportunities to the extent that non-school administrators favor them. Many administrators who would not be involved decline to support the concept, while those who could be involved clearly endorse the idea.

It is conceivable that school graduates are concerned
that they will have too much competition for positions if more administrators receive the credential, inherent in an external degree program.

Others may feel that non-traditional degree programs would lack quality.

It seems evident that many would like schools of hospital and health services administration to assume a larger role in the continuing education of hospital administrators. Schools have been criticized for concentrating on residential education to the exclusion of continuing education. Relatively few schools have committed an appreciable amount of resources to continuing education.

School graduates are more supportive of the American College of Hospital Administrators. It is possible that the ACHA is viewed as an organization for the elite of the field and not for the non-degree administrators.

Further, many seem to view the ACHA as representing the administrators of large hospitals rather than administrators of all hospitals.

The study discloses that many people do not perceive the ACHA as the organization to administer mandatory continuing education for the field. While this finding is clearly a minor concern of the ACHA, it may be representative of attitudes toward the professional society. At least, it seems that the ACHA would want to review its objectives and image.
Despite an apparent lack of visibility among voluntary organizations, it is clear that respondents do not want a government agency to administer mandatory continuing education programs. Hospital managements are concerned about government encroachment in the health field. Perhaps recent economic controls on the hospital industry could be a reason for the negative response to governmental involvement. In addition, widespread feeling seems to exist against the excesses of bureaucracy.

The study also discloses differences between administrators of larger hospitals and those of smaller hospitals. While this study finds that administrators of smaller hospitals do not engage in continuing education activities to the extent of the others, a question arises concerning other differences. Some people believe that there are great differences between the two groups with administrators of larger hospitals being more educated, more effective and more highly paid. The study does not examine the two groups in depth but indicates that the more experienced administrators are more effective.

**Recommendations for Further Study**

This has been a broad study of the influence of continuing education on perceived effectiveness of hospital administrators. Several studies are needed to explore,
in depth, findings of this study. The following are recommended:

1. A general study of the effectiveness of hospital administrators. Criteria on which to make judgments about hospital administrators are badly needed.

2. A study of the relationship between continuing education and effectiveness of hospital administrators. Most people would seem to agree that continuing education is needed. However, the question remains about whether continuing education can produce effective hospital administrators.

3. A study of hospital administrators who do not engage in continuing education. Characteristics of this group and reasons for their lack of attendance would be useful.

4. A study of hospital-related health executives to determine their perceptions of hospitals and hospital administrators. The present study uncovered differences between hospital managers and other hospital-related health executives that need to be explored.

5. A comparative study of graduates of schools of hospital and health services administration and other administrators to determine whether specialized education is needed to produce an effective hospital administrator.

6. A comparative study of administrators of larger hospitals and administrators of smaller hospitals to determine whether differences exist. Also, to determine methods by which smaller hospitals can attract school graduates should be a part of the study.
APPENDIX A

QUESTIONNAIRES SENT TO SAMPLE

183
Questionnaire for Administrators
A CONTINUING EDUCATION STUDY
IN HOSPITAL ADMINISTRATION

1. How many beds does your hospital have for patient care? _____
2. In which state is your hospital located? _______________________
3. How many years have you been the chief executive officer of a hospital? ___________________________________________________________________
4. Have you graduated from a Master's Degree program in hospital and health services administration?
   ______ Yes     ______ No
5. What is your date of birth? _______________________
6. How effective are you in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

   very effective  moderately effective  somewhat ineffective  usually ineffective
7. Have you taken advantage of continuing education opportunities in hospital administration?
   ______ Yes  (If you answer "Yes," please proceed to the next question.)
   ______ No  (If you answer "No," please skip the next two questions and proceed to Number 10.)
8. How would you describe the effectiveness of hospital administration continuing education in helping you to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?

   very effective  moderately effective  somewhat ineffective  usually ineffective
9. How do you rate quality of continuing education programs in hospital administration?

   excellent  good  average  poor
10. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?

_________ Yes __________ No

11. What content would you suggest for continuing education programs offered by schools of hospital and health services administration?

________________________________________

________________________________________

12. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?

_________ Yes __________ No

13. Should you be required to engage in hospital administration continuing education?

_________ Yes __________ No

14. What impact would mandatory continuing education in hospital administration have on your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

__________________________

great increase in effectiveness

moderate increase in effectiveness

no change in effectiveness

moderate decrease in effectiveness

great decrease in effectiveness

15. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

________________________________________

American College of Hospital Administrators

American Hospital Association

Association of University Programs in Health Administration

State Health Department

State Hospital Association

U.S. Department of Health, Education & Welfare

Other (please specify) _____________________________
16. Would you support a review mechanism in which a team of hospital administrators would visit you in your institution to evaluate your effectiveness in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

__________ Yes __________ No
Questionnaire for Chairmen of Boats of Trustees
A CONTINUING EDUCATION STUDY IN HOSPITAL ADMINISTRATION

1. How many beds does your hospital have for patient care? 

2. In which state is your hospital located? 

3. What is your date of birth? 

4. How effective do you think the administrator of your hospital is?

very effective  moderately effective  somewhat ineffective  usually ineffective

5. Has the administrator of your hospital taken advantage of continuing education opportunities in hospital administration?

Yes (If you answer "Yes," please proceed to the next question.)

No (If you answer "No," please skip the next question and proceed to Number 7.)

6. How would you describe the effectiveness of hospital administration continuing education in helping your administrator to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?

very effective  moderately effective  somewhat ineffective  usually ineffective

7. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?

Yes  No

8. What content would you suggest for continuing education programs offered by schools of hospital and health services administration?
9. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without full-time study on campus?

_______ Yes  ________ No

10. Should your administrator be required to engage in hospital administration continuing education?

_______ Yes  ________ No

11. What impact would mandatory continuing education in hospital administration have on the effectiveness of your administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

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</table>

12. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

____ American College of Hospital Administrators
____ American Hospital Association
____ Association of University Programs in Health Administration
____ State Health Department
____ State Hospital Association
____ U.S. Department of Health, Education & Welfare
____ Other (please specify)_________________________

13. Would you support a review mechanism in which a team of hospital administrators would visit your administrator in your institution to evaluate the effectiveness of the administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

_______ Yes  ________ No

March 18, 1974
Questionnaire for Chiefs of Medical Staffs
A CONTINUING EDUCATION STUDY IN HOSPITAL ADMINISTRATION

1. How many beds does your hospital have for patient care? 

2. In which state is your hospital located? 

3. What is your date of birth? 

4. How effective do you think the administrator of your hospital is?
   - very effective
   - moderately effective
   - somewhat ineffective
   - usually ineffective

5. Has the administrator of your hospital taken advantage of continuing education opportunities in hospital administration?
   - Yes (If you answer "Yes," please proceed to the next question.)
   - No (If you answer "No," please skip the next question and proceed to Number 7.)

6. How would you describe the effectiveness of hospital administration continuing education in helping your administrator to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?
   - very effective
   - moderately effective
   - somewhat ineffective
   - usually ineffective

7. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?
   - Yes
   - No

8. What content would you suggest for continuing education programs offered by schools of hospital and health services administration?
9. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without full-time study on campus?

________ Yes _________ No

10. Should your administrator be required to engage in hospital administration continuing education?

________ Yes _________ No

11. What impact would mandatory continuing education in hospital administration have on the effectiveness of your administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

______ great increase in effectiveness

______ moderate increase in effectiveness

______ no change in effectiveness

______ moderate decrease in effectiveness

______ great decrease in effectiveness

12. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

___ American College of Hospital Administrators
___ American Hospital Association
___ Association of University Programs in Health Administration
___ State Health Department
___ State Hospital Association
___ U.S. Department of Health, Education & Welfare
___ Other (please specify) ____________________

13. Would you support a review mechanism in which a team of hospital administrators would visit your administrator in your institution to evaluate the effectiveness of the administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

________ Yes _________ No

March 18, 1974
Questionnaire for Hospital-Related Executives
A CONTINUING EDUCATION STUDY IN HOSPITAL ADMINISTRATION

1. In which state is your organization located? ______________________

2. Have you graduated from a Master's Degree program in hospital and health services administration?

 ________ Yes  ________ No

3. What is your date of birth? ______________________________________

4. How effective are administrators in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

very effective  moderately effective  somewhat ineffective  usually ineffective

5. Have administrators taken advantage of continuing education opportunities in hospital administration?

 ________ Yes  ________ No

6. How would you describe the effectiveness of hospital administration continuing education in helping administrators to manage the hospital to achieve its objective of providing quality patient care at reasonable cost?

very effective  moderately effective  somewhat ineffective  usually ineffective

7. How do you rate quality of continuing education programs in hospital administration?

excellent  good  average  poor

8. Should schools of hospital and health services administration offer more continuing education programs for hospital administrators?

 ________ Yes  ________ No
9. What content would you suggest for continuing education programs offered by schools of hospital and health services administration?

10. Should schools of hospital and health services administration develop opportunities for practicing hospital administrators who do not possess a degree in this field to attain a degree without requiring full-time study on campus?

   ______ Yes   ______ No

11. Should administrators be required to engage in hospital administration continuing education?

   ______ Yes   ______ No

12. What impact would mandatory continuing education in hospital administration have on the effectiveness of administrators in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

   | great | moderate | no |
   |-----------------
   | increase in effectiveness | increase in effectiveness | change in effectiveness |

   | moderate | great |
   |-----------------
   | decrease in effectiveness | decrease in effectiveness |

13. If continuing education were to become mandatory for hospital administrators, which one of the following organizations should be responsible for its administration?

   American College of Hospital Administrators
   American Hospital Association
   Association of University Programs in Health Administration
   State Health Department
   State Hospital Association
   U.S. Department of Health, Education, & Welfare
   Other (please specify)
14. Would you support a review mechanism in which a team of hospital administrators would visit an administrator in his institution to evaluate the effectiveness of that administrator in managing the hospital to achieve its objective of providing quality patient care at reasonable cost?

__________ Yes __________ No

March 18, 1974
APPENDIX B

SEVEN U.S. DISTRICTS
OF THE AMERICAN COLLEGE
OF HOSPITAL ADMINISTRATORS
District 1
Connecticut
Maine
Massachusetts
New Hampshire
New York
Rhode Island
Vermont

District 2
Delaware
Maryland
New Jersey
Ohio
Pennsylvania

District 3
Alabama
Georgia
Florida
Kentucky
Mississippi
North Carolina
South Carolina
Tennessee
Virginia
West Virginia

District 4
Illinois
Indiana
Michigan
Wisconsin

District 5
Colorado
Iowa
Kansas
Minnesota
Missouri
Montana
Nebraska
North Dakota
South Dakota
Wyoming

District 6
Arkansas
Louisiana
New Mexico
Oklahoma
Texas

District 7
Alaska
Arizona
California
Hawaii
Idaho
Nevada
Oregon
Utah
Washington
APPENDIX C

LETTERS OF EXPLANATION
SENT TO SAMPLE
Dear Administrator:

Your help is needed.

The University of Missouri-Columbia faculty in Health Services Management is currently engaged in a study to determine if a relationship exists between perceived effectiveness of hospital administrators and continuing education. The enclosed questionnaire has been designed to gather the necessary information to make these determinations.

Your hospital has been randomly selected as one of 706 hospitals to receive the questionnaire so it is very important to us to have your response. The questionnaire is very short as you can see and will take less than five minutes to complete. A stamped, self-addressed envelope is enclosed for your convenience. Because of the scientific nature of the study, a follow-up letter and questionnaire will have to be sent if we do not hear from you.

The assumption has been made that the objective of all hospitals is to provide quality care at reasonable cost. This assumption is made to form a common basis of understanding and is not intended for your critique.

You can be assured that all information will be kept in strict confidence with absolutely no reporting of individual responses.

Please try to complete the questionnaire right away and mail to us by April 10.

Thank you very much for your assistance.

Sincerely,

Robert Boissoneau
Assistant Professor

RB:ng

Enclosures
Dear Board Chairman:

Your help is needed.

The University of Missouri-Columbia faculty in Health Services Management is currently engaged in a study to determine if a relationship exists between perceived effectiveness of hospital administrators and continuing education. The enclosed questionnaire has been designed to gather the necessary information to make these determinations.

Your hospital has been randomly selected as one of 706 hospitals to receive the questionnaire so it is very important to us to have your response. The questionnaire is very short as you can see and will take less than five minutes to complete. A stamped, self-addressed envelope is enclosed for your convenience. Because of the scientific nature of the study, a follow-up letter and questionnaire will have to be sent if we do not hear from you.

The assumption has been made that the objective of all hospitals is to provide quality care at reasonable cost. This assumption is made to form a common basis of understanding and is not intended for your critique.

You can be assured that all information will be kept in strict confidence with absolutely no reporting of individual responses.

Please try to complete the questionnaire right away and mail to us by April 10.

Thank you very much for your assistance.

Sincerely,

Robert Boissoneau
Assistant Professor

RB:ng

Enclosures
Dear Chief of Staff:

Your help is needed.

The University of Missouri-Columbia faculty in Health Services Management is currently engaged in a study to determine if a relationship exists between perceived effectiveness of hospital administrators and continuing education. The enclosed questionnaire has been designed to gather the necessary information to make these determinations.

Your hospital has been randomly selected as one of 706 hospitals to receive the questionnaire so it is very important to us to have your response. The questionnaire is very short as you can see and will take less than five minutes to complete. A stamped, self-addressed envelope is enclosed for your convenience. Because of the scientific nature of the study, a follow-up letter and questionnaire will have to be sent if we do not hear from you.

The assumption has been made that the objective of all hospitals is to provide quality care at reasonable cost. This assumption is made to form a common basis of understanding and is not intended for your critique.

You can be assured that all information will be kept in strict confidence with absolutely no reporting of individual responses.

Please try to complete the questionnaire right away and mail to us by April 10.

Thank you very much for your assistance.

Sincerely,

Robert Boissoneau
Assistant Professor

Enclosures
Dear Health Executive:

Your help is needed.

The University of Missouri-Columbia faculty in Health Services Management is currently engaged in a study to determine if a relationship exists between perceived effectiveness of hospital administrators and continuing education. The enclosed questionnaire has been designed to gather the necessary information to make these determinations.

You are one of a few hospital-related health executives to receive the questionnaire so it is very important to us to have your response. The questionnaire is very short as you can see and will take less than five minutes to complete. A stamped, self-addressed envelope is enclosed for your convenience. Because of the scientific nature of the study, a follow-up letter and questionnaire will have to be sent if we do not hear from you.

The assumption has been made that the objective of all hospitals is to provide quality care at reasonable cost. This assumption is made to form a common basis of understanding and is not intended for your critique.

You can be assured that all information will be kept in strict confidence with absolutely no reporting of individual responses.

Please try to complete the questionnaire right away and mail to us by April 10.

Thank you very much for your assistance.

Sincerely,

Robert Boissoneau
Assistant Professor

RB:cs

Enclosures
April 22, 1974

Dear Colleague:

We certainly would like to know what you think. Many of our colleagues in the health field already responded.

A few weeks ago, a copy of the enclosed questionnaire was sent. If that questionnaire did not reach you or you have not had a chance to complete it, would you take five minutes to fill it out? A stamped, self-addressed envelope is enclosed. Please be certain our address shows in the window.

You can be completely assured that all information will be kept in strict confidence. Absolutely no reporting of individual responses will be made.

Will you help? Thanks.

Sincerely,

Robert A. Boissoneau
Assistant Professor

RAB:dlr

Enclosure
APPENDIX D

FREQUENCY AND PERCENTAGE DISTRIBUTION OF NO RETURNS BY HOSPITAL SIZE GROUP
<table>
<thead>
<tr>
<th>Group</th>
<th>Administrators (N = 297)</th>
<th>Chiefs of Staff* (N = 371)</th>
<th>Board Chairmen ** (N = 458)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-bed hospitals and larger</td>
<td>141 (47.5)</td>
<td>174 (46.9)</td>
<td>214 (46.7)</td>
</tr>
<tr>
<td>99-bed hospitals and smaller</td>
<td>156 (52.5)</td>
<td>197 (53.1)</td>
<td>244 (53.3)</td>
</tr>
</tbody>
</table>

* Table 4 on page 119 indicates that eight responses were not classified by hospital size.

** Table 4 on page 119 indicates that two responses were not classified by hospital size.
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