An Exploration of How New Registered Nurses Construct Their Professional Identity in Hospital Settings

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Abstract

This study was based on twenty-one interviews with sixteen nurses who were within one to three years post graduation from nursing school. All nurse participants were working at three hospitals in Upstate New York. This study began with two main questions: How do nurses in the study think about their occupation and their place in it? And what factors do nurses feel influenced the construction of their professional identity? The interviews were conducted using an open-ended, semi-structured format.

Many nurses delayed their entry to nursing school related to family and societal pressures in conjunction with lack of appropriate academic preparation and gender expectations. The majority of nurses with a delayed entry had also experienced a "lifelong calling" to be a nurse. I argue that relationships with significant others and dissatisfaction with unfulfilling life circumstances tipped the balance in favor of entry.

All the participants reported on the rigors of nursing school independent of the type of program they attended. The rigors of nursing school were tolerable with the aid of supportive, encouraging faculty. Unfortunately, many nurses reported that faculty was "rigid," "inflexible," "judgmental," and "dehumanizing." I argue that faculty subject students to a hazing process similar to one they themselves were subjected in an effort to produce a "successful" nurse.

The data brought forth the need for a challenging but supportive environment in order to be successful in constructing a positive professional nursing identity. The norms of the hierarchical structure of the hospital environment which reinforce passive dependent professional behavior need to be challenged by all who interact within this environment. This challenge encompasses the societal view of the nurse as the "handmaiden" of the physician one lacking in autonomy and independent decision making ability. The change process surpasses the hospital environment to national policy making level.

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We, the members of the Oral Examination Committee,
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Chapter One

Purpose of and Introduction to the Research

This research study "An Exploration of How New Registered Nurses Construct Their Professional Identity in Hospital Settings" explored the experiences of registered nurses who work in hospitals one to three years post graduation from nursing school. The purpose was to interview nurses in order to gather data about experiences that contribute to the construction of their nursing identity. The study focused on the nurses themselves and the way in which they made meaning of their experiences. This study took place within the context of the current nursing shortage in early 2000 and the presumed lack of individual and professional identity clarity (Graham 1985; Rawnslay, 1990; Reverby, 1987). The study contributes to the knowledge base related to what motivates men and women to enter the profession of nursing, what experiences in nursing school positively or negatively influence their professional development and identity, and how nurses make meaning of their first three years of work experience in the hospital setting. This chapter will present the review of the literature, an overview of research methods, limitations, and significance of the study.

Nurses have traditionally found difficulty in defining nursing and distinguishing it as an entity different from, but closely related to, other health care disciplines. Kurtz and Wang (1991) suggested that the ethic of caring may well be the core of nursing, which separates it from other disciplines. Caring has emerged as a focus construct of contemporary nursing. While the value of caring is evident in the literature, the utility of the construct in the domain of practice is less certain. According to Rawnsley (1990) "the pragmatic value of any theoretic construct lies in its potential for identifying and solving problems in the discipline" (p. 42).

Graham (1985) argued that caring is not merely an identity; it is also work. Graham (1985) noted, "Caring touches simultaneously on who you are and what you do" (p. 13). Because of this duality, caring can be difficult to define and even harder to control. Caring is not just a

subjective and material experience, it is a historically created one. Particular circumstances, ideologies, and power relations thus create the conditions under which caring can occur, the forms it will take, and the consequences it will have for those who do it (Reverby, 1987).

Nursing was organized under the expectation that its practitioners would accept a duty to care rather than demand a right to determine how they would satisfy this duty. Nurses were expected to act out of an obligation to care, taking on caring more as an identity than as work, and expressing altruism without thought of autonomy either at the bedside or in their profession (Reverby, 1987). According to Reverby (1987) because nurses have been given the duty to care, they are caught in a secondary dilemma, namely they are forced to act as if altruism (assumed to be the basis for caring) and autonomy (assumed to be the basis for rights) are separate ways of being. Nurses are still searching for a way to forge a link between altruism and autonomy in order to have what philosophers have referred to as "caring with autonomy." Miller (1976) labeled this concept as "a way of life that includes serving others without being subservient" (p. 71). Reverby (1987) felt that the central dilemma of American nursing is the order to care in a society that refuses to value caring. This devaluation of what has been perceived as the core of nursing and the caring with autonomy dilemma have been identified by some as possible precipitants to the current nursing shortage. According to Reverby (1987) "unable to find a way to care with autonomy and unable to separate from the devaluation of caring, many nurses find themselves forced to abandon the effort to care, or nursing altogether" (p. 10).

The nation is facing a potentially dangerous nursing shortage. The risk of a major nursing shortage is both short and long-term, and is more serious in some geographic areas than others. According to Groom (2003) "Central New York is in the grip of a nursing shortage. In December, eight area hospitals had more than 180 RN jobs unfilled" (p. A-1). Additionally, Groom (2003) reported "The average age of a registered nurse is 47 years old. Add to this the nurses leaving the field because of dissatisfaction with the job and a deepening crisis is evident" (p. A-10). While shortages have occurred in health care throughout history, and especially since

World War II, experts are finding that the developing nursing shortage is uniquely serious. It is considered both a supply and a demand shortage, combining a broad range of issues that include: steep population growth in several states; a diminishing pipeline of new students to nursing; an aging workforce and a baby boom bubble that will require intense health care services just as the majority of nurses are retiring; and a broadening of job opportunities within health care. This shortage is worldwide (Nurses for a Healthier Tomorrow, 2000).

Unlike the shortage of the 1980s, this one is not about sheer numbers of nurses, but about having nurses with the needed specialties, skills and experience. A survey conducted by the American Organization of Nurse Executives and the American Nurses Association (2000) reported that the shortage is due to an increased demand for experienced Registered Nurses (RNs) in specialized areas. The Bureau of Labor Statistics indicated that jobs for RNs will grow 23% by 2006. That is faster than the average for all other occupations. About half of the RN workforce will reach retirement age in the next 15 years. Additionally, the average age of the new RN graduate is 31. They are entering the profession at an older age and will have fewer years to work than nurses traditionally have had. Also, RN enrollments in schools of nursing are down. Entry-level enrollment in baccalaureate programs has fallen 66% from 1999 (Nurses for a Healthier Tomorrow, 2000).

Saarmann, Freitas, Rapps and Riegel (1992) concluded that qualitative research would be useful to examine the characteristics of the professional nurse. Such an approach would allow the data to define the entity rather than testing a preconceived definition. Additionally, Saarmann et al. (1992) concluded that future research is needed to determine whether nursing educational programs have a significant influence on professional socialization when compared with the workplace. Current nursing research supports a disparity between professionalism which leads to reality shock and drop out from the nursing profession. Additional knowledge could help understand this gap and contribute to increased retention in nursing. Morse, Solberg, Neander, Bottorf and Johnson (1990) proposed that more research is needed to ascertain that "even if

caring is the main ingredient that makes nursing humanistic what else is essential to nursing (p. 12)?" The authors suggest that qualitative research is needed to further understand how caring is defined. According to Morse et al. (1990) hospital administrators often leave nurses with little time to care.

Review of Literature

In order to understand the current nursing identity, I trace the core constructs of the profession. The caring conflict and oppression of nursing emerged in my preliminary reading of the history of nursing. Also indicated in my early reading was the need to increase numbers of males in the profession in order to increase prestige and numbers in the profession itself. In order to understand the identity of the nurse, I explored how and why individuals chose the profession and the professional socialization process. In my initial review of the literature, no studies emerged related to professional identity itself. More recently studies have been conducted in other countries and will be examined in the review section.

The following section is a review of pertinent literature. Under the umbrella of nursing professional identity, seven major areas that are examined include a) the historical perspective of nursing; b) nursing as a caring profession; c) perception and choice of nursing as a career; d) role socialization in nursing; e) professional identity development; f) gender issues in nursing; and g) the oppression of nursing. Knowledge of research in these areas contributed to an understanding of the profession itself.

Historical Perspective of Nursing

Most of the writing about American nursing history began in the 1870s when formal training for nursing was introduced in the United States. Nursing throughout the colonial era and most of the nineteenth century took place within the family and the home. Tribicott (1983) purported that nursing was often taught by mother to daughter and became an important manifestation of women's expression of love of others, and was thus integral to the female sense of self. "You may be called upon at any moment," Eliza W. Farrar warned in The Young Lady's

Friend in 1837, "to attend upon your parents, your brothers, your sisters, or your companions" (p. 57). Nursing was to be a women's duty, not her job.

With the expansion of the economy in the mid 1800s, excess cash made it possible to hire a nurse when a female relative was no longer available for the task. Caring as labor could then be separated from love. For older widows or spinsters from the working classes, nursing became a trade. The permeable boundaries for women between unpaid and paid labor allowed nursing to pass back and forth when necessary and become respectable community work (Reverby, 1987). In this period of time neither credentials nor a professional identity gave weight to their efforts. This history influences the current perception of nursing as a profession.

Nursing was not limited to the home. In 1873, the United States had 178 hospitals and workers labeled "nurses" provided the caring. Hospital nursing could be the work of devoted women who learned what historians have labeled "ad hoc professionalism" (Reverby, 1987). Eliza Higgins (1976), the matron of Boston's Lying-In Hospital, described the hospital as a battleground where nurses, physicians, and hospital managers contested the realm of their authority. According to Reverby (1987), nurses fought to be treated as workers, not children, in what was described as a paternalistic environment. The efforts of nurses were undermined by the paternalism of the institution, class differences between trustees and workers, and ultimately the lack of a defined ideology of practice.

Much of this changed with the introduction of training for nursing in the hospital world. The influence of Florence Nightingale in the Crimea, efforts of American women during the Civil War, and the need to find respectable work for daughters in the middle classes led to a model and support for nursing reform. By 1873, three nursing schools in hospitals in New York, Boston, and New Haven were opened patterned after the Nightingale School in London. Nightingale envisioned nursing as an art, rather than a science, for which women needed to be trained. Accepting the Victorian idea of divided spheres of activity for men and women, she thought women had to be trained to nurse through a disciplined process of honing their womanly virtue.

Nightingale stressed strict adherence to orders passed through a female hierarchy. Nursing was built on a model that relied on the concept of duty to provide as its basis for authority. According to Reverby (1987) "She spoke in the language of duty, not rights" (p. 7). Nightingale assigned the duty of "caring" to the nurse. She sought to organize a female hierarchy in which orders passed down from the nursing superintendent to the lowly probationer (student nurse).

Between 1890 and 1920, the number of nursing schools jumped from 16 to 141 per 100,000 in the population. Administrators learned that opening a nursing school provided their hospitals with a young, disciplined, and cheap labor force. The service needs of the hospital continually overrode the education requirements of the schools. As a nursing leader Isabel Hampton Robb lamented in 1893, "the title 'trained nurse' may mean anything, everything, or next to nothing" (Robb, 1949, p. 11). Reverby (1987) felt that training emphasized the "one right way" of doing ritualized procedures. Until the early 1900's, there were no accepted standards for how much work an average student should do or how many patients she could successfully care for. In this kind of environment, nurses were trained but not educated. Independence was to be sacrificed on the altar of altruism and duty remained the basis for caring.

Believing that educational reform was central to nursing's professional efforts, a small group of elite reformers attempted to broaden nursing's scientific content and social outlook. Nursing leaders made up of educators and supervisors through an organization which is now the American Nurse's Association and the National League for Nurses, struggled to raise educational standards for nurses. Reverby (1987) stated "They were forced by the social conditions and ideology surrounding nursing to attempt to professionalize altruism without demanding autonomy" (p. 8). Duty became translated into following doctor's orders. This lack of focus on autonomy caused nurses in 1880 to look elsewhere for work and careers. The educators and supervisors lost touch with the pressing concern of their constituencies in the daily work world of nursing.

Reverby (1987) stated worker-nurses built on their pride in their work-place skills and character. Worker-nurses were those nurses directly caring for patients versus in administrative positions. They saw no contradiction between demanding decent wages and conditions for their labors and being of service for those in need. Those nurses received continual criticism from nursing's professional leaders. Worker-nurses felt that skills came from work experiences versus book learning or degrees. This split between worker-nurses and professional leadership has continued throughout the history of the nursing profession.

Much has changed in nursing in the last fifty years. The severing of nursing education from the hospital's nursing service has finally taken place, as the majority of nurses are educated in colleges. Nurses are still divided over what constitutes nursing skill, how this is to be learned, and whether a nurse's character can be measured in educational criteria. Nursing continues to struggle with the basis for, and the value of caring. Feminism, in its liberal form, appears to give nursing a political language that argues for equality and rights within the given order of things (Reverby, 1987).

Nursing as a Caring Profession

Leininger (1985) described caring as the "Core or the essence" of nursing. The lack of consensus regarding the definition of caring, the components of care, or the process of caring contributes to the ambiguity of what is nursing. After conducting a review of nursing literature, Morse et al. (1990) identified five categories of caring. The five categories identified were caring as a human trait, caring as a moral imperative or ideal, caring as an affect, caring as an interpersonal relationship, and caring as a therapeutic intervention. According to Morse et al. (1990), the nurse's educational experience professionalizes the caring through the acquisition of knowledge and skills. Benner and Wrubel (1988) concurred that caring is the basic way of being in the world from which all nursing practice evolves.

Watson (1988) reflected on caring as a moral imperative as the substantive base of nursing in preserving the dignity of patients. Theorists (Morse et al., 1998) who described caring

as a moral imperative concur that caring provides the basis for all nursing actions. If, as a profession, nursing holds caring as a moral ideal and present working conditions increasingly limit the opportunity to care (e.g., unsafe staffing conditions persist), then the survival of the nursing professional remains in question.

From the perspective of caring as an affect, the nurse is moved to act selflessly without immediate gratification or expectation of material reward. According to Morse et al. (1990) institutional incentive for the nurse to care is lacking, and professional socialization to remain objective, such as warnings to not get "too involved" with patients, continues to contribute to the devaluation of caring as an affect in nursing and contributes to a conflictual environment in which to practice. Authors who believe caring is an interpersonal relationship suggest that the nurse-patient relationship is the essence of caring. Nurses have the ability to adjust their approach and their style of interaction as they move from patient to patient. However, as nurses proceed with a caring attitude in this conflictual environment, how might this impact on their sense of themselves as a professional? (Morse, 1990).

According to Rawnsley (1990) "caring may be a desirable image for nursing, but is it meaningful?" (p. 42). Nurses need ways through which they can connect the conceptual concerns of the discipline with the raw data of experience. Through placing value on the other as lovable or worthy of being loved, the nurse moves to actualize the mutual expectations or goals for the patient, thereby fulfilling goals of personal and professional growth (Rawnsley, 1990).

Harbison (1992) has taken Gilligans's work on moral development and applied it to the nursing profession. She argues Gilligan's emphasis of caring and relationships accords with the common experience of the nurse, and echoes the current revival of interest within nursing in examining, and valuing the phenomenon of caring. Benner (1984) in her important descriptive study of nursing as practiced by experienced nurses, identified the central place which caring, that is a committed, involved stance in nursing practice, holds in their practice. Gilligan's gender-related theory may also be particularly appropriate for nurses, given the female domination of the

profession and provides a defense for those attributes of caring and sharing which traditionally have not been highly valued by dominant ideology.

Previously, quantitative measures have been utilized to examine Gilligan's paradigm. Rest's (1975) Defining Issues Test (DIT), Grishams's (1981) Nursing Dilemma Test (NDT), and Ketefian's (1981) Judgments about Nursing Decisions (JAND), were the most frequently used instruments. In a review conducted by Cassidy (1996), studies shifted from a quantitative approach to a qualitative approach. In a 1989 review, in order to better define caring, only one qualitative study was presented versus 26 in the Cassidy study. Of note is that in 29 nursing student studies only one was qualitative. Researchers continued to employ quantitative designs that were either descriptive, exploratory, or quasi-experimental with students. Studies of practicing nurses (N=40) represented a quantitative-qualitative mix. Peter and Gallop (1994) investigated the construct of caring, as it is defined by Gilligan (1977) utilizing a survey approach among nursing (N=68) and medical (N=51) students. They concluded that their findings supported Gilligan's model because the women participants used care considerations more often than men did. They also reported that an eclectic approach to moral reasoning was the representative model in these nursing and medical students because care and justice perspectives were seen in both groups.

Perception and Choice of Nursing as a Profession

Using a descriptive design, Stevens and Walker (1993) surveyed 641 college-bound high school seniors in the Washington D.C. area to determine why nursing is not selected more frequently as a career. The findings indicated that the decision to choose or not choose nursing was significantly influenced by demographic characteristics (age, ethnicity, and race), past experiences with nurses/illness, and characteristics preferred in a future career. Those respondents who selected nursing cited wanting to help people, to do important work, and to work with a variety of people as important reasons for their choice. Those not choosing nursing indicated dislike of dying people and the salary as the main reasons for choosing another career.

Kersten, Bakewell, and Mayer (1991), studied motivating factors in students' choice of nursing as a career. There was a three-fold purpose to this study: definition of nursing, reasons for choosing nursing, and who/what influenced their choice. The five most frequent responses to the questions "What does nursing mean to you" were: caring, personal growth, illness focus, professionalism, and job security. The most frequently reported reasons for choosing nursing were: nurturance, emotional needs, employment opportunities, financial benefits, and interest in science. Practicing nurses were identified most frequently as influencing students' image of nursing/choice of nursing. Kersten et al. (1991) concluded that nursing continues to be perceived as a caring profession, as well as, one that offers many personal benefits.

A similar study by Williams, Wertenberger, and Gushuliak (1997) utilized a survey with open-ended questions centering on reasons for choosing nursing, and perception of nursing. The results indicated that students choose nursing for the following reasons: job opportunity/security, helping others, working with people, interest in science, family influences, and previous job experience. Approximately 80% of the students studied indicated that being a nurse was a "lifelong dream." Students overwhelmingly identified nursing as a profession that is exciting, challenging, demanding, stressful, and hard work. Lack of public recognition of nursing was frequently reported as a negative attribute.

Beck (2000) studied 27 nursing students who attended a large, state university in New England. This study was described as an inductive descriptive research method (phenomenology) the aim being the discovery of the meaning of human experiences. Students were asked to respond anonymously in writing the statement "Please describe in writing an experience you had in choosing nursing as a career." The data were organized around the following eight themes: an intense desire and genuine love of helping others; profession in which patient and nurse reap benefits; prior work experience and hands on caring for family members; exposure to family and friends in the health care profession; observing nurses in action, something missing from original

career choice; first choice (being a physician) was unattainable; and a fascination with science and the human body.

The reviewed studies have several common themes for choosing nursing as a career including: caring for and helping others, influence of family and other nurses, job stability, financial concerns, and an interest in science. The studies primarily have focused on quantitative methods with focused surveys.

Role Socialization in Nursing

Since nurses traditionally enact their professional roles as employees in organized work settings, they are faced with how to operationalize professional values in these settings and how to integrate into their behavior and values certain role expectations of the agencies. Hinshaw (1977) labeled this issue "the professional bureaucratic conflict." The label acknowledges the existence of two dominant value systems, often requiring nurses to have two sets of behaviors.

Kramer (1974) described a socialization model consisting of four stages. In stage one, nurses feel incompetent and frustrated which generates the solution of throwing themselves into mastery of specific skills and techniques. The major concern in stage two is getting along with coworkers and becoming one of the group. In stage three, the incongruencies between the professional/educational imagery of how nurses ought to behave and the manner in which behavior does occur in the work setting become labeled and acknowledged. The new graduates feel frustrated, angry and betrayed by both their professional education and new work positions. Their perception is that they were not prepared adequately to function in the clinical environment. In stage four, Kramer suggested a typology for how graduates evaluate and resolve the conflict between value systems. Individuals will either capitulate their behaviors or their values or integrate the two dominant work systems, professional and bureaucratic.

Kelly (1993) conducted a qualitative study of 23 nursing students using Glaser and Strauss' grounded theory. She collected data through audiotaped interviews and written clinical logs examining how senior undergraduates perceive the real world of hospital nursing. She

concluded the following: students perceived themselves as powerless, felt a commitment to respect for patients, expressed disappointment that nurses do not stand up for the patient, and felt failure when they perceived they have participated in an abuse of patient rights.

Green (1988), studied 25 senior nursing students one month prior to graduation to examine relationships between role models and role perceptions of new graduate nurses. The study found the following: a majority of faculty role models of new graduate nurses are replaced by work-related role models in the first three months of employment; the most important role model characteristic was clinical experience/performance and; role perception orientations of new graduate nurses are overwhelmingly professional prior to graduation, but become more bureaucratic after exposure to work-related models.

Professional Identity Development

Recently more qualitative studies or combinations of quantitative and qualitative methodologies have occurred in the nursing literature. The literature is also beginning to focus on how one constructs a nursing professional identity. The majority of the studies have been conducted in countries other than the United States such as Sweden, Norway, Japan, and Australia. In this section, I will review these recent studies and identify areas for future study.

Increasingly, scholars have suggested definitions of professional identity or clarification of characteristics. Gregg and Magilvy (2001) described "The significance of self-identification with a profession" (p. 47). Ohlen and Segesten (1998) purported that nursing professional identity relates to the feeling of being a person who can "practice nursing with skill and responsibility and maintain awareness of personal resources and limitations" (p. 721). Fagermoen (1997) defined professional identity as "values and beliefs held by the nurse that guide his/her thinking, actions and interactions with the patient" (p. 435). Fagerberg and Kihlgren (2001) emphasized the importance of context within which the nurse works as pivotal for the development of identity, skills and expertise. In a study of senior nursing students, McConnell and Dadich (1999) contended that "validating the professional self" is the important

ingredient in professional identity and "Is a process that begins with challenging oneself and ends with affirming abilities and career choice" (p. 12). The importance of the work environment for the development of identity was stressed.

A series of recent studies have focused on characteristics inherent in a nursing professional identity. Fagerberg and Kihlgren (2001) in a longitudinal study focused on understanding "How nurses experience the meaning of identity as nurses, when they are a student and as nurses two years after graduation" (p. 337). Fagerberg and Kihlgren (2001) identified four perspectives: having the patient as focus, being a team leader, the importance of preceptorships and the focus of task orientation. Keeping the patient as focus involves being there for the patient and meeting their needs. Team leading involves ensuring work is done and care is received. Having supportive preceptors in school as well as the work environment is important in modeling how to work as a nurse. "Nurses need to share experiences with each other, learn from each other's experiences and get support" (Fagerberg & Kihlgren, 2001, p. 138). This study additionally displayed a connection between the accomplishment of technical skills and a positive self-concept. The study pointed out differences in learning environments as being either task focused or patient focused and suggested that lack of consistency between the work focus and the focus of the individual nurse can lead to turnover in the nursing profession.

The Fagermoen study (1997) concluded that human dignity and altruism were the most prominent moral values held by nurses. Work values were organized around the ability to be intellectually and personally stimulated. The overall philosophy guiding care provided by the nurse, as a result of both quantitative and qualitative analysis, is altruism or a moral orientation to the provision of care. Human dignity was identified as the core value. The findings of this study focus on content vs. process of nursing professional identity. The fundamental principle underlying the provision of nursing care is knowing the patient as a person, exploring patient perceptions, and creating a sense of trust. The nursing professional identity is thus perceived as other vs. self-driven.

Gregg and Magilvy (2001) identified six categories in the process of establishing the professional identity of Japanese nurses. The categories included: learning from working experiences, recognizing the value of nursing, establishing one's own philosophy of nursing, gaining influences from education, having a commitment to nursing, and integrating a nurse into self. The overall process by which each nurse established professional identity was labeled by the authors as "bonding into nursing" (Gregg & Magilvy 2001, p. 47). The authors felt that an understanding of the process of establishing a professional identity could contribute to the improvement of nursing practice. The model of professional identity development formulated by the authors exists as a spiral. Once a nurse goes through a stage he/she never returns back to the exact same stage. The nurse can return to a previous stage however change occurs at a higher level. This model has numerous implications for the work environment. Administrators should create an environment for nurses to continue working and provide opportunities for nurses to consider the meanings and value of each experience. Educators should teach about the value of nursing during basic nursing education.

McConnell and Dadich (1999) identified two themes of crystallization of the professional self: validating professional identity and valuing the culture of work. Validating professional identity consists of challenging oneself by exposing oneself to new opportunities, building relationships (staff, patients and families), learning from different experiences, and affirming one's abilities and career. Valuing the culture of work involves consistency between institutional mission and goals and those of the individual.

In the Oleson (2000) study, nurses identified professionalization and the academizing of their domain as a threat to what they see as the core content. Nurses in this study became nurses at a time where the core function was practical caring and the human contact with patients. Their professional competence is rooted in practical experience. Other nurses experience professional development as enrichment: high continuing education, specialization, and learning to use new technical equipment. Oleson (2000) concluded that "The same person might in different

circumstances assume one or another prevailing identity, and the same definition of a professional identity seems to have different subjective qualities to different people" (p. 6). Their interpretations of their professional identity are mediated by their own life experience. He saw the identity process as an ongoing concern of the professional in a field with two main objective components: the practice of his/her work and a cultural institution consisting of the profession as an institution. According to Oleson (2000) in this field "He/she has to define him/herself as an acting and able professional, adapting to the profession, and solving work tasks" (p. 13).

Ibarra (1999) described how people adapt to new roles by experimenting with provisional selves that serve as trials for possible but not yet fully elaborated professional identities. Qualitative data collected from business professionals in transition to more senior roles revealed that adaptation involves three basic tasks: observing role models to identify potential identities, experimenting with provisional selves, and evaluating experiments against internal standards and external feedback.

Issacson (1998), in a qualitative inquiry, studied the professional identity that emerges as a woman attains the superintendency. The focus was to delineate factors that facilitate and contribute to successfully attaining the superintendency. The research design was a qualitative interview approach with descriptive methods of data collection. In Issacson's (1998) study, themes identified in the development of a women's professional identity were: making a difference for kids; powerful personal motivation and drive; thirst for knowledge and experience; knowing the politics; and the importance of mentors and supportive spouses (Issacson, 1998). Findings did identify the following perceived barriers that limited advancement to the superintendency: difficulty in usurping male dominance in the position, stereotyping, and a women's self-imposed barriers (Issacson, 1998). The similarities to issues apparent in nursing literature is striking. Similarities identified in this research and nursing research include the qualitative approach, an attempt to focus on process, the emphasis on interactions with role models and the environment, and gender issues. The evolution of identity has clearly been

designated as an ongoing process. The models proposed by Gregg and Magilvy (2001) and Ibarra (1999) informed my study as I explored the first three years of identity construction. No other studies have assessed this period of time in nursing development.

Gender Issues in Nursing

Miller (1976) stated that from a socialist feminist perspective, nursing is an example of household work shifted to the outside world of production. Because this work was not valued when it took place within the home, it similarly received little economic or status reward when practiced publicly.

According to Kirkwood (1991):

> Nurses have emphasized perceived womanly qualities and differences from men by stressing a role complementary to that performed by men. This position, often labeled anti feminist, has led present-day feminists to disregard nursing because it tends to epitomize a set of characteristics and problems from which women are attempting to distance themselves (p. 53).

In this sense, nursing embodies the dilemma of early and present day feminists who, by seeking equality, deny the very uniqueness of their contribution to society.

In 1915, Flexner (a sociologist) presented a paper that identified the criteria for characterizing professions from an analysis of the universally acknowledged professions of law, medicine, and clergy. Flexner (1915) assessed American and Canadian medical schools and criticized schools that lacked facilities to teach laboratory-based scientific medicine and as a result 92 medical schools were closed or reorganized. Flexner's study also led to a definition of "profession" and that had significant implications for the future of nursing. According to Flexner (1915):

> Professions involve essentially intellectual operations; they derive their raw materials from science and learning; this material they work up into a practical and definite end; possess an educationally communicable technique; they tend to

> self organization; they are becoming increasingly altruistic in motivation (p. 904).

The perception of nurses was that the profession did not support the following definition inherent in these characteristics in the following ways: limited body of scientific knowledge defined as nursing and exclusive of other disciplines; phenomenon unique to nursing had not been articulated and studied; nursing lacked control over practice and was subordinate to he medical profession; varying levels of educational preparation resulted in the absence of pervasive ideology and monopoly over work. This definition stressed rationalism, scientific standards, and objectivity; all characteristics that embodied the masculine ethos. His masculine, sociological view was never questioned and the criteria became the sociological standard for distinguishing professions (Parsons, 1986). Baines (1991) described that professionals were dominated by men and "a culture developed that affirmed male-centered values of order, efficiency, and hierarchical division of labor" (p. 36).

According to Parsons (1986) "prior to Flexner, American nurses were secure in their identity as professionals" (p. 273). However, nursing did not measure up to Flexner's criteria. What nurses and other women striving for more traditional professions failed to recognize was that the criteria they were trying to meet were established by men. Nursing's major goal in fostering research was to achieve recognition of its professional status as defined by a male paradigm. Researchers have only recently begun to recognize that the scientific method is insufficient for addressing many of nursing's and society's concerns and are beginning to embrace more diverse, qualitative approaches to research (Wuest, 1994). Roberts (1984) stated that nurses felt "if they could attain characteristics of the professional status, they would be powerful" (p. 26).

The feminist movement pushed nurses to sever the link with domestic labor and establish standards of paid work; to challenge constraints on women in the workforce; to increase power base for change for the profession, and to refuse the limitations of gender. Nurses became

motivated to develop a unique body of knowledge with a single theory as the base for practice (Wuest, 1994).

Smith (1990) shed some light on the current division that exists between nursing theory and practice. Nursing theory has been developed by the elite and educated, the nurses who have wielded power in the development of nursing as a profession. The separation of these nurses from those at the bedside has been well documented. These nursing leaders identified a professional route for the development of nursing knowledge and endorsed the patriarchal structure. Hence, the approaches to nursing theory reflect the dominant culture rather than the lived experience of nursing at the bedside (Wuest, 1994). For example, nursing leaders have focused on research to develop the science of nursing in an effort to increase the power base of nursing as profession. Bedside nurses are focused on delivering patient care within a patriarchal environment which lends them little power to control factors impacting on patient care. Recent nursing literature (Kitson, 1997; Tusk, 1997; Roberts, 2000) has focused on the need to change the societal image of nursing and the environmental structure within which they practice.

Smith (1990) argued that women must create a reflexive critique through investigation that is grounded in the lives of women and people. This requires an exploration of women's every day experience with socially organized practices and an examination of how women's practices contribute to and are articulated with the relations that rule our lives. This emphasis on praxis is most consistent for the development of nursing knowledge that reflects the human experience of nursing.

Other gender related research in nursing focuses on the male experience. Villeneuve (1994) stated that although women have moved in significant numbers into traditionally male-dominated professions, qualified men seeking work and a career still largely shun nursing. According to Larsen and George, (1992) "Men have a long but often ignored history of caring for the sick dating back to at least the middle ages" (p. 79). Traditionally caring for wounded soldiers and other socially segregated populations, the withdrawal of men from modern nursing

coincided with the Nightingale era, the end of the American Civil War, and the push to establish careers for women. Kalisch and Kalisch (1986) argued that Nightingale's vision held no place for men in nursing "except where physical strength was needed" (p. 166). The exclusion of males during the genesis of modern nursing established a pattern that has become deeply entrenched in nursing and the larger society. Lewis (1981) argued that the feminine origins of the word nursing may have acted as a deterrent to men entering the profession. Preville (1993), a Canadian male nursing student, published an article confirming that the title nurse continues to be an issue in the socialization of male nurses. During World War II, the War Department would not consider the rank of commissioned officer for male nurses. They were forced to serve as Technical Sergeants. It wasn't until August 9, 1955 that President Eisenhower signed the Bolton Act, which provided commissions for qualified male nurses in the reserve corps of the armed forces services (Army Nurse Corps, 2003). In 1941 only 68 of the 1,303 schools of nursing accepted men (American Nurses' Association, 1950).

The assumption that women, but not men, would prefer to receive intimate care from nurses of the same sex abounds in the literature and in nursing practice (Greenlaw, 1981). Women have always nursed male and female patients of all ages. Greenlaw (1986) further purported that the troubling custom of keeping male nurses (but not physicians) away from certain patient groups implies "that a male nurse is somehow less professional than a male physician" (p. 29). Fagin and Maraldo (1988) found the proportion of men in nursing increased from approximately one percent in the United States in 1949 to approximately 3.3% by 1984. Although men constitute as much as 20% of the workforce in selected areas, women dominate the nursing workforce globally. Christman (1981) said, "The man in nursing has been faced with elements of myth, conjecture and stigma for much of this country's history" (p. 116). Compared with his female counterpart, the man entering nursing is more likely to be 1) older, 2) married, 3) more educated, and 4) choosing nursing as a second or subsequent career (Galbreith, 1991). In a study by Cyr (1992) the findings indicated that like women, most men enter nursing because of

their desire to help people. Many qualities revered in nurses may be devalued in a patriarchal society, role strain has been cited as a likely problem for male nurses. Egeland and Brown (1989) found that preferences for working in areas considered congruent with the male sex role (administration, emergency, anesthesia, critical care, operating room, psychiatry and occupational health) was "striking and stable over time, from student days to established career"(p. 705); however this strategy did not reduce role strain for these subjects. Gaze (1987) argued assumed homosexuality has been cited as a source of role strain for some men.

According to Larsen and George (1992) "Nursing education is still too often characterized by demands for good girl behavior, which rewards passivity and is intolerant of assertiveness" (p. 76). The authors purported that nurses have made little effort to attract men to nursing or to retain the few that do enter nursing. Kalisch and Kalisch (1986) stated the female nursing link seems stronger than in any other occupation and nursing has not traditionally been very flexible when it comes to accommodating those who are not what Curran (1992) comically referred to as "nice white women." Johnson, Goad and Canada (1984) found merely to survive in nursing school, male students may have to "decrease their traditionally masculine behaviors" (p. 390) – specifically, by challenging instructors less and becoming less competitive over time. Supporting this notion, MacPhail (1991) noted the disturbing "tendency of nurse educators and nursing staff, even today, to refer to nursing students as "girls" (p. 71).

Language is a powerful instrument that may have the effect of marginalizing any group. For the past century, men largely have been excluded from the language and images and therefore, the history of nursing. The nurse/female link in nursing's written history persists. Lynaugh and Fagin (1990) stated, "Nursing is a women's profession because it is nursing" (p. 32). London (1987) described nursing as "an intrinsically female profession, based on female values and morals and a holistic world view" (p. 80). Keddy (1992) described "nurses" worlds as primarily women's worlds and the most significant issue facing nursing scholars and practitioners

alike in the 1990s is related to feminist research, theory and epistemology" (p. 5). Men are over represented in administrative and other non-staff positions in nursing (Larsen & George, 1992).

In a study conducted by Kelly, Shoemaker and Steele (1998) the male students' perceptions of motivational factors, barriers, and frustrations encountered in becoming a nurse were explored. Eighteen students attended one of four focus groups representing the different levels of nurse preparatory education. The students' belief that society perceived nursing as a feminine profession was an underlying thread that related to many of their perceptions and feelings. The most influential support people noted were immediate family, especially wives. The participants also believed that high school counselors were of no assistance in choosing nursing as a career. Even though the schools of nursing were perceived as supportive, the participants had feelings of isolation and self-doubt. According to Villeneuve (1994) if society wants nursing to thrive in the 21st century, then it is the responsibility of all nurses to break down all the barriers such as men entering the profession. Villeneuve (1994) stated, "only by letting go of harmful traditions that restrict all nurses will we be able to attract the best candidates to nursing" (p. 225).

Holyoake and Dip (2000) offered a preliminary report into the exploration of the ideological nature of the masculine role as represented by male nurses. Holyoake and Dip (2000) stated, "the study of gender related issues, in particular masculinity in nursing, has always been limited and fragmented" (p. 31). They described a nurse-led research study exploring the nature of gender issues which is currently in progress and offer some preliminary results. They found men experience "feelings of isolation, comradeship and the constant defending of their masculinity" (p. 32).

Nursing As An Oppressed Group – Power, Image and Struggle with Professional Status

Literature in this area clustered around the historical struggle for nurses related to status and power and the effect of the media on the image of nursing. Bent (1993) stated "Nursing can be said to be oppressed. The profession is marked by a continuing struggle for autonomy,

accountability, and control over the profession"(p. 296). In the development of nursing theory, nurses often can be said to have become marginal to the extent to which they have internalized the empirical positivist values of medicine and the traditional male paternalistic health care structure.

According to Bent (1993), nurses who work in hospitals still suffer severe understaffing, occupational hazards, low job mobility, and low pay. Despite the responsibility that falls to nurses as the predominant mediators of patients' hospital experience, they lack overall administrative power and continue to battle for the right to control the pace and context of their work. The medical model has determined what and how nursing student learn. Nurses were presumed not to have knowledge of their own, and there were no rewards in the system for developing nursing knowledge. According to Bent (1993), the assault on professional nursing autonomy continues in the following ways: nurses have to prove their value and worth in the fight against non licensed personnel; nurses in hospitals have to ask to cost out nursing services, which for years were assumed not to have any revenue potential; home health nurses battle for third party reimbursement and the right to provide basic care to clients at home in a market that physicians reject for themselves.

Roberts (1983) studied oppressed group behavior and the implications for nursing. In Robert's study, the theory of Freire was displayed with its inherent similarities to the nursing profession. Freire (1971) stated that in most cases of oppression, the dominant group looks and acts differently from the subordinate group, and the characteristics of the subordinate group become negatively valued. The tendency for the subordinate group is to believe that to be like the oppressor will lead to power and control. In this way, in attempts to be powerful, the subordinate attempts to assimilate and become more like the oppressor. Persons who are successful at assimilation become known as marginal because they do not belong to either group. If the dominant culture does not value the subordinates' characteristics, the tendency is for the subordinates to feel hatred for themselves (Roberts, 1983).

According to Roberts (1983), "It is not surprising that the leaders of oppressed groups often have characteristics and beliefs that resemble those of the dominant culture" (p. 24). According to Freire (1971), leaders of oppressed groups are controlling, coercive, and rigid. These characteristics stem from dependency and low self-esteem and a hatred of their "own kind" and a desire to be like the oppressor. Roberts (1983) contended that nurses can be viewed as an oppressed group. The view of nurses as oppressed is supported by nurses' lack of autonomy and control over the nursing profession. Torres (1981) and Benoliel (1975) have noted that in academic settings, nurses have been rewarded for being marginal. Nurses have found it natural to think of themselves as second-class citizens. Characteristics of nurses (i.e., warmth, nurturance, and sensitivity) have been viewed as negative when compared with those of the dominant-culture, (i.e., intelligence, decisiveness, and lack of emotion) (Bush & Kjerwick, 1979; Greenleaf, 1978; Grissum & Spengler, 1976). According to Roberts (1983) nurses, like other oppressed groups, exhibit self-hatred and dislike for other nurses as evidenced in the divisiveness and lack of cohesiveness in nursing groups. This author views the lack of participation in professional organizations as evidence of lack of pride in one's group and a desire to not be associated with it. Bowman and Culpepper (1974) have documented the divisiveness in nursing and call for unity.

Le Roux (1978) stated that nurses have another characteristic of oppressed groups that makes change difficult: fear of success. They lack belief in the existence of alternatives to the status quo. Roberts (1983) believed that nurses have so internalized the medical model of health that they no longer know "what is nursing." The medical model is clearly hierarchical with the physician in control and directing patient care. Historically, nurses have struggled with how their role fits into this hierarchical structure. This lack of clarity as to what is nursing influences the identity making process. Another clear parallel between nursing behavior and that of oppressed groups is the submissive-aggressive syndrome. Stein (1967) articulated the way in which nurses must communicate with physicians to play the "nurse physician game." According to Stein

(1967) "The nurse is to be bold, share initiative and be responsible for making significant recommendations, while at the same time she must appear passive" (p. 699).

Torres (1980) perceived that "control is an important concept in relation to accountability ad vulnerability because it is essential to one's destiny or the destiny of the profession" (p. 5). Torres (1980) argued that dominance of nursing practice (particularly by medicine and hospital administrators), regardless of academic structure, creates a source of control of the educational program. She purported that faculties of nursing are unable to educate within the true meaning of academic freedom and are compromised in their ability to maintain the professional integrity of nursing. Torres (1980) stated "Whenever faculties and deans choose to become more accountable and in control of nursing education and nursing practice, they are subject to increasing attack by outside groups who are attempting to maintain control of the profession" (p. 6). The expectations of the community, health care consumer and employer vary considerably from those of the academic community. These groups expect production of practitioners at the lowest possible cost in the shortest possible time (Torres, 1980).

Torres (1980) stated that deans of nursing are often measured by their ability to collaborate effectively with top university administrators and the medical community both in and outside the university. The thrust toward collaborating with medicine is contaminated with the reality that "nurses are not generally viewed as peers or even as having a distinct profession by most physicians" (Torres, 1980, p. 10). Additionally, Torres (1980) argued the underlying reasons for the dominance of nursing by medicine may be related to deeply rooted philosophic differences between the two disciplines, a relative lack of sophistication on the part of nursing in dealing with the academics of the university and the health care system, and the fact that nurses are primarily women and physicians are primarily men. Consistent with the theory of oppression, nurses have been lead to believe that it is right or natural for medicine to maintain control of the entire health care enterprise.

Roberts (2000) stated "although oppressed group behavior has been discussed as important for empowering nurses, little has been written about the process of liberation for oppression" (p. 71). The major factor that keeps the oppressed from becoming empowered is poor self and group esteem and identity. Roberts has created a model for nurses based on models of other oppressed group. He proposed a process for nurses as they begin to understand their oppression and develop more positive images of themselves and other nurses. Robert's model (2000) described the following stages of nursing professional identity development: unexamined acceptance of status, acceptance of roles of nurses, unquestioned belief in the power structure belief that physicians should control the system (internalized negative view of nursing) synthesis, internalized new positive view of nursing, evaluating others on an individual basis, increase in interdisciplinary involvement, strategic approach to problem-solving, and nurses are different and equal. This model emerged from informal observation of nurses. Roberts (2000) believed that the development of a positive identity is critical to breaking the cycle of oppression. This process is intertwined with the need for systematic change to alter the power structure that creates oppression.

In a study conducted by McCall (1996) he found despite role changes in nursing, nurses still felt they were devalued and viewed as "handmaidens" as a result of managerial and medical domination. McCall (1996) found the staff nurses in the 1990's described examples of behaviors consistent with the Freire model. Gordon (1998) stated she "Has been struck by the negative messages nurses broadcast to one another" (p. 63) as she has observed them. In her observations nurses do not help each other and criticize each others work. Gordon (1998) argued, "Nurses need to stress their strengths and move forward based on an analysis and appreciation of those strengths" (p. 63).

Chandler (1995) observed that nurses lack a prominent voice that describes the contribution of nursing actions to the care of patients. She has observed that conversations are most commonly between nurses or between a nurse and her patients, but that nurses rarely talk

about their work in public. She also found that nurses have been derogatory about each other and nonsupportive in work settings. DeMarco (1997) found that staff nurses tended to silence themselves in order to maintain the culture of the workplace which supports the dominance of the physician.

Lusk (1997) sought to describe the official classification of American nurses as professional or nonprofessional. The author contended that although nurse leaders aspired to obtain the traditional criteria of professionalism characterized by independent responsibility and owning a distinct body of knowledge, criteria were subdued by political, financial and gender issues. This study demonstrated that professional status cannot be assured by the attainment of professional criteria alone. According to Lusk (1997) professional status is unclear, "Although most nurses consider themselves professional, others have argued that nursing can never have the authority associated with a profession and at best are semi-professional" (p. 227). Through analyzing minutes and correspondence from the American Nurses Association and the American Hospital Association, contemporary nursing and hospital administration journals, government policies related to the professional status of nurses, and contemporary nursing history texts, the author clearly demonstrated the following points: at the turn of the century events were marginally positive for nurses' professional aspirations; in the 1920s and 30s nurses' employers confirmed or denied nursing professional status depending on financial considerations; nurses have been affected by forces concerned with money, gender and power (forces not associated with the concept of a profession as described by early professional theorists).

According the Lusk (1997) "in spite of nursing leaders fighting for professional rank they have been overruled by political forces" (p. 241). This study presented a strong case as it presented much data to support its contentions. Time and again nurses have fought for professional status with the thought that "This would provide for dignity and attract better middle class young women" (Lusk, 1997, p. 229). According to Lusk (1997), "Female dominated helping professions have been thought of as intellectually inferior but altruistically superior to

male dominated professions" (p. 229). Throughout history, in census information and labor laws, nurses have been identified as domestic and personal service, professional and semi-professional. "The goal of being declared professional has often conflicted with labor rights such as decent hours and competitive wages, which have perpetuated a split amongst nursing leaders and nurses in the trenches" (Lusk, 1997, p. 299). In many states non-professional workers had wages and hours more clearly defined. The nurse leader has consistently strived for a professional status not consistent with the goal of the staff nurse for financial and personal rewards in the work setting (Lusk, 1997).

The most apparent conflict has occurred related to nurses in military service. Historically, nurses did not achieve officer status in the military. They had no rank. During World War I, this structure compromised patient care, as military officers would not listen to orders from nurses. The split in nursing was apparent as the superintendent of the Army Nurse Corp supported this arrangement by saying the "best type of nurse was content with patriotic fulfillment from serving their country" (Lusk, 1997, p. 232). Nurses did not receive full military rank with benefits until 1947.

Another study by Lusk (1999) analyzed the images of nurses in pictorial advertisements from all issues of hospital administration journals published in 1930, 1940, and 1950 (n=598). Content analysis of the data was based on Goffman's classic 1979 study on gender in advertisements (as cited in Lusk, 1999). Nurses were compared with other figures in the advertisements and nursing activities were described. Nurses were portrayed as female, young, eager to please and without the appearance of wisdom. In group scenes they were often placed in subordinate positions to physicians and hospital administrators. The results emphasized the following: there were stereotypical portrayals of nurses in all decades, the status of nurses was enhanced in World War II, and nursing was portrayed as more feminine than it was. Nurses consistently were portrayed in a subservient role, performing routine tasks. A strength of this study was that data were discussed in the context of history and the statistics of the times.

Other literature in the area of nursing image outlined similar issues. Kitson (1997) focused her study on the importance of identifying where nursing was heading as a profession and the exploration of the use of metaphors to explain its role in society. She concluded that nurses are sending ambiguous messages about who they are, what they do, and why they are important to health care. Kitson (1997) stated, "Nurses have tried to stress scientific contributions and skill while the public values them more as caring companions and patient advocates" (p. 113). Kitson (1997) traced the historic evolution of the image of nursing as "angel, handmaiden, and selfless devotion" (p. 113) and concurred the schism that exists between technological and the scientific base of nursing and the nurturing caring role. Kitson (1997) contended that future research needs to focus on what happens between nurses and patients in an effort to change the image of subservience to the physician.

Gunn (1999) stated "it has been unfortunate that in trying to exert exclusive control and gain authority over all health care, medicine viewed and portrayed nurses as handmaidens rather than as partners or community members" (p. 42). The author offered realistic examples from clinical practice of gender issues, oppression, the hierarchy of the medical model, and supportive historical data. Gunn (1999) argued that nurses must gain an understanding of their professional roots, history and personal contributions to attract new members and sustain its presence in the future as essential components to health services.

Greenwood (1999) proposed "an alternative to viewing nurses as an oppressed group, tyrannized by niceness, self-sacrifice and horizontal violence" (p. 128). She stated nurses need an alternative image displayed as energetic, curious and autonomous. Greenwood (1999) very effectively utilized a new Australian hospital soap to illustrate the current image of angel, handmaiden, and sex symbol. Greenwood offered as a solution to this image the importance of nursing research as well as the provision of transformational leadership. She further contended that research, education and practice should be intimately related. According to Greenwood (1999) "nurse managers and leaders must ensure staffing levels sufficient to allow research

training activities" (p. 132). The resolution to the image problem for Greenwood was a nurse as inquirer, which would provide a more appropriate image for nursing.

While current literature clearly portrayed a negative image of nursing as an oppressed profession and the effect on the nurse's identity and additionally offered some thoughts on ways to resolve this disparity, the conclusions addressed seem overwhelming, unrealistic, and without concrete application. The conclusions involve dismantling the current health care delivery system.

The image of nursing and the designation of nursing as an oppressed group are reflected upon differently in recent literature. Past literature focused on nurses as oppressed, however they contended they were blameless and thus not responsible directly for change. It is somewhat refreshing yet challenging that the more recent view proposed by Greenwood (1999) is nurses need to change nursing. This thrust is both exciting and potentially intimidating to a profession that has been historically described as passive and powerless.

Overview of Methods

This study utilized qualitative methodology. I interviewed nurses practicing in three hospitals within the first three years of graduation from nursing school. The interviews lasted between one to one and one-half hours and an open-ended semi-structured format was utilized. The theoretical framework of symbolic interactionism (Blumer, 1969) placed the participant as the central focus of analysis and stressed that each individual constructs their environment. Data analysis was conducted utilizing grounded theory as developed by Glaser and Strauss (1967). I will discuss the methodology utilized in this research more thoroughly in Chapter two.

Limitations of the Study

While applying to the Syracuse University Institutional Review Board, a pertinent question was raised that somewhat changed the scope of my study. I originally intended to include participant observation as a research methodology. By observing nurses doing their work, I hoped to gain further information relative to the essence of their work, their relationships,

their priorities, and their perceptions of self and others related to the value of their work. The question arose as to how I would proceed with ethical issues of any professional malpractice, negligence, or incompetent practice I might observe during the observations. Unsure of my own resolution to this question, I chose to delete this methodology from my study, as the risk involved did not outweigh the benefit. As participant observation was deleted as a methodology, the group perspective of nurses was not studied. This study focused on the individual perspective of the nurses interviewed.

In my original plan I was going to incorporate the use of exemplars, a phrase coined by Benner (1984). The exemplar is a short description of an experience in his/her nursing career that positively influenced their professional identity. Early in the study I received reluctance on the part of participants to provide this information in writing. Several nurses disclosed that their verbal skills surpassed their ability to convey their thoughts in writing. Since the nurses I interviewed so eloquently described these experiences during the interview, I decided to delete this methodology to decrease their discomfort with the process.

As in many research projects, my study was limited by time and other resources to complete the study and imperfect research skills. One problem that arose was where and when to interview nurses. Due to the nursing shortage, many nurses are working overtime and are often tired and wish to spend time away from the work setting as well as away from the profession. On five occasions, nurses forgot the appointment and either left work before I arrived or did not show up at the designated place. These appointments were rescheduled. This was consistent with my sense that due to the nursing shortage nurses might have difficulties making the time commitment.

Boice (1993) in his qualitative research of new faculty members concluded, "While complaining may play important roles in catharsis and social bonding, its prominence in spontaneous comments can give a distorted, overly skeptical view" (p. 330). This could be a consequence of interview studies such as the one I conducted. The use of semi-structured, open-

ended formats may elicit more negative responses than other approaches. While a portion of each interview did contain negative responses, it was often tempered by positive comments as well. Perhaps the use of multiple interviews with a portion of the participants also helped temper the participants opinions.

Since important data emerged at the three year point related to "moving on" and moving to yet another level of nursing expertise in both the technical and the psychosocial realms, a qualitative study of nurses' progressive development beyond these years would be meaningful. The study was limited to the first three years of nursing development.

Triangulation is also important. This study did not seek the perspectives of faculty, administrators or other professionals. Each nurse mentioned different kinds of nurses placed into different categories. All self-identified as the nurse with desired characteristics. I had one opportunity in this study to interview a nurse identified by her peer as the type of nurse who does not go the extra mile. This nurse also self-identified herself as caring and going the extra mile. Thus, there is some incongruity between self perception and perception of others. The perspectives of other professionals and faculty would have added to the study but might have violated confidentiality if I interviewed to ask specific questions about the nurse involved without their permission. In a general sense, peers and faculty could have been interviewed for their perspectives without violating confidentiality.

This study was limited to nurses working in hospital settings in central New York. Similar themes did emerge amongst nurses within the hospitals, however, the data and findings of this study are not to be generalized. Readers may however judge the transferability of the information to their specific situations (Baxter-Magolda, 1992). The very nature of qualitative work is contextual.

Significance of Study

No past studies in nursing literature have utilized nurses at early points post graduation and many have focused on homogenous populations. Both of these issues were addressed in my

study. I also recognized that male nurses particularly needed to be studied in more depth and therefore interviewed several male nurses in this study. Gregg and Magilvy (2001) contended that here have been previous studies to measure professional identity but no research reported about how they do it, thus one focus in this study was process. The multiple passage points negotiated by nurses in this study emphasized the reality of the complexity of this process. Sixteen nurses, selected by theoretical sampling, were interviewed in this study.

The literature review led to numerous other areas for further exploration including: situational influences on the development of the professional identity, the influence of social interactions on the process of establishing a professional identity, the relationship between professional identity and nursing practice, linking student experiences to those of the new graduate, transcultural similarities in professional values and tasks and patient focus as the core of nursing identity. Previous studies also identified that nurses focus on the patient and their identities are often other driven. This study adds data to each of these areas. The two most recent qualitative studies related to nursing identity development conducted in Sweden and Japan identified the need for a comparable study to be conducted in the United States for cultural similarities and differences.

This chapter has summarized the current nursing literature within the seven identified areas falling under the umbrella of nursing professional identity, briefly summarized the methodology of this study and addressed limitations, purpose and significance of this study.

Overview of Chapters

This first chapter has discussed the theoretical framework of this study as well as reviewing pertinent literature, significance of and limitations of the study. Chapter two outlines the methods and procedures used in this study as well as presents a profile of the participants and discusses the data collection and analysis process. In Chapter Three, I examine the current state of the profession of nursing, the educational preparation required for the profession, the basic nursing curriculum and basic traits of the profession to provide a context of the nursing field

environment for the reader. In Chapter Four, I analyze the experience of nursing school. I present what nurses have to say about their entry into the field as well as their thoughts and feelings about their journey through nursing school. Chapter Five follows nurses through their first three years following graduation as they experience such things as "finding their niche", orientation, boards, charge, movement from technical skills to the whole picture, and "moving on". In Chapter Six, I examine themes that emerged throughout this journey such as fragmentation in nursing and negotiation for power and authority.

In Chapter Seven, I offer conclusions that emerge from the study and discuss findings for future research for nursing faculty and higher educational institutions, and hospital administrators and nursing leaders.

Chapter Two

Study Design and Research Materials

In this chapter I discuss my methodological position, my research questions, the research sites, the participant profiles, the analysis of the data and the role of the researcher. Throughout this study, I was looking for the perspective of each nurse and reality as he/she saw it. I often said to participants that this was their story, their reality, and their meanings of their experiences. Utilizing the theoretical framework of symbolic interactionism placed the participant as the central focus of analysis and stressed that each individual constructs their environment. According to Bogden and Biklen (1998), in qualitative research, the focus is on how participants negotiate meaning, how certain terms or labels are applied, and how notions become "common sense."

Methodological Position

This study utilized qualitative methodology. According the Bogdan and Biklen (1998) "The best-known representatives of qualitative research studies employ the techniques of participant observation and in-depth interviewing" (p. 2). This study focused on the in-depth interviewing methodology. Bogdan and Biklen (1998) stated, "Meaning is of essential concern to the qualitative approach" (p. 7). In my study, I explored how nurses make meaning of their daily work lives and how these experienced influenced the construction of their professional identity.

Bogden and Biklen (1998) stated "Qualitative researchers are concerned with making sure they capture perspectives accurately" (p. 7). To this end, I audiotaped all interviews and then personally transcribed them after checking back with the interviewees to determine accuracy of my interpretations. According to Psathes (1973) qualitative researchers are continually asking questions of the people they are learning from related to what they are experiencing and how they interpret their experiences. Bogdan and Biklen (1998) described the qualitative research process

"as a dialogue or interplay between researchers and their subjects" (p. 7). These theoretical assumptions guided my interview process.

Blumer (1969) described the methodological position of symbolic interactionism as a qualitative research approach. Blumer described his discipline as a down-to-earth approach to the scientific study of human group life and human conduct. For Blumer (1969) the empirical world of such study was the natural world of such group life and conduct. According to Blumer (1969), symbolic interactionism rests on three primary premises, "The first premise is that human beings act toward things on the basis of the meanings that the things have for them" (p. 2). Symbolic interactionism holds the view that the central role in human behavior belongs to these very meanings. The "things" that may be included in this meaning making can be physical objects, human beings, or institutions. My interviews with nurses incorporated meanings of all three elements in their professional identity construction.

The second premise according to Blumer (1969) was that "the meaning of such things is derived from or arises out of, the social interaction that one has with one's fellow" (p. 2). Blumer (1969) stated symbolic interactionism sees meanings as social products that are "formed in and through the defining activities of people as they interact" (p. 5). In my study, I explored perceptions of the subjects' interactions with colleagues, patients, patient's families, their own families, physicians, faculty and society at large.

Blumer's (1969) third premise is that "these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (p. 2). Blumer (1969) elaborated on the importance of a self-interaction in which the person "selects, checks, suspends, regroups, and transforms the meanings in the light of the situation in which he is placed and the direction of his action" (p. 5). The practice environment of the nurse is exceedingly complex, thus this theory of self-interaction seemed particularly applicable to my study.

Social interactionism comprises a micro-level framework for studying social phenomenon not afforded by other major schools of sociological thought. Blumer placed his principal emphasis on the process of interaction in the formation of meanings to the individual. He proceeded to place those meanings in the central role in explaining and accounting for human behavior.

Research Questions

This study began with two main questions: How do nurses in the study think about their occupation and their place in it? And what factors do nurses feel influence the construction of their professional identity? After analyzing the data and reading the research literature, I found answers to the following set of questions: 1) how and when did these nurse decide to be a nurse and what people influenced them in terms of their decision to be a nurse; 2) what situations in their nursing education framed their sense of themselves as a nurse; 3) how they described themselves as nurses when they graduated and in the present; 4) what critical incidents they experienced in their nursing career; 5) their response to images of nursing in the popular culture; and 6) what people or situations have influenced them as nurses.

Research Sites

I conducted my research in three hospitals in an upstate New York urban area. The city in which the hospitals are located has a population of 147, 306 within a county populated by 458,336 individuals. The city has been established for 153 years and the largest employer is one of the hospitals included in this study. This upstate region consists of five counties and according to a recent census of manufacturing; the inhabitants are 19% more productive than the average U.S. worker. The number of residents who have completed some post-graduate college course-work exceeds the national average by 10.2%.

Hospital number one, whose nurses were included in this study, was a 431 bed comprehensive teaching medical care institution dedicated to providing quality health care to the residents of 16 counties in upstate New York. This hospital has a Catholic affiliation. In addition

to providing general medical and surgical care, this health center offers several specialty services, including hemodialysis, maternity, pediatric services, emergency care, intensive care, psychiatric services, suicide prevention, and certified home health care. Inpatient visits to this hospital average 20,000 annually while outpatient visits number 200,000 a year. The hospital's medical staff numbers 600 and almost 3,000 other health care professionals and support personnel are employed. This is an Associate Degree School of Nursing connected with this hospital. This hospital has served its community for more than 125 years.

The second hospital was a non-for-profit 356-bed hospital located in Upstate New York. The hospital opened in 1963. The hospital offers emergency services, medical and surgical care, intensive care, maternity services, inpatient psychiatric are, numerous outpatient testing, community health education services, a skilled nursing unit and a long-term care unit. Also available in this hospital are Wound Care Center, a Breast Center and an accredited Sleep Center.

The third hospital had been caring for patients for more than a century. They offer a full range of general and specialty care, inpatient and outpatient services and community health education and outreach programs. This hospital is a voluntary not-for-profit teaching hospital dedicated to promoting the general health of the community. Over time this hospital has changed names several times and merged with other local hospitals most recently forming a health care alliance with another local hospital. This hospital also has an affiliated Associate Degree School of Nursing and nurses working in this facility exist in a unionized environment. Annually, this hospital treats 25,300 inpatients and 235,000 outpatients.

The Interviews

I conducted twenty-one interviews with sixteen participants between September 2000 and August 2002. One participant was interviewed three times, three were interviewed twice, and the remainder were interviewed once. All interviewees were assigned fictitious names to protect their anonymity. I conducted the interviews using an open-ended, semi-structured format. No

further interviews were conducted because I reached the saturation point. Saturation is reached when the researcher no longer learns any new information (Seidman, 1991; Woods, 1992).

Initially, I contacted the Chief Nursing Officer of the first hospital and she provided a list of candidates meeting the criteria of one to three years post graduation and made recommendations related to diversity characteristics of ethnicity and gender. Additionally, the director of the School of Nursing associated with the hospital made recommendations based on the same criteria. The researcher then telephoned the potential candidates and set up interviews which were conducted in a conference room in the hospital either before or following the interviewee's work shift. Each interview was taped and detailed field notes were produced. The field notes included verbatim transcriptions of the interviews, researcher observations and comments regarding the nurses' responses and demeanor, and notations of any emerging themes. All interviews were conducted between September 2000 – November 2000. In this initial sample, five nurses were interviewed for a total of eight times. I began this study during the Fall 2000 semester to satisfy the requirements of a research methodology course in my doctoral program. After eight interviews, I developed some themes and completed my research apprenticeship. This dissertation expands on the themes addressed in the apprenticeship report. After that work was completed, I realized the sample was heavily skewed toward the perspectives of adult learners who had delayed entry into the nursing profession for various reasons. I also met with my dissertation committee and was encouraged to conduct further interviews with initial interviewees at the original site to obtain further data and themes to help select characteristics of further interviewees which would guide expanded investigation. What emerged from those interviews was that I needed further information from nurses of color, nurses who entered the profession directly from high school, nurses who had attended baccalaureate versus associate degree programs as their entry into practice, and another male nurse. With these issues in mind, I contacted the director of nursing at the second hospital and requested assistance with interviewing nurses who fit the information need as well as the original criteria of one to three years post

graduation. I was referred to the director of staff development who sent out letters to sixteen nurses meeting this criteria. The letter explained my research and asked them to reply if interested. I was then given phone numbers of nine nurses to contact. Of the nine nurses contacted, six nurses were enthusiastic to participate and three refused.

As I progressed to the third hospital, I reiterated the same criteria to the director of nursing. She contacted nurse managers who then forwarded to me names and phone numbers of nurses who met the criteria. I assumed that the nurse managers had discussed the study with the proposed nurses only to find upon telephoning them, that this assumption was not always true. However, the majority of the nurses consented. The interviews at the second and third hospitals were conducted in various locations: (e.g., hospital cafeteria, hospital library, homes of the participants, my own home, conference rooms on the nursing units, and staff education classrooms). This dissertation addresses issues of this more diverse population of nurses and it honed the themes first identified in the research course, the research apprenticeship, and the proposal for this dissertation.

Participant Profiles

My first, second and ninth interviews were conducted with a 43 year old female European/American nurse who graduated from nursing school three years prior to my interviews. She has three children between the ages of 17 to 22 who are all currently attending college. She graduated from the school of nursing associated with the hospital where she currently works. She worked on a unit that is devoted to the care of patients who have undergone open-heart surgery. At the time of the ninth interview, this nurse had transferred to work in an outpatient cardiac laboratory. Throughout my study, I refer to her by the name of Chris.

The second interview was conducted with a 47 year old female European/American nurse who also graduated from nursing school three years prior to the interview. Debbie works on the hemodialysis unit in the same hospital at which she attended nursing school. Prior to becoming a

registered nurse, Debbie worked on the same unit for several years as a Licensed Practical Nurse (LPN). Debbie is single and has no children.

Ed is a European/American male who graduated from nursing school one year prior to the interview. Ed is 39 years old, married, and has two children. Prior to becoming a nurse, Ed served as a paramedic. A paramedic is a trained individual who functions out in the community in a rather independent fashion. They usually work within an ambulance structure and transport patients in need to hospitals. Ed graduated from an associate degree nursing program approximately thirty miles away from where he currently works. He is employed in the medical intensive care unit.

My fifth and seventh interviews were conducted with a 22 year old single African/American female who graduated from nursing school two years prior to the interview. She also graduated from the school of nursing associated with the hospital in which she works and is currently enrolled in a baccalaureate nursing program. Anita works on a unit for cardiac (heart) patients.

Alex is a 25 year old single European/American male nurse who graduated from the hospital-based school of nursing one year prior to the interview. Alex works on the surgical intensive care unit. Alex had previously received a bachelor's degree in biochemistry from a local university.

My eighth and tenth interviews were with a 38 year old female European/American nurse. Karen is married and has two children. She has a 14 year old daughter and a nine-year old son. Karen graduated from the school of nursing associated with the hospital in which she works one year prior to the first interview and close to three years at the time of the second interview. After Karen graduated from high school, she traveled to New York City where she worked in the financial district. She met her husband there and married him at the age of 25. Karen put her career on hold to have her children. Karen worked on the cardiac (heart) floor in the hospital and was transferring to working the medical intensive care unit at the time of the tenth interview.

The nurse in interview eleven was the first nurse interviewee employed in the second hospital. I refer to this nurse as Jean. Jean is married and is a European/American with three children in their 20s. She is 50 years old. She had worked as an LPN for 20 plus years prior to becoming an RN one and one-half years prior to the interview. She works on a general medical/surgical unit.

Darlene is of African/American descent, is 37 years old, single and has a 10 year old daughter. Darlene works on an orthopedic (bones) unit and previously worked as an LPN for twelve years. Darlene had been an RN for one and one-half years prior to the interview.

Juanita is a 44 year old European/American, divorced female who has three daughters, the ages of 22, 20 and 18. Juanita works on a sub-acute unit in the hospital, which means the patients are not as acutely ill. She recently transferred to this hospital from the first hospital indicated in my study. She had been an RN for one year prior to the interview.

Maureen is a 25 year old, single European/American nurse who graduated from a baccalaureate school of nursing program almost three years prior to the interview. She is currently working on a medical/surgical floor.

Denise is a 20 year old single European/American female who graduated eleven months ago from an associate degree program. She also is working on a medical/surgical floor.

Alice is the first interviewee from the third hospital. She is an African/American nurse who grew up in Kenya. She is 32 years old, divorced and has a 12 year old son. She graduated from nursing school one year prior to the interview and works on a medical/surgical floor. Alice was interviewed twice for this study.

Julie graduated from a baccalaureate nursing program one and one-half years prior to the interview. Julie is 35 years old and grew up in China. She has a seven year old daughter and is married. She has been in this country for seven years. Julie graduated from medical school in China and spent two years in a residency program. She is M.D. equivalent in this country. She did not want to be a doctor in this country, as she wanted to spend more time with her daughter.

She also felt that the role of the nurse in the United States was more consistent with her personal philosophy. Julie works on a general medical/surgical unit.

Bob is a 57 year old European/American male who is married and has a 32 year old son. This is a second career for Bob. He worked also as an LPN for one year prior to becoming an RN. He graduated from an associate degree nursing program three years prior to the interview and works on an orthopedic (bones) unit.

Kris is a 25 year old single European/American female. She graduated three years prior to the interview from an associate degree program. She currently works on a medical/surgical floor but in the past has worked in oncology (cancer) and gynecology (female disorders).

The last interviewee, Amy, is a married European/American female who has a two year old son. She is 24 years old, started in a baccalaureate nursing program but graduated from an associate degree program three years prior to the interview. Amy works on a floor for patients who have undergone open heart or vascular surgery.

The basic education of the participants in this study is not consistent with the national average. The basic education level for nurses in this study was 81% A.D. and 19% B.S. The national average is 40% A.D. and 29% B.S. (U.S. Department of Health and Human Services, 2000). The additional level of education preparation at the national level is 30% for diploma education. There were no diploma graduates included in this study as there are no longer such programs in Central New York. This decrease of diploma programs is also a national trend. At the time of this study, two participants were enrolled in B.S. program and one had already graduated from a B.S. program. Assuming all three graduate, this would lead this group to a 37.5% B.S. degree for the highest education level of the group with a national average of 32.7% (U.S. Department of Health and Human Services, 2000). This study is thus contextual or situational to the location of practice and characteristics of the Central New York area.

Of the sixteen nurses interviewed, ten had a delayed entry into the field. Of the ten, six were previously employed in the health care field in other health related professions. The age

range was from 20-57. There were three males and thirteen females in this study. (See table A for demographics) The interviews were all audio taped and then transcribed by the researcher.

Analysis of the Data

I conducted my data analysis utilizing grounded theory as developed by Glaser and Strauss (1967). Strauss (1987) stated that grounded theory "is a style of doing qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density" (p. 5). Glaser and Strauss (1967) emphasized that theory development requires that certain operations such as coding must be carried out early and continually during data collection. Strauss (1987) purported the assumption that underlies their work is that "research should be understood and analyzed as work" (p. 9).

According to Strauss (1987):

> Grounded theory is a detailed grounding by systematically and intensively analyzing data, often sentence by sentence, or phrase by phrase of the field note, interview, or other document; by constant comparison, data are extensively collected and coded, thus producing a well-constructed theory. The focus of analysis is not merely on collecting or ordering a mass of data, but on organizing many ideas, which have emerged from analysis of the data (pp. 22-23).

Strauss (1987) described the steps in data analysis as consisting of the following: data collection, coding, core categories, theoretical sampling, comparisons, theoretical saturation, integration of the theory, theoretical memos, and theoretical sorting. Many indicators (behavioral actions/events) are examined comparatively by the analyst who then "codes" them, naming themes as indicators of a class of events or behavioral actions. This class may then be given a name, which then creates a coded category. By making comparisons of indicator to indicator the analyst is forced into confronting similarities, differences, and degrees of consistency of meaning among indicators. The process creates uniformity, which results in a coded category.

Table A

Name	Gender	Race	Age	Educational Background	Years Since Graduation	Location of Practice
Chris	Female	European/American	43	A.D.	3	Open Heart & Vascular Surgery
Debbie	Female	European/American	47	A.D.	3	Dialysis
Ed	Male	European/American	39	A.D.	1	Medical Intensive Care Unit
Anita	Female	African/American	22	A.D. Enrolled in B.S. Program	2	Cardiac (Heart)
Alex	Male	European/American	25	A.D. Previous B.S. in Biochemistry	1	Surgical Intensive Care Unit
Karen	Female	European/American	38	A.D.	1 year – 1st interview 3 years – 2nd interview	Cardiac (Heart)
Jean	Female	European/American	50	A.D.	1 ½	Medical/Surgical
Darlene	Female	African American	37	A.D.	1 ½	Orthopedics (Bones)
Juanita	Female	European/American	44	A.D.	1	Sub-Acute
Denise	Female	European/American	20	A.D.	1	Medical/Surgical
Alice	Female	African/American	32	B.S.	1	Medical/Surgical
Julie	Female	Asian	35	B.S.	1 ½	Medical/Surgical
Bob	Male	European/American	57	A.D. Previous B.A.	3	Orthopedics (Bones)
Amy	Female	European/American	24	A.D. Enrolled in B.S. program	3	Open Heart & Vascular Surgery
Maureen	Female	European/American	25	B.S.	3	Surgical
Kris	Female	European/American	25	A.D.	3	Medical/Surgical

According to Strauss (1987) "A second procedural step is that often a conceptual code is generated, then indicators are compared to the emergent concept" (p. 25). From the comparisons of additional indicators to the conceptual codes, the codes are sharpened to achieve their best fits to the data. Strauss (1987) stated "Further properties of categories are generated, until the codes are verified and saturated, yielding nothing much new" (p. 25).

According to Strauss's model (1987), concepts earn their way into the theory by systematic generation from data. As indicators change, generating new properties of a code, the researcher will eventually reach a point of saturation of ideas as indicated by interchangeability of indicators. The indicators will become repetitious or adding up to the same thing analytically. The more the researcher "Finds indicators that work similarily regarding their meaning for the concept, the more the analyst saturates the properties of the concept for the emerging theory" (p. 26).

My data were coded into thirty-seven categories. Strauss (1987) stated coding is the "General term for conceptualizing data" (p. 20). The process of coding involves raising questions, determining possible answers, organizing the data into manageable units, looking for core concepts, labeling them, and attempting to understand the relationship among core concepts (Strauss, 1987). Coding is a process of conceptualizing data and it allows the researcher to organize the data into sets that are manageable and to then understand the relationship between main components. During and following data collection, I reviewed and compared field notes and coded data into categories reflected by most students' comments. Examples of categories include: "Responsibility", "Learning", "Fragmentation", "Entry into the Field", and "Negotiation for Power and Authority". From the coded data, I identified key issues related to the nurses' perceptions of their experiences prior to and joining the profession of nursing. As the study progressed, codes were confirmed and modified. Themes emerged from the data. According to Bogdan and Biklen (1998) "a theme is some concept or theory that emerges from the data" (p. 189). These themes can take the form of an argument in providing a focus as to what you want to

tell your reader (Bogdan & Biklen, 1998). I continuously compared themes with data presented by the nurses resulting in the confirmation of some themes. Throughout the process of data collection and analysis, I wrote memos discussing my reactions, impressions, and ideas about codes and possible themes so that the context of interactions would remain intact (Bogdan & Biklen, 1998). Through the data analysis, I sought to describe and understand the perspectives of nurses. Both during and after collection, the researcher analyzed the data inductively and identified themes that helped to organize the data and lead to subsequent collection. Tentative themes were continually compared with data from all nurses, resulting in the confirmation of some themes and the revision of others.

I used Microsoft Word to help me organize the data. The data corresponding to the codes were sorted and stored in Microsoft Word files for each code. Microsoft Word was also used for editing the data, drafting the report, and integrating the quotations into the final written work. In total, the interactions with nurses and the document analysis resulted in over 1200 pages of data.

Bogdan and Biklen (1998) stated that in qualitative research, the researcher is the principal instrument of design, collection and analysis. I designed this study, conducted all interviews, transcribed all interviews and analyzed the data. Strauss (1987) contended that analysis was an ongoing interpretive process. As themes emerged throughout the data collection, I asked the participants to respond to what others had indicated as important issues. The themes emerged through the coding process, from participants' responses to issues that arose, and from an ongoing review of relevant literature. An in-depth review of the literature was conducted as themes emerged. Reviewing the literature is an on-going process, performed more vigorously as themes emerged (Bogdan & Biklen, 1998).

Role of Researcher

I am a registered nurse who has been practicing for thirty years. I have worked in various aspects of the role as staff nurse, nurse educator, clinical nurse specialist, psychotherapist, and director of education in a hospital setting. I thus came to this research with rich personal

experience in many aspects of this profession. I work in the first hospital where the nurses were interviewed as the director of education. While I have no supervisory role with any of the nurses interviewed, many are aware of my role within the institution. Nurses from this hospital who have been interviewed for this study have been open and seemingly unaffected by my role.

Having been a professional for this length of time, I bring potential bias to my role as researcher. I have had relationships with patients, families, doctors, peers, and hospital administration that influence both positively and negatively my sense of myself as a nurse. I have experienced first hand divisions in the profession at multiple levels.

The role I have played as nurse therapist placed me in a position to truly listen to what others have to say without imposing my own values and opinions. This role is one I have practiced throughout my career. The importance of open-mindedness and a focus on the meanings others make has become second nature to me in my professional life. My experience as a therapist has offered me an ability to analyze data which was helpful in coding and theming the data collected in this study.

According to Bogdan and Biklen (1998) "In one sense all qualitative research is done in another culture" (p. 83). Studies vary in the degree to which the people studied share your language, customs, and other aspects of every day life. While I approached this research as if it were another culture, my wealth of knowledge did achieve insider status in some sense. According to DeAndrade (2000) the insider status "Involves complex and ongoing definitions and negotiations of group membership" (p. 269). DeAndrade (2000) further stated, "Insider identity is not one-dimensional or certain, but needs to be negotiated" (p. 286).

The multiple forms and levels of insider status highlight the complex ways that groups are defined and group membership extended (DeAndrade, 2000). I clearly felt an insider to the profession of nursing as evidenced by interviewee comments such as "You know how this is", and "You know how doctor's behave." I responded to those comments by not assuming I "did know" and asking for further explanation and examples. The descriptiveness of their answers and

their openness in sharing thoughts and feelings led me to believe that my insider status enhanced my ability to collect meaningful data.

I examined my biases through the use of memos, observer comments and notes to myself throughout the data analysis process.

Having described my research methodology and theoretical stance and role as a researcher, the next chapter is devoted to providing context of the nursing field and environment for the reader.

Chapter Three

Current Status of the Nursing Profession

I am devoting this chapter to the explanation of what is a registered nurse (RN), how does one become an RN, where does an RN work and how much do they earn to better inform the reader of the nursing profession. Career paths available for registered nurses are also presented. Since a number of the nurses that participated in this study had previously been licensed practical nurses (LPNs) there will also be a brief description of that role in the health care system. The last section of this chapter will be a look at the current status of the profession, specifically the impact of the nursing shortage.

Nature of the Work

According to the U.S. Department of Labor (2002), Registered Nurses (RNs) work to promote health, prevent disease, and help patients cope with illness. They are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe, assess, and record symptoms, reactions, and progress; assist physicians during treatments and examinations; administer medications; and assist in convalescence and rehabilitation. RNs also develop and manage nursing care plans; instruct patients and their families in proper care; and help individuals and groups take steps to improve or maintain their health. While State laws govern the tasks that RNs may perform, it is usually the work setting that determines their daily job duties.

The U.S. Department of Labor Report (2002) stated that hospital nurses form the largest group of nurses. Most are staff nurses, who provide bedside nursing care and carry out medical regimens. They also may supervise licensed practical nurses and nursing aids. Hospital nurses usually are assigned to one area, such as surgery, maternity, pediatrics, emergency room, intensive care, or treatment of cancer patients. Some may rotate among departments. Office nurses care for outpatients in physician's offices, clinics, surgicenters, and emergency medical

centers. They prepare patients for and assist with examinations, administer injections and medications, dress wounds and incisions, assist with minor surgery, and maintain records. Some also perform routine laboratory and office work.

The U.S. Department of Labor Report (2002) further described that nursing home nurses manage nursing care for residents with conditions ranging from a fracture to Alzheimer's disease. Although they often spend much of their time on administrative and supervisory tasks, RNs also assess residents' health condition, develop treatment plans, supervise licensed practical nurses and nursing aids, and perform procedures such as starting intravenous fluids. They also work in specialty-care departments, such as long-term rehabilitation units for patients with strokes and head-injuries. Home health nurses provide periodic services to patients at home. After assessing patients' home environments, they care for and instruct patients and their families. Home health nurses care for a broad range of patients, such as those recovering from illnesses and accidents, cancer, and childbirth. They must be able work independently, and may supervise home health aids.

The U.S. Department of Labor (2002) reported public health nurses work in government and private agencies and clinics, schools, retirement communities, and other community settings. They focus on populations, working with individuals, groups, and families to improve the overall health of communities. They also work as partners with communities to plan and implement programs. Public health nurses instruct individuals, families, and other group regarding health issues, disease prevention, nutrition, and childcare. They arrange for immunizations, blood pressure testing, and other health screening. These nurses also work with community leaders, teachers, parents, and physicians in the community health education. Occupational health or industrial nurses provide nursing care at worksites to employees, customers, and others with major injuries and illnesses. They provide emergency care, prepare accident reports, and arrange for further care if necessary. They also offer health counseling, assist with health examinations and inoculations, and assess work environments to identify potential health or safety problems.

The U.S. Department of Labor (2002) stated that head nurses or nurse supervisors direct nursing activities. They plan work schedules and assign duties to nurses and aids, provide or arrange for training, and visit patients to observe nurses and to ensure the proper delivery of care. They also may see that records are maintained and equipment and supplies are ordered.

Career Paths in Nursing

Clinician – Clinical Nurse – Provides scientific, psychological, and technological knowledge in the care of patients and families in many health care settings ($30,000-$50,000/yr base)

Advanced Practice Nurse – Provides primary care and specialized advanced nursing services to patients and families. Includes: Clinical Specialist; Nurse Practitioner; Nurse Anesthetist; Nurse Midwife ($40,000-$65,000/yr+)

Educator – Utilizes educational methodologies to present current information in patient care settings, universities, and communities. ($30,000-$75,000/yr+)

Administrator – Coordinates the use of human, financial, and technological resources to provide patient care. ($40,000-$90,000/yr+)

Researcher – Utilizes statistical methodologies to discover or establish facts, principles or relationships. ($40,000-$75,000/yr+). (Sigma Theta Tau International, 2002).

Prerequisites to Nursing School

The following high school courses are either recommended or required to enter nursing school.

- English – four years (verbal and written communication skills essential)
- Math – two to four years (algebra necessary for success in chemistry and medical administration: geometry)
- Science – two to four years (chemistry essential: biology important: physics recommended: computer science)

- Social Studies – three to four years (psychology important: sociology: history: government – economics are all recommended)
- Foreign language – two years (highly recommended: some variation among individual Nursing Schools) (Sigma Theta Tau International, 2002)

Educational Preparation to Become a Nurse

According to the U.S. Department of Labor (2002) in all states and the District of Columbia, students must graduate from an approved nursing program and pass a national licensing examination to obtain a nursing license. Nurses may be licensed in more than one state, either by examination, by endorsement of a license issued by another state, or through a multi-state licensing agreement. All states require periodic license renewal, which may involve continuing education.

The U.S. Department of Labor (2002) further reported there are three major educational paths to registered nursing: associate degree in nursing (A.D.N.), bachelor of science degree in nursing (B.S.N.) and diploma programs. About half of the 1,700 RN programs in 2000 were at the A.D.N. level. B.S.N. programs, offered by colleges and universities, take four or five years. More than one-third of all programs in 2000 offered degrees at the bachelor's level. Diploma programs administered in hospitals last two to three years. Only a small number of programs offer diploma-level degrees. Generally, licensed graduates of any of the three program types qualify for entry-level positions as staff nurses. Many A.D.N. and diploma-educated nurses later enter bachelor's programs to prepare for a broader scope of nursing practice. They can often find a staff nurse position and then take advantage of tuition reimbursement programs to work toward a B.S.N.

Nursing Curriculum

The U.S. Department of Labor (2002) additionally reported nursing education includes classroom instruction and supervised clinical experience in hospitals and other health facilities. Students take courses in anatomy, physiology, microbiology, chemistry, nutrition, psychology

and other behavioral sciences, and nursing. Coursework also includes the liberal arts. Supervised clinical experience is provided in hospital departments such as pediatrics, psychiatry, maternity, and surgery. A growing number of programs include clinical experience in nursing homes, public health departments, home health agencies, and ambulatory clinics.

Location of Practice

The U.S. Department of Labor (2002) stated registered nurses held about 2.2 million jobs in 2000 and were the largest healthcare occupation. About three out of five jobs were in hospitals, inpatient and outpatient departments. The majority of nurses begin their practice in a hospital setting. Others were mostly in offices and clinics of physicians and other health practitioners, home healthcare agencies, nursing homes, temporary help agencies, schools, and government agencies. The remainder worked in residential care facilities, social service agencies, religious organizations, research facilities, management and public relations firms, insurance agencies, and private households. About one out of four RNs worked part time.

Controversy over Nursing Educational Preparation

There has been much controversy related to the various levels of preparation to enter the nursing profession. In 2000, the American Nurses Association (ANA) Board of Directors reaffirmed to its longstanding position that baccalaureate education should be the standard for entry into the professional nursing practice (Nursing World, 2000).

Nursing World (2000) reported in 1964 the ANA House of Delegates (HOD) adopted a motion "that the ANA continue toward baccalaureate education as the educational foundation for professional nursing practices" (p. 2). Since that time, this issue has been debated in policy meetings at the state and national levels of the association. The American Nurses Association (2000) reported that in 1985, the ANA HOD agreed to urge state nurses associations to establish the baccalaureate with a major in nursing as the minimum educational requirement for licensure and to retain the legal title, Registered Nurse, for that license and to establish the associate degree with a major in nursing as the educational requirement for licensure to practice technical nursing.

In 1991, the ANA HOD adopted the position that ANA support the baccalaureate degree in nursing as a requirement for all generalist certification examinations by 1998. The following year, the Board of Directors of American Nurses Credentialing Centered (ANCC) implemented the recommendations of the HOD. As a result, at the end of 1998, the BSN became an eligibility requirement for candidates taking ANCC generalist certification exams. In 1995, the HOD agreed to declare the baccalaureate degree in nursing as the educational requirement for the beginning registered or basic nurse. The ANA believed that baccalaureate nursing education is necessary to prepare the nursing workforce for the challenges of a complex and changing health care system. According to Nursing World (2000) ANA has long supported increased accessibility to high-quality educational and career mobility programs that utilize flexible approaches to individuals seeking academic degrees in nursing and a major plank in ANA's legislative platform focuses on ensuring continued support for nursing education both at the baccalaureate and graduate levels. Despite ANA's position about educational preparation for entry into practice, three paths for basic educational preparation for nursing practice remain in place. An individual must complete an accredited nursing program earning either a two-year associate degree, a three-year diploma or four-year baccalaureate in order to sit for the RN licensure. Licensure is regulated at the state level by agencies such as a board of nursing. Nursing World (2000) further stated that to date, North Dakota is the only state that has passed legislation implementing the baccalaureate as the standard for RN entry into practice.

Licensed Practical Nurses

According to the U.S. Department of Labor (2002) licensed practical nurses (LPNs), or licensed vocational nurses (LVNs) as they are called in Texas and California, care for the sick, injured, convalescent, and disabled under the direction of physicians and registered nurses. Most LPNs provide basic bedside care. They take vital signs such as temperature, blood pressure, pulse, and respiration. They also treat bedsores, prepare and give injections and enemas, apply dressings, give alcohol rubs and massages, apply ice packs and hot water bottles, and monitor

catheters. LPNs observe patients and report adverse reactions to medications or treatments. They collect samples for testing, perform routine laboratory tests, feed patients, and record food and fluid intake and output. They help patients with bathing, dressing, and personal hygiene, keep them comfortable, and care for their emotional needs. In States where the law allows, they may administer prescribed medicines or start intravenous fluids. Some LPNs help deliver, care for, and feed infants. Experienced LPNs may supervise nursing assistants and aids.

The U.S. Department of Labor (2002) reported that LPNs in nursing homes provide routine bedside care, help evaluate residents' needs, develop care plans, and supervise the care provided by nursing aids. In doctors' offices and clinics, they also may make appointments, keep records, and perform other clerical duties. LPNs who work in private homes also may prepare meals and teach family members simple nursing tasks. Licensed practical nurses held about 700,000 jobs in 2000. Twenty-nine percent of LPNs worked in nursing homes, 28 percent worked in hospitals, and 14 percent in physicians' offices and clinics. Others worked for home healthcare services, residential care facilities, schools, temporary help agencies, or government agencies; about one in five worked part time.

According to the U.S. Department of Labor, all states and the District of Columbia require LPNs to pass a licensing examination after completing a state-approved practical nursing program. A high school diploma, or equivalent, usually is required for entry, although some programs accept candidates without a diploma or are designed as part of a high school curriculum. In 2000, approximately 1,100 State-approved programs provided practical nursing training. Almost six out of ten students were enrolled in technical or vocational schools, while three out of ten were in community and junior colleges. Others were in high schools, hospitals, and colleges and universities. Most practical nursing programs last about one year and include both classroom study and supervised clinical practice (patient care). Classroom study covers basic nursing concepts and patient-care related subjects, including anatomy, physiology, medical-

surgical nursing, pediatrics, obstetrics, psychiatric nursing, administration of drugs, nutrition, and first aid. Clinical practice usually is in a hospital, but sometimes includes other settings.

Median annual earnings of licensed practical nurses were $29,440 in 2000. The middle 50 percent earned between $24,920 and $34,800. The lowest 10 percent earned less than $21,520, and the highest 10 percent earned more than $41,800 (U.S. Department of Labor, 2002). Many schools of nursing are implementing programs to assist LPNs to return to school of become RNs. Most Associate Degree Programs will give LPNs credit for some of the coursework completed to become an LPN.

The Nursing Shortage

The U.S. Department of Health and Human Services (2002) reported that in 2000, the national supply of full time equivalent registered nurses was estimated at 1.89 million while the demand was estimated at two million, a shortage of 110,000 or six percent. Based on what is known about trends in the supply of RNs and their anticipated demand, the shortage is expected to grow relatively slowly until 2010, by which time it will have reached 12 percent. At that point demand will begin to exceed supply at an accelerated rate and by 2015 the shortage, a relatively modest six percent in the year 2000, will have almost quadrupled to 20 percent. If not addressed, and if current trends continue, the shortage is projected to grow to 29 percent by 2020.

The projected shortage in 2020 results from a projected 40 percent increase in demand between 2000 and 2020 compared to a projected six percent growth in supply. Demand will grow steadily at a rate of 1.7 percent annually, a relatively modest growth rate when compared to the 2.3 percent annual growth in demand projected by the Department of Labor's Bureau of Labor Statistics. Factors driving the growth in demand include an 18 percent increase in population, a larger proportion of elderly persons, and medical advances that heighten the need for nurses (U.S. Department of Health and Human Services, 2002).

Data on the growth in new RNs, as measured by those passing the RN licensing test (NCLEX), show that after growing steadily during the first half of the 1990s the number of new

RN graduates fell annually in the last half of the decade, resulting in 26 percent fewer RN graduates in 2000 than in 1995. Declines were seen across all degree programs--diploma, associate degree, and baccalaureate. The decrease in diploma graduates continues a trend driven in the past few decades by the closing of hospital-based diploma programs. In contrast, the declines in associate degree and baccalaureate graduates are a more recent phenomenon, having occurred only since the mid-1990s. Further, due to declines in enrollments over the past five years, no increase in the number of graduates is expected in the short term. Although the American Association of Colleges of Nursing (AACN) did report a four percent increase in baccalaureate enrollment between 2000 and 2001, the relatively longer educational pipeline for baccalaureate students increases the length of time before licensed RNs will emerge. Associate degree graduates are declining at a somewhat faster rate than baccalaureate graduates, with the net result that baccalaureate graduates now comprise an increasingly greater share of total graduates.

The U.S. Department of Health and Human Services (2002) reported that this evolving shift from associate degree to baccalaureate-prepared RNs has, as noted earlier, a constraining effect on growth in supply. Baccalaureate-prepared RNs may need twice as long to complete their education and enter the workforce as those graduating from associate degree programs, thereby increasing the length of time needed for the average RN student to enter the workforce, thus creating a temporary hiatus in the growth of supply.

The average age for RNs has climbed steadily in recent years resulting in a greater proportion of nurses in the older age brackets who are approaching retirement age. Three factors contribute to this aging of the RN workforce: (1) the decline in number of nursing school graduates, (2) the higher average age of recent graduating classes, and (3) the aging of the existing pool of licensed nurses. Graduates of associate degree programs, the largest sources of new RNs, are on average 33 years old when they graduate, considerably older than in 1980 when the average age of a new associate degree graduate was 28. The result has been a significant

decline in the proportion of RNs under the age of 30. Between 1980 and 2000, the proportion declined from 25 percent to nine percent. This slowing of new, young entrants coupled with an accelerating retirement rate for older RNs will produce a national supply of nurses that in 2020 will not only be older but no larger than the supply projected for 2005. The number of new licenses in nursing is projected to be 17 percent lower in 2020 than in 2002, while the loss from the RN license pool due to death and retirement is projected to be 128 percent higher (U.S. Department of Health and Human Services, 2002).

In addition to the slower rate at which RNs were added to the workforce in the last half of the 1990s, they now appear to be leaving the RN license pool, through death or retirement, at a faster rate than ever. Over the four-year periods between the 1988 and 1992 surveys and the 1992 and 1996 surveys, the number of RNs leaving the license pool actually declined, from roughly 20,000 in the first four-year period to 23,000 in the second. Balancing these losses with the number of new graduates in each of these periods raised the RN license pool in those periods by 10 percent and 15 percent respectively. However, between the 1996 and 2000 surveys, the loss of RNs from the license pool increased six-to-seven-fold, to nearly 175,000. Balancing this most recent set of losses with new graduates resulted in an increase in the RN license pool of only five percent, one-third to one-half the increase seen in the earlier surveys. If current projections hold, the situation will worsen as the number of losses approaches and then exceeds the number of new entrants. After balancing projected losses against projected new entrants, the RN supply is projected to grow 1.3 percent between 2008 and 2012, and by the end of the projection period, to decline by 1.9 percent between 2016 and 2020 (U.S. Department of Health and Human Services, 2002).

The U.S. Department of Health and Human Services (2002) further stated in addition to the number of RNs who give up their license, there are currently almost half-a-million licensed nurses not employed in nursing. Between the 1996 and 2000 surveys, the number of licensed RNs not employed in nursing grew by 52,000 to over 490,000. Unfortunately, little is known

about this population. However, what is known is that 69 percent, or 338,000 of the 490,000 licensed RNs not employed in nursing in 2000 were 50 years or older. Further, analysis of data from the 2000 RN Sample Survey shows that only seven percent of the licensed RNs not employed in nursing were actively seeking employment in nursing.

Salaries are likely playing a role in the declining supply of RNs. While actual earnings for RNs increased steadily from 1983 through 2000, "real" earnings – the amount available after adjusting for inflation – have been relatively flat since 1991. Thus, on average, RNs have seen no increase in purchasing power over the last nine years. In contrast, the average salary for elementary school teachers has always been greater than that for RNs and is growing at a faster pace. In 1983, the average elementary school teacher earned about $4,400 more than the average RN; by 2000 this had grown to the point where elementary school teachers earned about $13,600 more. Furthermore, a good portion of the wage growth for these nurses appears to occur early in their careers, then taper off with time. In 2000, staff RNs employed full-time in nursing who graduated five years earlier, typically earned wages 15 to 17 percent higher than those newly entering the field, depending on basic nursing preparation, but only one to three percent less than nurses who graduated 15 to 20 years earlier. As their potential for increased earnings diminishes over time, staff nurses may be motivated to leave patient care for additional education and/or other careers in nursing or outside the profession (U.S. Department of Health and Human Services, 2002).

The U.S. Department of Health and Human Services (2002) also reported the major factors and trends behind the growth in RN demand include: population growth, aging of the population, increased per capita demand for health care, and trends in health care financing. The changing demographic nature of the population is a critical factor affecting demand for RNs. Recent projections show the Nation's population will grow 18 percent between 2000 and 2020, resulting in an additional 50 million people who will require health care. Much of this population growth can be attributed to advances in science and medicine that have increased life expectancy

and resulted in a higher proportion of the population being over the age of 65, a significant source of demand for RNs.

In contrast to the 18 percent growth in overall population, the subgroup 65 years old and older is projected to grow 54 percent between 2000 and 2020, adding 19 million people to the 65-and-over age group. While this amount is less than the 31 million added to those under 65, individuals in the upper age brackets contribute disproportionately to health care spending, spending over three times as much on average as those under 65. Individuals 65 and over have a high incidence of chronic conditions such as: arthritis (50 percent), hypertension (36 percent), and heart disease (32 percent). Many also have multiple conditions requiring more regular care. The result is a population that currently has twice as many contacts with a physician as those under 65, accounts for 13 percent of the population but 38 percent of hospital discharges, and has annual per capita health care expenditures of $5,400 compared to $1,500 for those under 65. The greatest per capita demand for health care, and thus the services of RNs, will quite naturally come from the very old, those 85 and over. This is the fastest growing segment of the population and a major user of long-term care facilities, home health care, and other employers of RNs (U.S. Department of Health and Human Services, 2002).

The U.S. Department of Health and Human Services (2002) stated the demand for health care services, and by extension for registered nurses, is also driven by the ability to pay for health care, either with insurance or through out-of-pocket expenditures. Since 1990, an average of 85 percent of the population has been covered by some form of health insurance, making health care available to the vast majority of the population. At the same time, real per capita disposable income has increased steadily, growing 16 percent between 1990 and 1999, making it easier to pay for non-covered health care with out-of-pocket resources, thereby increasing the demand for such care.

Further reported by the U.S. Department of Health and Human Services (2002) was that between 2000 and 2020 the demand for RNs will continue to grow in all employment settings,

but some will grow more rapidly than others, resulting in changes in the distribution of demand by setting. Hospitals have been and will continue to be the major source of demand for RNs but while the total number of nurses in hospitals will continue to grow, the hospital sector's share of total RN employment will remain stable at about 62 percent. Employment settings closely associated with service to the elderly are projected to increase their share of the total demand for RNs: For example, the demand for RNs in nursing homes is projected to increase from eight percent of total demand in 2000 to 10 percent in 2020. Similarly, growth in the home health care sector will result in an increase in demand for RNs from 6.5 percent to nine percent of total RN demand. These increases will naturally be offset by a corresponding decline in the proportion of demand in ambulatory and "other" settings.

My study took place in the beginning phases of the nursing shortage. Many of the issues addressed in the study were evidenced in the stories of the participants in my study. Several nurses mentioned salaries as a concern and feelings of being overworked and overwhelmed due to a shortage of nurses. The differences in education preparation were referred to as an area of conflict as well as the groundwork for differences in competency levels and role implementation. These differences influence the construction of professional identity as will be presented in the following data chapters. The information provided in this chapter provides the context within which to better understand and interpret the data within this study.

Chapter Four

The Experience of Nursing School

In this chapter I will explore the experience of nursing school as reflected by the participants in this study. The chapter is organized around issues of entry into the field and the experience of nursing school itself related to relationships with instructors, outside commitments, relationships with patients, the curriculum, and the fear and reality of failing.

According to Beck (2000), the career of nursing has been chosen for various reasons: "an intense desire and genuine love of helping others; profession in which patient and nurse reap benefits; prior work experience and hands on caring for family members; exposure to family and friends in the health care profession; observing nurses in action; something missing from original career choice; first choice was unobtainable (being a physician); and a fascination with science and the human body." I found consistencies with these expressed reasons in this study. I also found evidence for a delay of entering into the profession. This delay is commonly associated with family and societal pressures in conjunction with a perception of inadequate skills and academic preparation and gender expectations. Nurses in this study described entering the field to "better themselves," to "respond to a calling," and as a "life goal." Some nurses felt they "are not good enough to be doctors" or felt family members have "higher expectations for them." Nurses also felt "society deems nurses work to be mundane and without much skill" which also contributes to delayed entry into the field.

Direct Entry

Three of the nurses interviewed entered nursing school directly from high school. Their motivation for entering the profession was focused on influence of family and basic personality features, which they perceived were consistent with the profession, such as a caring attitude. For two nurses, it was a spontaneous decision without much thought, although upon more careful examination of their experiences the influence of family was important.

Amy entered a four-year nursing school right from high school. Amy described her initial motivation as stemming from the relationship with her mother and the skepticism presented by her. Amy stated:

> I think my motivation started with my mother with the implication that I couldn't do it and that really made me think well whether I practice it or not I am really going to do it. I was never a rebellious person but that must have been a rebellious teenage attitude. I didn't know a whole lot about nursing.

Amy's story was more involved as she described more thoroughly her connection to the health care system. According to Amy:

> My grandmother was a nurse. She graduated in one of the first classes at this hospital. When I was a freshman in high school, I just started thinking about what I wanted to be when I grew up and I always liked children so I thought about teaching and then I started to do a little bit in biology and I started volunteering in nursing homes and I found out a little bit about hospitals. Actually when I started biology and a little medicine I thought about pre-med, but didn't really want to go to medical school so I started talking to people about nursing. When I came home and told my mother that I wanted to be a nurse at the end of my sophomore year she said whey do you want to do that Amy? And I said I just want to be a nurse. She thought that I like to make things hard on myself and have a challenge. Maybe that was it a little bit.

Denise described her spontaneous decision to enter nursing school. According to Denise:

> Well it wasn't a long planned out idea that I was going to be a nurse. It was getting close to high school graduation and my parents said you have to go to college. I just picked nursing. I don't know if there was anything that geared me more towards nursing than any other profession but I just thought it would be something that I would like and I would be able to grow as a person. They just

> wanted me to pick something that was going to make me happy. They would have supported me no matter what I chose. They wanted me to get a better education than just high school. I made this decision when there was three months left in my senior year. I had no clue what I was getting myself into.

Additionally, Denise made the choice of what school to attend based on the dormitory and curriculum. Denise said:

> My mom and I went to the open house at two local hospital schools and I knew that I was going to be staying in the dorm and that is what swayed my decision. It was the only place I applied. Luckily I got in. Yes, it was more comfortable. More homey. I also picked this school because I knew the classes were taught by nurses and it was associated with a hospital. I just like their outlines a lot better than some other schools. The program outlines were just a lot better. When I went to the open house they give you outlines of what the first and second years are going to be like.

Anita also entered the field in direct response to parental influence. Anita spent a portion of the interview discussing her experience in boarding school. Anita described a very controlling environment at the school that seems to have contributed to a rebellious side of Anita, which in fact influenced her decision to become a nurse. According to Anita:

> It was really a learning experience because I had to do a lot of things on my own. It was very controlling. It was rigorous. It was a very difficult few years because you didn't have a choice. Everything was on a clock. I'm not a clock type person. I never really liked it and I think I came away with I just don't have to do things on a schedule. I think that my parents sent me there because they thought I would learn a certain way of life and to be more responsible.

Anita related this story in an, I told you so attitude. It is interesting that she has entered a highly structured profession, where nurses have discussed a strong sense of responsibility and sense of

control by others. While she complained about the rigidity and structure of boarding school, she entered a profession that others have described in similar terms. This lack of choice as explained by Anita later in the interview influenced her choice of nursing. When asked how she entered nursing, Anita described it as a need to be able to work immediately after graduation. She stated:

> I have to say that it wasn't like that life long dream that you hear about. It started for me that I had to take a professional track in my years post high school so I decided that I wanted a career in something like nursing because after my three or four year degree, I could start right our working as opposed to a degree in biology where you couldn't to this. I wanted to do the nursing program or some kind of program where I could take care of people. I knew I wanted to take care of people.

Family influences were more influential in her choice than Anita initially disclosed. She explained:

> I think it is like an influence. My parents are both in health care and I have grown up with adults that I have looked up to that were in health care. So I guess it is both an environmental and genetic predisposition. My father is a doctor and my mother has been an administrator in a hospital. It was like the only thing I was exposed to. My parents were like, well, that's good. Then you can go to medical school after that right? That was kind of their response. They were very supportive of me but I guess they expected me to become a doctor. Now that I'm getting my masters they say, well she is moving ahead. She is moving up in the world so I guess it is ok.

Anita's parents have continued to expect her to become a physician. She has appeased them by continuing her education within the nursing field. When questioned as to how her parents feel about her decision to be a nurse today, she responded, "They are OK. I think they still expect me to go to medical school in the back of their minds, but they will get used to it."

For all three nurses who entered the field directly, the decision was somewhat spontaneous. There was no feel for a "calling" to the field from any of them. There were strong family influences to better themselves and grow as people.

Delayed Entry

The remainder of the nurses interviewed experienced a delay in entering the profession. Many of these nurses had experienced a life long desire to be a nurse and had held off on this decision for varying reasons. Several of these nurses shared a common experience of working in another health related profession.

Alice is someone who always wanted to be a nurse and grew up in Kenya. She described her journey into nursing which extended across two continents and two different cultures. According to Alice:

> I think it is something that just naturally happened to me. When I was a little girl I liked taking care of dolls and I would pretend I was a nurse. I did a lot of caring for others in my family. When I finished my courses in high school and applied to be a nurse I had a very strong application. I did not have literature. It is very sticky about getting into nursing school. Our society is not really supportive of girls being educated to do things. You get information by word of mouth. I just didn't know what courses I needed to take. There were no guidance counselors. It is a social issue. I didn't have the right background to enter the profession. As a young child growing up I didn't have the encouragement to take the right courses. I had to sort it out myself out after high school as to what I need to do. In order to be a nurse I needed a strong founding in literature. I did not take literature because it was one of my weakest courses. I couldn't get into nursing school. I ended up being a math teacher.

Maureen did not begin school to be a nurse until she had been in college for one year. She described her story on her path to being a nurse. Maureen shared:

> Well actually, I never thought about being a nurse until I was in my first year of college. I was undecided. After high school, I was interested in working with people, so I decided to take sports medicine to start out with, and then I just liked caring for people and seeing how they progressed and getting better. I originally went to college to play soccer. I really did like sports and I wanted to be a physical therapist. After being at college for a year, I decided I wanted to transfer and I was interested in nursing and working with people. All of my roommates were nursing students. My family was happy, but they thought it was going to be a challenge, but they were supportive.

Juanita, who began her career as a respiratory therapist, discussed the issue of not being good enough to be a nurse. According to Juanita:

> I went to school to be a respiratory therapist a number of years ago. I felt that was what I needed to do. I didn't think I was good enough to be a nurse. I had seen nurses over the years and I watched what they did and I said I can't do that. They have to know too much. I have always had a lot of respect for nurses but I felt that I couldn't do it.

Juanita's entrance into the nursing profession was basically delayed because she felt it would be too difficult for her. "When I went to school for respiratory it was one of the hardest courses I have gone through." After working for a while as a respiratory therapist, Juanita decided "it just wasn't enough. There was so much more I wanted to do and to put together. My work was becoming more sales oriented. More so than patient oriented. I started looking into nursing and I went." There were many things that Juanita needed to accomplish in order to go to nursing school, which further demonstrated her commitment to becoming a nurse. She described:

> There were a lot of things that took place then. I had to move closer to this area. My daughter started going to a private school. I quit my job and I was not sure where I was going to work. I just knew this was something I needed to do. So I

> started school and I worked there as a student nurse aid. I found that is just clicked. I really liked it. It was very tough. I think just the requirements were tough. I loved what I did. It was worth it because I just really enjoyed it so much. I would have never gotten through nursing school without going to respiratory school first.

Juanita clearly felt that the people part of nursing was what was lacking in respiratory therapy. She stated:

> In respiratory you get down to the nitty gritty. You have to know how those ventilators work. I said to my teacher don't be offended by this but I hate this stuff. He looked at me and said but this is your whole career. I liked the people part. That was basically what it was. It didn't really matter what I was doing as long as I was doing something for them. I just didn't feel like I was doing enough for my patients.

Darlene, who also entered the profession in a delayed manner, did so at the encouragement of people around her. She described:

> Well actually it was a fluke that I got into nursing because I was going to business school. I was going to be a secretary. All the courses I took in high school were all business related. I took a job at a nursing home in the dietary department and they told me of a great opportunity because they were short nurses aids. They said that they would pay for my training and give me my regular salary while I went to school. My supervisor in the dietary department came to me and I think you would do good at that. I said I don't think so. She said oh really, why don't you just give it a try? So I did.

Darlene became a nurses' aid and found that she loved it. According to Darlene:

> I liked working with the residents. I liked being able to help them and being able to be with them. A lot of times I would go in on my days off and just help out.

> A lot of them didn't have families. I was their family. I loved it. I loved working the hands on.

The "hands on" experience was something often commented on as a positive one for nurses.

When asked how her family responded to her being a nurses' aid, Darlene shared:

> My mom always wanted one of us girls to become a nurse. She was a nurses' aid herself. She always wanted one of us to be a nurse. As I got further into it I said I don't think I want to do this for the rest of my life because I was working with people old enough to be my mother and I just said I can't imagine doing this when I am 60-70. I can't do this. So I got talking to a friend of mine who is a nun and she said why don't you go to LPN school? I said I don't think so.

In this circumstance, it was her licensed practical nurse friend who encouraged her to go to school to be an LPN. Her friend had seen things in her that she herself had not seen. According to Darlene:

> She had seen me with the residents and she knew I was very knowledgeable about when things were going wrong with the residents. I was always saying she's not eating right or she's not drinking right. She said you have pretty good assessment skills. I think you should be a nurse. I said well when you are a nurse here it takes you away from the residents. It is not hands on. She said it is not always like that. I said well then that is something to think about.

Once she completed school to become a licensed practical nurse, a supervisor encouraged her to continue in school and become an RN. Darlene shared:

> Well it was one manager. She said it was just the way I carried myself. She said it was the things that I know and the way I talk to the doctors. I am not intimidated by them. She said you are very knowledgeable. I said well I don't think so. She said well I think you should go back for your bachelors. I said I

> don't even have my RN. She said you're kidding. I said you never knew I was an LPN? She said no I think you are too bright to not be an RN. I said well it's the fear. It is the fear of the unknown. I said I don't think I can do it. She said I know you can do it. I'm glad that I did it but I'm also glad that I worked as an LPN for so long. I couldn't imagine going from a nurses' aid to RN school. You are learning the same things but you are learning them at a higher level. I need to understand why things are or why we do this. People were telling me you are going to be a good nurse. I just kept saying can I handle charge? Can I handle meds? Do I want all the responsibility on my hands? It took a while to build it up. I would look at other people. I would say well if she can do it I can do it. To be honest I saw a lot of nurses who were terrible. You would tell them things and they would just say never mind.

Jean told a similar story of delayed entry into the field and the sense that she was not academically prepared despite a long time desire to become a nurse. According to Jean:

> When I was in high school I failed a course and my father just looked at me and said well now what we going to do with you. He went in to see the guidance counselor and he said there is this BOCES course coming up for LPN's. My dad had heard me say that I would like to go into nursing but I never took any of the courses I would need because I just didn't do well in them. My dad came home and I had one week to decide. My dad said you will need to finish the year so you can get your 2½ credits but if you want to drop out then you can.

Jean had always wanted to be a nurse, despite the fact that this appeared to be an impulsive decision and one made out of desperation. While she did struggle with mastering the content in school, she was successful. Her long-term desire to be a nurse contributed to this success as evidenced in this passage:

> The church was cleaning out the basement one time and they found a form that I had filled out when I was in first grade. I never remember filling out this form. I laugh now. I said that I wanted to be a nurse.

Jean described her mother's death of breast cancer when she was three years old. Her only memory of her mother is lying in a casket in a white dress. Her father shared that her mother had experienced a lot of pain. When asked if her desire to be a nurse might connect with her mother's death, she shared:

> Oh yes. I think there is a big connection. I work in Oncology and we do a lot of death and dying there. I am very comfortable with that and I am very comfortable with pain control. I have no qualms with giving the patient the last shot. I want them to be comfortable. After the stories that the families tell about mom, I get very close to them. It is natural to get upset when someone you care about dies.

Jean was not allowed as a child to talk about her mother's death. In her nursing practice she shares with families another approach. Jean described:

> It wasn't OK to talk about her. You weren't supposed to talk about it. I try to tell other families that they need to tell children about their parents if they lose them early. It is such a mystery. There is so much that I don't know about her.

Once again family influences were strong in her decision making process. Jean felt that in her practice, she can somehow help others establish a connection to lost loved ones that she felt deprived of herself.

Karen also described a circuitous route to becoming a nurse despite what she referred to as the "calling" in the following words:

> When I graduated from high school I originally wanted to be a nurse. I went to college. It was something that I always wanted to do. It was very competitive and I was 18 and I really didn't want to work that hard at that point in my life. I

> didn't complete it then. The desire to be a nurse persisted. I got married and I had my daughter and I didn't want to go back to work right after she was born. I got some jobs. I babysat. I even had a cleaning business so I could be home and kind of work my schedule around them. Finally my husband said to me what do you think you want to do here? What do you really want to do and if you want to do it you should do it now. It really chokes me up just to talk about it. He is so supportive and he always has been. He said do it now. Do it while the kids are still young. So I did it and I have loved it ever since. I personally think it is a calling and if you feel it you should do it especially when you are young. I now feel like a part of me is complete. I really don't think I was mature enough to handle it when I was eighteen. You need to handle a lot when you are a nurse. You have to deal with every emotion and at 18 you just don't have the ability to handle all these emotions and to be a teacher and compassionate and all that.

Reminiscent of previous nurses was the feeling that she just did not have what it takes to be a nurse. Time, maturity and once again, support from a significant person impacted her ability to enter the field. Karen described the calling she experienced as a child. According to Karen:

> When I was a kid I didn't know it but my mother actually wanted to become a nurse. I don't remember the exact reasons why she didn't go for it. She went into dental hygiene but I think it was just something in me as I keep referring to the calling part of it. When I was a teenager my grandmother was dying and she was very ill and my family would talk about the things that I would do as a teenager that I would do for her that most people could never do for another person. The rest of my family was just surprised. I was just like a 15 or 16 year old kid.

Karen had much to consider in her life when she finally made the decision to go to nursing school. In Karen's words:

> I always said I wish I had gone into nursing. Why didn't I do it? I would always make a million excuses as to why. The cleaning business really got to a point where I needed to make a decision. I needed to decide to stay with it or to expand or whatever. My husband said if you don't do it you will never feel fulfilled. I wanted to do it but I think I felt that it would have been selfish because of the money that was invested in the business and my kids' lives. I guess I just thought it was a little bit selfish at that point but he said go for it. I could have thought about what would happen to everyone's lives but I just didn't do that. I just applied and I thought that whatever happens we will just deal with it as it comes along. It was just like the first time in my life that I didn't think it out to the point where I was comfortable with it. It worked out great!

Alex came from a family where the expectation was that he would become a physician. This was not his desire as he shared in this passage:

> I guess when I started to think about professions that I could go into I always thought about nursing. I came from this family that said no you need to go to a four-year school and you need to become a doctor. So I went to a university and I got a bachelor's degree in biochemistry. Then I decided that I didn't want to go to medical school and I didn't want to do anything like that. So I changed my mind and I came back here and went to nursing school. My parents were pretty understanding even though they had already shelled out a lot of money for me to go to the university.

Ed started his career as a paramedic and as a married man with children, Ed described his decision making in becoming a nurse. "I remember when I was 34 and I was looking at it and I said I'm a paramedic now which is not going any place. Ambulance services are run by small agencies. I'm not buying one so what is my career goal? So I looked at different professions in the health care field and I decided on nursing." There were some aspects of being a paramedic

that Ed liked such as having an autonomous role which he perceived caused resentment in nurses. According to Ed:

> Some nurses looked at me differently when I was a paramedic. It's like you don't know what you are doing. I think it bothers them about what we can do out in the field. We can start IV's (intravenous lines). We don't have to call up and ask for an order. We just have standards of care. I think that some nurses have not been exposed to the emergency medical system and what happens out in the field so they resent you.

By standards of care, Ed is referring to the fact that for different medical conditions, the paramedic has standard orders written by the physician and can start treatments and give medications without calling a physician to get the order such as nurses often need to do. He described a situation in which he perceived nurses were jealous of his autonomous role. Once Ed entered nursing school he felt an immediate change in how nurses interacted with him. Ed described:

> They were friendlier to you. They were the same nurses too. You would go into the hospital they would be like, oh no the paramedics are here. When I would go there as a nursing student they would say oh come here and let me show you how to do this.

This perceived lack of respect from nurses in his role as a paramedic was one of the issues that led him to nursing school. Ed stated:

> Actually I started to feel like maybe I wanted to be a nurse because I would get more respect being a nurse versus being a paramedic. I was a little upset about their view of the paramedic because, guess what, if you are out in your home it is going to be the paramedic who will be caring for you. I think a lot of it is, especially in this city, paramedics are starting to be part of the health care team.

Ed felt secure that he would always be employed in the nursing field. Ed was also desiring more respect from nurses with whom he interacted and desired a more stable job with room to move. Ed did go on to address the need to care for his patients. Ed felt that nurses need to ride the ambulance to see how a paramedic functions and how they fit into the team:

> They would realize that when you are out there you really have to work at caring for someone. They would realize that they are just an extension of the team from pre-hospital care to the hospital. We were always checking on what happened to people. We would call the hospital and check with the nurse to see how they were doing.

Ed was missing the relationship with the patient and the follow through in knowing the outcome for the patients that he treated outside of the hospital. Ed was also looking for more money and a career. "Actually I was a paramedic for ten years prior within the emergency medicine field (EMS). Although EMS is a field, it doesn't pay that well and it really isn't established yet. Where in nursing you have retirement, you have benefits and you have a career." The diversity in nursing was an additional drawing factor for Ed: "Right now I work in critical care but if I decided to work in home care or management or teaching or whatever, the possibilities are endless."

Debbie, who initially wanted to be a doctor, perceived strong societal and family influences in her decision making process. Debbie described:

> I've wanted to be a nurse since I was about eight or nine years old. I have a picture of myself as a little girl in a play nurses uniform at Christmas. My earliest memories are of wanting to be a nurse. I actually thought about being a doctor but in those days I really wasn't encouraged to do it. Today I probably would do it. Growing up in the 60s women weren't pushed to do things the way they are now. I had chemistry sets and microscopes and everything.

When questioned further about why she did not become a doctor, Debbie described needing to establish a career more quickly. Additionally, she described a sense of not being able to do it. "It seemed like it was just so far away and I just would never be able to do it. When I got to be in ninth grade I decided to go right into the Licensed Practical Nurse program as part of high school. It was something I could do more quickly. After fifteen years as a licensed practical I began to want something different." These thoughts of doing something quickly are reminiscent of Anita.

Debbie described what prompted her final decision to enter RN school. According to Debbie:

> I just wanted to do something different. I had been an LPN for so long. When I was thinking about what I wanted to do...anything that I thought to do for a career didn't entice me so I said I had better go back to school. I saw being an RN as more of a challenge, more independence, using my head more.

Ed, Juanita, Jean, and Debbie all expressed the need to do more in the relationship with the patient than they were able to in previous roles in the medical field. There was an overriding theme of being more involved, doing more, and being more challenged. Debbie stated:

> I saw the registered nurse working with the patients. You could see a change in them. You know when the nurse was doing orientation with the patients they would come in and the nurse would explain to them about what was going to happen and would answer questions. You could just see the change in their faces. They would come in so scared and then you would see a little less anxiety in their face. Then when they would teach home care they would just know nothing and it would go on and on. Every day when they would come in you could see a change in their moods. When you saw the change in the patients it just made you feel good.

Chris also delayed her entry into the nursing profession feeling that she would not be able to do it. She found herself as a cafeteria worker and described her ultimate decision to become a nurse. According to Chris:

> Well I stayed at home with my kids until my youngest was in first grade. I started working part-time in a school cafeteria running the cash register. One day I was standing around and realized that this wasn't what I wanted to do. In high school I had taken a career aptitude test that showed that I would do well as a social worker, teacher, or a nurse. I thought that being a social worker would not be good for me as I get too drawn into situations and I just wasn't interested in being a teacher. A nurse seemed to be somewhere in the middle. I was strong in science too. Through the process of elimination and some soul searching I decided on nursing.

In further describing this soul-searching process, it became apparent that Chris had wanted to be a nurse since childhood but felt she couldn't do it. She described:

> I was fascinated by Marcus Welby and all those shows that were on T.V. I wanted to help people. I really wanted to be a nurse. Even as a little kid I really respected nurses. I always thought I couldn't give a shot, which is why I didn't do it right out of high school. I hate needles. I had kids and then I did the cafeteria work. I looked at the environment and said I can't do this anymore. The kids love you but you are not really paid well or appreciated for what you do. I don't know it was just too hard, too unfulfilling. I was totally bored and I decided I needed to go back to school. I needed to get over this needle thing and just do it. I did. I remember the first day driving here going down the road going to school. I said what are you doing here? I was having a long talk just driving down 81 talking to myself. Getting married was easier. I said just get this done.

Not unlike some other nurses interviewed, Kris also wanted to be a doctor. Related to her own medical problems this became a difficult task. Kris shared:

> Honestly I wasn't interested in being a nurse. Actually in high school I wanted to go right into med school. My first week of school I came down with mono and I had to drop out of school and I was hospitalized for a week. I tried going back and I was a biology major at college in the spring and I got mono again. I said something is telling me that they don't want me here. I started fainting in class so I came home for almost a year. The following year I started taking some basic courses at community college just to do something. That was when I had ankle and knee surgery. I was out almost a year. At that point I was almost afraid to start something. I thought well maybe I could do the nursing and then from there just go up. I honestly never thought I would work as a floor nurse.

For Kris, nursing was something to do quickly and then move up. Kris was actually turned off to nursing because her mother was one. Kris stated:

> I never ever wanted to be a nurse because my mom was one and I wanted to do something bigger and better. My mom was going to nursing school when I was in high school. She would come home and tell me about all her experiences and I would just say I am never doing that. It was mostly the basic things like bedpans. Vomit. You know all those things that now don't even phase me. I always wanted to be some kind of a practitioner where I would be very independent.

Kris' perception was that nurses functioned in a dependent manner and that was not something for her. When questioned further about the dependent role, Kris responded, "That is just what I thought being young and not understanding. Also for me I did not see nursing as financially being a good choice either. I wanted to be making tons of money. Just doing a lot more. I wanted to kind of be in charge. Not that I can't be now but I wanted to be working in a

factory." It is interesting that issues of lack of autonomy and financial reward were deterrents for Kris to enter the field and attractions for Ed. Aside from the need to attain professional status quickly, Kris was ultimately influenced by her mother. Kris stated:

> My mom didn't really impact me in the opposite direction. She opened my eyes more to how nursing could be. I had a stereotype of nursing and when she talked about the bedpan thing it was like it just reinforced what I really thought. Then we started talking and I heard some of the good things, like the relationship with the patient and how much they appreciate nurses.

So for Kris, much like other nurses, it was the relationship with the patient that was the final draw into nursing and won out over previous values of autonomy and money.

Julie grew up in China and came to this country at the age of 28. Julie's mother is a nurse in China. Her mother wanted more for her. Her mother wanted her to be a doctor. She felt being a nurse was too simple. Doctors were more powerful. When Julie came to this country, she felt that nurses were more important in patient care. Her mother now supports her decision.

Bob began his career in the retail business and after 30 years he decided he needed a change. Bob described how he became interested in becoming a nurse. According to Bob:

> It is hard to put an exact figure on it. It has been in the back of my mind for a long time. I went to college and I have a previous background in business administration. I was not the least interested in nursing at that point. At least not consciously anyway. After thirty years in retail, the management end of it, it got to the point that I liked people better than I liked bottles of shampoo. Somebody suggested that I become a nurse. I can't remember who it was. A friend or an acquaintance. I had some friends who were nurses so I talked to them.

Bob's wife was supportive, as she also had started a second career, which he had supported her through. Bob shared:

> My wife was very supportive. We both are in second careers. She did her career change earlier and I said I think I would like to try something different. My experience in retail was probably a lot more people oriented than my employers would have liked. I said enough of this foolishness, I am going to try something else.

The results in this study are consistent with findings in other research. Williams, Werthberger and Gushuliak (1997) found that students choose nursing for the following reasons: job opportunity, security, helping others, working with people, family influence, interest in science, and previous job experience. Approximately 80% of the students indicated that being a nurse was a "lifelong dream." Beck (2000) studied 27 nursing students who attended a large state university in New England. Students were asked to respond anonymously in writing to the statement "Please describe in writing an experience you had in choosing nursing as a career." The data were organized around the following eight themes: an intense desire and genuine love of helping others; profession in which patient and nurse reap benefits; prior work experience and hands on caring for family members; exposure to family and friends in the health care profession; observing nurses in action; something missing from original career choice; first choice (being a physician) was unattainable; and a fascination with science and the human body. All of these themes were identified in this study, however, the qualitative nature of this study adds depth to specific family influences which are not always positive and reasons for delayed entry such as the perception of not being equal to the task or having the appropriate skills. Families also were discouraging and wanted something better for their children. The nurses who had delayed their entry were quite descriptive of how they needed to "do more," "make a difference" and have "connection to people." The nurses in this study were supported by significant others to enter the field they had felt unable to be successful in. Commonly there was a significant moment in which they felt their life had to change to be more fulfilling and nursing was the answer.

Nursing School

The Instructors

All of the nurses I interviewed had stories to tell about their experiences with instructors while they were in nursing school. There was consistency in what they perceived as helpful or unhelpful qualities in these instructors for aiding or impeding their development as nurses. Many nurses in this study commented on the rigidity or strictness of instructors. According to Kris "A lot of them are mothers. They were trying to do what they thought was best. Actually they were all mothers. They were very strict. They had their way of doing things. It is their way or no way. Some of them treated us like we were subservient. It was terrible."

Amy expressed this rigidity in instructors as the need to produce one type of nurse. If one did not fill this mold, there was a strong fear of failure and competitiveness. Amy shared:

> The second semester it kind of got challenging. I had a couple of instructors that definitely terrorized me. I didn't ever say that I was terrified. I was constantly afraid of failure. It was always pass/fail in clinical. It was never how well I was doing. It was how much can I get out of you. Nursing is such an art and there are so many ways to be a good nurse. I figured that out after I graduated and I have my own self now but in school they make it look like there is one type of nurse. It is very rigid. I always felt like I was proving myself or trying to. I was always competing. Not against anybody else but with passing and failing and trying to please. I didn't foresee it being like that but I thought it is not what I though nursing would be like.

Juanita also felt that instructors had a definite idea of what students should be like. Her perception was she could be singled out and humiliated if she didn't fit with this image. According to Juanita:

> There were a few instructors that really impacted me in good ways. I am the type of person who always tries to find some good in all situations. There were a few

> situations that were very painful to watch. Because I am a little bit older and I am a little bit more secure in who I am I didn't run up against the same type of problems that some of them ran up against. I usually sit back and I watch a lot. There were a couple of instructors that just broke my heart. Some of the instructors become so confident in what they do that they almost become arrogant. They are belittling in their approach in dealing with people. There were situations in which it was obvious that there were a couple of people that were singled out. Maybe they didn't care for their personality or I don't know what their reasons were. But it was quite obvious. The student just couldn't breathe right. Not only that it was discussed in front of all of us. Things that just were not professional. It was really uncalled for.

In an effort to conform to what she perceived as an expectation of being perfect, Amy spent a considerable part of her time in nursing school experiencing much anxiety, which impeded her learning as well as her self-confidence. Amy described:

> Perfect. You had to be perfect. You were always scrutinized. There were no mistakes. There is this one instructor that to this day I still have a hard time looking at her and she is such a wonderful woman. On the first day of my senior med/surg year I came up and asked her a question. It was a respiratory issue. The patient wasn't on the treatment the day before when I looked her up so after we got done I asked the instructor about it. She said Amy if you are graduating in May and you are going to be an RN you need to know that. That put me over the edge. That was the first day of clinical so I had four weeks left with her. I was terrified. Every day after clinical when I saw my husband I just couldn't stop crying some times for two days. The instructor knew that about me. She knew I was terrified. I met with her. I said I really want to be satisfactory. What do I need to do? It just snowballed all semester. I did a lot of things right. The

> instructor said you need to get some confidence. You need to change that about yourself. But then the next semester with another clinical instructor it was just better. I ended up doing fine. They were so nice. They kept telling me that I was going to be a great nurse. They were telling me all the right things. The feeling that I wasn't good enough was something I couldn't get rid of.

Despite reassurance following the first incident of getting negative feedback from an instructor, Amy was unable to shake off her sense of somehow being inferior.

Kris reported the inability to express their opinions to their instructors without being belittled, humiliated in front of peers, or even failed. According to Kris:

> It was actually a few things that bothered me. My first year I was financially in debt. So I had to work three jobs and go to nursing school full time. I did have a run in with my professor. She wanted to fail me for not cornering my beds (making corners with the sheets). I said if everything else is OK why would you want to fail me? What is the problem? It's hard. Instructors wanted you to kiss their butt. They wanted you to say what they wanted to hear. They couldn't hear what you wanted to say. Well I actually had an argument on abortions with my professor. I said that I was pro choice and she thought that was terrible. I was just trying to get my point across. She didn't feel that was right at all. I understood her point of view and I accepted it but she was not willing to accept mine because it didn't agree with hers. This happened in the classroom. I am the type of person who turns bright red. I just said this is my opinion. I am not belittling or disregarding your opinion. Of course, I am just a little student who is feeling about that big right now. I was about to cry. I figured she was going to hate me forever. My peers were watching me. There were about 50 people in the classroom.

Darlene had experiences in which it was her perception that her outspokenness caused negative repercussions including a failure. Darlene shared:

> At the end of a clinical rotation they give you an evaluation. One of my instructors failed me. I was surprised. I said give me a reason why you failed me. She said when I watched you give an insulin shot you did it wrong. I said well you were standing right over me and I was nervous. The patient was nervous because you were standing over me. I said I did it right. There was some other thing. I had to do a care plan for one of my patients over three times. I called this other instructor at midnight because I was so upset. She called me back the next day. She said Darlene come right up, you're frantic. She said there is nothing wrong with this. She said this is ridiculous that she made you do this three times. All of a sudden my care plan became satisfactory. I said this is the same one I have done three times already. She said I saw you in there with that other instructor and I respect that. I don't think it is fair that you saw me with one of the head instructors and all of a sudden I pass. It is not telling me anything if I am not doing it right. She said well I just don't understand how you do your work. I think she didn't like me because I was outspoken. I said before you even start I know you failed me. She said I know what you are doing. You just sit around and watch TV. I said let me tell you something lady. I have a full time job. I do 24 hours of overtime in between that job. I have a six year old at home that I have to care for. Her father works two jobs so I can go to school. When in the world do I have time to watch TV? I don't even read a magazine because my whole life is nursing school. I just left.

It was comforting words from another instructor that ultimately helped her continue in the program. Darlene described:

> One of the instructors called me and said what happened? You ran out of that room like a bullet. If I had stayed there I would have done something I would have dreaded. I worked too hard to get into this program. So I called Madeline (another instructor) and I left a message and she called me and said Darlene will you come and talk to me? I cried to her. I said Madeline I don't see where I failed. I said I know there is nothing you can do. I just want you to help me feel better. She said well that is what I am here for. I said I don't deserve this. She said we all know you work hard. We know you don't fool around. She said I don't know what happened because I wasn't there.

In a proactive stance and in continued worry of being prejudged, Darlene decided to discuss this situation with her next clinical instructor ahead of time. She described:

> When I went to the next rotation I said I want to talk to you before we ever get started. She said OK. I said I don't want you to prejudge me from what this other lady has told you. She said I appreciate you coming to me and telling me this but I would never do that. I told her that I respected her. She said I'm glad you feel that way. I told her you are the most professional person I have ever met. She said thank you. I don't know what happened between you two. When she told me she had failed you I found that hard to believe. If you fail one and pass another in the same rotation you don't have to make it up. I passed this clinical.

The nurses in this study also felt that nursing instructors encouraged them to not become emotionally involved with their patients. From Kris' perspective this contradicted her motivation for becoming a nurse and negatively impacted her early relationships with patients. Kris described:

> I actually had several nursing instructors who told me don't ever become emotionally involved with your patients. I just said then you know what is the

> point of becoming a nurse? If you can't become involved with those people, why are you here? It wasn't OK to cry or laugh with a patient. I think they teach it as professionalism as far as being the strong one. To a degree I understand, however, how can you tell someone not to be pretty much human? They are trying to teach us as far as stress we should not get too close. I remember my first year out I was just like a robot. I didn't even see the person there. I saw everything else going on except for the person. One day I had a patient named Josh who had leukemia. One of my orientors said you have to make sure Josh does this and this and this. Of course I am in the frame of mind that I am going to go in and I am going to be tough. I am going to make him do all these things. Well I went in and started talking to him I said Josh you really need to do this. He said "I'll do it when I am damn well ready and I am not going to have you telling me what to do. I've been living with this and I'll do whatever I want." I just looked at him and my jaw dropped and said you are absolutely right. That is when I saw the whole picture. When he did that that is when I started to see that there is a whole person there. They are not just an IV. I think that was in my third month after I graduated.

Mayer (1983) stated that the role-making process is enhanced if the one being observed is a role model – someone who can provide assistance and instruction on how a role is fulfilled. Riggin (1982) saw this as a problem in nursing because there is a dearth of consistent role models. Students progress from faculty presentations of the independent, decisive, idealistic nurse to the reality of the dependent, skills-oriented staff nurse in the workplace. As has been reflected in the stories of these nurses and is continued in the next story told by Bob, instructors are not necessarily seen as idealistic nurses. For the majority of the nurses in this study, instructors were not perceived as adequate role models, in fact, often displayed characteristics they chose not to follow.

Bob shared that he was forced to listen to stories of his instructor's love life in order to pass the course. He was willing to listen despite his objections because she insisted that if he passed this course, he would ultimately pass his licensing boards and become a registered nurse. According to Bob:

> I had one senior med/surg instructor who I did not like. It was more her particular approach to things. She said if you get through my course you will not have any difficulty passing the boards and she was right. Our relationship was a bit adversarial at times. Oh I just didn't like to hear all the stories about her love life. It was not in a way I thought the material needed to be presented. I found that to be unnecessary and in some ways offensive. I guess she got across what she needed to get across. Whether I like her or not really became irrelevant because I really did learn and because of that is why I felt I needed to walk back into her office and say you were right and I thank you. I never thought her sex life had any bearing on the material she was trying to put across. However, she got across the knowledge of all of that. We had to pass her tests to pass the boards and I found that absolutely to be true.

Ed found the words of one of his instructors to be somewhat defeating. Ed shared this interaction:

> In the beginning there was a lot of one on one with my advisor who was also my instructor. Out in the paramedic world you run basically by yourself. You don't call up and ask the doctor for orders. There are standing orders out there for you. We had a meeting and she said you are not in the paramedic world any more. You are a nurse. You are no longer autonomous. In my opinion she was setting her standards. You are not going to be autonomous any more.

Nursing literature supports some of what these nurses have had to say about their instructors. According to Larsen and George (1992) "Nursing education is still too often

characterized by demands for good girl behavior, which rewards passivity and is intolerant of assertiveness" (p. 20). Nursing education has traditionally not been very flexible when it comes to accommodating those who are not what Curran (1992) comically referred to as "nice, white women". Additionally, Johnson, Good, and Canada (1984) stated "Merely to survive in nursing school, male students may have to decrease their traditionally masculine behaviors, specifically by challenging instructors less and becoming less competitive over time."

The nurses in this study did have some positive things to say about their instructors. Positive characteristics of instructors revolved around sharing stories, imparting confidence, instilling professionalism, and fostering critical thinking skills. Positive stories about instructors were much less in number. When asked to comment on the influence of instructors, nurses often started with a quick positive comment and moved on to something negative. Of note, in several of the stories about negative experiences with instructors, the nurse would indicate that it was another instructor who helped resolve the conflict for them in a positive way.

Maureen valued the intensity and strictness of the instructors and felt the challenge enabled her to be a better nurse. "The instructors were pretty intense and strict. I think I am a better nurse because of it." Additionally she found their personal experiences to be helpful to her in learning. "I think their experiences and sharing situations they had with patients helped me to learn."

High expectations from instructors were helpful for Karen. Karen stated:

> Mrs. N. just seemed to set a standard in every way. She tried to keep the image of the nurse related to this hospital. She's the one who was always raising the bar and expecting more from me.

The ability to understand their needs as adult learners with other responsibilities was appreciated by Ed. "The instructors were geared to that too. They knew when it was time for a break. Sometimes the whole class would fall asleep and the instructor would just slam the door and say OK everybody just get up and walk around."

Critical thinking skills were fostered by faculty. According to Debbie:

> Relationships with faculty helped me to think more critically. A lot of the instructors were closer to my age. I felt like I could relate to them. I think it was a lot easier going to school when I was older even thought they say it is a lot harder. I think when you are older and the instructor gives you a push and says just go do it you do. When you are younger you are a little more rebellious. So you have a little different relationship with the instructors. It might be a little easier in some respects.

In this passage, it also seems clear that Debbie's age may have promoted a more positive relationship with faculty.

Debbie also felt that her instructor taught her to be a professional. She stated:

> They, the instructors, teach you to be a professional. They make you feel like you are important. You know, it's like it is a calling. It is like it is a spiritual thing. They instill leadership and a lot of self-confidence. You don't even realize you are learning it until the end. It just all clicks in and you know they just make you feel a lot of self-confidence. They make you reason things out for yourself. I remember those process guides that we all hated and they always made us do. The instructors would say that we think they are silly now but you just wait and you will see that you will learn so much. And we really did. It is also the way that they teach you. The instructors help you with self-confidence and independence by reasoning things out.

Kris felt that instructors empowered her by helping her see that she could make a difference. She stated:

> They just opened your eyes to the fact that you can make a difference. You can change. You can impact somebody's care. The fact that the instructors were so willing to work one on one with you was helpful. I really only had problems

> with two as opposed to 20 so that was pretty much it. As far as the rest of them they made you feel important and they were encouraging.

This sense of support and encouragement was reiterated by Denise "The instructors were great. They helped you in any way the could. They were always there for you with support and encouragement."

Several nurses commented on the ability of nursing instructors while they were in higher education to impart knowledge. In Denise's words, "If I was ever having trouble they (instructors) would always find the time to help me with whatever I needed. They would not condescend about the bad things. They helped mold you into a better nurse. I just felt that it was very positive how they reinforced all their teaching."

When questioned as to how instructors imparted knowledge, Denise shared the following: "The instructors always shared their own stories in class. They were very much not looking down to you as a student. That made it a lot better. Students and teachers were on a first name basis. We never called them Mr. or Mrs. It was always Mary or Sue. It was nicer because you could talk to them as a peer instead of as someone who was above you."

Juanita reiterated this importance of equality and story telling. She stated:

> The instructors were nurses who were working out in the field. They didn't have that same attitude do it my way or no way. They let you incorporate what worked best for you. They incorporated a lot more because they were working in different fields. They had a bigger view of things. They would say this is how you are being taught here because this is how they do it. This is your ultimate end result. This is how you get here. They talked about different ways to do it. They talked about different experiences they had had. They give you different scenarios. It was a just different flavor.

Additionally, Juanita discussed the importance of the teacher/student relationship in fostering learning. Juanita stated:

> I connected with all my instructors. I had a good relationship with all of them. They all stood out. In clinical you connect with certain ones more so than others. I really connected with a couple of them. You pull I think from all of them. You pull a little something because they all have their own strong points. One we worked with was very strong with heart issues. We learned a lot there. Plus her personality was very strong and you pick up on that. She helped you to feel like you were doing a good job too because she would praise you and give you that extra boost. There are a lot of instructors on clinical there and I do mean a lot, that seem to think that coming down on someone is the best way to teach. I find that the ones who don't teach that way, that teach with a softer approach and build up your self-esteem. We all have a low self-esteem. We are all in there fumbling. We don't know what we are doing and then we are thinking, oh no I just made a big mistake. When you have that instructor who says that was really good, you did an awesome job, and then take you through any areas that you didn't do well. With those instructors, the student would just flourish.

While the nurses in this study could identify both supportive and unsupportive behavior in instructors, the negative aspects identified far outweighed the positive. The negative comments came from nurses who had attended both A.D. and B.S. programs in nursing and from males and females alike.

It Is Tough

All the nurses in the study indicated that nursing school is tough. Hard work is expected and becomes necessary to succeed. While nursing programs varied, the overall expectations remained that becoming a nurse is a full-time commitment and consumes time and energy. The influence of the Flexner Report (1910) has significantly affected the definition of nursing practice as well as the educational process. His report was highly critical of schools that lacked the facilities to teach laboratory-based scientific medicine. The Flexner Report helped to establish

laboratory-based scientific medical education and practice. Flexner's study also led to a definition of profession and that had significant implications for the future of nursing (Wuest, 1994).

According to Wuest (1994) "Flexner's definition stressed rationalism, scientific standards, and objectivity, all characteristics that embodied the masculine ethos" (p. 360). Professions, reinforced by their scientific credibility, became sources of power and prestige. Parsons (1986) stated "Prior to Flexner, American nurses...were secure in their identify as professionals" (p. 273). Nursing did not measure up to Flexner's criteria. Nursing had a limited body of scientific knowledge defined as nursing and exclusive of other disciplines and lacked control over practice and was subordinate to the medical profession. Nursing leaders decided to respond to the Flexner report by establishing a scientific knowledge base. According to Watson (1988):

> Nursing adopted the empirical ethic of science through a research tradition that concentrates on objectivity, facts, measurement of smaller and smaller parts, and issues of instrumentality, reliability, validity, and operationalization to the point that nursing is in danger of exhausting the meaning, relevance, and understanding of the values, goals, and actions that it espouses in it heritage and ideals (p. 17).

Nagle and Michell (1991) noted, "Nursing is being driven by professional licensing bodies and accreditation bodies to adopt a single theory as a base for practice. Practicing nurses voice what they do and do not like about practicing within a specific, theoretical framework" (p. 18). The scientific focus of the curriculum, the one right way of doing things, the lack of humanism and caring in the delivery are all aspects touched on by the nurses in this study.

Amy described her experiences in both a baccalaureate and an associate degree program. She was able to express differences in expectations and curriculum from her personal perspective and experience. She started at a four-year school and described the process. According to Amy:

> I loved their nursing program. I did a full year there. We did nursing theory but we didn't do any clinical because it was a BSN program and we don't start out with clinical. The idea of being a nurse was just growing and growing. When I got my financial aid package for my sophomore year they had taken so much away I don't know where it had all come from. I had done great in school. I was going to have to come up with $10,000. I had kept my grades up really high and everything. They kept saying we can work with you.

Because of financial constraints, Amy was unable to return to the four-year school where she had felt so comfortable and did so well. She emphasized that she had only heard about nursing from a theoretical standpoint in her year there and had not yet entered the clinical area. As she pointed out, this approach is common for four-year programs. Since the image of the school in the community was important to her, Amy turned to the hospital-based school that had been included in her original choices. She described this transition. She shared:

> I wanted to go to this school when I was a senior. I could go on to another local school to get my BSN and it was very important to my family that I get my BS. The day before orientation started at this school I filled out my application and I got in. They were so good to me. They really were.

Ultimately, Amy was pleased that she will achieve her goal of a BSN in a slightly different manner. Amy reflected on her feelings in this transition as well as the perceived difficulty of a nursing program. According to Amy:

> Nursing was a real big deal at my first school. They placed a lot of emphasis on liberal arts there because it was not just a nursing school. If someone heard you were in nursing they would say you must be really smart. You must be a great person. It was supposed to be the hardest degree there. You really got praise for being in that program there. It has a great reputation in the area. When I found out I wasn't going to be able to stay there I just let myself be upset for about ½ a

> second because I was really obsessed with being a nurse. It was very important to me to be at a good school that had a good board passage rate. The first school had a 99% passage rate and so did this school.

Amy's strong desire to be a nurse and the respect and positive outcomes of both of these schools helped her through this transition. Amy became aware early on of some differences in the two programs in how they depicted the commitment to nursing school. According to Amy:

> The first week of orientation at this school is difficult. There were five hour days Monday though Friday and I remember sitting there thinking that the director and all the instructors came in and said you have to make this a priority. You have to put things aside. I'm sitting there thinking that it wasn't the depiction the other school had set up. I knew it was difficult from what everyone had said that they would never see me when they found out I was a nursing student. This school having five hour classes the first week kind of hit me that this is going to be a long two years. I remember sitting in orientation and wondering what I had gotten myself into. I thought it was a caring field and lots of people had commented to me that I was so caring and so nice in general that I thought it would compliment my personality.

Amy's impression of nursing school had been somewhat different at the four-year college. She described:

> I was really on a high at college. I was really kind of nervous. I was terrified that I wasn't going to be able to do it. I took biology and chemistry the first year. A lot of things I wasn't really good at. I could hold my own but I didn't excel by any means. Of course nursing majors talk. I had juniors right next door to me. You didn't see them. They were studying constantly. I was always very nervous about being able to finish and do it.

Amy felt anxious in nursing school and had misconceptions of the profession. She shared:

> This school is a very interesting school. It is not necessarily a hard school related to the schoolwork. Nursing is always a difficult program no matter where you go from what I have heard from other people. The amount of time invested was something. I didn't realize. I was constantly anxiety ridden. I don't think I ever had a good night's sleep. I had a total misconception of what nursing was all about. Because of my personality, I think people's first impression of me is that I will be a good nurse.

Amy felt that she was perceived as a caring person and that had helped her get through her first semester at this school. However, the rigidity of the approach at the hospital-based school caused her much anxiety and reinforced the responsibilities of this profession. She explained:

> There are different ways to be a nurse. There are procedures that are very rigid. I think that this school certainly taught me that under no circumstances do you not check your five rights (precautions taken in giving the right medication to the right person). Every time you give a med the five rights are important. It means people's lives and it is very important. That is so nailed into your head. For somebody like me this just escalated my anxiety. I just didn't know if I had what it took. At the end of my first year I was just happy I got through. If I ever vocalized it to anyone I know they would have been shocked that I was feeling the way that I was. I was too scared to say anything. I just felt like I was holding my breath as I went through the whole program. It looked like I was having such a good time.

As Amy continued in school, she received mixed feedback related to her competencies as a nurse. She described:

> I wanted medical/surgical to not be my weak point. I wanted that to be good. We did three semesters of that. I was good at consoling people and being there for people. I knew I had good communication skills. I heard from my psychiatric instructor that I would make a wonderful psychiatric nurse. I was definitely encouraged by the compliments but I never heard how good I was at medical/surgical. I talked to my mom at this point and she said Amy why not be what you are good at? I wanted to good at medical/surgical because it was tough.

Amy struggled with not hearing positive feedback in the area of the curriculum in which she most wished to hear it. Many nurses commented on medical surgical nursing as being the essence of nursing. The specialties of psychiatry and obstetrics were often not as valued. For Amy to not hear she was doing well in what was considered the essence of nursing minimized that she was performing well in the specialty areas.

Other nurses commented on the difficulty in negotiating the nursing curriculum. At one local hospital school of nursing it is possible for students to complete the associate degree in either two or three years. As Denise described:

> Hospital X offers a three-year program. I would advise this to anyone. In this plan you get your liberal arts courses out of the way before you begin the nursing part. I did the two-year plan with eighteen credit hours a semester. The nursing courses were very time consuming with the tests and everything. Then we had English and Sociology papers. I would definitely advise three years.

On the flip side, Denise obtained a sense of accomplishment in achieving her goal in such a timely manner, which has been reinforced by others. According to Denise:

> People are surprised because I am so young and I already am a registered nurse. They find it surprising that I am only 20 years old and I am already a registered nurse and that I have a job and I like it. I graduated from high school at 17 and went right into college and did my two years. It was very hard.

Ed discussed difficulties negotiating the curriculum at a local community college. Ed originally took liberal arts courses at the community college and had anticipated continuing in the nursing program there. Ed explained:

> Every time I tried to schedule a class at the community college it seemed like a hassle. Standing in line. You have to do it between these hours. Then when I went to meet with the advisor she would say you have to take these classes and I would say this is not listed on your curriculum and she would say well we strongly advise this. You would have to take seventy hours to go through their program.

After experiencing the difficulties negotiating the curriculum at this community college, Ed decided to go to school where he got a sense that people cared.

Juanita had negative experiences to share related to the rigors of the clinical component of nursing school. This discussion related to the power associated with clinical instructors. Juanita stated:

> These people hold a lot of power when it comes to grading. I have seen it where this stuff changes the whole course of a person's life because if you are the last person who is grading them and you get an unsatisfactory then you can't proceed. I don't agree with that. It doesn't matter if you had been satisfactory in the other rotations the whole semester. You just don't make it through clinical.

Juanita discussed a fellow student and her difficulties with this rule. According to Juanita:

> I have a problem with that rule. These were things I guess that were brought up with the higher ups there and they handled it the way they thought they needed to but one of them was a very good friend of mine and she is just plodding along. This person is an excellent nurse. She dropped out and is now back in the same program. She has a lot of gumption. It was unjustified. We had such a close

> class. We were very supportive of one another. When a handful of people were being singled out and I don't know for what reason. Maybe they were from a different nationality, maybe they were a little bit slower in understanding some certain tasks. I don't know what it was but for some reason they were picked on. It still bothers me tremendously.

Juanita felt that her peer was singled out by her clinical instructor and ultimately failed. Even though the student in question pursued this failure with the "higher ups" the decision stood. Juanita felt the decision was unfair and put forth how difficult it is for fellow students to deal with failures within their peer groups.

Two nurses commented on the attrition rate in nursing school as they experienced it. Kris stated:

> We started out with 100 students and there were maybe 30 that graduated. We lost seventy people in two years. In the first year we lost half. They kind of just get weeded out. This isn't for them or it's not quite time. Lots of them were older and going back to school. Lots of my buddies were in their 40s. Honestly that helped because I learned a lot more from them from their life experience.

Bob saw similar patterns of attrition, however, felt that adult learners had better success rates related to maturity. According to Bob:

> There were several adult learners within my group. Out of 65 probably 50 were fresh out of high school. Of that 50, one graduated on time. That is not to say that some of them did not graduate a year or two later on. A lot of them bailed out in a hurry for whatever reason. Most of the adult learners did better in terms of staying on track. I think that has a lot to do with maturity level. We were not into partying all night and all that good stuff.

Alice felt that perseverance was necessary for some adult learns to finish nursing school. Alice stated:

> It took me nine to ten years total to finish nursing school. I had a child, school, family. The sad thing is when you have all these things going on and you are trying to go to college and no one is really helping you. It took me seven to eight years to complete school at the last college I attended. I went every summer and all year too. I had my own business as well. I worked as a nurses' aid to cover my tuition at school. I had to do this to finish school.

The only positive experience with the curriculum in nursing school Karen shared:

> It was great. I loved it! I loved the learning and being part of the higher education institution. I was learning so much more about the human body. I was taking anatomy and physiology and I was thinking that it was just so amazing and I was really loving it and just feeling like I was being fulfilled in the learning. I just loved the clinical part and I just loved the classroom part.

Outside Commitments

Work and family commitments detracted from the ability to perform in nursing school. Darlene shared the following related to her commitments during nursing school. According to Darlene:

> Someone there told me you are a fool to go there (hospital based school). You will never be able to do that and have a kid. She also thought that I wasn't going to work. I was going to work part time. She said the community college has an easy program. I said I can't do that program. I am a very structured person. I need people to say this is due at such and such a time. I give nurses a lot of credit who graduate from that program. I can't do it. The hospital-based people were very good to me. I didn't tell them I was a licensed practical nurse because a lot of students said if they know you are a licensed practical nurse they will eat you alive. I was just there learning. I was working a lot. One of my instructors

said Darlene you better cut your hours down or stop doing all that overtime you are doing. She said how often do you study?

Darlene commented on the difference in curriculum and structure in different types of nursing programs. She decided that she required more structure as a learner. I asked Darlene if the instructor asked her this because she wasn't doing well in school. She responded:

> I wasn't failing. I thought if I had the time and energy I could do better. I was getting Cs. I probably could have gotten Bs. I took therapeutic communication. I told the teacher flat out that I thought this class was a crock. She said now Darlene that is not nice. I can't remember the right things to say. They made us make a video of one of us as the patient and the other one as the nurse. I got a B+ on the project. She said I thought you couldn't do it. You don't realize this but you use this everyday of your life. I said really! Well I guess. I survived it. I worked hard. I worked really hard.

In discussing her daily schedule, Darlene described:

> I would get home in the morning and take my daughter to preschool. Then at 11:30 or 12 in the morning I would go pick her up. Play with her all day long. Drop her off at my Mom's house and go to school until about 9:30 p.m. Then I would pick her up and go back to work at 11:00 p.m.

When asked when she slept she responded:

> I didn't. Sometimes the next morning when I got home. I said this is it. I can't do this. She said well I need you on nights. I said I understand that completely but it's too much. I said you girls convinced me to go back to school and get my registered nurse degree. Now I am trying to work on it. I can't do all these crazy things because I have a small child. So I looked around and tried to find something permanent days.

Darlene was able to find a job more accommodating to her school schedule and her role as a mother. "There was a nursing supervisor and the director of nursing at the time. Her name was Sue. They were behind me 100%. They would work my schedule around school. If I had school in the morning they would put me on evenings and then let me out one hour early so I could get up in the morning to go to school." The very people who encouraged her to return to school were the most unsupportive.

In a similar vein, Juanita discussed the family stressors caused by her going to school. Juanita explained:

> When I went into that program they warned us that for the next two years this is your life. Don't get divorced, don't have kids, don't get married. You just do the program. I was structured I think to do that. My kids where not happy about it. My middle child was still home and she said please can't you wait just one more year till I am gone? I guess it must have been really tough on her. For me to get my degree as a nurse we went through a lot. For a year and a half we were on the waiting list for the apartment I wanted. For that year and one half it was two months with a friend here and two months with another friend. Then we finally got an apartment up on the third floor someplace. First my car got broken into in the hospital and they stole all my stuff. Then my apartment got broken into and then my car got stolen so we didn't have a car for two months. So we went through a lot just to get this.

Kris described similar difficulties in working her way through school with the following words:

> I think it was determination. It was spite to tell you the truth. I also wanted to prove to myself that I could do it. Unfortunately because I had to drop out of college I lost a few thousand dollars. I started putting everything on credit cards and ended up in debt to the cards. My car died on me. I was working as a

> waitress my first semester. Being sacked with a bunch of medical bills. My insurance paid for most of it but not all of it. I did this by myself. I did this for two years straight and I paid for it by myself and I got myself out of debt. I worked three jobs the whole time.

Ed described a curriculum that attempted to accommodate his other obligations. This was a weekend program at a local hospital based program. According to Ed:

> The classes were scheduled more at my convenience. We would go Friday evening 6:00 until 10:00. Then we would go Saturday for eight to 12 hour days. First you would go to the clinical area and then you would have class. It was probably the best schooling I had. The hospital had a weekend program which fit right into my schedule. It was very easy for me to go to school full time and work full time. I had a two year old daughter at the time.

This type of innovative school schedule fit into his outside demands and made his life more manageable.

Chris had some positive experiences despite the adversity of attending school and her numerous outside commitments. She shared:

> Going to school as an adult was kind of good. The kids got to see me study and do homework. My husband had to watch the woman that he thought he knew turn into someone different.

When questioned as to what kind of different, Chris responded "It is just different. It is OK."

Relationships With Patients

Many of the participants in the study indicated that it was experiences with patients that helped them sustain the rigors of nursing school. Jean had been very nervous about going to nursing school after her many years working as a licensed practical nurse. It took her a considerable amount of time to get through school as she took one course at a time. According to Jean, she needed to be very diligent. She explained:

> It took me so many years because of my fear. My sister who is also a nurse had a bad experience in psych. I didn't want to do psych at all. And then the experience I had at the psych unit for 6 weeks was really interesting. I worked with a very withdrawn young man up there. The last day I was there he put his head on my shoulder and I was just so happy that we had connected. I felt like maybe I had a little piece in making him better.

It was ironic that this experience occurred in the very area she feared the most. This action by the patient, as insignificant as it may seem, helped sustain Jean through the rest of nursing school.

Denise shared a story about a patient dying when she was in the beginning of nursing school. According to Denise:

> Almost in the beginning of nursing school I had a patient that passed away. That helped me realize that this is a big part of it as well as helping them get healthy. That had a big impact on me and showed me that this is something that you do. It is just part of living. It is just part of being a nurse. It is part of taking care of people.

Prior to this experience, Denise had worked under the assumption that in her role as a nurse, she would make people better. This experience opened her eyes to a whole new role which could be rewarding in that you can make a difference in people's lives. "It took a while to take it all in and really comprehend it. Having it happen so early in nursing school helped me realize what I could do to help people even in this situation."

Denise experienced another situation that evoked similar feelings. She shared:

> We had one patient here who was comfort care and we were just trying to make her comfortable in her last hours and I just happened to be her student nurse that day and it was hard. This patient was going to go and I was trying to make the family just as comfortable as the patient. She did pass and the family thanked me

> and said they were glad I was there that day because I made it easier for all of them.

The reason that so many of these nurses entered school was the same reason that helped them be successful and continue under stressful circumstances and that was their wanting to help others and their commitment to their patients.

For Maureen it was the ability as a student to do an operating room follow through (what this means is being the nurse for the patient prior to surgery, during surgery, and post surgery). Maureen valued the ability to connect with the patient through the whole process. This connection was her most positive experience in nursing school.

Kris felt nursing school changed her whole personality. She stated:

> I was so quiet before nursing school. I was very shy and timid. Not outgoing at all. School totally changed everything. I think practicing with the patients. Talking with them. Talking with nurse practitioners. I wouldn't even look at anybody. I looked down. Never initiated conversation. The nursing profession in general has had a huge impact as far as realizing I need to be more flexible. Nothing ever goes the way you want it to go. You appreciate every day that you have because just like that it could be gone. It just really opens your eyes to a lot of things. It makes you thankful for what you have.

It was also an experience with a patient and her family that helped change Kris's personality. According to Kris:

> While I was in school I did some private duty nursing for hospice as a licensed practical nurse. I took care of a family I am still in contact with. I cared for this gentleman's wife the last year of her life and I got to know the son and daughter and got to be very good friends with them. She ended up going home with hospice and the family asked me to come in and take care of her at home. This woman had been basically dying for ten years. She started out with breast

> cancer. I remember sleeping on the couch one night with her just screaming out in pain. She just kept yelling. Eventually we got her pain under control. I gave her her last dose of morphine but I was there when she passed away. It was a rewarding feeling to be there for the whole family at the end. It made all my struggles to get through school seem worthwhile.

Bob told a similar story which occurred when he was working as an LPN and still in school to be an RN. Bob explained:

> I had a patient who was a 65-70 year old man who was a former FBI agent with all the images that might conjure up. He had a tumor and they took x-rays and found out that was not the primary site. He also had lung cancer. I spent a lot of time with him and his family. After discharge I kept in touch mostly through e-mail with a couple of family members. I would ask how the patient was doing. The daughter told me that in rehab they were able to get him out in a golf cart. He was an avid golfer. I got this e-mail saying dad busted a window. He wound up going to Maine to live with his son. He became difficult to handle just from his physical size as he became weaker. I got a call one night. The daughter called to say dad's dying and he wants to see you. That startled me because I didn't think I made that much difference. I drove to Maine. It was a nine hour drive. I got there about 6:30 in the morning. I got a chance to talk to him a little bit. He was not directly responsive. He died shortly after I got there. I think he was waiting. As a new nurse you do not realize the effect and influence you have on somebody. It just happens. I was going to miss some school so I left a message on my teacher's answering machine and said I won't be in. I'll tell you about it when I get back. I went to the calling hours, ate a little supper, slept for five hours at the family's house and drove back. I still hear from them from time to time. As a new nurse it is hard to appreciate you make that much difference in

somebody's life. It was just a wow experience because I impacted the whole family. Especially when I was taking care of him as my patient I didn't know I was making that much difference. This has made me much more acutely aware of the impact any of my interactions can have. I find this to be very fulfilling.

Failing

Failing out of nursing school was a concern for many of the participants. Darlene had experienced a failure in nursing school which kept her from graduating on schedule. She described the situation and her feelings in detail in the following passage:

> We had walked across the stage with the day students for graduation. The evening students weren't having a graduation. I said yes! Graduation! It was so upsetting to fail pediatrics six weeks later. I felt like jumping off a bridge. I said I can't believe I worked this hard and had to repeat it. What happened was we were the first evening program and the director came to us and said a lot of you people think you are graduating in July but you can't graduate until December. There is nobody to teach pediatrics. Well we said we have paper work saying that we graduate in July 2000. We said if you do not provide us with someone to teach pediatrics we will all withdraw from the program. Lots of us were calling up other schools. All of a sudden they came up with an adjunct professor. She taught us from another instructor's notes and I guess it is hard to teach from someone else's notes. Two of us failed. She said even the A students didn't do well. Another instructor called me up and said Darlene you are lucky. I said how am I lucky? She said at least you didn't do this in August. Then you would have to wait another year to take it again. I went back in August and I did very well. She said I think you did well not because I'm your teacher but because it was in the daytime. She said I could just see you dragging in here at 4:00 after

working all day. It was very hard to repeat a course when you are so close to graduating. I finished in October of 2000. My classmates finished in August.

Failing nursing school was an extremely upsetting experience for Darlene. She had felt all along that she wasn't smart enough to be a nurse. This just validated her earlier perceptions. To top it off, the failure occurred after she had actually been through the formal ceremony. She was disconnected from her peer group and attended her last class with total strangers. The nursing curriculum is often set up with such sequencing that it may take a year before a class you need is offered again. Ellis (1980) argued that self-confidence and self-esteem, which were higher at the beginning of nursing school, decreased with each subsequent year of the program. According to Arthur (1991) the effects of courses of learning in nursing school on self-concept is a valuable area of nursing research.

I attempted to research national attrition rates in schools of nursing only to find that such data does not exist. In a personal conversation with Dr. Lin Jacobson, the director of research for the National League for Nursing (NLN), Dr. Jacobson stated "There is no consistent or standard definition of attrition rate for schools of nursing, therefore, data cannot be compared." The NLN will be conducting a study in the spring of 2004 related to attrition. Thus, the high attrition rate as reported by the participants in this study has no current measure of comparison.

Entry into the field was an area of interest in this study and focused on exploring how the decision is made to become a nurse. Past nursing research (Stevens & Walker, 1993; Kersten, Bakewell & Mayer, 1991; Williams, Wertenberger & Gushuliak, 1997) stated reasons for entrance into nursing and were quantitative in nature. The findings in this student were consistent with many of those identified reasons such as: desire to help others, having cared for family members, exposure to family and friends in the health care profession, observing nurses in action, and something missing from original career choice, first choice (being a physician) was unattainable.

The qualitative nature of this study added depth to specific family influences that were not always positive and reasons for delayed entry such as the perception of not being good enough to be a nurse. The data on delayed entry is a new contribution to nursing research. The nurses who delayed their entry were quite descriptive of how they needed to "do more," "make a difference," and have a "connection to people." The nurses in this study were supported by significant others to enter the field they had previously felt unable to be successful in. Commonly there was a significant moment in which they felt their life had to change to be more fulfilling and nursing was the answer. The nurses in this study often delayed entry into the field based on these feelings of not being academically prepared or having the right skills to become a nurse. An understanding of the perceived inability to be successful in the profession offers information helpful in the recruitment of nurses into the profession to be discussed in the implications section. Another powerful influence on the delay of entry or why they came back was societal and family influences. Family members often had higher aspirations for their child such as becoming a doctor or having a position perceived as having more power.

This study adds to the literature reviewed as it displays cross-cultural similarities. In China and the United States there was a clearly indicated message that nursing is somehow an inferior profession. In both countries was the perceived need by families to want something better for their children. The subservient role of the nurse was prevalent in both cultures and was evidenced even more strongly in China where nurses are not trusted to do even routine tasks. In all three cultural backgrounds, the influence of family was strong. No other studies of a qualitative nature were cited in the literature related to entry and more importantly why there might be a delay of entry. The qualitative nature adds breadth to the understanding of how families and the society at large are factors in the decision making process. The strength of family influence was evidenced in virtually all the interviews. Quantitative research in the past has not focused on delayed entry nor on how family influences specifically influence this choice.

The nurses in this study had much to say both positive and negative about their faculty. On the negative side, nurses commented on the subservient role they played as students and their sense of competition and fear of failure. They often described being what they perceived as "humiliated" if they did not fit the image. Additionally, they described being placed in an environment in which they could not express opinions and were encouraged to not become emotionally involved with their patients. For many of the participants, this created confusion and conflict as they had entered a field because they wanted to "care for people" and then they were warned to not "care too much." The negative perceptions of faculty were not contingent on ethnic background, sex, age, or level of academic preparation of the participant. The review of the literature supported some of what these nurses said. According to Reverby (1987) training emphasized "one right way" of doing ritualized procedures. Morse et al. (1990) discussed the professional socialization process and the focus on warnings to not get "too involved" with patients. These beliefs are still reflected in nursing education as discussed by the nurses in this study.

On the positive side, some participants felt that the "strictness and rigidity" of faculty challenged them to do better. The high expectations and the challenge of "raising the bar" enhanced the capability of these participants. Behaviors that all participants found to be helpful from faculty involved being clinical experts themselves, telling stories of their own experiences, and fostering critical thinking versus a focus on one right answer and one way of doing things. Many participants commented on "reasoning out" and "empowerment" as qualities in faculty that helped instill leadership and self-confidence. The data in the study add depth to the understanding of the influence of nursing faculty on the professional identity of nursing students. Many nurses discussed fear, being anxiety ridden, feeling devastated, crying all the time, not sleeping, and feeling as if they were a "bad nurse."

All participants commented on the difficulty of the nursing curriculum and the need to be always studying. Several participants described being "anxiety ridden", being exposed to what

they perceived as "illogical and unfair rules in the clinical situation" and the powerful position of faculty in the grading process. Many commented on the high attrition rate in nursing school and the sense that peers were unfairly singled out and failed. Outside commitments such as working, families and lack of sleep detracted from school performance for several of the participants and many described a sense that "nursing school becomes your life, it consumes you." Innovative schedules such as weekend programs were identified as helpful with outside commitments. Relationships with patients/families helped participants sustain the rigors of nursing school and allowed many to continue. Many nurse participants described the issue of failing and how difficult in then became to continue in school related to the sequencing of courses.

This chapter has reflected on the difficulties of going to nursing school. Many participates described conflictual relationships with rigid judgmental instructors as well as a difficult curriculum which was all consuming in their lives. Since many of the participants were adult learners, they were additionally struggling with responsibilities such as work and families. Relationships with patients and patients' families were often described as instrumental in motivating the participant to stay on track and persevere. This data contributes to the identified lack of research of how the experience of nursing school encompasses difficulty in navigating the curriculum, fear of failure, anxiety in clinical work, and lack of positive reinforcement from instructors.

Chapter Five

Joining the Profession

Several critical points of movement emerged in negotiating joining the profession of nursing. Many nurses described the passage of nursing boards and the subsequent attainment of professional licensure as a point of movement requiring an increase in responsibility. Passing this test (boards) leads the nurse to the next professional step of "being in charge." Charge is a responsibility reflected upon by many nurses. Once one is in charge one is considered to be a "senior nurse" with the added responsibility of leading other nurses and taking responsibility for all care delivered. The responsibility of charge was espoused as early as Florence Nightingale. According to Nightingale (1969) "Being in charge is making sure that what ought to be done is always done" (p. 29). According to Nightingale (1969) "Negative results are often traced to such want of someone in charge" (p. 41). Thus, there is an early and continuing sense of responsibility for the safety and excellence of care delivered to the patient.

In this chapter, I will explore various passages or points of movement experienced by new nurses as they negotiate joining the profession of nursing. Passages addressed are issues such as "finding your niche," orientation, taking boards, learning change, "putting it all together," and "moving on." Within all of these passages the importance of relationships was identified as paramount to a successful transition. Themes of responsibility, learning and perfection were pervasive throughout all passages and were presented by the participants as an integral component of professional identity.

Finding Your Niche

The dilemma of role adjustment for the new graduate nurse has most often been resolved by the new nurse's adopting a role that fits comfortably with the rules and regulations of the employing institution (Green, 1988). Part of this process for the new nurse is finding a comfortable environment within which to practice. French and Kahn (1962) contended,

"Adjustment always depends upon properties of the person in relation to properties of the objective environment" (p. 45). Thus nurses' abilities and needs must be congruent with the environmental requirements and rewards for them to cope with the environment as well as to obtain job satisfaction (Takase et al., 2002).

According to McConnell and Dadich (1999) the importance of the work environment is stressed in "validating the professional self." "Validating the professional self is the important ingredient in professional identity and is a process that begins with challenging abilities and career choice"(p. 12). While there is some congruence related to identity development being a process and part of an internal sense of self, research indicates a lack of data related to influencing factors (Green, 1998; McConnell & Dadich, 1999).

"Finding your niche" involves finding a place where your values and skills successfully fit with the people with whom you work and the environment within which you practice. It also means negotiating the transition from the world of school to the work world. Involved in this transition is developing a beginning sense of what a nurse is and does and how does this compare to other health professionals around you. Lastly, "finding your niche" means negotiating the conflict of caring within the context of the work world.

The nurses in this study identified the importance of finding a work environment within which they felt comfortable or what they referred to as "fitting in." According to Denise:

> I chose this hospital because they were offering day/evening positions. I didn't want to work the night shift. The pay wasn't as good. I liked it because it was a smaller hospital and the people seemed friendly when I came up here. I had my interview and by the time I got home there was a message offering me the job. That made a big impression on me. The other hospital took a week to get back to me.

Maureen interviewed at several hospitals and chose one based on "the sense of family" and the following attributes:

> I don't know if it was because it was a smaller hospital. It was close to home and it had a good reputation. Smaller didn't really matter. Actually, when I interviewed the other hospitals...Actually, I interviewed one hospital for Outpatient Dialysis. There was also another medical floor, but they never got back to me. I remember not hearing back from them for about two weeks.

Again "fitting in" involved a sense of family and quick response to her application. Having a good reputation was an additional factor in feeling comfortable.

Juanita identified the right fit for her. She explained:

> I have had days here that were like wow it was fun. Even though we have the same problems and we are short staffed we are still happy. I heard a lot of angry people over at the other hospital. Most of the patients are just so grateful because you have people who care here and you can see that they take that extra step to do something extra for the patient. I can tell you that the family members of the patients up here are not unhappy with the care. It is pride. It is working to the best of your ability. I feel more professional here than at the other hospital. I can present myself like I know what I am doing. At the other hospital you are perceived like a baby. Here I am seen as competent. People ask my opinion and that feels good.

Juanita had a bad experience with her first choice in hospitals. Being happy, feeling professional, and delivering quality care to patients and families are important ingredients for Juanita to "fit in." Juanita shared the following when describing the original place she worked:

> I was a hard worker. I felt like I really wanted to care for people. I thought I could find where I fit in. I am not some fly by night person. I knew what I was looking for and it was very rigid. There is a different attitude here because I think they are willing to be more flexible.

Ed felt that in his experience as a paramedic he had the "inside scoop" as to how the local hospitals function. He said:

> As compared to hospital x there really is no comparison. I don't know if that is really related to working overtime or the stress of being nurses but...and at hospital y the nurses were unfriendly and I knew some of the nurse managers and I was not impressed with their credibility. I had an advantage over other people as I knew the inner workings of the hospital.

Juanita felt a conflict involved in leaving what is known to make a connection to something that "fits". Juanita described:

> I came here and spent a whole day following someone around. This was on a day off at the other hospital and before I had made my decision. I came to the open house and I liked what I saw. It just feels different. I know people are frustrated working on some of the floors but it is a different kind of tension. I love the other hospital. My kids were born there. My grandchild was born there. In all these years I have never been any place else. It was like leaving Mom. I was scared to death.

According to Kiger (1993) for nursing students confronting the issues of graduation and subsequent employment "A feature that underlay many of the students' accounts was a notion of belonging" (p. 311). The importance of belonging was stated as being "As one took on a nurse's identity as one moved to the inside of nursing, and one's life and self would be changed thereby" (Kiger, 1993, p. 311). This need for a sense of belonging was reflected in the data. Another factor influencing a sense of "fitting in" was the ability to feel your capabilities or skills were consistent with those required in the location of practice.

Maureen and Denise described the need to focus on medical/surgical nursing first. This is something commonly referred to by instructors that in order to become a competent nurse you need to first perfect your skills in basic medical/surgical nursing instead of going into a specialty.

According to Kiger (1993) student nurses images of nursing as connected to adult medical/surgical nursing as typical of real nursing persisted throughout entry to training and through early clinical experiences. Consistent with this finding, Maureen stated: "I was interested more in surgery so I think I narrowed it down to two hospitals as being the best ones for surgery."

Denise's words followed a similar track as she said:

> For now I am in med/surg. I don't want to say to get it out of the way but I want to get a year of med/surg experience just so I can get my skills up. My instructors pretty much told me to do this. They always said get your year's experience of med/surg and then you will be well on your way to whatever you want to do.

Greenberg and Levine (1971) found support for their hypothesis "that male nurses choose less intimate specialization areas within nursing (administration, anesthesia, and psychiatry) in order to manage role-strain within a female dominated profession" (p. 421). Likewise Egeland and Brown (1989) found preferences for working in areas considered congruent with the male sex role (administration, emergency, anesthesia, critical care, operating room, psychiatry, and occupational health) was "striking and stable over time, from student days to established career" (p. 705).

Alex's description was consistent with this theory. According to Alex:

> I had done floor nursing as a student nurse aid and it just wasn't for me. It was the acuity level just wasn't enough. It wasn't interesting enough. I wanted tubes and drips and all this stuff going on. By doing some shadowing experiences as a student nurse aid with some of the intensive care nurses I saw where I could fit in.

Alex is currently attending school to become a nurse anesthetist. Ed was a paramedic within the Emergency Medical System prior to entering nursing school and began his nursing career in a

medical intensive care unit. Bob's story is not consistent with this theory. However, he is working on an orthopedic unit where physical strength is necessary in assisting movement of patients.

Chris felt her location of work choice was connected to family history as well as perceived skills.

> My dad had a heart attack when he was 45. He was in the intensive care unit at another hospital for several days. Having always wanted to be a nurse, I said if I ever get there I would like to be a cardiac (heart) nurse because I was so fascinated by everything that happened. I knew from what I had read that family history is important in your own health. Being a student and working in the intensive care unit, I realized I didn't want to be like them and I didn't really want to have to learn the monitors, the machines and to do all that. That technical part didn't interest me as much as being with patients and talking with them.

Debbie described a situation of having made the wrong choice of where to practice. Debbie had spent many years working as a licensed practical nurse in the dialysis unit of the hospital. Upon becoming a registered nurse, Debbie felt that she wanted to try something different. Debbie used the following words to describe her perception of this situation:

> I physically could not do it. I was so tired and I don't know if it was because I was studying for state boards or whether it just wasn't for me. I think it is a great thing and someone needs to do it but I think it is kind of hard. And then there was my age. I was 44. It's a lot different than when you were in your 20s. You can acclimate to things more easily, you have more energy, you really do. The nurses that were up there that were my age did OK with it. They had been there for 15 years and they were used to it. It is like for me in dialysis. When the 20 year olds come to dialysis they just assimilate as things change. But to come in

> to a new field at that age I just couldn't physically do it. I just couldn't do it and I got frustrated and it was uncomfortable for me because it was new.

Others around her felt she was doing OK but the lack of knowledge of the new area after many years of practicing as a licensed practical nurse contributed to making this environment uncomfortable for Debbie. She explained:

> My manager knew that things were not going quite well but she kept saying not to worry that I would catch on. I just said that this is serious and I can't stay in intensive care. I really felt desperate. Again I liked the people but I just couldn't work there. I dreaded to go to work. I was losing interest and I wasn't happy. I just felt like I was in a holding pattern. I just wasn't advancing. I knew I wanted to leave. They wanted me to stay and stick it out. They kept saying that I could do it. My manager called my ex nurse manager and arranged for my transfer for me. My ex nurse manager called me up the next day and said do you want to come back?

When asked how it felt to leave, she replied:

> I felt a little bit beat when I left. As far as nursing I felt like maybe I didn't do the right thing. I felt like a failure. Yes. Everyone that I talked to when I said I was going up there to work said oh you will do fine there because you have been in the dialysis unit. It is a lot different. The acuity of the patient is a lot different. In our unit the patients are very sick but they are chronically sick. And it is different. I thought I would catch on easier.

While it was hard for Debbie to leave, she felt like she had done the right thing. She perceived that her skills did not match the new work area.

Corwin and Torres (1962) offered evidence that the discrepancy between the idealistic portrayal of the nurse's role in nursing school and the reality of the hospital situation can lead to

disillusionment. According to Valiga (1983) critical thinking and problem-solving skills are important outcomes of professional socialization. Valiga (1983) stated:

> Nurses who engage in professional practice must expand their cognitive or intellectual repertoire from one of following orders of others to one of making independent nursing decisions they must think broadly and be able to make sound judgments and decisions in practice (p. 116).

According to Mathews and Goul (1979) critical thinking involves the cognitive skills of comprehension, application, analysis, synthesis, and evaluation. Saarman et al., (1992) stated, "Learning to think critically is generally regarded as a major goal of academic instruction" (p. 28). If this is not fully accomplished in school it would seem that the transition from school to work and the resultant expectations would be difficult. Coudret, Fuchs, Roberts, Suhrheinrich and White (1994) stated "Differences in the education/practice dichotomy often become evident when students first assume the full practical role (p. 32). An abrupt unsupportive change may result in reality shock that can paralyze and undermine the novice nurse and ultimately weaken the profession itself. Many nurses in this study commented on the difficulty of this transition. According to Julie:

> I am a new graduate nursing student. I graduated one year ago. Everything was new. I learned a lot from my clinical work. From nursing school I think something is different. Nursing care for the patient is different from the textbook. Actually I really enjoy working with the patient. It is just different from school.

Julie's response when asked to elaborate on what was difficult:

> We would read the text and take a test. It was just multiple choice. Yes or no. Sometimes when you are doing your clinical work you have six patients – seven patients. At the same time you have a lot of answers to these same questions. What is the best for the patient sometimes you need to make a choice. I think I

> appreciate what I have learned from the university. In school they put an emphasis on critical thinking. We need more experience to make hasty choices for the patient because the textbook doesn't tell you there is a difference between these two kinds of patients.

In discussing her transition from nursing school, Chris replied "you can go to school for two years and you put in all that energy, all that time and you get here and you still feel clueless." Anita found that the technical approach she learned in her Associate's degree program allowed her merely to follow doctor's orders. In order to look at things from a "professional perspective" she needed to get her bachelor's degree. Anita explained:

> At this school they focused more on technical skills. I think that my bachelor's degree gave me a more rounded focus, looking at it from a professional perspective. Most of the nursing process at this school was based on doctor's orders. In my bachelor's program we learned more about nursing theory. It made you feel more like a professional person. A professional person has more knowledge and brings more to the table. I guess I see the whole picture now.

Alex felt that he was unprepared to deal with psychosocial issues when he graduated. Nurses commonly refer to psychosocial issues of patients and families. This basically means interpersonally dealing with the emotional and spiritual responses to illness. Alex stated:

> I think the hardest part was to take the first step. I had to tell myself that I do have something to offer this family. I have many technical skills down so now I can focus on the psychosocial stuff or on the family.

Since Alex chose to work in the surgical intensive care area, his skills in helping families deal with stressors were quickly called into play leaving Alex initially feeling what he labeled as incompetent.

Denise described how she felt about herself as a nurse as she entered the work world in the following way:

> Prepared but unprepared. I was prepared because I knew about all the different things but it was hard to put them all into practice and take care of the patients and have all that responsibility. In nursing school you always had an instructor watching over your shoulder and watching every move you made. They would never let you do something wrong. No one was looking over my shoulder as I actually became a nurse and was out working on the floor. I kind of had people to ask questions but you still felt like you were kind of on your own. I believe that my skills have come along. They are more refined. My knowledge base is much more in depth then they let you know in nursing school.

According to Alice, "there is not enough time in school to do what you need to do. It is when you get out of school that you put it all together. We need to like all that stuff we learned in college and apply it all the time."

For Chris the hardest part of the transition to becoming a nurse was clarification of the professional role itself. Chris shared:

> When I was talking to my brother-in-law who is a nurse about going to school to be an LPN. He said no you're not. Don't even bother. Just get your RN and get it over with. It was funny because I said what is the difference between and RN and an LPN and I have yet to meet a nurse to describe to me what is the different.

Later she said "Yes it is education. Critical thinking and nursing process. I know now that LPNs don't get that piece. But my brother-in-law couldn't describe it. Where he works he has little contact with LPNs." "There is an underlying theme of professionalism and responsibility. It isn't taught but it is expressed."

Chris described others telling her that she was going to be a good nurse and her sensing that in others. She was unable to put into words what is a good nurse. Another nurse said this to Chris about her decision to work on the evening shift:

> She said that is the best decision you have ever made because you are just going to learn so much on evenings. You are going to have to take everything you know and organize it and you are just going to learn. You are going to make mistakes and it is OK but you are going to be a good nurse. You have what it takes. I still don't know what that means. It is a gut thing probably because we can't identify those pieces of a person that make them a good nurse. I can't describe how I know this. I remember one nurse that I said to other people, she is not going to last, she is not going to be good. And a patient ended up dying because she did not recognize what was going on.

Anita described a similar difficulty in trying to establish a nursing identity:

> I'm not sure whether the theory preceded what I do or what. The theorists are much, must older than me going way back to Florence Nightingale, but you just wonder if the whole premise of nursing is about trying to identify ourselves as a professional. I think that is where the theory comes in is trying to figure out who we are and what we do.

This blurring is what is a nurse and what qualities determine a good nurse further complicated the early days in the nursing profession. As nurses began to work in the areas they chose and within which they felt comfortable, the orientation process began.

Orientation

Orientation is a process of learning the policies and procedures, rules and regulations, and role expectations of your job. During this process, nurses are typically oriented by someone called a preceptor who is a fellow nurse with more work experience. Preceptors are obligated to teach the way to do things as well as to determine the competency of the new nurse to accomplish basic job requirements. Orientation was a process referred to by all of the nurses in the study. Some felt it was a good experience while others felt very negatively about it. One critical determining factor as to the success of the orientation process was the relationship with the

preceptor. Mayer (1983) stated that the role-making process is enhanced if the one being observed is a role model, someone who can provide assistance and instruction on how a role is to be fulfilled. Riggin (1982) saw this as a problem in nursing because there is a dearth of consistent role models. Fauler and Rose (1987) suggested that nursing staff role models may have a greater impact on practice then the academic and clinical information gained during the educational process. Roberts (1983) labeled the term "horizontal violence" to express the feelings of self-hatred prevalent in nursing. This concept of self-hatred has been associated with a phenomenon labeled "eating our young" in which nurses are not supportive to other new nurses. The concept of "eating our young" was prevalent in this data.

Juanita had a very difficult transition in her first job. Her orientation ended up to be unsuccessful. She explained:

> I guess as time went on I wasn't real pleased with the orientation. At the time they were just switching assistant managers. The assistant manager that was coming in had some wonderful ideas but she started around the same time I was finishing school. I think they had a lot of expectations for me because I had been on the floor as a student. When you transfer into that role there is a lot of assumptions that you know how to do things. I happened to be in a position of getting a patient ready for knee surgery. I didn't know about the scrub out. My preceptor's response was you have been working this floor for how long and you don't know how to do that? I felt like saying I just started as a nurse!

Aside from lack of a role model for orientation, Juanita felt like many nurses had an attitude and were not willing to work with you. She described:

> There are areas sometimes you need help with. When you have seven patients, you have two people being admitted, and two coming back from surgery it is too much. You have all these things you are doing plus doing all your paperwork and everything the patient needs. It is almost impossible. I lost 20 pounds in two

> months. You could walk in and realize who you were going to work with and say I'm never going to make it through the night.

Debbie described similar experiences in the intensive care unit. "They would try to test your authority to see if you would back down when you had made a decision or something. There is usually a lot of testing that goes on to see if you really know what you are doing." Debbie also indicated there were situations in which her preceptor left her alone in a situation she did not feel competent to handle as she explained:

> One day I was helping an anesthesiologist who was putting in a line. He said you are supposed to be working with me so help me. I guess that I was supposed to be watching the monitor. My preceptor left me and said you will be just fine. This was the first time I had ever done a line with anyone. So she left and the doctor got quite upset that I had not been watching the monitor. I just felt...well number one I felt like I had been let down by my preceptor because she really didn't go a good job of orienting me.

This lack of support during orientation was ultimately what caused Debbie to leave this unit.

Maureen described differences in her orientation based on what shift she was working. She stated that "the night nurses are different" and also stated:

> The day people are open to questions. I still didn't know what I was doing when I went to the night shift. I felt like I was more on my own. I kind of held back on asking people questions. I wasn't sure if they were going to get upset.

For Kris there was a difference in preceptors as well. She was assigned to two preceptors. She described them:

> I worked with another nurse whose name was Mary and she was just wonderful. She was supportive and encouraging. You could not have a more perfect person. I had two orientors. One was Mary and then there was another one who was very difficult. I just thought she was trying to kill me. Everything I did was wrong. I

> got to the point where I would speak up for myself. She then totally degraded me in front of my co-workers. Her non-verbals were really bad. She would be looking all around and not making eye contact right in the middle of what you were saying. I just started totally blocking her out. I didn't listen to her anymore.

When asked how she survived this preceptor, Kris responded:

> I went to other people on the floor. I found out that she was not a very well liked person. She was very backstabbing also. I just thought when you have a new nurse on the floor why would you do something like this? What really irked me too was that she takes credit today for the kind of nurse that I am. Someone was commenting on how I was a good nurse and she commented of course she is because I trained her. Several people have told me that.

Karen felt these behaviors have continued on her unit with new nurses. Karen said:

> When we have new nurses on the floor the nurses usually give them a hard time. There are a few nurses on the floor that maybe had it happen to them and they say no this is not the way. If somebody is doing great it is OK to go and tell them they are doing great.

Karen had occasional experiences with nurses that were positive and encouraging but were far outweighed by the bad. Karen described:

> You are going to be a good nurse. Pick me up. Those people I remember. So I always try to do that to. You need to become a successful nurse and get through those initial experiences because a lot of times it can be very discouraging. You are walking in a set of shoes and now it becomes a whole new world. People don't understand that it is OK to make a mistake. I think a lot of people get discouraged and drop out.

Karen had many thoughts about why nurses are not supportive to new nurses. She shared:

> Personally I think it is a self-esteem thing. I think they don't have a good self-esteem and they are worried. I always feel that you do not lose knowledge when you give it to someone else. If they have knowledge it doesn't make you look less. They have to point out when other people make mistakes. Write things up all the time. I know some people that do that. They say well I had it hard and I had to pay my dues. I just think that is not right. That is not it. It is too bad you have to go through that. It does not have to be that way. I think it is self-esteem but I also think it is they want people to go through what they went through. The weird thing is most of the people that do this, they are good nurses but they are the ones that stay. You feel comfortable with where you are and you just want to stay there.

Nurses tend to repeat the bad experiences they had as a new graduate with future graduates almost like a pay back system. Karen has also noticed that nurses who partake of this behavior are also resistant to change and stay doing the same job in the same location throughout their career. She perceived a connection between these behaviors and felt the link might be a lack of self-confidence.

Karen felt that some people are good preceptors and some are not and nurses should have a choice about being a preceptor and who their preceptor is. Karen described:

> My manager is really good about that. Most of the time people are happy with who they are with. Sometimes they say oh she is so mean or she doesn't give my any input. I know what I would do if I were a manager. I would choose certain people and send them to the preceptor workshop and that would become part of their job description. Not everybody likes to do it. There are people who have to do it that really don't want to do it. Sometimes there are a lot of people on our

> floor that have to be oriented and there is no option. My manager is very open to orientees telling her what is good and what is not.

Alice described a situation in which she was terminated from her first job. She blames this termination on her poor orientation and racial discrimination. Alice did not successfully complete her orientation and subsequently became clinically depressed and required psychiatric treatment. She described the situation:

> Very bad things happened there. My feelings were very hurt. It was just a terrible experience. The hospital is bad. As a new person on the floor there was no one who asked me if I understand. I felt like people could not understand me. I had a lot of problems there. I made a lot of errors. I just don't want to talk about it. The floor was very short staffed. The manager did not have enough staff on her floor. Nurses floated from other floors. I was not oriented and I was on my own with other nurses unfamiliar with the floor. The blood sugar was very high on the patient. There were a lot of nurses involved in this situation. Because I was the nurse who worked Friday night I got blamed for it. The patient was not treated for the high blood sugar. I also gave the wrong medication on another occasion. The people were fine. The supervisor wasn't.

Alice's perception was that in this situation she was not oriented properly, the unit was understaffed, and other people made the same mistakes. The end result was she felt such a sense of failure that she became depressed and temporarily dropped out of her master's program. She described:

> I was demoralized. I was not given a chance to explain. They didn't care that others had misunderstood the dialysis instructions as well. These were my patients. I wanted to do the best things for them. The manager has a problem with minorities. Inside she just hates minorities. You can see it in the way she looks at you.

Denise described a favorable initial response to orientation:

> I was nervous but they were very open, very receptive. Their orientation was very good. We had speakers on every different part of the hospital. Security etc, the orientation was great. The period of time on the floor was good because I looked into other orientations in other hospitals and their orientation was only four to six weeks. Here it was a full eight weeks rotating both shifts so that was good.

Once Denise was out on the floor taking care of patients things seemed different as she described:

> Once you get out on the floor you learn that not everyone is pleasant. Not everyone is a young nurse. Not everybody is receptive to somebody who is asking questions. Some of the patients would look scared when I was asking somebody questions about what I was doing. Like does she know what she is doing?

The inability to feel comfortable asking staff questions was a problematic situation for these new graduates as they did not yet feel comfortable in their competency as a nurse.

Alex felt favorable about his orientation. He described.

> I think my confidence has just grown in leaps and bounds. I think that it just has to be that way. When I started to work here I was afraid to put one foot in front of the other. I was scared to walk into a patient's room. I think having a preceptor was important because they just kept asking you good questions over and over until you got it.

For Alex a good preceptor made all the difference in how the orientation proceeds. Alex perceived a difference in orientation related to the nursing shortage. He described:

> The new preceptees are working on nights where they have to do a lot of technical skills and they are working with people who do not know how to do the things to help them out. On the day shift they do a better job of freeing up the

> preceptor to precept. On the night shift you are usually shorter staffed and you have to take your own patient assignment. It may only be one patient but you still have to do that plus take care of the preceptee who is three months out of school, whereas on the day shift, at least it used to be that way, the preceptor did not have to take an assignment. On nights they also have to take care of the preceptee's patient and that is a big difference. Especially here you are on the night shift and you are precepting and you are expecting a certain level of competency, at least that is the way they came to you in the past. You now have to teach as well. That slows everything down.

Sometimes nurses who are pretty new themselves are pushed by management to orient others. Alex himself, a year out, has been asked to precept others as he described:

> I am not a preceptor but I have precepted out of necessity. You know I have gone to give meds with someone when a preceptor doesn't have time. I have even seen people who graduated with me put through the preceptor class under the guise of well you are newer so you will relate more to the new grad. At the same time it is hard with their level of experience to precept.

Some nurses reported having what they referred to as a good preceptor. Maureen stated:

> It was overwhelming. I had a good preceptor here. When I was on my own, she would want to oversee everything I did; even if I said I knew how to do it, she still wanted to watch me.

Nurses commented on "being watched" as a good thing. The nurses in this study felt more comfortable with a longer orientation and an attentive preceptor. Maureen continued to say "Probably the first couple of days we just followed around a nurse. We have a good thorough orientation here – it's ten weeks long. They start you out by following a nurse, they kind of work with you that way."

Like Alex, Maureen commented on a difference in support one receives from different shifts:

> I was scared. I was a fresh nurse and I was kind of on my own. I kind of got comfortable in my position and my nurse manager asked if I wanted to switch to evenings. At first I said I didn't want to I said no. I don't know why. It gets kind of busy on days. You have a lot of patients. On evenings you don't have any beds and baths to do but you get admissions and people are coming back from the Operating Room. If they have been in the Emergency Room most of the day they will come up to us at 3:00. Evening staff works as a team.

Bob had worked as a licensed practical nurse and then became a registered nurse on the same unit. He stressed the importance of receiving a whole new orientation for the new role:

> I went through a complete orientation process as a registered nurse. I learned a lot along the way. I thought I knew a lot as licensed practical nurse but I really didn't. It was a growth period. I think I learn through experience. By doing it. Through life experience. My first six months out of nursing school I survived on life experience not on anything from school. It continues to help me. If a patient shrugs you off for whatever reason, just too tired or whatever. I think life experience is a huge plus.

For Bob, he needed to learn through experience. Recently Bob made a job change and has been somewhat frustrated with his orientation. He feels he is being observed doing things he has been doing for some time as he described:

> The preceptors say I know you know how to do this but we have to go through it any way. I think they make us all jump through the same hoops no matter what our past experience. Five years from now if I'm still here and I am orienting someone with experience, I don't think I will do it to the same degree. My preceptors have been able to listen to my concerns about this, that and the other

> thing. I say if this is the way we are supposed to be progressing why are we doing this as opposed to that. Usually we are able to come to some sort of happy medium along the way.

He was finding that his preceptors were willing to work with him on this.

Throughout the data presented in this section, the importance of a good orientation process was stressed as a solid foundation to enter the profession. When the orientation process is not successfully negotiated, it can result in voluntary or involuntary termination with resultant feelings of anger and a sense of failure. Things that were identified as helpful were preceptors who were open to questions and available to help, teamwork, life experience, and time. Alex identified what he considered to be a disturbing trend that preceptors are now novice nurses with little experience themselves and numerous other demands. He feared the result was a poor orientation as well as nurses not prepared to enter the profession. All too often in the data, nurses identified a lack of support within the system as well as from their preceptors.

The Conflict of Caring

Patricia Benner (1984), in her descriptive study of nursing, as practiced by experienced nurses, identified the central place which caring, "that is a committed, involved stance in nursing practice, holds in their practice" (p. 170). As Graham (1980) argued "caring is not merely an identity, it is also work" (p. 13). As Graham (1980) noted, "Caring touches simultaneously on who you are and what you do" (p. 13).

Reverby (1987) argued, "Because nurses have been given the duty to care, they are caught in a secondary dilemma, forced to act as if altruism (assured to be the basis for caring) and autonomy (assumed to be the basis for rights) are separate ways of being" (p. 5). According to Reverby (1987), "Nurses are searching for a way to forge a link between altruism and autonomy that will allow them to have what has been referred to as a "caring-with-autonomy" (p. 5). Several of the nurses in this study referred to this dilemma in the "conflict of caring." Anita was the most articulate and passionate about how the theory she has learned in school related to caring

is in conflict with the structure of her work setting. Anita was currently in her bachelor's program and was learning more about the theoretical aspects of caring. As a result of what she was learning in school she felt she functioned somewhat differently that other nurses she worked with. She described:

> I look at patients as individuals. I know some people look at them as the heart in room 10. I just have never been able to refer to a patient like that. I have been able to tap into what is really different about them. For example, when I was listening to report (information about patients given to nurses starting a work shift) this morning I am wondering how their day went. Did they sleep? I think this is very basic but it is an individualized approach to care. I don't give report and say things that are not pertinent to that patient. So I think I give like a lot of individual care. So I really try to apply what I am learning to my care.

Anita discussed a theory of caring she was learning in school and how difficult it is to carry out some days at work within the work structure. Anita shared:

> Watson's theory is a very unique caring for the person. I guess for her it is like connecting with someone. Like I said before it is just a genuine caring for someone. You are caring for them physically and psychologically. It is an all around approach. It is a natural approach to a person. She goes from the premise that a patient knows when someone is genuine. Her caring practice can be for me like some days I care, some days I don't. I think that really is a combination of where you come from or just what kind of day you are having. You could be having the kind of day where you just want to get your job done and go home or you could be having a day where you really care about them.

When asked to describe how she as a nurse views caring for her patient, Anita shared the following:

> I think there are different levels of caring about someone. I think that I genuinely care for people but I think sometimes it is almost like we are crossing the line. I don't want to cross the line or be the patient's friend. Which is not bad but we need the kind of relationship where we can walk away. I have had patients say oh call me. You don't want to do that. That is crossing the line. I think you get to a point where you genuinely care for a patient but you are looking back and trying to claim yourself as a professional. You have to have this caring attitude. You know caring is kind of hard to explain.

This "crossing the line" concept was something also addressed in nursing school. Participants mentioned that instructors did not want them to get too emotionally close to their patients. As Anita indicated, as a new graduate she struggled with how much a nurse can truly care for her patient. Anita tried to describe differences in caring. She stated:

> Well I mean for a family member you are there. You would want to hold a patient's hand 24-7 if you could but realistically you can't. With your family it is not like you are obligated. With a patient you have to be there. You have to try to meet all their needs. With you family you want to be there. You know you can call them up at 2:00 in the morning and you know they will bring you to the ER. You know they will provide friendship for you, all the things that a nurse might not be able to supply. A nurse comes in and they want to take your vital signs (temperature, pulse, and respiration) and make sure you are breathing OK. You want to tap into their emotional needs. Like how is your day? That is probably as far as you want to get. I don't want to know too much. You know they are going to take up 20-30 minutes of your time and you don't want to get deeply involved in their life. You have to be there. You want to be able to step away. First of all you have a personal responsibility and second of all you a professional responsibility. Other people look at their patient and they try to

> distance themselves. They don't want to get too involved. It is extra emotional pain. That is what it is.

I asked Anita if she could describe what it meant to get too involved with a patient and she stated:

> They become too reliant. You are almost scared that you are doing something that is not within my scope of practice. You have your license and your scope of practice and you always wonder am I out stepping my bounds? Am I within my scope of practice?

The dilemma of what is a nurse and what do they do influences how able Anita is to care for and get involved with her patients. She described:

> Well it is not written down anywhere. I don't know if it is something that you learn in school but when you go to clinical you are expected to be in and out of the patient's room. Clinical is defined as 7-11. You get your patient and you write up on your patient and then you get another patient. Sometimes you get the same patient but their focus is that they want you to get a diverse idea of patients so they want to give you new patients. So the way you are encultured is that you a four hour block with that patient and you do whatever you can do in four hours and get out. When you get to the floors, the culture is also that you have eight hours with the patient. In that eight hours you can develop whatever relationships evolve but it should only last for eight hours.

For Anita the concept of caring was time limited. Within the hospital structure, Anita said her time was limited with each patient. She described the conflict in caring she experienced:

> It is hard. Now more than ever I just go home. I have other responsibilities. I find myself every once in a while coming back to work and I wonder how did that patient do? Did they go home? Did they do well? Did they make it through their open heart? I just wonder. It doesn't happen too often like it used to. I

> work part-time so I don't work every day of the week. Sometimes I work four to five days in a row and those few times when you do follow a patient...I guess in a way I know I would want that to follow patient from day to day. The patient would say oh I remember you. How are you doing? You almost have that rapport. You don't have that introduction phase. You have already formed an alliance with that patient. The patient is a little more trustworthy of you. You almost have an edge. You are able to identify the patient's condition a little quicker. Maybe even for a long term. In our practice here it is more like let go and move on. But you do come back and you have those patients where you really connect. You not only care for them but you almost are willing to step into that patient's role.

Anita also described the system constraints:

> I think I just kind of got tired of having to worry. Not really tired but more like just stressed. It probably created extra stress in your life and extra baggage. You couldn't care for the patient the way you wanted to care for that patient. I guess you just have to look around in your life and choose what is important. When you come to work they give you a totally new assignment than you had the day before. It is not a primary concern of anybody. They don't say oh they were here yesterday and they took care of this patient. If there is any reason for you being there with the same patient it isn't for their comfort. I have never heard any one say oh the patient is more comfortable with her. Most times what you hear is, were you here yesterday? Did you like where you were? If you enjoyed where you were yesterday then did you want to be there today? They would prefer not to move your assignment but it is never from the patient's perspective.

For Anita the whole issue of caring was a difficult process. She shared:

> It is kind of rough to end the relationship. Most of the time I go home and the only way my patients know that the relationship has ended is because I leave at 7:30. It is kind of sad. I think sometimes I go in and I say to a patient well if I don't see you again have a good day. I think sometimes that the patient doesn't realize that it has ended until the next shift comes in. I think there are a lot of times when they get to like their nurse and it just happens abruptly. The next nurse comes in and just says I am your nurse for this shift. You never know if that nurse that you liked on the previous shift will be there again.

The data in this section clearly reflects conflict in caring, both as an internal struggle and one reinforced by the hospital structure.

Boards

Probably the most difficult passage for nurses in the study was taking their boards examination to become a licensed professional nurse. Nurses generally apply to take this test when they graduate from nursing school. The test is taken on a computer and the test is different for each participant as it goes up or down or stays the same in difficulty depending on the skill of the test taker. The minimum number of questions one answers is 75. The computer will shut off at which point you have either failed or achieved competency. The test taker is not immediately aware of the results and the boards can be taken numerous times. However, there is a time lapse during which you cannot retake this exam. If a nurse fails the exam she/he may have to leave her/his work unit if only registered nurses work there such as in the intensive care environment. Other options might be to work as a licensed practical nurse or a nursing assistant. Passing the boards is an experience that basically means you have made it and you now are a credentialed professional.

The nursing literature abounds with information related to outcomes and predictors of success with the NCLEX-RN exam (National Council Licensure Examination for Registered Nurses). There are virtually no studies addressing what this experience means to nurses. A study

by Lengacher and Keller (1990) in studying academic predictors of success on the NCLEX-RN stated "the student can be affected psychologically if she/he fails. The loss of one's self-esteem can be devastating" (p. 168). Additionally, Lengacher and Keller (1990) stated "There can be effects upon peers and faculty. Peers experience personal loss when they see their classmates fail. Faculty experience loss when they believe personal time and energy was of no use in trying to assist the student to achieve" (p. 169).

Darlene took her boards to be a licensed practical nurse twelve years previously and she had failed. At that point she described being embarrassed and having to go back to working as a nursing assistant. Darlene described her current experience:

> It had been 12 years and back then I took them it was on paper. Now with this computer business. I finished school in October and I decided to wait and take them in January. My instructor said come to my review class. She said you are going to apply for a permit right? (This is to work as an LPN if she fails). I said no I don't want to jinx myself. She said she could understand that. I went to a review class from January until March. I thought about taking my boards in May and then June. A lot of things happened. I got in a car accident. Then I lost two of my favorite uncles. So I said I might as well wait. I waited until July. It took forever to get the results because everyone was graduating from nursing school in May. So I got my paperwork some time in August. I took them and I prayed. I am a strong believer in prayer. My mom told me to knock off the anxiety. She said you were 24 when you took the LPN boards. You were young and immature. So I went in and took them. My biggest fear was of failing. I needed to read things carefully and that was what I did. You are already on edge. I did not sleep the night before. We get there and the place is not even open. There were five of us taking the RN boards. I get in there. They tell me to take off my jacket. I say I am cold and they tell me to take if off anyway. I had to sign my

> name. She says that does not look like your name. I said that is my name. I said is this a test for your anxiety? I went in there and it took maybe a half an hour. I went in at 8:30 and came out at 9:30. I finished at 75 questions. A lot of people said if you finished at 75 questions then you failed. I was just moving along and I looked up at the number and it said 74 and I said oh my goodness I was afraid to go to 75. You hear so many things about the different numbers. So I waited and waited and waited and the next thing I heard...and I didn't tell anyone I was taking them. I found out on a Thursday that I passed. I had all that anxiety for nothing.

The anxiety associated with this experience is apparent. Of note was how badly she perceived she was treated when she went to take the exam. There are centralized learning centers where people go to take all kinds of tests. Many of the people taking exams in these centers are not nurses. Many of the nurses stated that they did not tell anyone they were taking the exam for fear of failure.

Debbie, like Darlene, had taken the LPN boards previously, thus had a frame of reference. She had not failed them, however, her anxiety about this test remained high. She described:

> Well, I had to take it on the computer. When I took my LPN boards back in 1972 it was a written test, all day long. In the morning something happened and they were delayed. There was some kind of problem so we didn't get our results until October. I took it in July so it was a long wait. In the morning when I went to take the test, the computers were down. We were all sitting in this room waiting. It was myself and two other people from my class there together. We ended up starting at 9:30 instead of 8:30. So I know ahead of time that there would be three practice questions and then the real questions would start. So I'm answering these questions and I'm going along and all of a sudden I realize that I

> am taking the state boards and they never told me when they started! All of a sudden I realize that I have answered 15 questions and I said this is it. This is two years of school. I knew I could take them again if I failed but you know to me it would be devastating if I had to do that. So I was doing them and I said these questions are not getting bad, I wonder why. I got a couple of questions that were off the wall. Finally the computer shut off at 75 questions. I said it shut off at 75 that is good (the word has it that if you get 75 questions which is the least possible number, it probably means you have passed the test). Then I started to think that I had probably gotten so many wrong that it just stopped. Well I passed and it really wasn't bad. It is just like a surreal thing. It is like at that moment when you realize that you are really doing this. You have done all this studying and it comes down to this one test. It took about 45 minutes to one hour. That is all it took.

Like Darlene, Debbie did not know right away if she had passed. She described her wait:

> It was kind of scary. It was sort of surreal. I felt like now I should probably feel different but I was a little scared. Actually I tried to get the results through the computer but when I went in it wasn't there. My assistant head nurse went in to check for me. Everyone else was finding out that they passed and she went in to look for me and my name just wasn't there. Finally about five days later she went in to look for me and she found it. I had a class the next day and I got a message to call the unit. My assistant head nurse read off my license number and I said you're kidding I passed! She had gone home to look for me because she knew that I was upset. I thought that was so nice. I was so upset because everyone else's results had come back.

Debbie responded to passing her boards with mixed emotions. She stated:

> It was scary. I felt proud and it felt good. I felt mixed emotions. It was something that I really wanted but now that I had it I was feeling scared. I knew I could do it because I had gotten through school...if you get through school you have such confidence. You might be scared but you know you can do it. Maybe it is just me because I did it and I wanted the responsibility even though I was a little scared.

Denise experienced anxiety related to boards, however, had more self-confidence than other participants in the study. She stated:

> I took my boards in September. It was nerve racking. I was nervous but I was confident. I knew the material. I had been studying since the day I had gotten out of school. I was pretty confident. I had 81 questions. I felt I either did well to get done with 81 questions or I really didn't pass. I knew that I knew the answers to quite a few of the questions.

When asked if she told anyone she was taking boards she responded that she told everyone on the floor because she was confident that she would pass. This was certainly different than several of her peers and possibly indicated a higher level of self-confidence.

The most moving story was told by Amy who failed her boards a total of three times. She described her journey through this process and her feelings of sadness, despair, hope and anger. Amy described:

> There were nine of us on my floor who were new graduates. I took the boards with a couple people that day. I had 265 questions. The full five hours. I failed. I didn't find out for two weeks. Everybody had passed. It was probably one of most terrible experiences I ever went through. Everybody interprets their failing of the boards differently. You do get paranoid. I made myself just take people at face value. I told myself that people were just very sad for me. They didn't think I should have failed. They were very encouraging. Honestly at the time I

sat down for the test I was so terrified I didn't have a prayer. They could have thrown me the easiest questions, things I knew very well and I was never going to pass that test. After 75 questions I started to cry. Just because it was the boards and it was so significant to me. It shouldn't have bothered me so much but it did. I was so sad. Everybody had passed like I said. I had passed everything else at work. Everyone was shocked which helped. That meant that I really shouldn't have failed and I really am good enough. The director of the school was just wonderful. She was surprised which helped me. She said don't worry about that. It is fine. It was tough. I kept working and I started school in the fall anyway. I took review classes all over at the school. About three months later, and almost no one knows about this except my husband, I took it again and failed. I tell you this because it is probably very significant in my development as a nurse. My manager knew. I got 265 questions again and I failed it. I had my two-week notice in my hand and I handed it to my manager. I told her I failed again and I just can't do it any more. It is just too hard to come into work everyday. It is so embarrassing. I just can't tell people any more that I did not pass it. She just looked at me and said please don't do this. I am going to call the director over at the school. She called the director at the school and she told me that it is not the answer to quit. It wasn't. So I stayed and took my licensed practical nurse (LPN) boards and passed them just fine. I got 80 questions, which is the least amount you can get for an LPN board. It was probably because it wasn't the registered nurse boards. After that semester I didn't go on in school. I got pregnant. I probably wouldn't have gotten pregnant if I had passed the boards. I ended a semester at school and just figured that going to school was not the answer at this point. I had to concentrate on boards. I did another review class. I kept studying. This is what people don't know. I took the boards again

> and failed them after 75 questions. That meant that I did horrible on that test. I got almost every single one wrong. When I got my results back, the first two times I was right on the border of passing. The people I counseled with, the instructors, they said don't even study you are very close. No one knew I had taken them a third time. I wasn't even close to the passing line this time. I had taken a course through a local hospital. It was an amazing review course. It made everything look easy. I called up the corporation that had done the review class and the director herself got on the phone. I told her everything that had happened to me. I was getting very emotional. I couldn't even cry anymore. I said to her maybe I shouldn't be a nurse. She said maybe that is true. That was all I needed. I got so mad that she said that. I said well if that is the case or not I am going to take this test until I pass. I have to be relaxed enough sometime to be able to do it. I was just so anxious. I had my LPN license and I said I love nursing. I said I am just going to stay here until I have the baby and then I will rethink it then but I am going to take the test every three months. After that I was talking to my mom and she just asked me when I am going to take the boards again and she said you know Amy I always thought you had a learning disability.

Amy was tested for a learning disability and found that she has Attention Deficit Disorder. She described:

> This really disappointed me because I really didn't want to have a learning disability. I wanted to be so good and I took that as I'm not. I had a really hard time with that. The only people that know that are my mom and husband. I thought that I would just send the paperwork into the boards people from the doctor. Someone from there called me back and said they were so sorry. Anything they could do to help? What do you want? What do you think you need? I wanted a private room and I did not want to see that clock tick down for

> five hours any more. He said that is done. I did not study for four months. I did not open a book. I tried to do other things rather than obsessing about the boards. So four months later I had read through the book the director of the boards course had sent and I had done some questions and I sat in a private room and I took 101 questions and I was done. I passed. It was just awesome. It was over with. It took about two weeks and my husband got the word and told me it is all over Amy. I learned a lot about myself now when I think back to those days and I realize what I need as a person to make myself a success. Still when people give me compliments, I just had my eval today, it was a wonderful eval. In the back of my head I'm thinking I failed boards three times. There is always a little voice inside me that keeps me very, very humble. I know now that I do take care of patients very well. I do understand pathology. I am very safe. I have made the school of nursing proud regardless of failing them so many times. It wasn't about what I didn't know. It was about how anxious I was. I wasn't doing the things that I needed to not be anxious in order to pass the test.

While this experience with taking boards was outside the norm and complicated by the presence of a learning disability, Amy clearly described the influence of this failure on her sense of herself as a nurse.

Charge

The next passage to negotiate as a nurse is that of becoming the charge nurse. The concept of charge is operationalized differently in varying hospitals, however, basically involves the process of leading other staff and coordinating the care for a group of patients. Being in charge was described as a major milestone for many of the nurses in this study, but once again they fought with anxiety and a sense of responsibility. Negotiating this milestone solidified their career as a nurse and meant they were now guiding others as the "senior nurse."

According to Osguthorpe (1997) "The charge nurse is expected to effectively lead a healthcare team in achieving beneficial outcomes for patients while efficiently managing personnel and medical resources" (p. 64). Despite these expectations, "Very little has been published about charge nurses or their role, functions, and competencies" (Osguthorpe, 1997, p. 64). Osguthorpe suggested that the competencies identified by Ortez as desirable for nurse managers are applicable to a charge nurse. According to Osguthorpe (1997) these behaviors include "Clinical competence, knowledge, superior technical skills, trustworthiness, resourcefulness, ability to serve as a role model, personableness, fairness, and supportiveness" (p. 64).

Nightingale's thoughts about charge certainly support the sense of responsibility. Nightingale (1969) stated "Being in charge means what ought to be done is always done" (p. 29). This charge responsibility additionally required that the nurse "arrange that things be done whether you are there or not" (Nightingale, 1969, p. 38). According to Nightingale (1969) to be in charge means "Providing against anything wrong arising out of my absence" (p. 41). Further discussion of Nightingale's (1969) thoughts on charge include the following:

> Results are often traced to such want of someone in charge. It is important not only to carry out the proper measures yourself but to see that everyone else does so too. People in charge often seem to have a pride in feeling that they will be missed. You should be able to deliver everything up to others and know that it will all go on as usual. No one shall be missed (p. 43).

Darlene discussed her role transition from LPN to RN and the main distinction being the responsibility of charge. She stated:

> I am still having a hard time changing roles. I know that I am an RN but I still have trouble remembering that I am an RN. I can take off my own orders, I can put them in the computer, I can write orders. It is hard. Some days I am the only RN on the floor and I am the charge nurse. If we have certain procedures I have

> to do it. I have more respect. They look at me differently. I have already learned charge. There is one RN and one LPN for 18 patients on nights. Charge is horrible. There is a lot of responsibility. When I am in doubt I call the supervisor. I have questions about calling surgical residents. You never know what will happen. I am training for day charge. I am in charge for 18 patients with three to four staff. People are always coming at you with a lot of questions. Families and staff. Everyone is coming at you. Lots of RNs don't work together. There isn't a lot of teamwork. Everyone drops things in the charge nurses lap instead of taking care of things for their own patients. I think they are pushing me to be a charge nurse too soon. Because I was an LPN they are not treating me like a new graduate. They do not listen to me about my orientation. They give me six patients. I am treated differently than other new RNs. I work charge and then they combine charge and patient care.

Darlene however is not alone in her feelings of being pushed too soon as other participants shared similar thoughts. The conception of everyone coming at them and everyone bombarding them with questions is a shared experience. Maureen felt she did not have much of an orientation on how to do charge. She had been a nurse for one year when she was exposed to this process. She explained:

> My manager talked about it a lot. She said she wanted to orient me but she didn't have enough staff. I spent a day just watching a nurse do charge. What I was learning first was charge on the evening shift and then I pushed over to days. They really don't give you that much of an orientation. I had maybe three or fours days. They feel that you should probably know everything. You kind of just learn as you go along with the different problems. I don't think I know half of what I could know.

For Maureen it has been a learn as you go process that instilled mixed feelings in her. "I don't mind it. I kind of miss the 1:1 patient care. When you are in charge sometimes it is overwhelming. The responsibility is great. You are responsible for the whole floor."

Many nurses in this study expressed the sense of responsibility involved in being a nurse. For Maureen and several others, charge instilled the uppermost in responsibility. In her words, "Any little thing that goes on means that you have to do something. You may have to call the doctor. Sometimes when I go home I am thinking did I do everything? Is there something I forgot?"

Amy also felt she did not have much orientation to charge. She said:

> When I came back from maternity leave they wanted me to go right into charge. I had done patient care as an LPN for a year and they knew my bedside care was very good and they were going to throw me right into charge. I wasn't going to do a good job if I was going to feel that anxious. Those aren't my best skills so I knew I needed to get very organized. But I was going to get thrown right into it and I was down there for orientation to charge. I knew it wasn't going to work. That I would not be a good charge nurse if that happened. I got very intimidated but as soon as I voiced my opinion everyone understood that. It always amazes me when people don't talk. There are nurses out there who won't talk to speak up. They are just out there complaining about their orientation. If they spoke up they would get what they wanted. When I talked to my manager she said what do you mean? I said well an intense two day orientation is great but I want someone right by my side when I am out there. Everything that I wanted, I got. The whole concept of charge is definitely mandatory especially on a floor like ours. I don't know what else we would do to run the floor.

Amy learned that if she asked for additional assistance she received it. She perceived that all too often nurses do not ask for help.

A difficult thing identified about charge was the need to make decisions. Amy explained:

> As long as I am told what to do I can do anything. When you are in charge as a nurse you are not told what to do. You have to make your own decisions and your calls. When are you going to call the doctor? What am I going to say to this patient to make them stay here even though they are so angry with the physician and they want to leave the hospital? What can I do to make them stay here because they need to?

While this is a mandatory experience for nurses working a hospital setting, Amy, like others, described the responsibilities of charge as difficult particularly on shifts other than the day shift when staffing is better. Amy explained:

> To organize eight or 12 people's care is your role as a charge nurse. On an average day that is way too many. It is better on the day shift. They have beefed that up a little. I am always precepting new graduates. I always tell them as far as the communication goes that the school of nursing didn't really teach me what my role was related to charge. When I found out what an RN did for charge I found out that I could do a great job. Even go above and beyond. So I was telling the new grad that we are not utilizing the multidisciplinary team the way we should because we don't understand how. I am not the kind of person that understands when someone says no. If I am asking someone for a pain med and they say no I go someplace else. I go another route. No one has ever complained about me doing that. It was kind of the way I did it. I kind of got around things. Nurses don't think they should have to do that. The fact is that is the way the system is. When I figured that out I didn't come home so tired. I did like my job even more. I felt like I was doing a good job. I think people get out of hospital nursing because they feel defeated. If nurses would just stop complaining and put that stuff aside they can look at how the can make things better.

Amy has found ways to work with the system to facilitate making her role of charge easier. .

Kris described the overwhelming nature of charge and the consistent perception of so many people approaching you at one time:

> It is hard for one person to keep track of it all. You have one doctor saying this and one doctor saying that and the physical therapist saying something else. There is just so many people. It is hard to keep track of who is thinking what, where, when or why. Some people come up to me and I haven't been on the floor for a week and I don't know any of these people. It is very chaotic. I can't be behind the desk and out on the floor. I would never get anything done. The charge nurse has to make sure things get done very quickly. They are the communication process. The doctors come up to the charge nurse and want to know about patients. They like to go to one person who should know everything. When you have 40 patients it is impossible to know everything about everyone.

Kris explained that she feels nurses come to rely on the charge nurse to take responsibility for decisions they in fact should be making. She described:

> The nurses there have relied so much on the fact that there is a charge nurse. They are basically afraid to do anything for themselves. If they tell the charge nurse then it is covered. If they come to me with a problem I say what do you thing we should do about it? You are a nurse. You have a license. You can make decisions. That is what we need to push. Autonomy. Independence.

For Debbie taking on the role of charge meant the ultimate responsibility. She described:

> I found that the decisions I was making now were the same decisions I was making in my own mind before. I was doing a lot of the same things but I was just reporting them to the charge nurse which is what you are supposed to do. So now I am doing a lot of the same things but I am responsible. Before I had that charge nurse that I had reported off to and she was ultimately responsible.

Like Amy, Debbie felt that other nurses relied on the charge nurse to take responsibility for their actions. Respect for Debbie was a two way process and part of charge involved educating other nurses on how they can work together to care for the patient. Debbie stated:

> When I started out as a charge nurse I just wanted to be fair. I wanted to make people be responsible. I wanted them to be more observant. So I try to teach people what to do and I want them to respect me. I don't want to treat them like they are idiots. I don't want to sound like I am some sort of a super nurse but I want people to feel like their job is important. I depend on them. Maybe they will understand what a professional is. People have said to me that they like it when I am in charge because other charge nurses will yell at them that they are idiots. It's only because they don't know things. They are so new.

Julie's description of the qualities of the charge nurse added credence to what others in the role felt as incredible responsibility for the actions of others. Julie described:

> I think she is a role model for every nurse. If you have some kind of situation that you can't handle the charge nurses will take care of it for you. They help you do clinical work. They are very helpful and very experienced. I like this kind of system because if you did everything by yourself you wouldn't know what is wrong and what is right. Sometimes you look at the charge nurse for how she did it. You can also learn that there is a different way to do things. The textbook just gives you general ways. They don't teach you how to do good for the patients just how to avoid harm. The charge nurse is very experienced and very smart and very efficient. They do things very quickly. They have to do that. Otherwise they cannot handle 20-40 patients.

Karen, three years out, felt that the ability to do charge was something that changed over time and became easier. Karen stated:

> I have gotten a lot more organized. At first I was like how am I ever going to do this? The first two months you have two patients and it is overwhelming. Now I am a charge nurse for twelve and fourteen people. Now I can keep it all in the air and everything is OK and we are all kind of chugging along. So I am proud of that. In my first few days I said I will never be able to do this. It is too much. I can't believe I ever wanted to do this. When you first come out you are overwhelmed by the paperwork and dotting all the i's and crossing all the t's. I could barely keep my head above water with the tasky things let along trying to talk to the patients.

I will explore this process of change in the next section.

Bob described being oriented to charge when he was six to nine months out of nursing school. He described the responsibilities of handling communication, being responsible for the whole unit, being a resource to other people, and handling staffing issues over the next twenty-four hours. Bob described:

> Scary to start with. It was another one of those oh my experiences. There were people there to ask questions. If you were really green there usually was a more experienced RN on the floor. I always felt comfortable to say I've got this going on what do you think? I tried to always come with an idea or suggestion. I would come with my thoughts on the matter and talk it over.

Juanita was the only nurse interviewed who described an unsuccessful transition to the charge role. "All of a sudden they wanted me to do charge." Juanita was asked to orient to the charge role two months after graduation. Juanita did not feel ready and felt like management heard her and were supportive. However, her own peer group contributed to her feeling deficient and guilty. Juanita stated:

> They were very open to me when I said I wanted to hold up. They were very open to that idea but you get a lot of pressure from other people on the floor.

> Other people were orienting. It was tough for them but they did it. Then you get everybody saying well I was only here for two months and I started charge. You get that pressure kind of thing. Then you start to think that something is wrong with me if I don't do charge early. I think there was a lot of expectation because I had worked there as a student nurse aid and they thought I knew a lot more than I knew. From a nurse aid point of view I knew how to handle things but I didn't even know who the doctors were. They said weren't you watching? I said yes I was watching but I was busy running from room to room. They were more than willing to work with me. I just didn't feel comfortable after a while.

Her experience as a student working on that floor was felt to be helpful in her transition to this role. Juanita did not perceive it that way as she described:

> My brain was so fried I couldn't think. At the end of the day you have to give report. My mind wasn't clear enough to think because it was too much for me. I think if they had given me a consistent preceptor and I was not bounced around a lot and if I was given two rooms and let me handle those two. Let me handle that for a day and then give me an extra room. Get used to the doctors names and the patients. Instead they give you around 10 patients and they tell you this one has to go there and we need to clarify this test over here. Sometimes it would get to be a little bit too much. They all said if I wanted to back off they would let me. They were very disappointed when I said I did not want to do that any more. Very early on I made a decision that this was not it for me. Doing charge. I was not able to do that type of nursing. I apologized. They all disagreed with me. Nicely. I just realized that was not what I was looking for.

Juanita felt part of the problem for her was the type of person orienting her. She described:

> Actually the first person that they set me up with I might have been OK if I stayed with him because his style was like mine. He was very calm. I liked the way he presented things. He wrote things down. I write things down. When I went from this preceptor to the next one and I took out my paper to do report they said what are you doing that for? I said because this is how I keep track of things. They said well it's going to confuse people. Somewhere I needed to find my own way of doing it and it was just difficult. I didn't feel like I fit into that position.

Ultimately Juanita decided to leave this unit related to the charge issue but couldn't because of hospital policies and procedure related to transfers. Juanita explained:

> I wanted to just stay there and work. I liked it. In reality I had to do charge in order to work there. I didn't have any choices. I went and spoke with the recruiters and told them where I was at. I kept apologizing the whole time but I just knew. They knew I had really thought it through but because of certain policies at the hospital their hands were tied in a lot of ways. They would not let you transfer to another unit unless you had been there for a year.

Juanita made the decision to leave this hospital despite the fact it would cost her money. This hospital had paid for her school and she was under contract to work for three years. Leaving this hospital meant paying back the contract as well as a stiff penalty. From Juanita's description she made the right choice to leave. At the new hospital she went to work on a sub-acute unit where the patients are not as seriously ill. She described the attitudes about charge as being remarkably different between the two hospitals:

> I don't know how to describe it. The attitudes are different. You have help. I constantly hear people coming together over things that they haven't done in a while. They ask for help. They don't feel ashamed to ask for help. Sometimes people look at me and say she just graduated from school she probably knows

> how to do it. That makes me nervous. It is different because it's doable. It's doable because it is comfortable. I wish I could find a word to describe it. It is just I think that people are happier here. We have always said that we run a really good floor here. I fit with the people here like I have never fit before. Just being me. If I don't know how to do something I ask questions. I don't feel like someone is going to laugh at you or complain about you.

Once people successfully negotiated charge, they began to describe themselves as the "senior nurse." Alex, Bob, and Chris all had stories to tell that explained the thoughts and feelings related to this informal designation. Alex, one year out, was ambivalent about his role as senior staff. In some ways he saw other senior staff treating him as an equal and on the flip side he himself felt unprepared to serve as a preceptor and thus a senior nurse. Alex described the feelings of his peers who work shifts in which they become designated as senior staff:

> If you are just now getting comfortable taking your own two patient assignment, to give you a third now it is like double the work. Not only are you trying to take care of the patient but you are trying to teach at the same time when you have no experience teaching and you are still firming up your own skills. I have been talking to the preceptors who were once my preceptors. I feel like we are more colleagues. They share with me some issues they are having with new nurses.

While Alex obviously had graduated from being the new nurse, he described himself as "sort of a senior nurse." When asked what that meant, Alex responded:

> Well on nights it is a little different because there is always someone around to ask questions. There is usually at least one or two of the really senior staff around. I still have people that I can look up to. Some of my colleagues that graduated when I did are perceived on the day shift as being senior staff. That is scary.

Bob, who was three years out, still experienced being the "senior nurse" as scary but felt more prepared. "That's scary. I'm not really scared. I enjoy it. I feel I have something to share. I feel I have a few gaps occasionally. I enjoy teaching what I know. I enjoy learning what I don't. I'm just real lucky. That's the way I look at it."

Chris, who was also three years out of school, described similar feelings. She explained:

> It is kind of funny because I have been there for three years. When somebody is new in charge not only do I have the nurses that I am working with, I have all of the new charge nurses coming to me and sometimes I have been put into positions where I have had to intercede on behalf of the patient and say to that new nurse, Come with me, there is something we have to figure out. Thankfully everyone has been good about that. They recognize that I am not trying to make them look bad. That I am trying to help them learn primarily for the patient. I say, Let's look around and see what we have missed. It is a lot. Sometimes I look around and say I do not want all of this responsibility. It is scary to think that there will always be a senior nurse and a new nurse. It is very scary when that nurse is so new. And I am the senior nurse.

Chris also shared that being the "senior nurse" did not always mean being the most knowledgeable or the person who has worked there the longest:

> There have been times on the floor when the senior nurse has not been the most knowledgeable. Some nurses do it and some don't. There are days when the more knowledgeable nurse is one of our newer graduates.

The stories told by these nurses related to the experience of charge reflect many possible stressors. While all the nurses shared that the position of charge was overwhelming, stressful, and something undesirable as it often removed from them from patients, many of the nurses agreed that certain events make it more manageable. These events or behaviors included the following: knowing how to negotiate and change the system, having adequate supports to help

you through the process, having the appropriate timing or amount of experience prior to beginning the process, and having the ability to be assertive in making sure the previous issues are addressed. The success or failure of this experience in the experience of these nurses was contingent on these factors.

According to Miller (2000):

> Far too frequently, nurses with insufficient experience or skill are put into a charge position for which they are not ready. This can jeopardize patient care and undermine nurses' confidence in their abilities. A properly experienced and trained charge nurse will be able to anticipate problems, coach and develop peers and others, and report standard-of-care practices that are not being met.

It is apparent that many nurses felt they were not ready nor had they developed the prerequisite skills or competencies as defined in the literature. Many of the nurses in this study indicated that school did not prepare them for this experience. Perhaps more problematic was the expectation that new graduates can achieve the competencies required of charge so early in their professional development.

Technical → Competent → Whole Picture

Nurses in this study identified a progression of skill development similar to that described by Benner (1984). The title of this section describes this transition. According to Benner (1984) "Clinical knowledge is gained over time, and clinicians themselves are often unaware of their gains" (p. 4). Utilizing the Dreyfus Model (1981) of skill acquisition, Benner developed a five stage model of nursing proficiency development. Stage one, designated as the novice, consists of nurses who have had no experience of the situations in which they are expected to perform. Benner (1984) stated "The rule-governed behavior typical of the novice is extremely limited and inflexible" (p. 4). Since they have no experience of the situation they face, they must be given rules to guide their performance. According to Benner (1984) nursing students and any nurse entering a clinical setting with no previous experience are novices.

Stage two, or advanced beginners, are nurses who can demonstrate marginally acceptable performance. Benner (1984) stated "Ones who have coped with enough real situations to note (or to have pointed out to them by a mentor) recurring meaningful situational components" (p. 22). For the advanced beginner, a beginning understanding develops of how to intervene in patient situations today based on what they remember from past situations. According to Benner (1984) "Competency, typified by the nurse who has been on the job in the same or similar situations for two or three years, develops when the nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware" (p. 25-26). In this plan the nurse is able to distinguish what interventions are most important and which ones can be general. Benner (1984) stated "The competent nurse has a feeling of mastery and the ability to cope with and manage many contingencies of clinical nursing" (p. 27). The competent nurse is Stage three.

The proficient nurse (Stage four) "Learns from experience what typical events to expect in a given situation and how plans need to be notified in response to these events" (Benner, 1984, p. 28). In the final stage, expert, Benner (1984) stated the nurse "No longer relies on rules, guidelines, or maxims to connect her or his understanding of the situation to an appropriate action" (p. 31).

Benner (1984) further described seven domains of nursing practice: helping, teaching-coaching, diagnosing and monitoring, management of emergencies, therapeutic interventions, ensuring quality health care practices, and organization and work role competencies. The helping domain involves providing emotional support to the patient/family. The teaching role involves teaching or coaching the patient/family. Diagnosing and monitoring involves assessing patient/family needs and changes in condition. Management of emergencies refers to involvement in rapidly changing situations. Therapeutic interventions reflect technical skills. Delivering quality care involves setting priorities, while organizational competencies focus on organizing one's care.

Benner's model has been a widely accepted model for the clinical profession of nursing. The nurses in this study mimic some of these behaviors, and described a process of gradually taking in a bigger picture (typical of Stage five). For the nurses in this study this process was strongly influenced by relationships with patients, patient's family members, and peers. This influence was evidenced in Benner's work through the domains of practice however the development of these practice domains was not apparent.

Reflective of Benner's (1984) theory, many of the nurses in this study described experience as helpful in developing skills. Most of the nurses who were one year out of school said similar things about their progression of skills. Alex described his progression from technical skills to what he called psychosocial skills:

> I think the hardest part was to just take that first step. I had to tell myself that I do have something to offer this family. There is something I can educate them about. I guess it was more a confidence issue in believing that the nursing skills that I had acquired so far would help me to give something to the family. I thought, well I have my technical skills down so now I can focus on the psychosocial stuff or on the family. That was a progression for me in nursing school and it is still a progression for me today in the intensive care unit. At first I almost never left my patient's room or took my eyes off them. I have been out of school for about a year and one half now and I'm starting to be more relaxed.

Alex described that in nursing school he identified the need to advance his psychosocial skills. Nurses commonly refer to psychosocial skills as including psychological and social factors. According to Norris, Kunes-Connell, Stockard, Ehrhart and Newton (1987) psychosocial nursing interventions involve the emotional needs and resources of the individual their family and their community. Social factors involve the process of adapting an individual to the social customs of society (Thomas, 1985). Alex described how he attempted to expand his skills:

> If I had to pick two instructors that were just great and were fantastic motivators it would be the two of them. Since the psychosocial piece was a weakness of mine, I was kind of drawn to them. People that didn't have the technical piece sought out other people. Since I was already used to dealing with that and felt comfortable with that, I felt that the psychosocial stuff was kind of foreign to me. These instructors have both been good resources for me.

For Alex to further develop these skills he sought out role models. He described his role models in the following passage:

> I think role modeling has something to do with it but I think more than that. It is just their confidence with patients. They could just walk into any situation and just be totally in control of themselves or subtly just take control of the situation. So much of what we do is based on experience. The only way to do it is to go out and practice. If you don't actually practice it then you need someone to tell you stories. So little that I see in nursing is what you learn in nursing school. I mean you touch on the bare bones of it. You get some basic technical things down but there is a whole world of stuff out there and if you come in with an attitude that I already know that then you are setting yourself up for trouble. You can't possibly know everything in nursing school.

In congruence with Alex, Alice stated: "You are there with the patient. You take care of all of their needs. You are the leader of the whole team. You get into their psychosocial and family issues. The problem is that you don't have time to do all this. The psychosocial part gets lost."

Darlene, like her peers, was still practicing on building up her technical skills. Darlene stated:

> I started here in October. I felt I needed more experience. More hands on. So I needed to get out there and flush lines and do care plans all of those things that I need to use those skills.

Maureen initially defined nursing as getting tasks done. When asked how she perceived the nurses role when she first graduated she replied, "Passing medications, giving baths, and taking temperatures." One year out of school Maureen described her role in these words: "I guess I am task oriented. I am organized. Prioritizing is important. I had to learn how to prioritize. I think that was one of the biggest tasks. Learning how to take care of six – nine patients at once." Consistent with Benner's (1984) model, these nurses described behaviors typical of the advanced beginner. Maureen was just beginning to grasp that there is more to the picture than tasks and organization. She is beginning to see what she and many other nurses refer to as the "whole picture." She described:

> Nurses are seen as just doing different tasks. I think the image is just an image. It is the reality. If someone is going to be discharged we see the whole picture. If they can't walk we find out if they could walk before they came to us. The doctor would just send them home without even finding that out.

Part of the whole picture for Maureen was assessing all of the patients' needs and not just narrowly focusing on the problem they came into the hospital for.

Denise said that her focus at this time in her career is skill development. "I need to learn how to operate equipment, other skills, and time management." Denise was also perfecting her communication skills. "I think I am well rounded. I can communicate with my patients very well. I can get my patients to communicate back to me which I feel is very important." Denise has perfected her skills as she described:

> Just talking to patients and letting them know you are willing to listen to them. Advocate for them. I think that makes it a lot easier for them to speak back to you about their concerns or any problems that they have. I believe that my skills

> have come along. From when I first became a nurse my skills have become more refined. My knowledge base is much more in depth than what they let you know in nursing school. I have learned this through experience.

Julie had begun to recognize that taking care of patients was not just about the disease they have. She described:

> In the school we just think about disease. When you are working with the patient it is personal. Take the disease pneumonia. There are different kinds of care for different patients. A patient who is 97- years old is different than the patient who is 42 years old. There are lots of issues that are totally different. We have to do a lot of clinical work too so we have a better idea of what we are doing. We need more experience to do these kinds of things because the textbook doesn't tell you there is a difference between these two kinds of persons.

Julie seemed to be progressing beyond what Benner (1984) has described as the novice stage of focus or "what the rules tell us" to the context of the situation. Julie was beginning to see that there are different responses in different situations as she described:

> Sometimes nurses have to think of some procedures or some ways to protect the patient. No textbook teaches you how to do these kinds of things. A lot of the basic nursing knowledge really helps me but sometimes we have to take some risks. Sometimes when you do something for patient safety you put yourself at risk. I have to say yes I want to take this risk to protect the patient. We deal with the doctors and we deal with the patients and lots of times we have questions inside the nurse herself.

Julie had begun to recognize that there is more to know and there are ways to better take care of her patients. Julie explained:

> The other nurses say you are good. You made no mistakes. No mistakes is OK. Nothing happened for the patient and that is good. The patient didn't complain

> of anything so that is good. The nurse is also supposed to do some education for the patients. You don't have any time to do it. I know I can do more for this patient. You learn a lot from the patients, from nurses, but I still know I can do much better. I think with more experience I can learn to take care of more patients. I want to be the nurse who takes care of the whole patient.

Julie realized there was more to nursing than just passing medications and not making mistakes. She also recognized that she will expand her capability through experiences with patients and from watching her peers. Julie shared:

> The basic part seems to be getting an order and passing the meds. Actually, it should be to make the patient feel comfortable. Make them not have pain. We have to take care of their emotional needs. We have to explain a lot of things to them. Sometimes there are family issues. Sometimes they don't have any children and they are in the hospital. Sometimes they need to learn about what kind of disease they have. They need education and they need emotional and medical needs taken care of.

In this quote, Julie was able to see what is beyond the basics but as yet had not progressed to a point to do all these things she felt that the patient needs.

Jean, who has only been a registered nurse for one year, bought many years of experience as a licensed practical nurse with her, which has positively influenced her ability to pass beyond the basic skill level. According to Jean:

> Experience. Also personal experience. When I was a patient after surgery I couldn't go until I could get out of bed. Your own experience plus past experience with other patients. Repositioning a patient you learn in school. It is like nobody listens or nobody remembers. How could you not remember something like that? It is so basic. I feel like I baby-sit all evening long. It's like they come to me and say OK mommy what do I do now? It is like I am

> telling the same people over and over again what to do. They either don't listen or they don't care.

Jean was somewhat frustrated that other nurses do not have the same level of problem-solving skills with patients as she does. She said that her years of experience have helped her to problem-solve and prioritize.

Anita, at two years out of nursing school, had begun to be able to "sense" when things are happening to her patient, which seems consistent with Benner's (1984) competent level or Stage three. Anita said:

> I think that experience goes a long way. When you go to school and you experience it there and then you are on the floor and you see it there you are experiencing it through different senses and you are using all of your five senses. You can hear it and be able to recite it when you are in class but you are not sure what the clinical picture looks like. I think it makes a difference because I might know all of the signs and symptoms of pulmonary edema (fluid in the lungs) but it wasn't until I saw and heard pulmonary edema that I really knew what it was. I said oh that's pulmonary edema. That brings it all in. Experience does go a very long way.

Anita felt she needed to experience patient's symptoms through all of the five senses and that understanding could not be accomplished by reading books alone. This is consistent with Benner's (1984) idea of experience leading to mastery and ability to cope with new events. Anita could now sense what is going on with the patient at a subjective level without the objective measurements. She used objective measures to validate what she already knows. Anita described the process of understanding as a sixth sense:

> I clearly remember the first day that I saw a patient in pulmonary edema and I said something is wrong. I didn't know what was wrong. I took his blood pressure and he was sweating and it wasn't until another nurse said that the

> patient is in pulmonary edema and I said oh my God if this is pulmonary edema this is bad. I couldn't connect pulmonary edema with the patient's symptoms but now I knew what a patient with pulmonary edema looked like and he didn't look very good. I don't know how it happens but I think it is just something by experience. It is like a sixth sense almost. It is not really what your eyes see or what you hear. It is almost like a sixth sense. When you see it you go directly go find the proof that is heart failure.

The ability to see "the whole picture" had begun to develop and Anita saw that ability as absent in other healthcare professionals such as physicians. Anita perceived that "seeing the whole picture" was part of a nursing model of care and came with experience. It was a phase beyond being task oriented. She stated:

> Physicians have learned objective measures for diseases and they just don't see the person. I think that is a big missing part in the medical profession. They should see the body and the mind and the person. Usually a disease affects the whole person. People respond so differently. These new doctors or residents that can't see the whole picture I think that all comes through experience. In a way I think the nursing model is the better model. I think sometimes because of all the bureaucracy and all of the stuff that is going on, we tend to revert to the medical model in terms of what is going on with the patient. We don't always remember that we are nurses. We are not supposed to be so task oriented. We should always remember that there is a person lying right there we should not forget that.

The nurses that had been practicing for three years described a sense of progression beyond tasks, the psychosocial, and the whole picture. Bob described his progression:

> I feel competent. Comfortable. I feel I have reasonable communications skills. For the most part I think my patients feel comfortable talking to me. When I

> have time, I can do more of the psychosocial stuff. I have a little more time to hold the little old lady's hand. I can spend a little more time and give them reassurance. I feel relatively comfortable in my assessment skills. I recognize that I have much to learn. I still feel like it is very much enjoyable. Some days I still say do I really have to go home?

As Bob became more comfortable with numerous skills he began to really enjoy his work. He however, did not always have the time to deliver care involving the "whole picture." Bob had recently changed to a new job in a new specialty area. He described a background movement similar to Benner's description of the novice nurse being also one who changes specialties and starts something new. Bob stated:

> I remember one of the instructors saying remember this is a profession and it takes three to five years to become a competent nurse. Not an expert nurse just a competent nurse. So don't beat yourself up if you didn't see something or you didn't understand something. It was really the truth. I remember that very well. I guess I am just starting to feel competent. I am working on my fourth year. I am beginning to feel competent in my assessments and things like that.

He described himself as being back at the task level in some ways related to his new specialty, while his basic skills as a nurse allowed him to progress in other areas. Bob described competence:

> Being able to handle most situations you run across in an average day. Do care and assessments relatively comfortably. The problems that you don't know how to handle become fewer and fewer. A degree of comfortableness. Being able to be charge nurse and have the whole unit in the back of your mind.

Bob's description is similar to Benner's competent stage of nursing development.

Chris discussed her innate sense of what is happening to a patient. She described it like a gut sense similar to Benner's highest level of expert nurse. Chris felt that this gut sense of things was linked to where you work and thus what particular skills you developed. She described:

> I think that there are nurses on some other units that know what I know and they don't need a monitor to tell them that. If I were to float to the gastrointestinal floor I would not have the special skills to identify some things associated with those disorders. I think that every floor, even if it is just a non-specialty floor, still has their own specialty. I think your assessment skills are honed by the type of patient that you generally get.

Karen was able to describe the changes she made as a nurse in her three years of practice. She described:

> I think when I first started being a success would have been just getting through all of those tasky things. It is kind of dynamic. You need to get really good at bedside care. Give the best bath. Make the best bed. Sending a patient home better than he was. Knowing that I have had my input and I have made some kind of difference. Knowing that you didn't leave that person uncovered in any way. You really tried to do the best you could. I have made some difference in their lives. Being so comfortable in your role as a nurse so you know you have taken in all the things you need to.

Initially Karen wanted to talk to a patient. She now understood that listening was more important. She described this progression:

> I had it in my mind that I would want to talk to the patient. I knew that was part of helping to solve their problems. In my mind I would feel this pressure. I had this timetable in my head. If I don't keep on track then I'm not going to finish. I learned that it was more important that I listen. I needed to know what the person needs. The nurse is really the key.

Karen understood that it wasn't a matter of just being able to do technical skills or addressing psychosocial issues. They began to meld together and become one. According to Karen:

> You can mix them. You can definitely mix them. When you first start out it is very difficult because you are so focused on whatever it is you are doing that you have to divide it. It is like now it is psychosocial time. Like now I can be doing many other things kind of looking at the person. You know fully looking at them. You can tell if they are in pain or they seem like they are depressed. You can just tell by body language. What makes a good nurse is taking all the parts and being able to mix them all together. Now I can do it all.

Nurses begin to be able to juggle numerous tasks at one time. Karen said:

> I think it is a lot of things. But I think it's...it's funny because sometimes I see those commercials for nurses for our hospital and I think you're this and you're that and it's kind of goofy but during the day you almost want to laugh because it's comical. We are literally doing 20 things at one time. People are talking to you and you are trying to do at least two other things and it is difficult to say what a nurse is. It is a lot of things. A mentor, a parent in many cases, a sounding board.

Karen supplied a good description of what other nurses have described as the whole picture:

> Doctors are kind of in and out again. They will list a whole bunch of tests that the patient has to go for. The doctor walks in and says this is what we are going to do. Then we kind of come in after that and we take care of the rest. The rest is half of the pie. I will ask the patient do you know what that test is. The patient won't have any idea. So we have to be a teacher. So we are educating. Then we have describe whatever will happen. You know they are sick through some of the preparation. So we are there for that part of it. We try to be compassionate.

> We are kind of the caretaker. There are usually a lot of things that we have to check. The doctors are just there to set it up and look at the results. We are there for the rest of it. We have to take care of the whole person. A month and ½ ago I had a situation where a doctor came in to see the results and he told this woman she was going to have to go up to the unit (intensive care) he told her she would probably have to have another whole surgery. He stood between the door and her bed and he was talking very loud and he was just throwing information at her. I thought she would probably have a heart attack just from the information. It took us at least a hour and a half to calm her down. We had to help her to absorb small amounts of what was happening to her because it was too much. He came in and he totally devastated her and wrote a bunch of orders and then we had to pick up the pieces. We are there for the whole thing. Every part of it.

Karen described a gut sense similar to what Anita labeled a sixth sense:

> You sense it. I used to not know what people were talking about when they said this. Now I see it. We have a patient on our floor right now and he doesn't want to admit he is in pain. I could tell from the minute I saw him. He didn't make eye contact and he kind of looked like an egg the way he was holding himself. He is so focused on not showing he is in pain that he can't really function at all. I talked him into taking some medication. He is a changed person. I think that comes with time you know.

Karen explained how she developed this ability:

> It just takes practice. Not giving up and you know just a lot of experience. I can look back and say I used to walk in a room and look at a patient and I didn't know what was going on. Now when I walk in a room I am already looking at everything. When someone is talking to me I am looking to see if they are really breathing heavily. As you are talking to someone you start to really look at them.

> I think it comes from just doing it. From watching other good nurses. They would walk out of a room and tell me something that was going on with a patient. I would walk in and say oh yea how did I miss it? They would tell me stories about their own experiences with people. Every day I learn ten new things and I think that is wonderful! Everyday! Oh my God! Well I learned my ten new things today. I am always learning.

The following story clearly portrayed how a nurse puts it all together. According to Karen:

> You really have to be a calm person. You can't be uptight and worked up all the time. You would miss those small things I was talking about before. You have to stand back and take a look at the whole picture. Even in the emergency room. The calm ones are the ones who bring it all together. There is a time to be acting fast. I think this comes with time. They say well the monitor says they are in ventricular tachycardia (an arrhythmia of the heart). Well if you go in and the person is fine you need to be a little bit calmer about...like yesterday my patient's heart rate went down into the 30s. A lot of people came running into the room. My patient turns to me and says what is going on? She had just come back from a procedure. I had just put the monitor back on her. This was all they had on her. She had been in the 60s earlier in the day. She had been given medications. I said we need to go out quickly and look at the chart. Is someone's blood pressure is 80/40 but its always 80/40 that is OK. You have to look at the patient first before you do anything else. I think that just comes from experience. That patient was fine. I just said well thanks for coming. I said to the patient isn't this great! You see the service we give here. She just smiled and laughed because she was of course panicked.

This passage described how Karen as a more experienced nurse gathered data from various arenas before acting.

While the data collected in this study have similarities to Benner's (1984) model, the process described by these participants incorporates greater breadth. The nurses clearly incorporate varying aspects of skill development extending beyond basic technical skills to being able to communicate with patients and families or develop the psychosocial components of the nursing role. While Benner's (1984) model addressed what has been referred to as the science of nursing, this data encompasses more of the art. The ability to see the "whole picture" and to do multisystem assessments that are missing in the Benner (1984) model. The individuality and differences in patients is an added aspect the nurses in this study described. The depth of the significance of emotional relationships with one's peers, patients, and families strongly influenced development skills in these participants. Many nurses described a significant experience with a patient, family, or peer that was a turning point or catalyst for forward movement. While Benner (1984) focused on the novice being a person who lacked experience in a certain area, the nurses in this study acknowledged that past clinical or life experiences place them in a position at a higher level than the novice and facilitate a faster movement forward. While Benner's model is a linear one, the nurses in this study described a more dynamic process with multiple influences such as relationships, increased knowledge or education, a change in level of patient being cared for, and stressors within the health care system itself impacting skill development.

Moving On

Gregg and Magilvy (2001) identified a model of professional identity development that exists as a spiral. Once a nurse goes through a stage he/she never returns back to the exact same stage. The nurse can return to a previous stage, however, change occurs at a higher level. According to Gregg and Magilvy (2001) the stages include 1) gaining influence from your education; 2) integrating a nurse into self and 3) having a commitment to nursing. The overriding

core category as Gregg and Magilvy (2001) saw it was "Bonding Into Nursing" which was defined "as the process by which each nurse established his/her professional identity as a nurse (p. 47).

The nurses in this study who were approaching or at the three-year point had interesting things to say about the perceptions they had of themselves as a nurse at that point in their development. Their thoughts and actions move beyond what Benner has identified as the expert nurse to a totally new level of understanding their role. This progression has some similarities to the spiral developmental model of Gregg and Magilvy (2001). The nurses in this study discussed taking skills to a higher level by joining a new area of the profession. This process would reexpose them to the novice level of nursing while at the same time they would be learning new skills which would ultimately take them to a higher level of overall performance. This process of going back also involved a return to "finding your niche." Nurses need to find a new fit at this point. It also involved a return to why they entered the field. Nurses discussed family issues that had influenced their original entry to the field and at this three year point felt a need to address those issues once again in a different way. Of note is the sense that all nurses did not experience this at the three year point or by report not ever. Some nurses stay and do not move on to something different.

The one nurse in this study who was at the three year point and did not wish to move on was Maureen. Maureen was as yet not comfortable with where she was. She explained:

> I feel like I have an opportunity to learn more and more. They say once you have learned charge on this floor you can go anywhere you want. Once I become comfortable with that then I may move on to some other kind of nursing. I have kind of gotten attached to being here.

For Maureen, if she were to not move on she would feel that she was missing something:

> I would wonder what I was missing out on. I think if I did leave it would not be to go to another hospital. If I were to leave here and get another job I don't think I would do hospital nursing. I might do outpatient or whatever.

Denise, who was not yet three years out of school, had some thoughts about moving on. Denise had decided to work medical-surgical nursing for a year at the advice of her instructors with the goal of getting into pediatric nursing. These were her current thoughts about the movement in this profession: "For the time being I think I would like to find something a little bit closer to home. I might try the dialysis center down the road from me. It is closer to home and my older sister works there as an LPN." Denise was looking at convenience rather than challenge at this point in her career. For Denise, the conception here is to gather basic skills in a variety of specialties, not to use new experiences to advance to a higher level skill which is evidenced in the nurses at the three year point:

> I think for myself I would rather be well rounded in every area and not be exceptional in one area. I would rather have a little bit of experience in a lot of different places. This floor has helped out a lot with time management, giving medications. I am always getting new things on the floor. You never see the same thing twice. It is just nice to know that there is always different people with different diseases and that everyone grows.

Denise was still learning in her present job.

Alex, who was almost at the two year point at the time of this interview had definitely moved on. Alex said:

> I'm going to go on to get my masters in nursing anesthesia. So I will be leaving this hospital for the first time in about five years. It is a lot like intensive care. It is a much more compact version. You know. It's technology, it is medications. It is being in the operating room. I love being in the operating room! I love the environment of it. I love the clean, sterile nature of the operating room.

Throughout his nursing career to date, Alex had struggled with developing his psychosocial skills. He had always felt comfortable with his technical skills. He described wanting to take the technical skills to a higher level:

> The psychosocial piece is there but in a much more limited capacity. It is there in seeing the patients the day before surgery. You let them know that you will be there for them in the operating room. You calm their fears as they go into the operating room. You help them manage the pain after surgery. In other hospitals nurse anesthetists cover the intensive care units and the emergency department for emergencies. Here they are just relegated to the operating room. That is where they are needed most. Other hospitals that have more of an abundance of them have a much more expanded role.

Alex wanted to further expand his skills in the technical area without totally abandoning the psychosocial piece. This preference could be a function of being a male in nursing which is supported in the literature (Egeland & Brown, 1989). Additionally, it could be a function of wanting to further develop a strength, consistent with the spiral effect (Gregg & Magilvy, 2001).

Karen, who was at the three-year point, described a similar but more complex journey. Karen reflected over her three year progress as a nurse:

> Well so much as happened to me. In this profession so much happens. I am now starting my third year as a nurse. The first year or so I was really into that novice stuff. You just don't worry too much about the big picture. You just try to get through the day. Then you start to not only see the big picture as far as patient care is concerned but you learn how the floor works and how you interact with staff, who each person is and how every job done well interacts to give the best patient care. We rely on each other. As you are taking care of the patients you kind of live that. It is much more comfortable place to be. You just feel like so much is flying by you. Every little thing means something. I wouldn't even

> have notices these things before when I was a novice. Becoming comfortable is part of nursing identity.

Karen used the word "comfortable" on several occasions. She went on to say she is now comfortable in saying she does not know something. Karen stated:

> If something does come up that I don't know I do ask why. I am not afraid to seem like I don't know it all. I don't have trouble with that. When the doctor comes through if he is doing something. I will ask why. The patient will want to know. You know how doctor's talk. Their foot is kind of half out the door and they shout something in and that is it. I think it is just becoming more comfortable with yourself in that role. I would say over the last year I have become much more comfortable.

Karen had made a decision to do something different:

> I just put in my transfer to the Medical Intensive Care Unit. I really feel now that I am ready for that. I feel like I have learned so much on my floor. When I think about new graduates going to critical care areas I just don't know how they can do it. They have to learn so much at first just to feel comfortable in the role, let alone all the equipment. Now I feel that I have so much of the basic stuff down that the rest of it just comes sort of natural now.

Like Alex, Karen wanted to move on to a higher technical level. She described:

> I want to do all that technical stuff. I feel I am ready to handle that. I don't know that I would stay there forever because I really like teaching. I really like that part. I think you get more respect as you build your educational base. There are good points to staying in one area for a long time. You become a great resource. They are the "go to" person. They have pretty much been there, done that. But for me I feel like I want to learn more. I am kind of getting to the point where I am stagnating a little bit.

Karen was posing a distinction in nurses. There are those nurses who continue to develop skills in a particular area and become the experts in that narrow field and then those who move on. For Karen, that is a valuable nurse. For herself, she wanted to learn more to bring herself to a different level. Karen stated:

> I might go back to my original floor again once I learn what I want. I think there are people who are comfortable there. I think that could be a very comfortable place. I am not ready to stay in that one place.

At this point in her career, Karen did not want to just stay in a comfort zone. Karen described how she was going to take her technical skills to a higher level:

> It is a more advanced technical skill. You go way more into the pathophysiology. The nurses there have a lot more power. It is like 1:1 with the patient. You really get to know them inside and out. Up there you are really the one. There is a lot more autonomy up there. You are the go to person. The doctors have respect for you. They know you know what is happening and they really come to respect your opinion. You just deal with more critically ill patients.

Karen described the conflictual response from her peers to moving on:

> Some of the staff is kind of mad at me. For the most part everyone is just sad. I get along with everybody there and we have good times. It is just a real comfortable place.

Chris had moved to a new position since the first time I interviewed her. At my third interview with her she had changed positions within the hospital in the previous month. Chris was somewhat mixed about this change. "It is like starting all over again. It is a lot of things. It's frustrating. Some days I hate it. Some days I say what every possessed me to do this and why did I make the change when I did."

Chris described how she had begun to feel like she no longer fit in in her work area:

> I just stepped back and took a look at my world and I just started thinking. I just looked at what I have been taught and what my perception of what a leader on a floor should do. It was very different from what was going on and I don't like it.

In the "finding your niche" section the importance of fitting in was emphasized. At this point in Chris's career she felt like she no longer fit. She described:

> I didn't see evidence of a lot of change. And then I got thinking that I have a very strong personality and people like me down there and I felt that in my role I functioned very well down there, I knew who my resources were and how to tap into them. Whether it was day or evening I just knew how to do it. I knew the things that I needed to accomplish quickly.

Chris also shared her feelings about original goals when she entered the field:

> I guess I still do see myself in some kind of management position. I think my mother kind of groomed me for that my whole life. I had to raise my children first and I got kind of a late start at it. My mother was in management for a long time. That was how my parents had raised me. To be fair and to look at both sides. Assess the situation and if somebody is not going to take charge in utter chaos then you need to get your head together and take charge. I guess that is how I do things. I think technically maybe I should be in charge.

Chris decided to make a move based on her original aspirations in the profession and family expectations. Chris's basic ideas as to quality nursing care were not being followed on her old unit. Chris stated:

> When I think about going into the hospital and having people take care of me I expect people to understand the kind of things that they need to do. Like a nurse that works on a cardiac floor needs to walk in and automatically be able to assess that a patient is going into heart failure and is having a respiratory issue. You need to know that something is wrong and have to have a plan. That could lead

> them in the direction of an answer. I think that was probably one of the things that made me leave the floor. They were very resistant to that. They just didn't.

Chris moved from the cardiac unit to a laboratory environment where advanced cardiac testing is performed on both in and out patients. Chris, like Alex and Karen, described her new responsibilities as highly technical and working closely in conjunction with physicians:

> I am learning how to do echoes and I need to become competent to do the job. That is kind of true about the nursing thing. You get kind of comfortable and confident in your position. You are comfortable. You basically know how to do the job. There are just little things that you need. You need clarification of what your values are.

Chris described the same feeling of being competent and comfortable in one's old job and the need to reestablish this sense in the new area. It was not easy for a nurse to basically start over. Chris shared:

> I have days where I chuckle. I have days where I go home and just cry and say what have I done. It is just frustration with doing something new. I went from something that I did without even thinking to something that every step I make I have to think about. It is very uncomfortable. But that is OK. I visit with my friends down on the floor. My expectations for myself are much higher.

Like Karen, Chris felt that she needed to develop more at this point, even if it was uncomfortable. "I say to myself why can't you get this? I realize a day or two later that I do get it. Mentally just doing it is awkward. There are all kinds of parts to this. I just think how awkward it is the second time you do it. The newness is just something." Chris shared that it was difficult after feeling comfortable with one's knowledge to begin again. Early into this new experience, Chris was beginning to once again identify a sense of comfort, of contribution, and a higher level of putting it all together. Chris stated:

> My teachers are physicians. There is a lot of interaction with the patients. They are scared. A lot of them have never had an echocardiogram. They are scared about what are you going to find. It is up to the doctors to tell them what we find. You can comfort them. You can talk to them. Some of them are really, really sick. There is a portion of it that is gratifying. Sometimes you can say it is not your heart there is something else going on. It is interesting because as we are doing things I can look at it and I'll say I understand that. I am putting a lot of my nursing together.

Nurses at the three year point were reportedly taking different paths. Many participants felt a need to learn more and take their skills to a higher level. Some nurses felt they needed to learn more in their current area. According to the nurses in this study a further group did not change their location of practice. The nurses in this study described a definite progression in nursing skills influenced by clinical experience, continuing education, and relationships with peers, physicians, patients, and families, and management. Nurses described a sense of comfort, competence, and putting it all together. As nurses gained work experience their perceived sense of confidence in communicating with physicians improved. Many nurses described an experience of increased respect from physicians that they related to their increased self confidence and assertiveness skills. Nurses additionally described an increased ability to manipulate the hospital setting to meet their needs and those of their patients.

Responsibility, Learning and Perfection

In this section I will discuss themes that have traversed all passages in joining the profession. Responsibility, leaning and perfection were issues and challenges discussed by all participants as they joined the profession in their first three years. For the nurse a sense of responsibility is closely aligned with the need for continuing education. Some nurses see formalized education as a way to achieve the knowledge required to be a nurse. Education and professionalism become tightly integrated. Nurses have also commented on the responsibility to

be perfect. Nursing instructors often teach students to strive for excellence by always "raising the bar." The need to learn is thus constantly present and evolving. Development of assertiveness skills and knowledge acquisition becomes equated with respect from doctors. While nurses espouse that much of knowledge is "gut" or "intuition," they also recognize the need for formal continuing education in order to gain respect and to present oneself as a patient advocate.

Nurses saw strong connections with colleagues as a further means of informal continuing education and knowledge expansion. Nurses learned from their peers through story telling, question answering and posing and role modeling. Professional competence also is routed in practical experience. Nurses experience professional development through three main vehicles: high continuing education, specialization, and learning to use technical equipment.

Continuing Education

Participants identified the acquisition of knowledge as a never-ending process. According to Chris, a graduate of three years:

> I remember my first few weeks on the floor and I said, oh no, this is a huge change again. This is almost worse than the first day of school. I got through it and I graduated. I said it is amazing what you still don't know. I'm still awed. I was talking to a student last night and I said you really get a great foundation across the street because they require your brain to be actively involved in your learning. You are totally blown away by what you don't know. You can go to school for two years and you put in all that energy, all that time and you get here and you are just clueless. It is kind of like you are always evolving. I recognized when I got out of school that there is this huge learning curve. I think that I am probably through the biggest part of it for my specialty. If I were to go somewhere else it would start all over again. I am still learning though it is not every day and it is not quite as much. I am not as overwhelmed. I don't feel the same kind of pressure to learn things as I did. It is like you are always evolving.

Chris shared that she read articles, watched television shows related to advances in the health field, and spent hours on the internet searching for advances in nursing. Chris's quest for knowledge was related to the responsibility she felt to provide quality care to her patients. "You need to understand the pathology and you really need to understand what is happening with your patients." Chris reflected on the life and death nature of her work and emphasized the importance of positive outcomes. In her words, "I feel responsible to know as much as I can. If I don't know something, I must go find out as soon as I can in the library or go to someone and say I don't really understand this, can you help me to understand it?" The life and death component was clearly reflected by Chris in this statement, "My lack of knowledge could kill someone. I really don't want someone's life on my conscience." Chris summed up her definition of professionalism in the following words: "As a nurse you need to continue learning, you need to understand what is going on so you need to find that information. You need to research different diseases and find out what you as a nurse can do in the initial stages."

Denise, much like Chris, kept current in her profession in a more informal way:

> Nurses need to keep learning new stuff. It is because equipment changes, procedures change. Sometimes you have to learn different things between two different patients because the way you do it on one patient won't work with another. You have to keep educating yourself, keep teaching and learning for others as well.

Jean felt learning happens on the job and is intimately related to professional satisfaction. "I learn something new every day. It has really been a lot of fun. I have always had so much fun in nursing. I can't believe the things I've learned. It is like I have probably forgotten more than some people have ever learned."

Anita (two years post-graduation) felt responsibility for continuing education was stimulated by family expectations regarding level of education. Anita discussed:

> After I graduated from school here I went right on to get my bachelor's degree. I had planned to do this all along. It was an expectation for myself and an expectation I was born with. I had to have at least a bachelor's degree. I guess for my family the least amount of education that you could receive was this level.

For Alex, the need for formal education related to professional goals:

> I want to become a nurse anesthetist. That is my ultimate goal. To do it, you need intensive care experience and you need a bachelor's degree in nursing.

Alex viewed education as a stepping stone but not necessarily valuable in daily work. Alex stated:

> It is interesting. To be honest, I don't care much about it. In my daily work at this point it has not relevance. I'm sure it will in the future. Classes like community health nursing and settings where I don't practice now and probably never will just seems like work.

Karen also felt that formal continuing education would increase her marketability as a nurse:

> I think it will make me more marketable. My mother lives down on Long Island and she says that all the ads for nurses want a bachelor's degree. I think it would just make me more marketable if I were to leave this area. I also have an interest in going further. I have an interest in ethics and that type of thing. Eventually, I would like to go to law school after I get my degree.

Amy reflected that education helps one advance in the profession:

> Over this last year (second year out of school) as I have thought about getting my B.S., I have been thinking that maybe I should start looking at other avenues. I graduated with my B.S. in December. I got thinking about other places. I would want to go in the hospital. I investigated the intensive care units and other areas of the hospital where traditional nursing care is delivered and I realized that

> wasn't what I really wanted to do. I was thinking that I might really want to try other skills as far as advancement. I am looking forward to going on to graduate work.

While Amy valued varied experiences as a means of gathering knowledge, progression in nursing as far as advancement required formal education. Additionally, Amy saw other nurses around her who have progressed without formal education. For Amy, this led to problems in effectively implementing one's job responsibilities and in clearly understanding one's role. She described:

> My manager doesn't know how good she is because she doesn't have her BSN. I think that people think that A.D. grads are better than BSN grads. I think that initially clinically they are. By six months, I think the BSN graduate catches up. After that, the knowledge of the BSN's graduate is much broader as I have been through management classes and group process classes and I have really taken advantage of my BSN program. My manager doesn't really know how great her communication skills and interpersonal skills are because she doesn't see how many people don't have it. I wish she would go to school. I told her I think you would find yourself an even different nurse and person. Getting my BS has definitely fed into my role as a nurse. There is more to nursing. I had no idea.

Perceptions of significant others clearly influenced life goals. The interconnectedness between self-expectations of others and continuing education was also apparent. Maureen said:

> My boyfriend has grown up with a mother who is a nurse practitioner. He knows my life as a staff nurse is stressful. He wants me to become a nurse practitioner. I would like to go on to some sort of school. You always need to be learning so don't stop now. You always need to learn more.

Some nurses felt that varied experience is a way of knowing. Bob stated:

> I think I was ready to learn new things. Had I not left where I lived before, I would have probably looked to change units and get more experience in other

> things. What I was thinking about was going into a float pool (move from one unit to another related to staffing needs). That is a great way to expand your knowledge. I think that in most cases nurses should start in a medical/surgical environment and get a breadth of experience. You will find different things that will strike your fancy.

Bob stated, as did many others, that experience in varied areas provides opportunity to gain a different body of knowledge. Ohlen and Segester (1998) purported that nursing professional identity relates to the feeling of being a person who can "Practice nursing with skill and responsibility and maintain awareness of personal resources and limitations" (p. 721). Continuing education as reflected by these nurses enhances the ability to practice nursing within this definition.

Alice summed up the importance of education, both formal and informal, in nursing in the following quote:

> Florence Nightingale said it best. To stand still is to fall behind. I love that quote. Now I kind of know what she is talking about. You cannot learn and don't care if you have been a nurse for 20 years. If you don't learn something new everyday then I just don't consider you an open nurse. Education is a tool that betters ourselves, makes us more...it empowers us...as women it makes us more powerful. In this field especially that is mostly women, it is hard to get ahead. I just think education is what we need to do. I know many nurses who do not feel that they need to go on to do that. They should be open to learning.

Learning From Others

Many nurses reflected on learning from various others particularly other nurses, nursing instructors, and preceptors (assigned staff who help orient new nurses). Karen was eloquent in describing how to receive from and give knowledge to peers. She stated:

> Don't be afraid to ask questions. I'm so laid back and approachable that people don't have a hard time with me. I tell them you can do anything you want to. We will do everything together. Don't be afraid of new experiences. Face it. Deal with it. Think I am going to learn this. Not that I am going to do it wrong. Be open to new experiences. Ask questions. If you are not getting what you need, find people you can get it from. Even if you have to go above the manager or whatever.

Learning by observing more experienced nurses helped develop Chris's critical thinking skills. In telling a story about another nurse who mentored her, Chris shared:

> There was one girl who just took me under her wing. I really respected her because she was very calm and very willing to say that she didn't know. Those occasions were very few and far between. She was so knowledgeable. She had been a nurse for about five or six years. I just looked at her and said that is the kind of nurse that I want to be. I want to be able to handle all of this and be calm so I can think the situation through. She would always make me think. We went into a room one night and the patient wasn't doing very well and she said, what do you see and what do you think we should do? She just kind of talked me through it. If I were starting to go down the wrong path, she would say why do you think that? I was always learning. She would say, I understand why you are thinking that way but...we are going to a new level now and this is what is going on.

Alex described his resources for knowledge development as focused on formal hospital designees as well as peers working the same shift. He described the process of how to obtain and to receive this knowledge. When asked how he gained knowledge, he said the following:

> It is through experience and also from NRED (the education department of the hospital). They are just wonderful! Lynne (staff educator) is just phenomenal!

> My education here has been wonderful. I work straight nights and there is a core crew that work just straight nights and they have been there for five plus years and they have seen it and they know it and they, if you can get into that crowd, they are your resources right there. When you are on the floor all night you get to talk to people. Those of us that work all night get to be a close group. Once you can get into the group, then you can turn to any one of them for help or to answer questions.

In Alex's description, there is an intimidation that gaining knowledge is conditional to fitting in and being accepted by the group.

As a new nurse, mentors or preceptors are critical in the learning process. Denise discussed the importance of readily available information from senior peers:

> I liked my preceptor because you always had someone there who could answer your questions and guide you through different things. Especially with the skills. I just wanted someone there to kind of walk you through it. They were very pleasant about it and very receptive to me. They never made me feel dumb for asking a question.

Kris described her positive relationship with her preceptor in the following words: "She has been a nurse for almost 30 years. She would just talk through things with me and say I wonder what you're thinking. I wonder what your thoughts are. If you were wrong, she would say that is not exactly what I was thinking but. She helped you. She just walked you through it with without telling you the answer." This type of learning relationship is characterized by acceptance, support and encouragement. According to several participants this approach facilitated the development of critical thinking and a positive professional identity.

Bob described himself as a learner who learns by doing and articulated a relationship with his preceptor similar to Kris's description. Bob stated:

> Basically I am a tactile learner. I just have to do it. Get in to the problems and then say OK, now how do I get myself out of it? I always had a preceptor there. Even after orientation if I didn't feel comfortable I would go to my preceptor and say I am not real sure about this one. My preceptors were very open to me. They continued to be until the day I left. I had fewer and fewer questions, which I am sure, should have been the case.

Bob shared: "Early in my nursing career, I had an experienced licensed practice nurse who taught me very much in terms of something I had not picked up on. She took me into a room and we sat down and very much up front, she said this is what happened, this is what should have happened, this is what didn't happen. I said great. Let's go out and deal with it again and we did." This positive non-punitive approach was described by Bob as invaluable in his professional learning.

Fagerberg and Kihlgren (2001) identified the importance of preceptorships and the focus of task orientation as critical components of professional identity development. Having supportive preceptors in school as well as in the work environment is important in modeling how to work as a nurse. Fagerberg and Kihlgren (2001) stated "Nurses need to share experiences with each other, learn from each other's experiences and get support" (p. 138). The findings of this research study are consistent with the data presented in this study.

Responsibility to Patients

The responsibility to provide high quality care to all patients was discussed at length by many nurses. While this need was never questioned, many nurses interviewed purported numerous obstacles that negatively impacted their professional identity. Denise disclosed the following when describing her early nursing experiences, "I didn't realize that had so many responsibilities. So many patients first of all. You had so many patients it was hard to do everything throughout the day. The number of things they had to do plus I didn't realize the little things you would have to do for each patient." Denise's description of the term "caregiver,"

which she used to describe what a nurse does, is a person responsible and accountable to the patient. She described:

> A person who is always there. Someone who is willing to listen to the patient. Someone who is willing to take the extra care and go the extra mile. Just being there. A lot of times the doctor might go over something really quick and we have to sit down and talk to them about it and listen to their concerns. We are the caregiver versus the physician who just comes in and dictates what needs to be done. We are actually doing these procedures to these patients. We are with them 24 hours a day.

Ed combined responsibility to patients and learning in the following discussion:

> That is just the nurse role. But in the same sense you have the responsibility for caring for that patient but overall the physician is responsible. Overall the nurse is still responsible. When you are a nurse you are always learning so you are really keeping up on your education, but there is always a resource to ask for help. In the hospital you have in-services and everything so I think it keeps you up to date. I also feel that you have a personal responsibility to learn. You are responsible and it is a personal value. In a teaching hospital nurses have to keep up to date and learn and remain competent. If you aren't always learning then you are not being responsible.

Not having the right information can have disastrous results for the patient and was tied to a sense of responsibility. According to Chris:

> I looked around and I thought about the other people I was working with and I thought I need to understand because someone's life depends on whether or not I know this stuff. I don't want to go home some night and think that I have played a part in someone dying because I didn't know something.

Julie described the transition from the responsibilities of being a student to those of graduate nurse, "We also need a lot of experience to make a very hasty choice for the patient. Sometimes when I was a student, I was just thinking about how do I get a good grade. How can I pass the courses? Working as a nurse I am also thinking about the patient. What is safer for the patient? I have been working just for one year. I am a new nurse."

The responsibility to the patient sometimes created difficulty for the nurse. According to Julie, nurses sometimes forget themselves in carrying out their responsibilities to patients. "We also have to think about how do we do something to protect our nurse. Sometimes I think about the patient and I forget myself. Sometimes I don't document everything because the patient was very demanding. I am doing this and doing that. You just have eight hours. Time goes by quickly. You do everything for the patient. I don't document sometimes. I worry about that legally."

Julie was the only interviewed nurse to discuss legal implications for lack of responsible care. Nursing care exists within system and role constraints, which according to Julie, places the nurse in a vulnerable position. Julie stated:

> You do too much. Too many. You can't write everything you did. I think I am trying to get some kind of balance here in patient care. There was a situation in the intensive care unit that after many years ended up in court. You just cannot predict everything that will happen to the patient. The nurses have their limitations because they are a nurse. The nurse cannot do prescriptions. We have to call the doctor if the patient is in an emergency situation. Then the doctor doesn't answer. I think that is really dangerous for the nurse. It is also dangerous for the patient. We have to keep calling for them.

The nurse's focus on responsibility to the patient being foremost in the nurse's mind can jeopardize the nurse. Julie dramatically described the nurse's need for self-protection:

> As a nurse we have to think about the patient. We have to do something to protect ourselves. We do documentation. Documentation will protect us from lawsuits. We follow the procedures and rules. We will do everything according to this rule. We have to learn a lot about hospital policies first. We have to learn where to get extra help so we don't do something wrong. Sometimes the charge nurse can't help because they are busy.

Chris's sense of responsibility stemmed from her moral values as well as those of her parents and society. Chris stated:

> With any profession you bring who you are. My parents are very moral. They always said you are responsible to other human beings. You have responsibility to society as a whole. When I came to school and I was in clinical with my instructors, their professional manner was like this is an extremely important job you are undertaking. You need to understand the pathology and you really need to understand what is happening with your patients. I really respected that. I thought they are hard because this is a profession in which you truly deal with life and death. This could have a really bad outcome or this could have a really good outcome. If something bad happens to a patient, I want to feel like I have done everything I can to prevent this.

Debbie discussed her responsibility as well as the responsibility of others in caring for the patient. At times, Debbie seemed to protect herself by blaming others but ultimately felt self-accusatory and owned ultimate authority and responsibility. Making mistakes, as evidenced in this story, was a concern of nurses. Debbie stated:

> Just recently I was devastated. We had a patient who came in and he had a fever the night before. It was 103. I started to assess him and his temperature wasn't up so I called for blood cultures (a test to determine if he has an infection in his blood). The nurse practitioner said that she was going to call the doctor and he

> would probably be started on antibiotics; she said the patient would probably be getting vancomycin (an antibiotic) and left the order book open and somebody closed it. He became worse. He became septic (infection in the blood stream). So, the nurse practitioner came over and said well he got his IV vancomycin right? I said, no and she said what do you mean, I wrote the orders for it. I said I had not taken off any orders. She had written it at 1:00 in the afternoon. I was devastated. She gave him the antibiotics but I felt so bad. I felt bad because I had missed the order. I was just devastated. I came in the next morning. I talked to the nurse practitioner and I told her I was so sorry. I guess she was going to write me up. She knew it was not like me to do this sort of thing. She said that she knew I wouldn't just ignore it.

Anita, like Debbie, described the fear of making a mistake:

> The responsibility part was I guess coming in and knowing that I might just give a drug and that could harm someone. I guess there is just too much power in what you could do to a patient. Even now I feel a huge sense of responsibility because I always wonder what if I made a mistake? Even now when I have a patient that codes (heart stops or stops breathing), I wonder did I not do something? Did I not pick up on something? If the patient didn't make it then it is even worse.

This sense of responsibility was felt to be instilled in nursing school and was presented by nurses as a difficult part of this profession. Making mistakes happens and it was reported to cause anxiety in knowing that your mistake could kill someone.

The transition to what is presented and perceived by nurses as overwhelming responsibility is difficult for all nurses but as Anita expressed, may be more difficult for young nurses who enter the profession right out of high school. Anita stated "I think coming out of high school it was little different in that I was a little wet around the ears so the speak." Anita felt that

her lack of life experience impacted on her ability to enter this role. "It was hard to enter such a professional role after being in high school. I thought doing clinical and taking care of people and having that kind of responsibility was difficult."

The responsibility for the actions or lack of action of others was also an evolving theme. Nurses sometimes feel like they need to take the responsibility for inaction or faulty action of others. Chris criticized other nurses for missing important information on patients:

> Usually what happens with this situation is the nurse taking care of the patient I will see a few days later and I will ask them what happened. I am not good on confrontation. It is hard for me to say how did you miss this? When you put someone in this position, you put them on the defensive and no one learns anything. When I got to him and he was coughing and he was so bad, I think the other nurses should say why did she see this and I didn't?

Debbie was concerned with the responsibility to supervise others. She stated:

> Now we get licensed practical nurses right out of school. We used to require that they work in the hospital for a year before they started. They don't have the experience. I am responsible more than ever. I feel a little more scared about my license. You can't watch every little thing every minute. So it's scary. Because if anything goes wrong with the patient I am the one that is going to be called down with questions like how come you didn't see this or how come you let this go on?

Chris described a situation that occurred while she was in nursing school that she felt influenced her sense of responsibility today:

> I remember a lady on the Women's Unit. She came in for a hysterectomy (removal of the uterus). She was in her 50s or 60s. When I got on the floor she developed a pulmonary embolism (blood clot in the lung). My instructor was leading me through the process of helping this woman. I wasn't scared, I was

> like what do I need to do. This woman was in a really bad place and what do I need to do to help her. It had started during the night and they just didn't catch it. She unfortunately did die. I thought I did everything I could for her. Sometimes even doing the right things doesn't stop it. That I made it comfortable, that I made her last hours as good as I could make them is all I could do for her. This is important.

Nurses sometimes took the responsibility to know when to get others to help. This sometimes caused frustration when others did not respond as anticipated. Assertiveness on the part of the nurse can sometimes save the patient, which contributes to an additional sense of responsibility. Chris explained:

> Two days ago this guy started coughing. I was thinking that I just don't like that cough. I said to the charge nurse, we need to watch this. The nurse said that this has been going on. I said it is just not right. We need to figure out what it is. When I came back the next day, I found out that he had been confused. I said to myself that is not how I want to start my morning and I called the physician's assistant to help me because this patient's heart was failing. He agreed but he just stood there and did nothing. I said in the meantime I will order arterial blood gases, a chest x-ray, etc. Then I went to him and said, well I have him on oxygen now and he just said OK. I was just dying. So I went and did all those things and I finally went over to him and I said come over here to see this patient with me or I am going to be very unhappy with you. He came over and said, oh yeah, I guess he really is sick and I was like, I could hurt you but I am not going to do it until you write the orders for the unit. On this morning if I had not known what to do, this guy would have died. He was very close.

Indicated in Chris's story was a gut or intuitive sense of knowledge, which was not always understood or appreciated by others and is consistent with Benner's (1984) model.

The sense of responsibility does evolve over time according to Chris and involves negotiation with the patient. Chris said:

> What is my responsibility and what piece does the patient own. They need to be responsible themselves for a certain piece. We had a woman this week that was discharged but didn't want her husband to come get her but couldn't leave. Her daughter-in-law couldn't come to get her until the next day. I just stood there and said that I do not own responsibility in this. I did not make the arrangements. You are ready to go home. You are walking the halls and caring for yourself. You do not need to be here as a patient. You need to be home to recuperate. It became a huge issue for the whole weekend. She made her discharge arrangements. It is her responsibility to tell her husband what she has done. Not mine. I am not part of that marriage. I am a nurse taking care of her. I am not her social worker. It was kind of funny. All the staff just wanted to make it right. I said she just needs to take care of it. We are not privy to this. She has her issues with her husband that are separate from this.

The boundaries seem to shift over time with the nurse becoming somewhat more aware of the responsibility of others and in this case specifically the patient. According to Chris, "This is really an evolving process. It is now three years and will probably be forever. Probably forever."

Perfection

For many nurses, being a nurse meant striving for perfection. Karen eloquently described her sense of being perfect in the following quote:

> I think being a nurse means excellence. If you say you are going to do something you do it. I think it is double-checking things and making sure you follow through and everything we do needs to be perfect. Not in an anal way. You just wanted it to become part of who you were. There was no room for error at all in anything you do.

Karen understood that others are not yet perfect but requires this in herself. Karen explained:

> I try to strive for perfection. I mean I'm not weird about it. I'm a realist about it. In this world I know that there are so many people involved in a patient's care that it is not going to happen but if I say I am going to do something and if I say I will look into this, then I do. If I can't, then I will go back to them and tell them I couldn't. I have heard patients say that they asked someone to do something and they never came back to do it. So I really try to do it.

Karen equated the need for providing perfect care with caring for her own family. Karen stated:

> I try to look at the person in the bed as someone from my own family. I think about, what if this were my mother or my father? How would I want them to be treated? I think that a lot of people don't remember that and it bothers me when I see that because someday it will be your mother or father or you.

Anita discussed perfection in the context of making mistakes or having negative patient outcomes. Anita shared how she responded in situations where what she expected to happen for the patient did not:

> I go back to the patient's chart and look and look at the heart monitor and the medications they are on. I have never found anything that would signify that anything was wrong. You get over it. You do get over it. You say, well you are only human and we can't foresee everything. It is just perfection. You have to get everything down.

Anita responded in the following way to a self definition of perfection:

> For me I just need to recognize that I see that the potassium had dropped and I knew why and I could address it. I noticed that their kidney function was deteriorating or I was able to assess their needs when I met them for the first time

> or at the time of discharge. I just feel like I need to be able to foresee. It is not so much the need to be perfect but the ability to foresee the future. Don't ever make judgments. That is one of the hardest things I've ever had to do. You hear from other nurses this is going on or that is going on. You need to come up in your own mind what you think is going on. I try to put myself in their position and think what would I be doing? People make very broad judgments when they have no idea what it is like to live for that person. I think that is one of my huge pet peeves and I think this is just necessary to survive as a nurse.

The issues of responsibility, learning and perfection have early roots. Many quotes from Florence Nightingale herself have significance to my data. Nightingale's thoughts on how to educate mimics what nurses told me related to qualities they found helpful in preceptors and instructors. Nightingale (1969) stated, "I do not pretend to teach her how, I ask her to teach herself, for this purpose I venture to give her some hints" (p. 4). The responsibility of nurses for their patients' health was also espoused by Nightingale. The following quote lays early foundation for the responsibilities described by nurses I interviewed. According to Nightingale (1969):

> I have known two cases, the one of a man who intentionally and repeatedly displaced a dislocation, and was kept and petted by all the surgeons; the other of one who was pronounced to have nothing wrong with him, but who died within the week. In both of these cases, it was the nurse who, by accurately pointing out what she had observed to the doctors, saved the one case from persevering in a fraud, the other from being discharged when actually in a dying state (p. 121).

The data in this study point to the fact that nurses also need to be good observers and reporters. Nightingale (1969) stated, "a man who really cares for his patients will soon learn to ask for and appreciate the information of a nurse who is at once a careful observer and a clear

reporter" (p. 125). The critical nature of accurate reporting is presented by Nightingale (1969) in the following way:

> She must have respect for her own calling because God's precious gift of life is often literally placed in her hands; she must be a sound, and close, and quick observer; and she must be a woman of delicate and decent feeling (p. 126).

When I first read the words of Florence Nightingale, the founder of the nursing profession, I was half way through my data collection process. I was astounded that words originally published in 1859 had relevance to the words I was hearing from nurses today. These historical words were formulated by Florence after fourteen years of observation on the subject of bedside care of the sick. She drew upon her experiences in the Crimean War as Lady Superintendent in Chief of female nursing in the English General Military Hospitals. Upon questioning my peers in nursing, I discerned that this book is often read as part of nursing school curricula. I myself had not read it. It was shocking, yet I guess not really grounds for surprise, that nurses still reflect these early values related to the responsibility to patients.

In the process of analyzing this data many themes evolved. Nurses required support, encouragement and positive reinforcement in order to learn and develop in their profession. The need to have a relationship with mentors with elements of mutual respect was clearly evident. Nurses needed the opportunity to think things through with the person who was helping them learn versus being told what is right and wrong. There was a need identified for formal education to advance in and better understand one's role. Informal education was identified as essential to perform one's clinical work. All the nurses interviewed valued informal education while approximately one half felt a strong need to advance themselves through a formal education process.

Throughout the experience of joining the profession, the participants traversed several passages that influenced their professional identity. The significance of "finding your niche," being oriented, passing boards, learning charge and skill development was emphasized by all

participants. The professional identity of the participants was often reported to be adversely affected by each of these events. Support and positive feedback from peers, preceptors, managers and patients allowed for successful movement through the various passages. The Benner (1984) model was validated by the participants of this study, however greater breadth and depth of context and interpersonal supports was evident. Benner's (1984) linear approach of technical skill development was not adequate to describe the cyclical movement of these participants and the holistic skill development. The psychosocial (interpersonal and emotional) aspects of development presented by these participants has not been significantly reflected in previous studies.

Various aspects of importance in "finding your niche" included: "fitting in," "sense of family," right personality or skill mix for practice location, respect for others, and having a good reputation. Nurses often start in medical/surgical nursing as directed by their instructors as a stepping stone to other types of nursing. The nurse participants who felt they made the wrong choice disclosed feeling like they were a failure. The education/practice dichotomy led these nurses to often feel "prepared but unprepared." The blurring of what is a nurse and what qualities determine a good nurse complicated the early days of practice.

Past literature (Hinshaw, 1977; Kierman, 1984; Meleis, 1975) focused on how a nurse integrates into the work situation related to role expectations, role modeling, and role preparation. This study adds to the breadth of knowledge of the factors which influence a successful adjustment to the work world. The qualitative approach added substance to the importance of being perceived as successful in one's first job and how this success influences professional identity.

The data related to the orientation process disclosed examples of "eating our young" that is reflected in nursing literature (Gordan, 1998; Greenwood, 1999). Nurses described the preceptor as the person who often made or broke the orientation process. Many nurses discussed issues of lack of confidence in their preceptors that resulted in "pay back" behavior in which they

felt very unsupported in the challenges of their new role. Related to the nursing shortage and lack of retention of senior staff, several nurses discussed being oriented by novice nurses who were not able to appropriately guide them. Often nurses disclosed being uncomfortable with asking other nurses questions and felt left on their own. Nurses commented on the lack of consistency in preceptors which left them in situations of learning redundant behaviors or being pushed too fast. Lack of support from senior nurses as they struggled with skill development impeded their learning process as well as integration of a positive nursing identity.

Much of the data in this section were consistent with findings in previous research. Miller's (1975) concept of a life serving others without being subservient was apparent. These nurses described an environment consistent with Reverby's (1987) discussion of caring in a society that refuses to value caring. The nurses in this study discussed at length different kids of nurses. One type of nurse "cared" while the other was interested in putting in time only. I argue that the conflict of caring contributes to separate paths taken by nurses. This finding is not evidenced in nursing literature.

Passing nursing boards and becoming a charge nurse and subsequently "senior nurse" were additional movement points for nurses. Boards were fraught with anxiety, fear of failure, and an increased sense of responsibility. Failure of boards influenced professional identity in a negative way as reported by these nurses. Virtually no nursing literature discusses the emotional responses related to board failure and how we might better support nurses through this process, thus this study offers some insight into this area. The passage of boards can either make or break a nurse early in their career as reported by these nurses.

Charge was described by nurses as overwhelming, unrealistic, the ultimate in responsibility and something that can make or break you. Two nurses in this study left their jobs because of their inability to master charge. One problem identified in this study was that nurses hesitate to ask for help, so in the situation of charge can again feel left out on their own with no support available. Many nurses reported that over time, they found ways to make it easier by

manipulating the system. Charge can be manageable with the right number of staff, however, all too often these nurses felt the numbers did not match the responsibility or tasks involved.

In developing as nurses from technical → psychosocial → competent → whole picture, nurses described the importance of role models, experience, and relationships with patients/families. Nurses described the importance of distinguishing the needs of the individual patient versus the textbook presentation in the school environment. A "sixth sense" or "gut sense" was described by many of these nurses as they gathered more skill as nurses in their experiences with patients/families or heard stories from preceptors. The technical and psychosocial skills were described as melting together over time as they learned to juggle numerous tasks. All participants described the need for the successful nurse to "put it all together." This concept of putting it all together involves repeated contact with patients and preceptors or experienced nurses as well as "hands on experiences with patients." To progress through this skill development, nurses described a need to gather data from various areas before acting. Most of the nurses at their three year point described a need to "move on" to a higher level. This process involved a new process of "finding your niche." There evolved a need to find a new fit. Being comfortable or being in the "comfort zone" was deemed as being "bad." This movement to another level involved a higher level of skill development than what had been previously accomplished. This process appeared less linear than described by Benner (1984) and similar to the spiral bonding process inspired by Gregg and Magilvy (2001). Unlike Benner (1984), the nurses in this study described taking core knowledge with them to a new area without returning to the novice level except for the new area of focus. The process described by these nurses involved greater influence from varying sources than described by Gregg and Magilvy (2001). The qualitative nature of this research supplied more feedback in influencing forces. The forward movement reported involved a process of taking comfortable perfected skills to yet a higher level and involved a process of "starting over" which was perceived by these nurses as a

healthy movement in nursing professional development. The starting over phenomenon has not been identified in previous research.

Responsibility as a theme is also reflected in nursing literature. Coudret, Fuchs, Roberts, Suhrheinrich, and White (1994) examined graduating student nurse role conception changes that occurred during a concentrated clinical preceptorial socialization. They concluded that professional nursing requires the development of critical values, a strong commitment to the service that nursing provides the public, a belief in the dignity and worth of each person, a commitment to education, and a sense of autonomy. These themes were all apparent in my data. Oleson (2000) found that it was characteristic for nurses that they feel their professional competence is rooted in practical experience. Nurses experience professional development as enrichment; high continuing education, specialization, and learning to use new technical equipment. The responsibility for continued learning is reflected in my data.

Many nurses commented on the need to learn new things on a daily basis either formally or informally. This responsibility to learn was presented as directly related to providing quality care to patients and families. Responsibility was also associated with the varying points of movement in the profession such as passing boards, being in charge, and becoming the "senior nurse." Several nurses return to school to enhance their ability to care for patients or to learn how to help patients manage pain or ethical dilemmas. After nurses disclosed the need to learn more so they could better education their patients. Nurses also have commented on the need to be perfect and the responsibility associated with this. A sense of responsibility was a critical component of the nursing identity and manifested itself in many ways and most importantly through the need for perfection, the continuing quest for knowledge either formally or informally, and in gender related expectations.

Various relationships were emphasized by these nurses as influencing their professional identity. Relationships were another focal point emerging from the data as integral to the formation of the nursing identity. Relationships with doctors, patients, peers, patient's families,

faculty, mentors, parents and society were all identified as being significant to the nurse's identity and in how one negotiates for power and authority. Relationships with parents were critical to the nurses I interviewed. Parents were either supportive or unsupportive of this role and their perceptions seemed to correspond to those of society at large. Anita and Alex came from families that wished for their children to become doctors. They both still struggle with convincing their parents that this profession is OK for them. Both sets of parents are appeased by their child's focus on continuing education as a mechanism of upward striving. Debbie chose the profession of nursing over being a physician because she felt that society discouraged this at that point in our history.

Chapter Six

Overriding Themes

Throughout the interviews themes emerged that carried through the processes of entry into the field as well as joining the profession. These themes involved issues of negotiation for power and authority and fragmentation in nursing.

Negotiation for Power and Authority

Since nurses traditionally enact their professional roles as employees in organized work settings, they are faced with how to operationalize professional values in these settings and how to integrate into their behavior and values certain role expectations of the agencies. This issue has been labeled "bureaucratic conflict" (Hinshaw, 1977). Despite the responsibility that falls to nurses as the predominant mediator of patients' hospital experience, they lack overall administrative power. Traditionally nurses have been presumed not to have knowledge of their own. Roberts (1983) contends that nurses can be viewed as an oppressed group and have found it natural to think of themselves as second-class citizens.

According to Torres (1980) "nurses are not generally viewed as peers or even as having a distinct profession by most physicians" (p. 10). Nurses have been led to believe that it is right or natural for medicine to maintain control of the entire health care enterprise (Torres, 1980). This domination by a powerful group has led to what is commonly referred to as the "nurse/physician game" as a mechanism of asserting needs of patients and the image of the profession of nursing. Many nurses interviewed felt they must fight a socialization process into a bureaucratic role orientation.

The exploration in this section of negotiation for power and authority is structured around components of the nurse/physician relationship, system issues and issues of the profession.

Nurse/Physician Relationships

The relationship with the physician has historically been an area of concern for the nurse. Stein (1967) articulated the way in which nurses must communicate with physicians to play the "nurse/physician game". According to Stein (1967) "The nurse is to be bold, share initiative and be responsible for making significant recommendations, while at the same time she must appear passive" (p. 699). This conflict is evidenced in the data of this study.

In describing physician relationships, Denise shared:

> There was one time when a physician did yell at me at the counter with everyone standing around. There were other physicians there. It made me question what I was doing even though I knew what I was doing was right. It made me realize that if I know what I am doing then I really should stick to my guns and not let anyone else tell me that it is wrong. That kind of had an impact with me being screamed at by the desk with families and visitors and other nurses and other doctors.

When asked how she handled this situation, she responded:

> I nodded my head and just took it. I really didn't know what else to do at that time. It was just a choice. I didn't think it would be a good idea to argue back. I just took it.

When questioned as to the response from the observers, Denise responded, "They just said to let it roll off my back. He has done it to other nurses too. Other people just ignore it." Torres (1981) and Benoliel (1975) have stated that nurses have found it natural to think of themselves as second-class citizens. The response of her peers is consistent with this characteristic.

Denise did not feel she should be treated as a second-class citizen. She shared:

> I think the doctors should give us a little more respect and a little more faith because we are the ones taking care of their patients. We are doing the best that

> we can. We can't always make all the right moves, just like the doctors can't always make all the right moves.

Kris discussed her sense of powerlessness in carrying out her work without cooperation from the physicians. According to Kris:

> Patient discharges can be held up by lack of cooperation from physicians and can lead to verbal altercations between physicians and nurses. Sometimes if the patient is being discharged then they need prescriptions. You have to wait for the doctor. Sometimes I just keep calling and calling and calling. I don't know why when they did the discharge paperwork; they didn't write the prescriptions. Why don't they ask the patient if they have this medication at home. It is a very simple question. The patients don't know the questions to ask. They don't know what medication is missing. We have to think about that and call the doctor. Then we have to fight with the doctor.

In this scenario, Kris felt her ability to deliver quality nursing care was hampered by having to deal with what she perceived as an inattentive physician.

Sometimes the nurses interviewed felt dumped upon by physicians. As work builds up, more and more falls on the nurse. Kris, who in the past worked as a nurse in her own physician's office, described the negative feedback, as well as the never-ending workload:

> Well, she would just say the nurses need to do this. Then we were buried in paper work we did all the patient care and we did the history and physical which she wanted done in five minutes. She wanted the height, the weight, the urine, their vitals and the history and physical in five minutes. It wasn't realistic. We had 50-100 phone calls every day. There were either two or three of us. We were responsible for all the lab results. It got to the point where she wanted us to clean the rooms. Wash the walls down. She was constantly blaming the nurses for things that she would do.

Kris went on to describe a series of perceived events with this physician that she contributed to several health problems for herself.

Many of the nurses discussed the dilemma of whether to call the doctor. The nurses hesitated to make a move due to the fear of getting "hostile" responses or "being put down." Over all, it was their desire to see the patient receive adequate care that precipitated what they referred to as patient advocacy. According to Julie, "Sometimes when it is not an emergency situation, I still need to call. Maybe the patient wants to go home." Julie described a situation in which a patient had not had a doctor talk to him since he had been admitted to the hospital. He was requesting to be discharged. Julie attempted to converse with the patient in an effort to help him feel better but he still wanted to talk to the physician. In Julie's hierarchical work situation, she was unable to directly call the physician and was required to go through her charge nurse. Julie stated, "The charge nurse said that is not an emergency, let him go. It doesn't mean that they are not good. They are just too busy. They have to deal with dying patients. I think this is an emergency situation for me. I did not want him to go against medical advice. At that time, I decided to call the doctor or the nurse practitioner myself." Julie further described her frustration with her perceived lack of power in the following words:

> Sometimes the charge nurse is very supportive. She will say here is the phone number, you call by yourself. Sometimes, they say I am too busy, I cannot give you any phone number. Let them wait. We can read the chart but we don't know which doctor to call. This is a situation we have all the time and I think everyone is right. The patient is right and so is the charge nurse but what can you do? No textbook taught me this kind of situation. We have to fight with the patients. Fight with the nurses. When you call the doctors, they don't call you back. When they finally call back, you are just mad about that.

This feeling of fighting with everyone was reiterated by other nurses interviewed. Calling the doctor was discussed by many other nurses as something difficult to do. Maureen described it as an evolving process. Maureen stated:

> It depends on the doctor. I find myself more comfortable now dealing with them. When I first started I didn't want to call anybody. Sometimes when you are talking they might look down upon you.

Sometimes it is hard for nurses to identify the source of the physicians' anger when they do make that call. Maureen stated, "I just kind of agree with them. I mean I didn't mean to bother you, I don't know if they really yell at you for calling or you can tell in their voice they are mad for getting the phone call." This relationship does change over time. Maureen described:

> Sometimes you have nurses who have a small problem who feel they need to call. When I first started out I would say I need to call right away. Now I just say OK, we'll watch him and in 30 minutes we'll call if we need to. I learned a lot of this from my nurse manager. I have learned how she does certain things and what her views are on certain situations.

The decision as to when to call the doctor, with what information to call the doctor, and how often to call the doctor was commonly referred to nurses as the "doctor/nurse game." Woodard and House (1997) identified gender issues that may impede nurse-physician communication and offered suggestions for improving it. They encouraged nurses to adopt several rules and to apply them in practice. "Get to the point, use powerful prose, exude expertise, and expect respect" (p. 40-41). Woodard and House (1997) additionally explained that bigger than gender differences are the different professional backgrounds with different philosophies and values. Frequently these differences are described as "physicians cure" and "nurses care." "Physicians are problem-oriented and thus see the patient in limited terms. What is your problem and how can I fix it" (Woodard & House, 1997, p. 41)? Nurses on the other hand, not only see the problem but also put that problem into the context of the patient's life.

"This approach is by nature more globally focused; thus when nurses speak about the patient, they naturally have more to say" (Woodard & House, 1997, p. 42).

Jean described what she has learned related to calling doctors. "At the very beginning one of the nurses told me something and I called the doctor who was covering. I know now that I have to go look at the patient. I have to get every bit of information that I possible can." Jean described the following tactic to respond to the physician's need for information. Jean stated:

> I wanted to give him some information before I asked him my question. He kept interrupting and asking me what my question was. He was rushing me. I said to myself. No, you always want information. I'm going to give you what I know before I ask my question. I would ask you for a medication or whatever and you are going to ask me why. This way I am giving you the information first. He calmed down a little bit but he still was rushing me.

Jean explained another tactic to deal with physicians:

> I try to combine calls too. I know they hate getting three calls in an hour for three different patients. Sometimes if it is not a real pressing thing then I will wait on it for an hour or so and see if there are any other problems I will need to call them about.

Jean also described situations in which her judgment was in question by the physician:

> The other night I think one of the docs that was covering was having a bad night. He snapped at me. He said well did you have an order to call me? I don't know where these doctors are coming from. Maybe they would want the patient to have a transfusion. When he asked me that question I said no I did not have an order to call you. I just felt that this was a significant drop and I should notify you. He just hung up. About an hour later he called me back. He said Jean are you the one that called me about the blood count? He said are we OK with that? Is everything OK? I said yeah. I think that was his way of apologizing.

While the nurses at times were comfortable with their skills, an interaction such as the one described by Jean can lead the nurse to question her or his abilities. Jean stated:

> I think he realized when he got off the phone that he shouldn't have said that. That made me feel good but maybe I shouldn't have called him. It made me question myself. I'm still not sure of my instincts is what it is. I'm just afraid that someday someone will say you should have called on this.

Talking to other more experienced nurses can help nurses make decisions of when to call. Jean described this process:

> My hardest thing is that I get lab work back and I think whether I should call the doctor or not. If it's normal I know. If it's abnormal, but not that abnormal, I just can't decide if I should call. This is my biggest problem. I pick Beth. The lady who works every Friday, Saturday and Sunday because she has done it for a long time. I say OK Beth should I call on this? Is this something you would call on? I'll say I had this situation what would you do? She is very honest. She will say yes and no about what she would do even knowing what my decisions have been.

Karen described similar situations in calling physicians. Karen shared:

> There was an order to call to inform the doctor of a certain patient's blood sugar. I called the doctor and he said what kind of idiot would call on that kind of blood sugar? I said what kind of idiot would ask to be called on that kind of blood sugar? Then there was a pause and I said oh no. I said oh boy maybe I won't be working here any more. All he said was touché and laughed. If I am wrong then I will admit I'm wrong but if there is something that I want to say I will. He set himself up for that one.

Karen perceived that nurses often allow themselves to be treated poorly by doctors. She shared:

> There are a couple of people that I work with that I think take a lot of abuse. They will allow people to speak to them in a very disrespectful manner. I have been off for a few days and then you come in and you're trying to figure out what is going on. You don't know what is going on with the patients and then people start firing questions at you. I just say I don't know let me figure it out and I'll let you know. I'm not afraid to say I don't know right now. Other people they just kind of fall apart. But I also think that is my age. Maybe I am a little more confident. I have lived a little more life.

Karen reacted to the words "taking orders" from physicians and felt that the nurse/physician relationship is changing. Karen saw nurses as playing a less subservient role to physicians. Karen stated:

> I don't think I could do this if I thought of it that way. I mean the subservient kind of thing. Even some times when I hear the word orders, they are giving me orders, it makes me just want to run away. For the most part a lot of the nurses I know are really very intelligent people that make good calls on things. They will call up the doctors and I even have to suggest things to the doctor. We might say something like how do you feel like looking into this test? A lot of times they will respect that and they will say that's a good idea. Some of the older nurses I see will get up and give the doctor their chair. I wouldn't even consider doing that. I would never do that but I think it was expected years ago. The nurse of today would not wait on a doctor and I think that is a good thing.

Karen described the change in her own relationship with physicians as she became more comfortable with her role. In her role, three years out of nursing school, Karen became more assertive with doctors. She explained:

> One day I had a patient who couldn't breathe. We had done anything we could do in our realm and I went to talk to the doctor. He started going off about why

> is this patient on our service? I just cut him right off and I said I don't why he is on our service but if you can't help me, who can because I am not going to talk to you about why he is on our service when he can't breathe. Right then and there he gave me orders and he came down and he said oh he is OK now. I said thank you doctor you saved the day. He put his hand on my shoulder and he said no you saved the day. Since then that doctor and I have had great respect for one another. It made me feel good because I stood up for my patient. I'm not playing this game. That is the bottom line. The patient. I have a tough skin.

In advocating for a patient with psychiatric issues, Karen clearly identified that a new nurse would be unable to stand up to a doctor. In Karen's judgment, the patient who was to be discharged from her unit was medically stable but not psychiatrically stable. Her response to the physician was that "she is OK medically but she is a whole person and she has other needs." The physician persisted in wanting to discharge the patient. Karen responded:

> She stayed. It was the evening shift and he wanted to discharge her and we called the supervisor and we said you need to call in a psych consult. We need a psychiatrist saying that she is stable enough to go home. Reluctantly, they called in whoever was on call and she was transferred to the psych unit. She was too sick to go home. I mean there were a lot of issues. As a new nurse you are afraid to do that. Because you don't feel you have enough power or you don't feel it is acceptable to speak to a doctor that way, whereas, now I don't back down.

Anita described a similar approach to communicating with physicians. She felt uncomfortable telling doctors what she thought was wrong with the patient so she described the symptoms instead. "Sometimes you get a certain feel from some doctors that they do not want you to tell them a diagnosis or they just want to hear the symptoms. It is not really in my clinical practice to make a diagnosis. I would probably say something like I think the patient probably has a low potassium at this time." This indirect means of communicating thoughts is a more

effective way to relate to physicians as in her experience her thoughts have been discounted. According to Stein, Watts and Howell (1990) nurses couch their practice suggestions in language that implies that the doctor initiated the idea.

Respect from physicians can vary depending on where they work. Anita stated:

> Most of the heart doctors that I work with are pretty good about it. I think most of them have a respect for the nurses on our floor. They have told the residents that if a nurse from our floor calls them up then they had better get there. Sometimes we have doctors that are learning and they are anxious but you tell them there is a problem and they don't see the problem like you do. They are looking for all of these little things and I am saying that this patient is in need of care right **now**. They just stand there and they do not respond as fast as you want them to. The doctors that we usually work with are pretty good. They respond to us when we need them.

Anita also described situations in which she used her nursing judgment and bypassed physicians to do what she perceived as best for her patient. Anita stated:

> Sometimes I have gone up and above or sometimes I have called the attending myself. Sometimes they have not been so supportive so sometimes we just call the nursing supervisor to help us out because they have more power than we do. They get a little more response. And sometimes you know that something is wrong but you can't quantify it. You know something is wrong with the patient but you can't get anyone to investigate it more. Then you just have to let it go. You have done everything that you can do. You have told the doctors and they just don't believe you and then something usually ends up happening. I feel like saying I told you so but that is so inappropriate. You are not proud that you were right. You just wish that they had listened.

Anita has learned to utilize other power bases within the hospital system such as the nursing supervisor to get things accomplished. Anita, a woman of color, described her feelings of difference from other nurses which she feels has enabled her to be somewhat more autonomous in her role:

> With doctors I won't follow orders if I don't like them. I will question them. I don't just wear the typical uniform. I try to jazz it up or make it a little different. Sometimes I just feel a little sad. I feel like I am alone. Other nurses are just not like me. Sometimes they like it when I stand up to doctors and other times I am just out there all alone with no support. I guess I am used to that because of being a woman of color.

Anita disclosed that this feeling of aloneness has been there throughout her life and saw a direct connection to her race. While this at times makes her sad, it does allow her to be more assertive with physicians and in her nursing role in general. Benner (1984) in her qualitative study of practicing nurses found similarities in the nurse/physician relationship to what Anita reported. Benner (1984) stated that nurses often fill in the gaps when physicians are not available and the patient requires care.

Chris described a similar situation as other nurses in her attempt to see that a patient and his wife received the care they deserved, and the need to learn to stand up to the physician:

> I used to think that you just never spoke back to doctors. I find myself saying not to speak to me that way. I would not speak to you that way, please don't speak to me that way. I had a patient that had a bowel obstruction. He had this for a few days and they thought it was resolving and then he had more acute abdominal pain. I called the physician and I said I need to explain to you what is going on. He said did I give him medication for pain and I said that I had. He said call me back in couple of hours and we'll go from there. He was OK and in about two hours he began to have really acute pain again. I called the physician back and

> he said he was coming in anyway and he would stop by to see him. He went into the room and touched the patient twice. The couple felt the doctor was rude and brusk with them and he said this patient does not need surgery and he has had this pain before and I don't even know why I am here. I just stood there looking at him thinking this is inappropriate, unprofessional, and he is going to be mad at me when we walk out of here. He turned to me and said come with me into the hall. I went out there and he started yelling at me. The patient's wife came out and said I can't believe that you walked in there and said those things to us. My husband is very sick and this pain is new. You are not going to order any tests to find out what is going on. He said your husband does not need surgery and we are not going to do anything. She walked away in tears. I wrote him up. To this day he will not look at me in the hall.

While Chris was able to confront this physician, her perception was that it negatively affected her relationship with him. Tragically the patient died. Chris was so disturbed by this incident that she went on to report the physician's behavior within the appropriate channels of the hospital hierarchy. Chris shared:

> I wrote an incident report. I wrote on a separate piece of paper what had happened in terms of the conversation and I gave it to my nurse manager and I explained to her the situation and she went in and talked to the family and she gave everything that I had written to the medical director and that was all I ever heard of it.

Chris felt that nothing had happened as a result of her interventions and felt "sad." She had followed all established channels within the hospital structure and still felt a sense of helplessness.

Chris did find some physicians to be excellent teachers and respectful of nurses. However, she has also had physicians demean her in public places. Chris shared:

> There are a couple of physicians that will sit down with me and teach me about pacers (devices that help control the rhythm of the heart). I ask doctors about procedures they do and what does that mean to me when I get the patient. It depends on the doctor. One of our cardiac surgeons will stand there and act like a child. I think that when my kids were teething they acted a whole lot better than this. He was really yelling at me and I said that I was not going to do this with him right now and he walked away. He didn't know what to do with that. I felt that I would not do that to you. I would not embarrass you or myself like this in public.

Chris, like Karen, described a change over time in her ability to communicate with physicians. According to Chris:

> I think just having to make the decisions I have had to make sometimes have led me to be more assertive. There was certainly a point in my life where I would never have walked up to a physician and said I need arterial blood gases, a chest x-ray, and I need you to write orders for the unit.

When asked to describe how this change took place, Chris shared:

> Talking to physicians. It came from knowing the educational material. My ability to assess my patients. Thinking the process through helps. Taking care of patients is like a puzzle; I always wonder what piece am I missing? What am I not getting? I have talked to doctors and doctors. I try to realize that doctors are not Gods. They are people. They make mistakes. That is why they have nurses. I am their eyes sometimes because they are not there. I need to be able to tell them what is going on. For the most part, the doctors are OK. Sometimes they feel that I am calling them about unimportant stuff. I then say no that is not what I am calling you about. You need that piece of information because why. Then they say, Oh. They don't listen very well sometimes.

One male nurse, Alex, commented on his relationship with physicians. Alex stated:

> I think that they are very good. I mainly deal with cardiac surgeons and anesthesia. It is just like any kind of relationship. It takes time to get to know them. Once you do, they are human beings. They are very receptive to new ideas and thoughts. They are current with what is in the literature and you try to stay current as well. We are in and out of the operating rooms at times for orientations. That just kind of opens the door for communication. This is probably the most important part that we communicate.

Alex shared positive overall feelings about his relationship with physicians; however he still described similar challenges in relating to the physician. He emphasized the need for competent skills, knowledge and communication. Alex talked about earning respect from physicians. Alex stated:

> The more I work in the intensive care unit and the more comfortable I am in my skills and the more confident I am, the more respected I am particularly by physicians. I think it is especially evident, not just with nurses, but also with physician assistants who kind of trust your judgment. You become peers instead of them just giving orders to you. You kind of collaborate instead of being the one to just carry out the order.

In general, the nurses I interviewed described what they perceived as disrespectful relationships with physicians, strategies they have learned to more effectively work with physicians, and a change over time which they relate to increased knowledge and experience in the work situation and in communicating with physicians. Some of the strategies for dealing with physicians discussed by nurses were: giving information, combining calls, talking to experienced nurses, and describing symptoms. Throughout the data, several issues of powerlessness for the nurses interviewed emerged. Many nurses felt humiliated, debased, and devalued by physicians. Most nurses described a basic lack of respect from physicians. Nurses described the

physician/nurse game that is consistent with past literature. Ways of coping with this perceived abuse included increased knowledge, maturity, experience, and watching more experienced nurses. Sometimes, nurses reported support in their efforts from nursing superiors such as nurse managers and supervisors; however this was not consistent. Some nurses felt that the new generation of nurses were inherently more assertive while others reported their inexperience was a deterring factor.

System Issues and Issues of the Profession

Farrell (1997) argued that because nurses are dominated by a patriarchal system headed by doctors, administrators and marginalized nurse managers, nurses lower down the hierarchy of power resort to aggression amongst themselves. I will discuss these issues in this section as reflected in the data. Nurses discussed money as an issue for them in the profession. According to Lusk (1997) "Nurses have been affected by forces concerned with money, gender, and power" (p. 227). Money can also be equated with societal value. Bert (1993) argued that nurses who work in hospitals still suffer severe understaffing, occupational hazards, low mobility, and low pay. Nurses lack overall administrative power and continue to battle for the right to control the pace and context of their work.

Darlene started out as a nursing assistant, went to school to be a licensed practical nurse, and then became a registered nurse. Throughout this process, Darlene, as well as other peers advancing through the process, lost money. Darlene explained:

> There is no incentive for girls to go back to school. We are losing money. One of the girls went to the director of nursing and she said I am not going to work for $7. I have worked here for 15 years. So she said OK, we'll try to accommodate you girls. So she gave them $.25 raises. So a lot of them end up leaving and going to hospitals or other nursing homes.

Darlene went to another hospital and found that she had been misled about her salary. According to Darlene:

> I found out that the hospital had lied to me. They told me I would be making $8.10 and I really was making seven something. This was a $.10 pay cut from the nursing home because I had five years of time there. When I approached them about it they said well the reason we told you that was because you were hired for day/night and there is a differential for nights.

Darlene was never assigned to work nights so she once again began job-hopping to attain a decent salary.

Chris also described the loss of nurses related to not enough money. "The staff don't stay long. They come and they go. It all comes down to a money issue. I just love to be a nurse but I also love to get paid."

Chris felt a lack of control over her salary and attributed this to a lack of value of the nursing profession. Chris stated:

> I don't know who has control over it. I really don't. I think it is frustrating for me to think that someone can graduate from college and become a teacher and make $36,000 a year brand new. I think teaching is very important, but nursing (pause) is just as, if not more important and we make way less than a teacher. I have been a nurse for three years and I still don't make what a brand new teacher would make.

Many nurses interviewed compared the profession of nursing to that of a teacher and consistently felt nurses came up short despite having what they perceived to be valuable positions.

Chris discussed what she felt is a lack of societal appreciation for what nurses do. Additionally, she attributed this phenomenon to being part of a female dominated profession. Chris shared:

> I just wish that society as a whole could appreciate what we do. You can have the best surgeon in the world but if you don't have a good nurse they can have a terrible experience in the hospital. I just think that is has been a female

> dominated profession forever and unfortunately our society's value of a woman is different than that of a man. And men are perceived as being the breadwinner, therefore they make a higher salary. In our society, the major breadwinner in the family tends to be the single mom. I think that once society recognizes that women need a better income, nurses will receive a higher income.

Ed agreed that the money issue in nursing is associated with gender. Ed stated:

> If you talk to the females in the intensive care unit, they feel that they make less money because they are female. Well it is a national trend that males do make more. They feel that if there were more males in he profession they would be making more money. It is probably true. Any kind of study that you read states that the male gender makes more money.

Alice described financial issues within the profession in terms of the hardship it creates for her as a single parent. According to Alice:

> I feel like I work hard and get little credit for it. I do not make enough money and I have to work two jobs to support my son and myself. There is no financial reward for getting my bachelor's or even my master's plus I have lots of student loans to pay back. Actually, working at the nursing home is more financially profitable. There is really no place to go here in the hospital. No way to advance to something else. I want to go back to school. It is better to be working in the hospital than the nursing home because they will help pay for it. I am half way through my masters.

Various nurses disclosed situations within the hospital system in which they felt they lacked power. Anita described a situation in which she attempted to utilize supports with the system. Anita stated:

> I was in charge one night and a patient wanted to leave the hospital against medical advice. It was 4 AM. The patient was stable and he just wanted to go

> home. At 4 AM, I called the person covering for the attending physician. That person would not make a decision. The patient was causing a lot of problems and I just didn't think that this was something that could wait until morning. I knew it would take a lot of energy to try to keep him and it was going to keep me busy all night and detract from the time I had for other patients. I decided to call the nursing supervisor for help. It is usually the nursing supervisor who is authorized to call the attending physician. The nursing supervisor wanted me to call the attending myself, or wait until 7 AM. I was really angry. She said that she was not going to make the call. I did make the call and the physician did discharge the patient. The physician was initially angry but I was assertive about how this patient was adamant about leaving and it would detract from caring for his other patients. He ultimately agreed and said that he respected me for pursuing this. I felt totally unsupported by the nursing supervisor. I think that she was afraid to call the physician herself. She was just going to leave me hanging there in a very uncomfortable situation. That was not OK. I think sometimes that nurses just are afraid to do these kinds of things. My having to be different because of my color has allowed me to develop the skills to stand up for things. I wish more nurses were able to do this. I think that our profession would gain some respect.

Anita attributed her ability to be assertive and stand up for her rights as a nurse to her history as a woman of color. She was frustrated with her lack of designated support within the system. She feels this behavior contributes to the lack of respect for the nursing profession. When asked how she felt about the lack of support in the nursing infrastructure, Anita responded:

> I am used to it. The supervisor was no support whatsoever. The next day when my manager came in she just commented that she had heard about what had happened last night. She really didn't give an opinion either way in terms of

> whether she approved of what I had done. She didn't look happy. I was alone on it.

Chris also expressed many concerns related to lack of support from administration available for nurses. Conflicts with administration were prevalent in systems related issues. Chris stated:

> When there are problems like the staffing issues in some ways I think that is done on purpose. When you choose to work on a floor there isn't an opportunity to get to know people on other floors unless you went to school together. I don't understand why that is true here, as opposed to other businesses. When I worked in the school district I got to know all of the teachers not just because they came through the lunch line. There were opportunities sponsored by the school to get together. When I was in high school, I worked at the phone company and they had things like workshops, the same kinds of workshops that we have and there were opportunities to meet people. Workshops here are difficult to attend because of short staffing. It is like how do you build a cohesive unit?

Chris felt that purposeful separation of nurses was a ploy by administration to decrease the power base of nurses. Chris shared:

> I really believe that we are fragmented and that we are fragmented on purpose. And that is frustrating. One year ago we had a meeting with some of administration. They would come to our floor and talk about issues and then they would go to another floor and talk about issues. They would say things like this floor is able to do this and that floor is able to do that – why can't you? I don't like the idea that they pit one against the other. I would like to believe that they don't do it on purpose but it does happen.

Additionally, Chris felt that administration compares nursing care delivered on one unit with another which impacts on the nurse's ability to deliver quality patient care. Chris described:

> Administration would say, this particular floor can do it with X staff why can't you do it? It leaves you feeling like you are not making the grade. You don't work hard enough. My license says that I am not supposed to take on more patients than I can safely care for. I know that what I can safely care for is different than what someone on the orthopedic floor can safely care for. The patients are different. I think there needs to be guidelines to help figure out what are safe nurse/patient ratios on different floors. Teachers have guidelines as to how many students they can teach.

Again, Chris compared the professions of nursing and education, with nursing coming up deficient. Chris felt the lack of administrative support to deliver what she considered to be safe patient care.

Chris's sense of powerlessness to change things within the system stems from her sense that the chief nurse is herself powerless to change things. Chris disclosed:

> I believe that the things that her bosses think are important, their demands and their expectations of her job impact us. There are things that she has to do that we don't know about. Probably we don't need to understand. It's like Madge, the manager on our floor, she does things that I don't understand and then later I will overhear things and then I will say now I understand. She did that for that reason and it makes sense. I don't need to know everything all of the time. Some of the time, yes. I really believe that Jean is for the nurses. I think that she fights for us very hard. I like her both personally and professionally. When I hear her say she is trying to do the best she can I really do believe that, but I think there is just so far that she can go. She needs the support of the people above her.

Juanita became frustrated with management pushing her to proceed with her orientation faster than she felt she was able. Juanita attempted to transfer to a different floor and became

immersed in a battle with the human resource department who had a rule that one could only transfer after working for one year on a specific unit. Juanita stated:

> Human Resources kept saying I might not have a job and then they said why don't you wait a couple of months. I just kept thinking that I might be out of a job. To be honest with you, I saw the open house for the other hospital and it was on my day off and I said maybe I will go and look for something different than regular floor charge nursing.

Juanita's inability to negotiate changes at the first hospital caused her to seek a job elsewhere. This was not without difficulty as the first hospital had paid for her education and not only did she need to pay back the contract, but also the penalty. "Because of the contract situation, I needed so much money up front. I had to pay back the penalty before I left which was large. There is a $4200 penalty."

Juanita felt strongly enough about her inability to be successful in her first job and her inability to negotiate any changes within the system that she was willing to pay back both the contract and the penalty. Because of the current shortage of nurses, Juanita felt she was able to negotiate a deal with the second hospital to help pay back the money to the first hospital. According to Juanita:

> I would have paid any amount of money. I just knew it wasn't right. They have a tuition buy back here (second hospital), but it was not enough up front to pay for the penalty. For three months they battled it back and forth here. Finally, they figured out some way to do it. They gave me a little extra up front and as it comes up each year, they will subtract from the amount what they gave me up front.

According to Juanita, the shortage precipitated a change in the value of nurses, but she was left with a negative sense of power, control and responsiveness from the first hospital. She stated, "if

one is not able to fit within the mold and conform to all the rules and regulations, one is expendable."

Chris felt that other areas of the hospital negatively influenced her work functions. Chris shared:

> That is probably one of the most irritating things to me right now is that I am at the mercy of the nurses on the floor. I depend on the floors sending patients to our department in a timely manner. I like organization. It is very lacking in my department. I think having our own transporter would probably help. Yes, it's out of control. We have the operating room calling for stat (right away) tests. There is just this whole scheduling thing that is going on. Outpatient scheduling just doesn't think they need to tell us when they are scheduling things. They just schedule these things. They think that I must know by osmosis. So, our secretary keeps having to call everyday to see what is going on with that. Then you have to incorporate into that seeing all the patients from the floors. There are five million reasons why they can't get them up in a timely fashion.

Ed felt there is a lack of autonomy within the nurse's role which is another issue of the system. Ed stated:

> In some sense, you are more autonomous as far as being a nurse. In another sense you have restraints on you. You have to have doctor's orders to do certain things. Sometimes it is frustrating as the nurse when you know you have to do something and you can't without a doctor.

This sense of knowing what you are doing and yet being dependent on other professionals was an issue identified by several other interviewed nurses. As evidenced in the data, stressors involved in this profession do at times cause these nurses to search elsewhere for jobs as their perceived sense of inability to change things emerges and their sense of being devalued by the system influences them.

Within one of the hospitals where nurses were interviewed, there was a severe issue of financial difficulty, turmoil and resultant changes. Nurses within this facility expressed concern for the future of their profession. According to Alice:

> I need to take vacation days. I need to get away periodically. I need some support there to continue. We have a lot of stress here. The director of nursing is leaving. We are unsure of our future as nurses here. The director just couldn't fit in with the way things were going here. As a floor nurse, I am really worried about my future. They are going to lay people off and cut positions. The director is a really nice person. I don't know how she is feeling, but she didn't really share why she was leaving. I just guess. She sent out a memo to all the nurses telling us she was leaving and when. I appreciate that. She has been helpful to me in transferring and other things. She is in charge of all the nurses here. This is upsetting to us.

Alice's concern related to lack of power of the chief nurse mimics Chris's earlier statements. Kris discussed what it is like to work in a union environment. Kris explained:

> People say in the middle of a shift, I'm leaving. I hate the union. They allowed someone to hit a nurse and not do anything about it. The union can be good, however they do not promote professionalism. They basically allow people who do not do a good job or do it worse. People continue to do the bare minimum. I have had nursing assistants yell at me and say I am not doing that thing. You, as a nurse, can't refuse to do anything. They seem to want to protect the person who punches somebody else. They don't seem to protect nurses. It just denotes unprofessionalism. It just allows people to get away with things that they shouldn't be doing.

Nurses identified system issues such as inadequate staffing, powerless chief nurses, devaluing the nursing profession, and lack of support from other nurses or departments as further

issues contributing to a sense of powerlessness for nurses. Many of the thoughts expressed by the nurses interviewed are consistent with previous research. In a study conducted by McCall (1996), despite role changes in nursing, nurses still felt they were described and viewed as "handmaidens" as a result of managerial and medical domination. DeMarco (1997) found that staff nurses tended to silence themselves in order to maintain the culture of the workplace. These conclusions mimic the thoughts expressed in the preceding data.

Fragmentation or Split in Nursing

Fragmentation in nursing takes many forms. Nurses are fragmented by where they work, by their sense of caring and "calling," by their gender, by educational preparation, by their age, by their years of practice and experience, and by the organization of the profession itself. There is a clear distinction made between types of nurses. Many nurses comment on nurses who have the "calling" and those who don't, nurses who come to work for a job and those who really care, and nurses who graduated in the past and those graduating today. These distinctions take on a flavor of good versus bad or wrong versus right. The difference in educational preparation of nurses is identified as a further dividing factor. A nurse may enter the profession with a diploma, an associate's degree, or a bachelor's degree. In fact, today some nurses don't begin practicing until they have received a master's degree or PhD. Nurses are divided over what constitutes nursing skills, how they are to be learned, and whether a nurse's character can be measured in educational criteria.

Education

The issue of different levels of educational preparation was evidenced throughout the data. Anita, who started out with an associate's degree and then received her bachelor's degree, had the following to say about what she can offer that is different from the physician and is associated with her bachelor's degree. According to Anita:

> I like my role now. Actually, it wasn't until after I got my bachelors that I felt like I had something to bring to the table that was different than the medical

> profession did. I like the interaction that I have with my patients. I think that there is a mind/body connection that I interact with more than the doctor. They come in and they want to treat the patient's blood pressure or the patient's pulse or their heart condition. I can understand the anxiety in regards to why is my blood pressure so high. I can interpret for them. The doctors come in and they say you are hypertensive and whatever and when he leaves they turn to me and say what did he just say? I break it down for them and I go away saying, well they learned something from this.

This different focus, Anita attributed to her baccalaureate education and distinguished her from nurses prepared at the associate degree level. Additionally, Anita felt that one reason the nursing profession has such difficulty in defining itself relates to the different levels of entry into the profession. Anita shared:

> We are still defining ourselves as a profession. I think for nursing there is a big problem of not viewing ourselves as a professional because there are so many ways to become a nurse. There are associate's programs, diploma programs, and bachelor's programs. There are so many different entry programs that kind of blurs whether we are truly a profession.

Anita clearly saw herself functioning in a superior level to other nurses. Anita explained:

> I think for me, the nurses at my level of practice related to how many years that I have been working as a RN are not functioning in the same way. I see myself at a level with nurses who have been practicing much longer than I have. For instance, if I call the doctor, I am able to tell them a little more about that patient. I push more for something that I want as opposed to waiting for the doctor in initiate it. Sometimes the doctors say what do you want me to do? I will tell them what I want them to do. So I see myself practicing at the level right now. I think that I do that a lot. I don't see other nurses doing this.

Anita perceived that her level of education allows her to practice at a level of nurses who have been practicing much longer. Anita described:

> At this school, the A.D. school, they focused more on technical skills. You have only two years to do that. They had to focus on the technical skills because they didn't have time. I think that my bachelor's program gave me a more rounded focus, looking at it from a professional perspective. They encouraged nurses to get involved with professional associations and to look at yourself as a professional. Most of the nursing process at this school (A.D.) was based on the doctor's orders.

From Anita's perspective, the professional way of thinking and behaving is a product of her bachelor program while her technical skills are derived from her A.D. program. Anita explained:

> It was a combination of the science and art of nursing. After a four-year degree, most people come out and feel like they are professionals. Getting a four-year degree just makes you feel like you have a bigger edge. You were expected to do...you were not really expected to practice differently depending on whether you had a bachelor's degree or an associate's degree but the courses that they taught showed you what a nurse can bring to the table versus what you have to do to follow doctors orders. The nurse as educator class that I took was excellent and that taught you how to educate your patients. In my associate's program, I didn't get this focus on educating the patient. We learned that education happened. It was incorporated into the different classes that we took. But in my bachelor's program this was a whole course. It taught you how to teach patients and it worked toward more growth in terms of what you can bring to the profession.

Alice, who entered the profession with a bachelor's degree, shared many of Anita's perceptions. For Alice, associate degree graduates cannot think critically. Alice explained:

> There is not enough time in school to do what you need to do. It is when you get out of school that you put it all together. We need to take all that stuff we learned in college and apply it all the time. Nurses that did not go to a BS program don't have the critical thinking skills. We know how to think but we need time to apply it. Nurses from other programs do not see the whole nursing process taking place. My course on nursing leadership was wonderful. I am able to look at situations with patients and see the whole picture and understand what they are going through because I have the knowledge base.

When asked how associate degree nurses cannot put it all together, Alice offered:

> The discharge process. They just can't put it all together. The social worker will call up and say that someone is coming back because someone did not put it all together. They, the A.D. graduates, will tell you that they had all the same stuff but they are really lacking in leadership skills. They just have the bare basic knowledge. They do not know how to be a patient advocate.

Alice felt that A.D. nurses complain and have difficulty with the change process:

> Nurses also bitch a lot. I think this also relates to education. These nurses can't stand change. It makes them nervous. They deal with it by complaining and bitching. That's the way I see it. They don't see the patient as a whole. The family as a whole. They just can't see it. They just don't advocate. They don't get the right orders for patients.

These two nurses definitely perceived that baccalaureate prepared nurses provided a higher level of care. As indicated by Anita, the different levels of preparation influenced the professional identity of the nurse.

Practicing Location

Another area that was felt to divide nurses was where they work. Within the hospital structure nurses choose to practice in various locations. Different locations attract diverse kinds of nurses. Many nurses felt that this separation divides nurses.

For Chris, working in a hospital adds status to the nurse. She shared:

> When you work in a hospital it is obviously more difficult than working in a physicians' office. It is nothing more than a glorified secretary. For some people that is fine but it is not stimulating enough for me. I don't think I'll ever be a nurse in a doctor's office.

Chris felt there was a sense of competitiveness among units. These units reflect personalities, perhaps beginning with the manager of the unit. She described:

> I think this is a competitive environment. It was one of the reasons when I was a student and I was working throughout the hospital I felt stressed. I felt the most unwelcome in the surgical intensive care unit, the cardiac monitoring unit and the kidney failure unit. I was so welcomed everywhere else. Is it the type of personality that is drawn to these floors? Are they stressed to the breaking point and this is the only way they can be? Is it the manager that promotes the attitude or feelings on the floor?

Ed attributed his sense of receiving respect as a nurse to the atmosphere in the intensive care unit in which he works. "If you tell someone you are an intensive care nurse, they say oooh!" When asked what that was about, Ed responded, "I don't know. An intensive care nurse deserves greater respect than a floor nurse. If you say you work on a floor, people do not have as much respect for you."

Alex, who currently worked in a surgical intensive care unit, had decided to work in the operating room. Alex responded with the following when asked what he liked about the operating room:

> You know, I think it goes back to control issues. I must sound like a control freak. It is amazing the kind of things that we can do. I think it goes back to acuity as well. Floor nursing didn't interest me because everything was kind of done. The patients on the floor are just kind of hanging out and waiting to go home or whatever. It is just not critical enough for me. You are sometimes dealing with minute-to-minute issues as to what is going on with these patients.

The sense of superiority in an intensive care nurse seems consistent with Chris's previous statement about nurses who work in that environment. The notion that different areas judge themselves as functioning in a different way is also a theme consistently expressed. Alex was able to draw a distinction between nurses who work in the medical intensive care unit and the surgical intensive care unit. Alex stated:

> I like that we in surgical intensive care are fixing them. In most cases, they get better and move on. Having floated to medical intensive care a couple of time, it seems to just seem like a dead bunch. Where I think we are actually being more proactive with our patients. We are making a difference. We are making them better. I try to not blame the patients when things go badly. We have tried everything and sometimes it doesn't work. We have exhausted all of our medical resources and I guess now we blame the patients. We have done this for years and years and years.

Alex chose the area of nursing in which to practice based on excitement and control. He described:

> I like the adrenaline rush. I like the excitement of it. I like the varied nature of it. You never know what you are going to get. I thought a long time about going into the emergency department. I like the surgical setting. I like that clean setting. Again, it is control. In that kind of environment, things seem under control.

If the practice environment does not contain these the elements of excitement and control, Alex felt that not much is happening there and not much skill is required to work there. Alex described:

> I think we have more of an autonomous practice. Granted we have guidelines and standards of practice and general parameters that are defined by physicians but those parameters have some real flexibility that the floor nurse doesn't necessarily have. You kind of think for yourself a little more. You kind of troubleshoot. We present certain possibilities to the doctors. We see them more often than the floor nurses.

Chris had negative things to say about the nurses in the intensive care environment. She shared:

> I think that in intensive care they are very technical. They also have---the older nurses don't but the newer nurses do---I think they portray that they are better nurses. That they are somehow better than we are. They may be good at what they do but they would not be good at what I do. They just have this air that what they do for the patient is somehow superior.

Nurses also perceived differences between practices in different hospitals. Some hospitals allow nurses to do more things than others. Some of the nurses interviewed that had practiced in different hospitals found these differences to be irritating and condescending. Darlene has practiced as a licensed practical nurse in two different hospitals in the same city. Darlene shared the following about that experience:

> Between the two institutions, everyone had their own rules. When I came here from the other hospital, some of the procedures I had been doing I can't do here. One of the nurses asked me how all my locks were getting flushed. Did you know you are not supposed to do that? I said, well I was doing it at the other hospital. I said that is not fair for the night nurse. She had to go around and

> flush all of them for us. After a while the switched over to a saline lock and we could do it. I was irritated because a lot of the jobs I did at the other hospital I couldn't do here.

The inconsistency in role expectations across hospitals adds to the confusion of the nursing role. Additionally for Darlene, it left her unfulfilled in her role as licensed practical nurse. Darlene stated:

> I like the hands-on care. I like doing my own treatments. I would like to do more for my patients. I didn't like to ask people to give medications for me. They took that freedom away from me. I thought if I was an LPN I could do XYZ. I didn't realize every institution had their own rules.

Bob shared similar experiences as he transferred from one hospital to another in his role as registered nurse. Bob explained:

> There have just been some different protocols. I feel very much like I am on a short leash with a lot of stuff. I have to have a registered nurse go in with me to do things that I have done before. I need to have some experiences with patients where things are not right so I can begin to recognize when things are wrong.

Bob had some understanding that different hospitals did things in different ways, however it was difficult for him to be watched in basically everything he did. Bob stated, "In a way, that is the short leash I am referring to. I am kind of chomping at the bit." The differences identified by nurses practicing in different locations is perceived by the nurses interviewed to further divide the profession and add confusion to their professional identity as discussed in the next section.

Solidarity (or Lack of) in the Profession

Many nurses felt a lack of solidarity in the profession that negatively influenced their professional identity. Chris compared the nursing profession to the teaching profession and disclosed her perception that fragmentation of teachers doesn't lead to the disorganization that

appears in nursing. Chris felt that nursing professional organizations are not as vocal in expressing needs of nurses. She attributed this to lack of organization and unity. She explained:

> The whole business aspect of the medical field is affecting nurses. I don't understand enough how it trickles down to the bottom to nurses. I know that what HMO's say is you get paid so much for this illness and it doesn't matter how long you have stayed here you receive X amount. I know that the hospital loses money from that. I know that Medicare cuts feed into it. It is still like...where would the patient be without us? It is just unfair but there are a lot of things that are unfair. When we talk on the floor about the nursing shortage...pretty soon there is going to be a teaching shortage. They are going to organize and there is going to be enough of a ruckus that you are going to hear about it. I don't understand why nurses can't be as organized as the teachers are. We have several organizations like the National League for Nursing and the American Nurses Association but they don't seem to be real vocal. At least if they are, I'm not hearing it.

This lack of unity she attributed to living in your own little world within your work setting. Chris shared:

> It doesn't seem to be that we are very organized. You are out here and you are doing a job and you kind of live within your own little world. It might be the doctor's office or your home care agency or the hospital. I have friends that are teachers and they seem to have a lot more continuity between all of them. There is a lot more going on through their organizations.

For Chris, this sense of discontinuity existed within the entire profession and influenced her sense of herself as a nurse. She felt that other professions do not suffer from the same discontinuity. She explained:

> I want that continuity. I want the other people that I work with to understand that it isn't just us. We have other colleagues out there and other peers that are going through exactly the same things we are. It is not just here in this hospital. It is here in this city and all the other hospitals and all the other floors. I think in any profession you find people who are really dedicated to it. It becomes a part of who they are. There are other people who just come to work. They do their eight hours and they just go home and that is good enough for them. Many of the people that I work with are searching just like I am. They read nursing journals and they are looking on the Internet. There are just so few of us. I think when I started there were a lot more experienced nurses on the floor. They had a lot more information in just conversation they could give to each other.

The comparison of professional unity in nursing with other professions, particularly education, was prevalent in the data. Several factors were felt to influence this lack of unity such as location of practice and lack of influence of professional organizations. A lack of professional socialization has been identified as an issue negatively affecting the collective self-concept of nursing as a profession (Cooley, 1968; Festinger, 1954; Mead, 1968). According to Takase, Kershaw and Burt (2002), "Nurses' self-concept may be positively affected by the professional socialization process whereby they identify with a professional role model and thus acquire a professional identity" (p. 197). The data in this study reflected that systemic environmental patterns negatively influenced the opportunity for socialization and connection between nurses.

Gender and Race

I will review the influences of gender and race on the nursing professional identity in this section. Both males and females who were interviewed indicated differences in how male and female nurses are treated in the work situation. Gender and race were further sources of division in nursing. Chris described a situation in detail that involved a male nurse not rendering care which she perceived as adequate. Chris stated:

> I worked with a male nurse three weeks in a row, and three weeks in a row I went home exhausted. His patients never got baths, they never got out of bed and he doesn't do frequent vitals and I said to him in the morning, you know your people need to get out of bed, they need to be up and he still doesn't get them up. I ended up this past weekend writing a list down of things that were going wrong the whole weekend and I took it to my manager. He told the manager that it was a personality conflict between he and I. We had to have a meeting. I was angry and I was frustrated. In the meeting, he said that he had done those things that he had not. I went with my manager to the chart and the vital signs (temperature, pulse, respiration) were not documented. The first day I gave them all baths but yesterday I didn't. I had other things that I had to attend to. He said that everyone got a bath yesterday. I said I just took Mrs. P's gown off her that she came to us in two days ago. How could she have gotten a bath? Even if she did it herself, you would have changed her gown for her. He just proceeded to say that I was treating him unprofessionally and I was unapproachable. I said, you have been here for six months, there is a level of performance that you are expected to be at. That expectation is not any different than it was for me. Afterwards I said to my manager that I was concerned.

When questioned about how she felt following this meeting with the manager, Chris's response was this. "Well that was just a human thing. It was knowing that he was going to turn it back on me. It was now my problem and I was being unrealistic. That I was out to get him."

The manager was supportive in this situation and reinforced the responsibilities of the male nurse. According to Chris:

> I think that she handled it really well. I think she made him aware of his responsibility and I was hoping that she would support me because I think it was important for him to understand. One of the things I wrote down was that his

> organization skills needed to be improved. His rooms are a mess. The assistant manager said that this was a guy thing so it was OK. I said, no it is not OK.

Chris discussed her concern that there are two different standards for male and female nurses on her floor. She described:

> With the men that are on the floor, they will say oh well they are men. Well they are men, but they are nurses. Men are expected to be a little unorganized, a little bit slower. But this is not OK. With their disorganization, the next person behind them has to clean things up. Or I have to go clean it up while they are doing their thing.

Chris believed that men are expected to do the job somewhat differently. Chris shared:

> I think in some way people think that men are more adept. Capable. I don't believe that. I think every person is as capable as any other person. Physically, men do certain jobs because physically I cannot lift a 225-pound sewer cap. It is beyond me. Do I think I should expect a man to do fine detail handwork when he has huge hands? Probably not. There are differences that way but men and women can do the same jobs. By their desire, their knowledge base, their experience one can do it better than the other but not because of gender.

Karen shared her thoughts about gender issues in nursing:

> People say that nursing as a profession is not going anywhere because women kind of gum it all up. You know how men-based businesses all run. Sometimes I look at this profession and I see a man that has risen all the way up and I think that it is 90% or 80% women. If a man rises up in it, it is just so funny to me. Women should be running everything there is to do with nursing. Men still come out as the ones to lead it. I would like to see myself somewhere in the hierarchy of nursing. I would like to be up at the top.

In considering percentages of each gender rising to the top in nursing from Karen's perspective, the balance is tipped in the favor of the male. Karen's thoughts have been supported by previous research. Larsen and George (1992) argued that men are over-represented in administrative and other non-staff positions in nursing.

Bob felt that he was given different treatment as a male in nursing. Bob describes the issue of "eating our young" within his own experience. "I have come across a few that have followed that old axiom of a profession that eats it's young. Maybe because I was older I never really experienced that. Perhaps because I am a guy too. I got growled at a couple of times and I growled back and it was over. We went on about our business." Bob also indicated that prior to entering the nursing profession he had some gender related concerns. When questioned as to what he meant by that, he said he "had concerns of how a male nurse would be accepted clinically." He felt this was not founded in his own experience. Greenlaw (1981) said the assumption that women, but not men, would prefer to receive intimate care from nurses of the same sex abounds in the literature and in nursing practice. Women have always nursed male and female patients of all ages. The troubling custom of keeping male nurses (but not physicians) away from certain patient groups implies "that a male nurse is somehow less professional than a male physician" (Greenlaw, 1986, p. 29).

Alex described his own experience with the issue of providing care to a female patient. Alex stated:

> When I was a nurse on the floor as a male I was definitely in the minority. In my class in school of 80 students, four of us were male. So we definitely stood out on a floor that is 99% women. Being a male there and saying, hello I am going to be your nurse today was kind of a shocker. Not that I ever really had a violent reaction to it. There was one 82-year-old Italian lady who wouldn't have anything to do with me. She didn't feel comfortable with me taking care of her. She was very adamant that I could not be her nurse. I admit that that is her right.

> You know at the time I was kind of like this is like taking care of my grandmother. I was kind of uncomfortable but you get over that. For the most part, I have gotten really positive comments about being a male in nursing. People are kind of at first like, oh yeah you are a guy.

The third male I interviewed, Ed, described a similar experience with a female patient. "There are some patients you can never talk to. One patient threw me out of her room one day and just said, I do not want you to be my nurse." When asked how he responded to this he said, "I just attributed it to personalities. You and I don't get along? OK. No one had a problem with it at all. My manager was fine and just switched things around. She gave me a male patient then. I'm not sure if that had anything to do with it." After Ed considered this he said, "Some people just don't consider men to be nurses. Especially the older generation. I just had one bad experience, other people don't have a problem with it." Ed continued to discuss issues of being in a female dominated career and went back to the original patient situation again. "I'm not sure what that patient was thinking. With some of the older patients, I just go in to put them on the bedpan and I just reassure them that I am not going to expose them. After the initial shock, then it's no problem."

Alex discussed what he called "the male thing." The "male thing" in Alex's words was working in a technical floor. Alex said:

> The male thing? It is funny because the patient I was taking care of today said you're a nurse? From the time she has been here all male nurses have been taking care of her. I said that yes there are quite a lot of us working here. I think that it is the kind of floor that men kind of gravitate to it. I think it is the technical piece. I think men are more comfortable with machines than people which is why I have had to have role models to help me with the psychosocial piece.

Alice agreed with Alex's perception. In describing her work on an orthopedic ward, Alice delineates differences in the male/female role. Alice shared:

> It was hard work. It was hard physical labor. There were some men who worked on the floor. Even when I work in the nursing home it is the same thing. We need the men to help move and lift the patients. The men don't get involved with all the complaining that goes on with the female nurses and they get their work done. The men don't get psychologically involved.

When asked to elaborate on how she felt men do not get psychologically involved with the patient, she responded "in some ways the men get more involved with the patient but don't hang around talking the way the nurses do. They use their time more productively. They do better with change."

As discussed in the section on education, Alice felt that nurses have difficulty with change and had attributed the differences to different levels of education. Alice also attributes different reactions to change to gender. Alice stated.

> I think if we had more males, it would be a better-respected profession. The men are not afraid of change. They do not stand around and talk about it. They just get out there and do it. Everything becomes an issue with the females. If the male nurse is unhappy with their circumstances, they are either going to work to change them or move to a different situation. They don't stay and "bitch" about it. Female nurses don't do anything to facilitate change. They talk about it but nothing happens. We expect other people to change for us.

In discussing the respect he has received and his ability to function autonomously, Alex was not sure if this was attributed to his gender or working in an intensive care environment. Alex shared:

> Our population in our unit is pretty split down the middle. We are half male and half female. I think it makes for a good work environment. I don't know if it is

> because we are an intensive care unit or because this is an open heart hospital but we earn a little more respect from the physician maybe. I think our opinions are heard. I don't think this is necessarily a male thing although it might be with some physicians. I think our intensive care status kind of gives us a little more respect. I think our opinion might be respected a little more.

The propensity for male nurses to work in technically oriented areas is supported by previous research. According to Egeland and Brown (1989) preferences for working in areas considered congruent with the male sex role (administration, emergency, anesthesia, critical care, psychiatry and occupational health) was "striking and stable over time, from student days to established career" (p. 705).

Three women of color were interviewed during this study. All three identified ways in which their racial background affected their professional identity. Anita felt like she has always needed to prove herself. This has been a lifelong issue for her, which perpetuated itself in nursing school. She explained:

> Well, I have always been different. I have always felt like I needed to prove myself. It has always been there. Even when I was in boarding school I felt different. Like I always had to do better than anybody else just to come up equal. I always had to work so hard and I always was different anyways. I think I just resigned myself to the fact that I would be different and I would always have to work hard. It was frustrating but it became something that I could deal with.

I was surprised by the situations Anita experienced as a nurse of color. She described:

> When doctors or emergency room nurses or residents come to the floor and they are looking for the charge nurse they usually walk right by me. They see me, and they bypass me and they try to give other people the orders. They are unable to see me in the charge nurse role. They walk right by and ask who is the charge nurse? Sometimes they have asked me and when I say that I am, they still

> continue walking and will go up to a white nurse and ask the same question. I think they perceive me as the cleaning lady.

I questioned Anita as to how she felt about this response. She shared:

> It makes me feel really bad. They just walk right by me and give orders to other people like I am not there at all. One night I was working with a licensed practical nurse who didn't know I was in charge for the whole shift. She kept asking me to help her with things. She kept asking me to do her work. At the beginning of the shift, I talked to her about her assignment and she just looked at me and walked away. I wasn't sure what was going on. Then as the evening progressed, she just kept ordering me around to do things. Finally, one of the other nurses said to her, do you know that Anita is your charge nurse? She was shocked! She thought I was a nursing assistant. I felt hurt. A lot of things have been hurtful and I always feel different. Like I am proving myself. Well, there is a positive side to this whole thing. I have learned to be pretty autonomous and it is not OK to order me around. I found that it is OK to be different. Some nurses do let themselves be ordered around but I just don't stand for it.

It seemed that being a woman of color as well as a nurse caused Anita to feel different and has resulted in more autonomous behaviors. It appeared that Anita had taken on characteristics such as more assertive, autonomous behaviors as a result of her sense of difference. Roberts (1983) contended that nurses lack autonomy. Anita has fought this status by increasing her level of autonomy and assertiveness. Anita felt that her coping mechanisms have been helpful but she still experiences moments of sadness, and feeling bad and hurt.

Darlene described similar responses as Anita. She felt that there are not enough black nurses which is a further dividing factor. Anita said:

> We need more African/American nurses. Doctors walk by me and they think I am an aid. In fact the majority of aids are black. No blacks are going into

> nursing. They feel they can't do it. They feel the opportunity isn't there. I am the only black nurse on my floor here. We have never had a black nurse on this floor. People make comments sometimes. One nurse said, well Darlene stands out in front of us as different. She would not explain what she meant by that. There is one other registered nurse here who is black and she is Jamaican. There is one LPN who is African/American.

Alice also described the difficulties she has experienced in connecting with other nurses of color. One positive factor in her life was a faculty member while she was in nursing school. Alice stated, "the last year I was in college one of the faculty impacted me. She helped me a lot. Me and several other nurses from Kenya. She is one of the professional people who impacted me." I asked Alice to elaborate on this. She explained:

> She is a strong person and she is very knowledgeable. She is very aware of social issues. Especially those affecting minorities. She helped connect us to other black nurses. She does not tell you to do anything. She does tell you what connections there are available. It has been the biggest problem for me to connect with other black nurses. I don't have the hours. I don't have the opportunity to spend time.

Unfortunately because Alice has had to work two jobs to support her family and put herself through school, she has been unable to connect with other minorities. Alice felt it was hard for nurses of color to succeed in the job market. She shared:

> There were seven of us that went to college together. We kind of stuck together. We all went to the same place to work. None of us made it. We had a manager who would just say what you wanted to hear. I don't know what actually happened. Part of it was education. The nurse manager did not like people of color.

It was Alice's perception that she and others lost their jobs because of their racial background and not because of job performance.

Kinds of Nurses

Kiger (1993) conducted a qualitative study of student nurses' images of nursing from entry to training through early clinical experiences. In the accounts of students in this study, there was a clear differentiation between the features that made staff either good or bad. According to Kiger (1993), words used to describe the good nurse include "friendly and welcoming, treat others as individuals, recognize need for and provide support, share in the work, and provide a friendly atmosphere" (p. 312). Additionally, you have to be caring to be a good nurse and must call nursing a profession, career, or calling (Kiger, 1993). Nurses in this study (Kiger, 1993) portrayed bad nurses with the following characteristics: "Unfriendly, treats people impersonally, us and them attitude, give only, negative feedback, don't recognize or acknowledge, and don't share in the work" (p. 312). In this current study similar distinctions between kinds of nurses were made.

All the nurses I interviewed, except two of the three males, referred to the issue of different kinds of nurses existing within the nursing profession. One of these types of nurses was always considered to be lacking or different in some way that has a negative connotation. Themes of what separates the kinds of nurses were age, the "calling," the sense of "caring," and doing nursing as a job versus "nursing from the heart." The theme of different kinds of nurses was not gender or race specific. It existed everywhere. All the nurses interviewed perceived themselves as the nurse who "cares." This self-perception in the data was contradicted by peer assessment. When I interviewed a nurse who was discussing this issue, she identified a peer who she stated met the criteria of the "other kind of nurse." I was able to interview this other nurse and by her own self-description, met the criteria of the "caring, dedicated nurse." This contradiction was interesting in the sense of all nurses being consistent in identifying different kinds of nurses, however, always perceiving oneself as the "caring, dedicated nurse." This self-

perception may not be accurate or the nurse's appraisals of others may not be accurate. This concept warrants future investigation.

According to Chris, "It is frustrating. I am older. This is my second or third career if you count being a mom as a career and I have raised children and I just feel a great deal of responsibility about the things that I do. I am on time to things. When something is due, it is due. When I look at other people that I work with and I say is my work ethic different?" Chris also shared, "There is a connection between age and responsibility. I think it is life experience." Chris added, "I think there are a lot of nurses that did it because they think it is an easy thing to do. It's a job more than part of who you are." For Chris, nursing is a part of who she is and defines who she is as a person. "I think that the nurses that I most respect feel that way. When you meet people they may talk about who they are. I am a nurse. This is what I do. This is what I am about. I have met women who never tell anyone what they do."

Chris elaborated on the differences she saw in other nurses. She stated:

> Being the overachiever that I am, I go home and I think things over. I am not fanatical about it but if something is new to me I will go home and look it up. I will research is until I have in my mind a fairly good idea. At that point, I pretty much know what I am looking at and it will trigger something in my mind. I don't want to end my career and have someone's death on my conscience.

This sense of responsibility and, as discussed in the responsibility and learning section, is another distinguishing feature between the different kinds of nurses.

For Debbie, the different kind of nurse was one who was just coming out of school and who didn't seem to have the same calling:

> I was speaking with our nurse practitioner. We were just talking about how a lot of new nurses that are coming out don't seem to have a calling for nursing. They don't take their job seriously. You know how I said that I was really young when

> I wanted to be a nurse? Well she was really young too. You just know it inside. It was just a calling that got somehow reinforced when I was in school.

Debbie went on to say that this new kind of nurse does not have the same values. She shared:

> They just don't seem to understand the importance of their job any more. It was understood that when you got out of nursing school that you would be working holidays and weekends and brand new people come they want Christmas off and they want to go home. I end up working the holidays and within a year they are gone and they have never worked a holiday. They want to work permanent shifts, they don't want to rotate.

Debbie expressed feelings towards the new graduate nurse who, from her perception, is not held to the same standard. She stated:

> It was just the way it was. Nurses just did that. It is part of the job. When I became a nurse, I knew that I would be working every other weekend and I had to do my share of holidays. That was it. The new ones just say that they are not going to do it and the manager says OK because they don't want to lose them. Meanwhile, all the old ones are still working all of the holidays.

While Debbie herself has only been a nurse for three years, she was referring to her previous work as a licensed practical nurse or to her age. Debbie seemed to be describing a real shift in values in the nursing profession.

Alex also shared that he saw a difference in the new graduate nurse. Alex said:

> I have only been out a year but there is a decided difference in the class that graduated this year and is working in my unit, and the class that graduated last year. They are not asking questions. They have a "cop me an attitude" like I already know this. This is just not safe in an intensive care unit. I still have a number of friends on the faculty and they say the same thing. They say that this class made it through but they are not 100% confident in them. We have

> preceptors now who are working with these people and they are not going to put them through orientation as fast as someone who is asking questions. The comments the preceptors are making are like; these guys don't ask any questions. I don't know what to say to these guys because they are not scared. I think that is a necessary part. I think in their cases something bad is going to happen before they learn.

Alex perceived positive qualities in the new graduate as well. He described:

> I think that the younger nurse of today is better at being in a less subservient role. They are getting more doctors indoctrinated into the fact that I am a health team member. I am a member of this team that is providing care. I think it is just about classic roles and stereotyping. I think it is the image of wearing the hat and the white uniform and the bedpan. I think it takes people who have been there and done it to say this is not how it should be and teaching that to the older generation. You should be respected. I think that if we continue to teach that to new nurses, things will change.

Alex believed that instructors have begun to teach nurses ways of being respected. He felt the stereotypes are changing of the traditional nurse and this can be perceived as a good thing. Alex seemed conflicted as to whether the qualities of the new nurse fit any particular mold as described by previous nurses. What seems inherent in his conversation is that there is a change. Alex was able to identify a difference in types of nurses and the influences of the media on these distinctions. He described:

> There is the large, rotund, matronly kind of nurse who is going to give you a shot in the behind or there is the seductress nurse who does whatever with the doctor behind the curtain. Never do you see the male nurse. When you do see the male nurse like on ER, then we are sensationalized. It is not real life. I watch ER but it is just a TV show. It is like I watch the show and I say that is not right or that

> would never happen. I think that the media just reinforces the traditional role and they make a comedy out of it. I think that nurses do a lot toward changing those stereotypes in the work that we do. I think that when they see our level of involvement and our competence, caring, and that our practice is always there, then it changes how they see it. I think that it is the only time that this image will get corrected is when we have these families that are in crisis and have to be hospitalized, otherwise you see the nurse that takes your temperature and your blood pressure.

Karen also described different kinds of nurses. For Karen, it involved "the calling" and "caring." Without these two qualities, Karen felt it would be difficult to do this job. Karen shared:

> Since I have what I referred to as the calling and I see others that don't is hard. I just can't imagine doing this job without that. It is not an easy job. If someone is in the throws of getting violently ill, if you can't wrap your arm around them and say it's OK, I will be with you through all of this. I can't imagine being able to do that if I didn't feel like this was something that I needed to do. I think you need both the calling and the caring. I can't imagine doing it without both.

Karen described what could contribute to differences in nurses. According to Karen:

> It doesn't seem to matter if they have been there for 20 years or that they are burnt out (common phrase in the profession to indicate someone who lacks motivation and really doesn't care about the profession any more). I don't know if they don't feel any more? We need to have that compassion and remember that you should treat them as if they were your mother or your father. I don't know if certain things like that can be taught.

Karen's perception is that the different kind of nurse is one who does not care.

Darlene also perceived a difference in nurses. She described:

> When you pass meds and a patient asks you what is this for or do you know what this is? They wouldn't answer them. When a patient or family asked a question and they couldn't answer it, they wouldn't. Sometimes when were short staffed they would go our and help the girls. Sometimes we might say, could you help me lift up this patient in the chair? They would say I can't do that. They didn't want to get involved. They just wanted to do their work and that was it. No more, no less.

Juanita described similar characteristics different types of nurses. According to Juanita:

> I think having the opportunity to work all over the hospital with some wonderful nurses who were really meticulous in their care. Their feelings for the patient are obvious. They were so connected to them. That was awesome. When I first started I had a lot of contact with that type of people and it was just wonderful to be mentored in that way. I just wanted to be like them. On the opposite side I worked on some floors where being a nurse in the system was different. They were not very friendly towards having you there. They were not really very comfortable with having someone else around.

Again, the "caring" and meticulous qualities are the desired ones in nursing and are qualities to which one aspires. On the other hand, some nurses are unfriendly and not welcoming.

According to Jean, there is the rude nurse who doesn't appreciate the workload of others. Jean described:

> They are not willing to give information. No one is as busy as they are. That really drives me crazy. I know that the emergency department is busy. I know that because I am busy getting all your patients. Six admissions every night. But don't be rude to me. You don't have to be rude to me.

Jean described the differences between two nurses that she was supervising. Jean stated:

> One of them is in her first 13 weeks with us. She is wonderful. She is very experienced. She has 30 years experience. I never hear from her. She just does her work. One night she had two transfers. Those patients were gone and the rooms were cleaned before I even knew it. This other girl, I ended up having a meeting with her. She would roll her eyes or she would be unhappy if I was giving her another admission. I would always divide up the admissions. There was always some attitude. Even with the patients. I walked by the room one time and I heard her say to the patient, now what do you want? I said wait a minute, you do not talk to people like that.

Jean further described different types of nurses. She explained:

> There are some of them that are just into it for the money. I can see where girls who have been in it for a long time have gotten burnt out or they have just given up in fighting everyone else. There are the ones who really do care and the ones where it is just a job. I think part of it is the schooling. They push so much to get the meds on time, to get those treatments done, but don't talk to the patients. They don't spend any time with the patients. They are zoned in on all the technical stuff. They are not doing any of the caring any more.

Maureen stated, "There are a few nurses who just want to come and get the job over and leave." Maureen described one nurse with whom she worked, "It is not that she does not care about her patients. I think she does. Sometimes we feel here that she acts like it is just a job. She acts like she knows everything too." Maureen's further distinction was expressed, "Before I graduated, the nurses that I observed were task oriented. The way we learned they either are very caring and spend a lot of time with their patients and take care of emotional needs as well as physical or not. I learned to be caring." Maureen thus identified herself as the caring nurse versus her peer she previously identified as "just here for the job." I felt I needed more information on this other kind of nurse and discovered from Maureen that this nurse, Denise, was

also a graduate of one year; thus meeting the criteria for my study. I called up Denise and set up a meeting. One difference I immediately noticed was that Denise wanted to meet before her shift was over. All the other nurses I had interviewed in fact wanted to meet one-half to one hour after their shift just to make sure they were done with their work. The interview with Denise however did not support the description given by Maureen. When Denise was discussing her experiences in nursing school, she disclosed that she had also seen different kinds of nurses. According to Denise:

> A lot of times I would see nurses and their bedside manner wasn't the greatest. They just wanted to get through things. It wasn't the way our instructors had taught us. A lot of times your conscience would kick in, you would say I cannot leave a patient like this when another nurse would.

In describing what she had seen in other nurses, Denise used the following words that were almost identical to other nurses. "They were very rushed and they seemed like they were there more for a paycheck than to really care about the patients. I've seen nurses be rude. Yell. That was what I did not want to do." In describing the kind of nurse she aspired to be, Denise again used similar words to her peers. According to Denise:

> They were friendly with their patients. They had good rapport with everyone they worked with. They seemed very knowledgeable about what they did. They were willing to take the time to explain this is why we give this medication and this is how we do this procedure. I think that helped a lot. They were willing to take the time to talk to me as a student even though their day was so busy. They would go an extra five to ten minutes over instead of making sure they got out of work on time.

I found it interesting that Denise who had been perceived by a peer as someone who didn't take the time with patients, did not describe herself in those terms. Denise explained:

> I leave about 4 or 4:30. My shift ends about 3:30. I am usually doing paper work to catch up. I would rather be in there with the patient doing hands-on than sitting at a desk doing charge. I like working on the floor and giving care from the heart. If you like working on the floor, then that is what you should do.

When asked to define care from the heart, Denise had this to say. "You really care about your patients. You are there for the people. You don't care about the money. You are only there for the people who are sick and need you." Denise's self-perception did not match the perception of her peer. Both nurses perceived themselves to have the same desirable qualities.

Julie framed differences between the young nurse and the elderly nurse. Julie described:

> The nurses here are very elderly. I think they are over 50 years old. They are elderly but they are very experienced. They remember things to help us get through our experiences as a new nurse. They know the kind of situations that we have to handle. They can explain a lot of different ways to do things.

For Julie, in contrast, the young nurse is the one who doesn't go the extra mile in caring for her patients. According to Julie:

> The young nurse does everything quick. They say I'm finished. I'm done. That's it. The nurses do everything for the patient. When I was a student nurse there were a lot of young nurses. They do things very quick. Very efficient. They just do everything according to the order. When they are finished, they stay in the nurses station. They just stay there and do their own documentation and that is it.

The elderly nurse, according to Julie, has taught her to do everything for her patient instead of the basic essentials she sees performed by the young nurse. Julie described:

> The young nurse will just put the lunch tray there and leave. The elderly nurse will ask you did you get what you wanted? Can I help you with something? Do you want more? Did you get the wrong menu? Do you want more juice? They

> may tell you something. We need to keep asking them what do you really want? So I have learned a lot from the elderly nurse. I have learned about emergency situations as well as general nursing care. They do everything for the patient.

In this case, the ideal nurse for Julie was constantly assessing and anticipating all the needs of the patient. Julie did not perceive that the older nurse loses the ability to care.

Kris also talked about different kinds of nurses. She described:

> There are two kinds of nurses. There is the nurse that shows up for the paycheck. Is either burnt out from being there way too long or just doesn't care. From the second she walks on the floor she is complaining about everything and everybody. Then there is the nurse who walks in and says you know what this is, what we have to do, let's do it. She goes above and beyond. She truly cares about the patients. I think the other nurse at one time did care. There are parts of them that show me that they still do.

While Kris describes essentially the same types of nurses, she perceived that the older nurse may fall into the category of the nurse who doesn't care, but once did.

Alice distinguished between types of nurses in the following way:

> Their personalities are different. There is a huge difference in how they interact with patients. Some are not the type to get involved with people. They don't do extra. We get the same paychecks, but I do much more work. They don't help out others. When their work is done, it is done. They don't go beyond the basics with their patients. They don't anticipate discharge needs. They don't work with the nurses' aids to help out with basic care. They see that as beneath them.

Bob was the one male nurse who commented on differences in nurses. Bob described his ideal nurse similarly to the female nurses. Bob stated:

> Most everyone I have run across are very supportive caring people. They are my idea of how to be a nurse. I am very proud to be associated with those people.

> There are some people who do not work that way but I think that is true in any profession. All the people I have worked with have been the ideals with that.

Bob saw extremes in nurses. Bob stated:

> Occasionally, I would run into a nurse who would say I just don't want to do that admission (admit the patient to the unit). That wasn't very often. I also saw one or two who would take the admission if they were up to their eyeballs and swamped. These are extremes. I think part of management is recognizing those particular characteristics. That is part of the growing more comfortable with the competency. I see that in my fellow workers. Hopefully in myself too. We need to focus on finding the middle ground.

I found Bob's perception of extremes and the need for balance interesting. His thoughts seemed consistent with nursing literature. According to Reverby (1987), because nurses have been given the duty to care, they are caught in a secondary dilemma: forced to act as if altruism (assumed to be the basis for caring) and autonomy (assumed to be the basis for rights) are separate ways of being. Nurses are still searching for a way to forge a link between altruism and autonomy that will allow them to have what philosophers have referred to as "caring with autonomy." Reverby (1987) felt that the central dilemma of American nursing is the order to live in a society that refuses to value caring. According to Reverby (1987) "unable to find a way to care with autonomy and unable to separate from the devaluation of caring, many nurses find themselves forced to abandon the effort to care, or nursing altogether" (p. 10). Perhaps this dilemma is what leads these nurses to define different types of nurses and Bob's search for the middle ground.

As evidenced in this data, relationships with physicians took on varying forms. Physicians were described as teachers, mentors, and colleagues. Physicians were presented as a stimulus for developing assertiveness skills and also as a source of frustration when they do not respond to nurses' intuition and gut-based knowledge that things are not ok with the patient.

Some nurses indicated that respect from physicians was contingent on where they worked, with higher value being placed on more technical environments such as intensive care, the emergency room, and the operating room. The ambivalent relationship with physicians that emerged in my study is also evidenced in the literature. Stein (1967) articulated the way in which nurses must communicate with physicians to play the "nurse physician" game. "The nurse is to be bold, share initiative and be responsible for making significant recommendations, while at the same time she must appear passive" (p. 699). Many nurses in this study discussed strategies they employ when calling or communicating with physicians.

Nurses' relationships with each other are conflictual. The theme of fragmentation in nursing is evidenced frequently in the literature. Chandler (1995) contended that nurses have been derogatory about each other and nonsupportive in work settings. DeMarco (1997) found that staff nurses tended to silence themselves in order to maintain the culture of the workplace. Reverby (1987) described a split between "worker-nurses" and professional leadership. The nurse at the staff level ("worker-nurse") builds pride on work-place skills and character. They saw no contradiction between demanding decent wages and conditions for their labors and being of service for those in need. Those nurses receive continual criticism from nursing's professional leaders.

Reverby (1987) further stated that nurses are still divided over what constitutes nursing skill, how skills are learned, and whether a nurse's character can be measured in education criteria. Roberts (1983) discussed that nurses exhibit self-hatred and dislike for other nurses as evidenced in the divisiveness and lack of cohesiveness in nursing groups. My study did not reflect self-hatred, however did display fragmentation and difference. Lack of participation in professional organizations can by valued as evidence of lack of pride in one's group and a desire to not be associated with it. Bowman and Culpepper (1974) have documented the divisiveness in nursing and call for unity.

Fragmentation in nursing takes many forms. Nurses are fragmented by where they work, by their sense of caring and "calling," by their gender, by their education preparation, by their age, by their years of practice and experience and by the organization of the profession itself. All of the nurses I interviewed commented on a difference in nurses depending on where they practice. The professional identity of the nurses in this study was strongly influenced by where they worked and the prerequisite skills. Many nurses commented that each floor has its own set of personalities and expertise which further adds to division in nursing and complicates professional identity of the nurse.

The difference in educational preparation of nurses was identified as a further dividing factor. A nurse may enter the profession with a diploma, an associate's degree, or a bachelor's degree. In fact today some nurses don't begin practicing until they have received a master's or PhD. For some nurses in this study, getting a four year degree made them feel like they had a bigger edge. The various levels of educational preparation for the nurses further added to a sense of fragmentation. The issue of conflict related to differing education preparation is well documented in nursing literature (Reverby, 1987; Nursing World, 2000; American Nurses Association, 2000).

The idea of different types of nurses was prevalent throughout the data in this study. Fourteen of the sixteen nurses described the concept of different kinds of nurses. The description of nurses in categories did not exist on a continuum but as distinct, clearly defined categories. One type of nurse was described as being there just as a job and for the money. This nurse did not function as part of the team and did no extra work. These nurses at one time may have cared but no longer do. These nurses do not have the "calling." The focus in the care of these nurses was described as technical vs. psychosocial and did not involve expanding energy to educate the patient/family. Another category of nurse went the extra mile, stayed overtime, had the calling, focused on the "whole picture," was not content in the "comfort zone," focused on patient education, could not say no and "cared from the heart." Without fault, all female nurses and one

of the three male nurses described these types of nurses in this way. All the nurses interviewed described themselves as the nurse who has the "calling" and cares. Explanations provided for discrepancies in nurses involved age, newness in nursing, burn out, and lack of commitment to nursing.

Several nurses described a difference in nurses who are graduating today. Newer nurses were described as more assertive and playing a less subservient role; however, do not ask questions while being oriented, don't want to rotate shifts, or work holidays or weekends. They were not perceived as team players. Another distinction in types of nurses related to the technical versus the psychosocial nurse. I interviewed two males who were more comfortable with "tasky" things while the females liked the psychosocial. This ability to attend to psychosocial needs is something which seems to evolve over time. Nurses described technical and psychosocial skills as being required for all nurses but as two distinctly different skills. The nurses I interviewed felt that the ability to be there for the whole patient is the essence of nursing. The males seemed to aspire to developing the psychosocial skill as much as the females but felt that it was something they needed to work harder at.

A final distinction that emerged in this study related to gender. Nursing literature abounds with issues of gender. Within my research evolved the notion of societal devaluation of a female dominated profession. From a societal feminist perspective, nursing is an example of household work shifted to the outside world of production. Because this work was not valued when it took place within the home, it similarly received little economic or status reward when practiced publicly (Miller, 1976). DeVault (1991) stated "women have also been constrained and oppressed by the burdens of caring for others" (p. 2). "Caring has been mostly unpaid work, traditionally undertaken by women, activity whose value is not fully acknowledged even by those who do it" (p. 3).

Kalisch and Kalisch (1986) stated that Nightingale's vision held no place for men in nursing "except where physical strength was needed" (p. 166). Lewis (1981) argued that the

feminine origins of the word nursing may have acted as a deterrent to men entering the profession. The assumption that women, but not men, would prefer to receive intimate care from nurses of the same sex abounds in the literature and in nursing practice (Greenlaw, 1981). Many comments made by males and females, I interviewed are supportive of these themes.

Two of the males I interviewed perceived some role strain related to being a male in a profession dominated by women. Because many qualities revered in nurses may be devalued in a patriarchal society, role strain has been cited as a likely problem for male nurses (Wilshaw, 1987). Preferences for working in areas considered congruent with the male sex role (administration, emergency, anesthesia, critical care, operating room, psychiatry, and occupational health) was "striking and stable over time, from student days to established career" (Egeland & Brown, 1989, p. 705); however this strategy did not reduce role strain for these subjects. Two of the males I interviewed were employed in intensive care environments and had a self-proclaimed difficulty in dealing with psychosocial issues. They focused on technical skills in an autonomous position. A new finding reflected in this data was the perception of several of the nurses that males receive preferential treatment by managers. They are expected to do less and are held to lesser standards. Their female counterparts are expected to pick up the pieces of their incomplete or sloppy work.

Much of the data presented in this chapter related to fragmentation in nursing is consistent with the literature reviewed. According to Roberts (1983) nurses exhibit dislike for other nurses as evidenced in divisiveness and lack of cohesiveness in nursing groups. Lack of participation in professional organizations can be viewed as evidence of lack of pride in one's group and a desire to not be associated with it. Bowman and Culpepper (1974) have documented the divisiveness in nursing and call for unity. The data in this section clearly pointed to areas of divisiveness in nursing such as gender, race, location of work and education. A distinction in this study is that nurses express a strong desire to unite, however feel restricted by environmental

factors and elements of the profession itself. The descriptions of different types of nurses is new data not reflected in previous literature.

Chapter Seven

Summary of Findings, Implications and Areas for Future Study

In light of the questions that emerged in the review of the literature, this study is timely and pertinent. This research helped explore how nurses view caring in their nursing practice. The ongoing debate in the nursing literature as to what is caring, is it critical to the nursing profession and is it realistic in today's professional climate were all issues discussed by the nurses in this study. Many nurses discussed the "conflict of caring." This "conflict of caring" was described as negotiated early in the first three years of practice and was a passage identified in the construction of professional identity.

I argue that the current health care environment with its focus on the business aspect of the provision of patient care is in conflict with a culture of caring. With financial reimbursement being connected to a decreasing length of stay for patients, nurses are unable to get to know their patients in any depth. There is a revolving door of admissions and discharges which further complicates the ability to care. Many nurses in this study commented on the business aspects of the hospital environment. I purport that nurses who often connect their competence with the ability to care for families and patients, and who identify that positive feedback from patients and families contribute to their professional identity, are in danger of losing main reinforcements their professional identity in this business environment.

Past research suggested that nurses in practice have a more legitimate perspective of nursing than nurse leaders and educators (Coudret et al., 1994; Greenwood, 1999; Lusk, 1997). My study focused on nurses in practice and their perspectives and meaning making. Wuest (1994) purported that the distinctive experience of nursing practice should guide nursing research and the outcomes of research should be tested within the reality of practicing nurses because that reality may be quite different than that of the nurse researcher. This idea was the very essence of my study. Wuest (1994) disclosed that she was hopeful that this research approach "may reduce

the current chasm between nursing practice and research" (p. 363). I will identify ways to reduce this chasm later in this chapter.

The issues raised in this data, relate to Sanford's (1967) theory on challenge and support. According to Sanford (1967) "a person strives to reduce the tension caused by a challenge and thus to restore equilibrium" (p. 49). Unless needs are taken care of by other people "the striving will continue until he has found some means for reducing tension and restoring equilibrium" (Sanford, 1967, p. 49). For Sanford (1967) the "goals of adjustment, stability, and piece of mind are fundamentally incompatible with the goal of development" (p. 50). Sanford (1967) believed that "the essential point is that a person develops through being challenged; for change to occur, there must be internal or external stimuli which upset his existing equilibrium" (p. 51). Additionally, Sanford (1967) stated, "people develop when stress is great enough to challenge their prior modes of adaptation, but not so great as to induce defensive reactions" (p. 52).

I argue that this balance of challenge and support is critical to the development of the nurse's professional identity. There are various movement points, beginning in nursing school and progressing through the first three years of professional development, in which this balance becomes critical. I propose that the attrition rate, as reported by the participants, in nursing school may relate to the balance being higher on the challenge side versus support. The stories of challenge reported by these nurses often indicated a lack of support or that adequate support was the one thing that sustained them.

The decision to enter the profession of nursing is influenced by many factors. Family influences and those of society either positively or negatively influenced this decision as indicated in the data. The image of nursing presented by the media often negatively influenced potential nurses as nurses were represented in dependent positions lacking autonomy. Cultural supports were not always present, as indicated in Alice's story of being unprepared in Kenya and Julie's story of the limited role of the nurse in China. Societal influences as well as lacking academic preparation were reflected as reinforcing the dependent role of the nurse. Some nurses

performed poorly in high school courses that were felt to be important in becoming a nurse, such as science and math. In this study, many nurses delayed entry into the field related to many of these influences. Many of these nurses entered the field at a much later date and did so because of support and encouragement from someone significant in their lives and a sense that they just needed more to feel fulfilled in their lives. Many had wanted to be a nurse for as long as they could remember.

Many nurses described the challenges and supports of nursing school. As previously described, many nurses entered nursing school concerned with whether they had strength in the right courses or the appropriate skill mix to be a nurse, and reported situations that negatively influenced them and their sense of themselves as a nurse. The curriculum was difficult, instructors were often described as rigid and devaluing, they experienced concern for lack of success of peers, and felt a lack of encouragement from practicing nurses. These factors contributed to great challenges in school. My own experience in nursing school and as a faculty member mimics the description of these nurses related to faculty. The experience of clinical work as a student can be compared to a hazing process. A conflict revolves around the provision of safe and quality patient care and the need of the student to be creative and flexible in the provision of that care. The students' perceptions of the faculty member often involve a sense of one right way to do things with no room for creativity and no positive reinforcement. Faculty members are often feeling that in a learning environment in order to keep patients safe the student cannot vary from established protocol. Additionally, having survived the hazing process themselves that involves strict, rigid somewhat controlling and demeaning behaviors, faculty perhaps find this treatment essential to survive a hierarchical demeaning system. Faculty may in fact perceive this hazing process as helpful in surviving the system, thus inadvertently reinforcing a subordinate role. The balance of challenge and support thus is further complicated by determining what is best for patient safety as well as negotiating the hierarchical system. Relationships with patients and families, instructors, and peers often provided the support needed

to proceed with the pressures of school. Outside commitments were a further challenge often perceived to be unrecognized by administrators and faculty.

Upon graduation from nursing school, nurses reported traversing several passage points in the first three years of practice and in constructing their professional identity. Influential in traversing these passage points was an appropriate balance of challenge and support from the system, peers, colleagues, patients, etc. Nurses negotiated "finding their niche", passing boards, orientation, charge, being a senior nurse, the conflict of caring, nurse/physician games, developing from technical skills to seeing the whole picture, and then potentially moving on to new skill development. Throughout these passages, nurses were challenged by: an overwhelming sense of responsibility to their patients; a need to be perfect; power and authority issues within a hierarchical patriarchal system; the necessity for continuing education; and relationships with administration, other nurses and physicians. The very elements that were perceived as challenges also became supports. The balance of challenge and support ultimately influenced the successful negotiation of these passages and the construction of professional identity.

Since the literature reviewed revealed only one article referencing emotional responses to the experience of boards, this is an area in need of research. The data collected in this study enhanced the dearth of knowledge in this area. This study added further data to identity issues identified in previous nursing research in the following areas: issues of support, influence of environment, consistency in goals between self and employment institutions, the importance of positive role models, and emotional responses to nursing boards.

Implications and Future Study

I will examine implications of this study in several domains throughout this section. This discussion is structured around the domains of nursing faculty, hospital and nursing administrators and

staff educators in the hospital setting, and the societal image and nursing profession. This examination of implications will identify areas in need of future study as supported in the data.

Nursing Faculty Domain

The participants in this study had many positive comments related to their faculty, however, often felt devalued, not listened too, and as if they were shoved into a mold with no room for differences or growth. Perhaps this is reflective of their own education and history within nursing. Faculty that encouraged problem solving, critical thinking, and who challenged them by placing high expectations on them were respected and admired. While faculty who were perceived as judgmental and rigid were small in overall numbers, their influence was strong. Administrators of schools of nursing and faculty should be aware of the behaviors described by the participants and make efforts to modify this hazing practice. Students described watching peers fail the clinical component without understanding why. Faculty are not at liberty to discuss the progress of students with other students, which leads to faulty student perceptions of why their peers are unsuccessful. This perception contributed to evaluating faculty within a negative framework.

The majority of participants felt the rules of clinical were rigid and stressful with little room for individuality. From a patient safety standpoint, educators have traditionally supported learning one correct way to do things. Variations from this approach might be incorporated later as the nurse has more experience within the clinical setting. The participants in this study did not see beyond the rigidity of the instructor approach. While the majority of participants felt supported by the faculty, most had "horror stories" with at least one faculty member that stood out in their memory of nursing school. Other faculty and perhaps administration were aware of the behaviors of their colleagues and from the perception of these nurses did not attempt to halt it. I would urge nursing faculty to relook at the balance of challenge and support in the nursing school environment. The level of anxiety as reported by the nurses in this study was perceived as detrimental to their learning process.

I identified in the review of the literature some information on "eating our young" as it exists in the profession of nursing (McCall, 1996; Farrell 1997; Leap, 1997). There are no studies that address this in relation to the student nurse and the part that the education system or the curriculum has to play in it. Most of the nurses in this study related stories from their student days that they felt were not dealt with in a constructive manner and remained unresolved. Hastie (1995) challenged nurse educators to explore this issue through a process of education, reflection, and consciousness raising. Freire (1972) defined conscientization as an awareness of the competing human interests and power structures that manufacture and perpetuate social situations.

Askew and Carnell (1998) claimed that nurse education needs to be based on a model of transformatory learning and emancipatory action. Transformatory learning is not just concerned with the acquisition of technical and practical skills but also with emancipatory concerns such as justice, freedom and social equity. Traditional approaches to education and curriculum development can lead to acquiescence and collusive behaviors. Traditional approaches to nursing education have suppressed the imagination of the student in the focus on what has been referred to as "educare", meaning filling of an empty vessel (Neville, 1989). As a result nurses lose the capacity to be autonomous learners and the potential for accountability.

The data in this study has pointed to the enculturation of the nurse to be subordinate. Also reflected was the inability of nurses to tolerate change and to complain and bicker with one another instead. Education that is based in knowing and reflecting on self in practice is deemed to be a method of accomplishing widespread change in practice but only if insight gained is acted upon and the practitioners involved value the change. This has been a battle in nursing. Nurses in this study often reflected that faculty were not open to change and differences of opinion. The system was perceived as unchangeable.

Utilizing the concepts of reflective practice in nursing education is a potential place for change to take place. Issues of inequality and power could be explored in the clinical work

setting. Nurses could be encouraged to think outside the box and challenge issues while they are engaged in practice. The rigid rules as discussed by the nurses in this study should be open to challenge by nursing students and faculty as well. Facilitators of education and clinical supervision should address subtle power messages within everyday clinical practice. Traditionally, nurses have not found it easy to stand in their own power. One could question whether teachers of nursing (mainly nurses) feel able to use their own legitimate power. Duke (1996) argued that the current process of nursing education is in danger of reinforcing the submissive position of nurses.

I propose that in order to change how nurses perceive their power base and control their practice we need to begin with transforming the education of the educators themselves in an attempt to change a cycle which reinforces a subordinate practice. Research should be done incorporating the work of Freire in consciousness raising for nurses to halt the process of comfort in a subordinate role. Empowerment can be defined as "a process aimed at changing the nature and distribution of power in a particular cultural context" (Bookman & Morgen, 1988, p. 4). It involves the enabling of others to recognize and feel their strengths, abilities and personal power. Empowerment is an energizing experience that mobilizes one's resources and enables change. When one is empowered, one experiences a sense of hope, excitement and direction (Mason, Costello-Nickitas, Scanlan & Magnuson 1991). According to Mason et al. (1991) a prerequisite to acquiring power is a plan to unify and empower one's self as well as the profession by developing politically astute change skills. Education of nurses to enhance power and influence in the workplace could include discussions of: getting and using power, creating an image of power, planning for change and overcoming resistance to change, marketing change, doing a political assessment, developing a support base, building coalitions and managing conflict with emphasis on constructive confrontation and principled negotiating (Mason et al., 1991). Nurse educators should be exposed to these concepts themselves in their own education process and then should integrate them into the existing nursing curriculum.

I identified through data analysis that many of the participants were academically weak upon entry into nursing school. They often had not performed well in required subjects for the nursing curriculum. Emphasis in recruiting into the field should be on candidates with stronger academic preparation which ultimately might improve image and skill development. Perhaps an earlier focus in primary education on needed academic preparation for nursing would additionally be helpful in this process. I purport that a stronger academic preparation would enable future nurses to better survive a rigorous nursing curriculum as well as an adversarial work environment.

Innovative programs, such as the weekend program referred to in this study, are needed to enhance the ability of nontraditional students to be successful in nursing school. Many participants described the struggles of balancing families and employment while in nursing school. Student affairs professionals need to be cognizant of these additional burdens and pursue such supports as childcare and potential flexible employment options such as working as student nurse aids as described in this study. Also, a flexible curriculum to enable the working parent the opportunity to engage in varied life activities would be helpful.

Teamwork was stressed as being critical for success in the profession. Team activities should be part of the nursing curriculum and in the clinical area as well. Many participants felt a focus on their own provision of individual nursing care left them disadvantaged in assisting peers. Many of the nurses in this study felt disadvantaged in dealing with other members of the health care team in a collaborative fashion. They felt their education did not focus on collaboration skills in the planning and provision of patient care. Team treatment planning activities could be incorporated into conferences held both pre and post clinical experiences. The focus on leadership and teamwork was more prevalent in the participants who received a baccalaureate education. The associate degree and diploma programs should place more emphasis on this in their curriculum.

The physician was identified as a team member who was challenging to work with. Increased autonomy for the nurse will require a fundamental shift in the way that practicing nurses see themselves. This shift must be accompanied by a comparable change in physicians' perceptions of nurses (Carpenter, 1995). Change in relationships must be a two-sided process. Nurses need to change their perceptions of the physician as arrogant and uncaring or it will be difficult for either party to behave differently towards the other. One recent approach to changing interprofessional relationships is through shared learning (Areskog, 1995). The concept of shared learning has been incorporated into medical and nursing curricula in England. The program consists of interprofessional shared learning for final-year medical and nursing students (Carpenter, 1995). The program focuses on intergroup behavior for positive attitude change. The theoretical foundation includes: institutional support, equal status of participants, a cooperative atmosphere, successful joint work, and concerns for and understanding of differences as well as similarities (Carpenter, 1995). The program staff are encouraged to help the participants identify similarities and differences in the attitudes, skills, roles and duties of the two professional groups. This type of program has demonstrated that the promotion of more collaborative teamworking is enhanced by the fostering of positive stereotyping and the diminution of negative stereotypes between the professions (Carpenter, 1995). I purport that programs of this nature should be developed in the United States.

Faculty and hospital recruitment officers should provide additional support in helping graduates identify their initial work setting. The importance of "finding their niche" was evident in the data and a successful fit positively impacted their sense of professional identity and success in the field.

Since this study focused solely on the nurses themselves, further study is warranted in the area of faculty perception of how to better create environments with a balance of challenge and support. Faculty perceptions of how best to educate nurses given the constraints of rigid policies and procedures and a hierarchical hospital environment should be explored qualitatively as well

as their perceptions of the student learner, in an effort to discern congruence between self-perception and perceptions of students.

Hospital Administrators, Nursing Administrators and Staff Educators Domain

The importance of a supportive environment within which to begin their practice was inherent in all interviews. The relationship with their preceptor was paramount in their perceived ability to integrate into their chosen profession. As a result of the nursing shortage, numerous participants reported on experiences of being oriented by novice nurses who were uncomfortable with their role. This challenge for nursing administrators and managers perhaps is overwhelming in light of the shortage. Ultimately experienced, motivated nurses should be utilized as preceptors. Creating an environment in which nurses feel free to ask questions without being scrutinized is another challenge for hospital management. The hierarchal nature of the hospital setting presents an environment in which nurses in this study felt devalued and frustrated as many participants referred to a cycle in which bad treatment perceived during one's own orientation becomes displaced on the new preceptee in a "pay back" ritual. Many participants felt this cycle needs to be broken and is counterproductive to nursing retention.

The balance of challenge and support often is disrupted during movement points or passages in the first three years of practice. Nursing administrators, peers, and staff educators should be aware of additional support needed for new nurses when working in their first location, during orientation, while taking boards and when orienting to charge. While charge was perceived as overwhelming, chaotic, and as an intense responsibility, it became manageable when timed correctly and with adequate supports. Managers often were perceived as responsive to the needs of their new nurses, however, peer pressure often resulted in new nurses moving forward in orientation to charge without feeling ready. This forward movement without readiness and adequate support resulted in failure and job transfer for two participants. Retention efforts in hospitals should focus on decreasing the barriers to the provision of quality nursing care within the system. Perhaps the best way to accomplish this in any hospital setting is through the use of

qualitative methods such as focus groups to assess the needs of nurses within a given facility. Hospital administrators need to support this type of assessment of needs and follow through on changing the system to meet the identified needs.

The nurses in this study reported that the assignment of patient care within the hospital structure often conflicted with their ability to care for their patients. The nursing shortage influences the ability in the current hospital environment to foster connections to patients. Nurse managers however should foster an environment of continuity of patient care by allowing nurses to care for the same patients on subsequent shifts in order to foster this relationship. Many participants shared that this continuity is not valued by those making assignments. These findings are consistent with Greenwald's (1999) emphasis on the nurse's need to change the system.

The emphasis on the importance of continuing education, both formal and informal, charges hospital education and human resource departments to provide innovative, timely education both internally and through tuition reimbursement programs. The overall philosophy of the hospital environment should be one of valuing and supporting continuing education for all nurses. Administration needs to support this process. Most healthcare institutions are highly complex organizations where change does not come easily. Many nurses were frustrated in their attempts to bring about changes that would improve and facilitate their every day practice. According to Mason et al. (1991), "It cannot be assumed that nurses have the confidence or skills to make changes in the workplace in politically astute, effective ways" (p. 5). Mason et al. (1991) suggested the development of continuing education programs for nurses utilizing the feminist model of empowerment. This model reflects on three dimension of empowerment: consciousness-raising, building self-esteem, and skill development for change and managing conflict. These types of programs should regularly be incorporated into hospital continuing education programs and should include nursing administrators as well. Empowerment must begin at the top. Many nurses in this study perceived the chief nurse as powerless.

Takase et al. (2002) raised two factors as indicators of nurses' job dissatisfaction. The first was a personality disharmony between nurses' self-concept and the work environment, which was influenced by the stereotyping of nursing. Walsh and Holland (1992) argued that the stereotypical image of nurses constrains nursing practice, thus creating a nurse-environment misfit. The second factor was nurses' collective self-esteem (self esteem of the profession of nursing as a group) (Brockner, 1998). According to Brockner (1988) the collective self esteem is impaired by the public stereotyping as well as poor working conditions, such as low monetary reward. The implication is that hospital administrators need to provide opportunities for professional socialization in the workplace to influence a more positive collective self-concept. Socialization in the work setting could be focused on Gilligan's (1982) ethic of care that values the connectedness and concern for others, as well as for oneself. The importance of nurses supporting and empowering other nurses and using positive stroking to create and maintain a supportive work environment should be recognized. The nurses in this study often reflected on nurses not connecting with each other in a positive way. The ethic of care was perceived as central to nursing's identity and should be applied to nursing colleagues/coworkers, as well as patients. Hospital administrators should support the involvement of nurses in hospital wide committees with decision making authority. Takase et al. (2002) further noted a correlation between job performance and satisfaction in nurses. Research should be conducted to explore whether opportunities that expand the nurses power base in the hospital, such as decision making authority, positively influence job satisfaction, performance, and thus retention. Retaining nurses would positively influence the complaint of nurses in this study that they were oriented by novice nurses.

Finding support is crucial for nurses. Particularly for new nurses, the opportunity to talk to other nurses to receive support at the identified passage points is essential. Hospital administrators need to incorporate support groups for nurses into the work schedule without requiring additional time spent in the workplace. Group facilitators should be skilled in

reinforcing a focus on ventilation and change versus complaining and lack of support for each other.

Formal mentoring programs for nurses should be established within the hospital structure. "Senior nurses" should be encouraged to become mentors and be rewarded for doing so, either financially or through other desired reinforcements. Blackwell (1988) defined mentoring as "using one's experiences and expertise to help guide the development of others" (p. 429). As Blackwell indicated, an effective mentoring relationship is a close interpersonal relationship that involves helping the protégé achieve professional goals. These types of relationships need to be fostered within the hospital environment and voluntarily chosen.

Nurses in this study emphasized the need to decrease fragmentation within the profession itself. Hospital management needs to support contacts with other colleagues at professional conferences or meetings. Travel to such meetings should be encouraged and supported. Despite the economic constraints that currently exist in health care, hospital budgets need to ensure funds for nurses to attend conferences. Within the hospital environment, management should develop initiatives that encourage nurses and other health care professionals to exchange ideas and reduce feelings of isolation. Some nurses in this study felt that he hospital environment did not provide them with opportunities to connect with each other. Opportunities should be created in the hospital setting for collaborative research projects to foster collegial relationships.

The U.S. Department of Health and Human Services (2000) reported that aggregate levels of job satisfaction vary by the setting where nurses work. Nurses working in nursing homes and hospitals reported the lowest levels of overall job satisfaction, at 65% and 67% respectively, while 83% of those working in nursing education were satisfied with their job. Even at 83%, the job satisfaction level among those in nursing education only approached the level of job satisfaction in the general population. The authors further stated that between 1992 and 2000, the number of RNs not employed in nursing increased about 28%. According to the U.S. Department of Health and Human Services (2000) "the level of job satisfaction provides a

window into the working conditions that nurses face, and the relationship between these conditions and nurses' expectations regarding their work" (p. 38).

The Federation of Nurses and Health Professionals (2001) in a telephone survey found that retention appears to be an especially severe problem in hospitals, where 47% of current nurses acknowledge it as a major problem for their health care facility, whereas 36% of nurses in clinics and 33% of those in other types of health care facilities agree. According to the Federation of Nurses and Health Professionals (2001) "Fully 50% of current nurses say that, within the past two years, they have considered leaving the patient care field for reasons other than retirement. Nine in ten former nurses (91%) confirm that they voluntarily decided to leave the direct patient care setting and 56% of these nurses stated the biggest cause for their departure was the stressful working conditions, especially as they relate to understaffing (Federation of Nurses and Health Professionals, 2001). The authors additionally stated that while these nurses left hospitals because of stressful working conditions, 90% stated that their current job involved the use of their nursing skills or training. Thus they continued working within the profession in a non-hospital setting.

The Federation of Nurses and Health Professionals (2001) further found that current nurses working in (74%) hospitals perceived a much lower level of morale among their colleagues than do those working in clinics (55%) or other types of health care facilities (53%). This study further found that all current nurses and potential leavers registered low levels of satisfaction with the support and respect they receive from management, career-advancement opportunities, and salaries and wages. These findings are consistent with areas of concern raised by the nurses in my study. The Federation of Nurses and Health Professionals (2001) further found "three in four (74%) potential leavers said they would consider continuing in patient care for longer if conditions at their job improved" (p. 21). When potential leavers were asked to name specific things that could be done to continue working as a nurse within a hospital setting, increased staffing (42%) and better salaries (36%) topped the list. Other changes they indicated

would make a difference to them included better hours and schedules (21%), more respect (21%), more of a voice and input on how things are done (11%) and more support from management (11%). Four in five potential leavers also believed that providing more time to spend with patients would be very effective, which is a change that is directly linked to increased staffing ratios. With more than two-thirds of potential leavers strongly endorsing performance-based bonuses (71%) and more flexible schedules (69%), these are changes with a potential to make a real difference in retention and recruitment. These findings are important because, although the nurse shortage is clearly a serious problem, it is not unsolvable. The system changes suggested in this research should be taken seriously by hospital administrators.

The real challenge is finding ways to change the hospital organizational culture so that it becomes one that understands, accepts, respects and values nurses. The recent retention research displays concrete ways in which this can be accomplished and should be listened to. More in depth research should be conducted to explore the organizational climate of the hospital environment in an effort to decrease frustration and increase the sense of power and authority of nurses practicing within that environment.

Societal Image and Nursing Profession Domain

The nursing profession itself has historically been perceived as one without unity and a solid understanding of their place within the health care arena. In order to recruit and retain nurses, the image of unity, mutual support, and internal value needs to be addressed. Many nurses in this study discussed the unity present in other professions such as education, and expressed a desire to feel this in their own profession. This sense of unity should start with the nursing leaders of this profession.

Nursing leaders promote fragmentation in the profession as evidenced in varied professional organizations such as the National League for Nursing, American Nurses Association, and the American Organization of Nurse Executives. These organizations historically have conflicted with one another over various issues including the basic issue of level

of education required for entry into practice. This lack of unity at the top perpetrates the fragmentation evidenced in the data of the study. Nursing leaders need to change the image of the nursing profession and enlist the aid of powerful societal forces in this process.

Recruitment of new nurses into the field should focus on males and potential nurses who may delay entry into the field related to societal perceptions, lack of perceived supports, and inaccurate understanding of the profession. Historically, the media has portrayed nurses as "handmaidens" in a dependent, passive role. Recent campaigns such as the Johnson and Johnson efforts have done much to portray a greater understanding of the profession of nursing as one that can be truly rewarding and challenging. Guidance Counselors in high schools should receive a better understanding of the profession including the responsibilities, challenges, opportunities, requirements and skills needed to be successful in this profession, and the educational process required in an effort to recruit nurses who might potentially delay entry into the field.

The concept of different kinds of nurses warrants further study for significance of the findings of this study. Why is the nursing profession categorized by age, education, race, experience, burn out, calling and caring and various other delineations, which further alienates and isolates an already fragmented profession? The qualities as described by these nurses may or may not be accurate and further research should explore the reality of division. Several areas for future study emerged through the data analysis process. Issues of race and gender emerged as further influencing professional identity development, and adding to fragmentation and isolation in the nursing profession. More research of a qualitative nature should be conducted to further explore the influence of these differences as well as how to better recruit and retain these nurses in the profession. The female nurses in this study identified a distinction between male and female nurses. Males were identified as not being held to the same standards and females were expected to "pick up after them." Past research has focused on role strain of male registered nurses (Egeland & Brown, 1988 and Kadushin, 1976). According to Halloran (1985) "sex role stereotypical behaviors are consistent with relative paucity of men in nursing" (p. 974).

According to Kadushin (1976) role strain for males may result in the propensity of men in nursing to seek out islands of masculinity within the profession. I argue that the male nurses identified in this study were responding to role strain by decreasing amounts of direct physical care provided such as bathing the patient. Behaviors that typically have been associated with female work may cause role strain for males. Furthermore, females have typically taken care of and picked up after males. Gender related behaviors thus require further transformation to east this identified tension in the profession.

Since this study was limited to the first three years of professional practice, qualitative studies should be conducted to explore development beyond these years. Reports from the nurses studied indicated that nurses take one of two roles at the three year point. One type of nurse is uncomfortable with lack of change and development and moves to something new to further perfect skills. The second type of nurse stays in their original location of practice. The nurses in this study placed a sense of "badness" on the nurse who does not aspire to something new. This concept warrants further investigation. It would seem apparent that cultivating nurses to become experts in a particular area could have positive outcomes for patients as well as satisfaction for the nurse. The nurse who stays was often categorized as "stagnant," happy with the "comfort zone," and "burnt out." Why is it that some nurses still feel a "fit" with their original location of practice while others do not? Answers to these questions might well positively influence the retention of expert nurses.

The profession of nursing has been identified as an aging profession (Oleson, 2000). As the image of the profession is changed to a more positive one interest in entering the profession may improve. The high number of participants who had delayed entry, despite high interest, warrants further study. A study of students in high school or grammar school and contemplating future careers should be conducted to assess interest and perceived barriers or obstacles to becoming a nurse. Engagement of nurses at a younger age offers a potential reprieve for the

aging nursing profession. Similar studies of nurses functioning outside the hospital setting should be conducted to compare and contrast challenges and supports.

Takase et al. (2002) emphasized the positive and negative effects of public stereotypes on nursing practice. Thus, it is essential to improve the public perception of nurses. Nurses need to develop preventative measures to counteract the effects of nurse stereotyping. According to Watson (1998) "media images of downtrodden, low paid nurses have reinforced negative perceptions of nursing as a career" (p. 12). Watson purported that long-term promotional campaigns that have focused on low pay has damaged the public perception of nursing. Watson (1998) further stated, "nursing lacks confidence and children have picked up on it" (p. 13). The invisibility of many of the skilled and intellectual aspects of the nurse's role – such as planning patient care, interaction with other medical services and colleagues, administrative and management roles – is an influential factor of nursing image. The nursing profession needs to change the visible image of the nurses to reflect an organizational change of value of the job itself. Value judgments and status have been linked to the visible dimensions of the work (Watson, 1998). Nursing persists as a female-dominated profession, with professional concern and public confusion related to differing modes of education and levels of practice. This negative image of nurses as well as women from the past may have helped to shape the present status of nursing. This type of portrayal persists and must be changed by improving the media image through campaigns such as the current Johnson & Johnson initiative.

According to Torres (1980) "confrontation with our own reality and expulsion of the myths that have been created in the past can help transform a group, which in turn will free individuals within the group" (p. 14). It is through a sense of unity and organization that the strength will recreate the world in which nurses live and work. The changes required to effect this change transcends the profession of nursing, the hospital structure and the medical profession. Change needs to occur at the national policy level to financially support and improve the societal image of this profession.

Appendices

Appendix A

Interview Protocol

How is it that you became interested in becoming a nurse?

When did you decide to be a nurse?

What people have impacted you in terms of being a nurse?

Can you describe any situations in your nursing education that you feel framed your sense of yourself as a nurse?

What is your best memory of being a nurse?

How do people react when you tell them you are a nurse?

What does it mean to be a professional?

How would you describe yourself as a nurse when you first graduated from nursing school?

How would you describe yourself as a nurse now?

What opportunities have you experienced as a nurse?

Can you describe any critical incidents in your nursing career?

What is your response to images of nurses in the popular culture?

How do you see others respond to these images?

Appendix B

Sample Letter to Chief Nursing Officer

March 27, 2001

Dear Chief Nursing Officer,

My name is Denise Deppoliti. I am a doctoral student in Higher Education at Syracuse University and am about to begin a qualitative research project for my dissertation. I will be completing my coursework this semester. I am currently employed as the Director of Network Resource, Education and Development at Hospital A. In addition to this position, I have worked professionally as a psychiatric nurse, nurse educator, and clinical nurse specialist for the last thirty years. I am writing to you to receive the appropriate authorization and access to interview nurses at Hospital A.

Through this research project, I am interested in gaining information about how nurses, in their first three years of their profession, construct their professional identity. I am hoping that this information will provide information to help recruit, retain, and educate nurses in the time of this nursing shortage. I will ask individuals to participate in this research study, assuring them that their participation is completely voluntary, so that they may choose to participate or not. All information that the nurses will share with me in our interviews will be kept confidential. Their names will not appear anywhere and no one will know about their specific answers except me. While complete institutional anonymity cannot be guaranteed, the name of this hospital will not appear anywhere.

The study would include initial one-hour interviews with nurses with the potential for follow-up interviews.

The benefits of your institution's participation in this research is, that this will help me to better understand the experiences of today's nurses in the formation of their professional identity. This information could then be used to facilitate recruitment, retention, and education of nurses. While the risks of participating in this study are minimal, they do exist. Nurses could fear the repercussions of sharing information with me. Let me assure you, strict confidentiality will minimize these risks. I will use pseudonyms for each nurse to conceal their identity and only I will have access to the specific information they provide. If a nurse no longer wishes to continue, they have the right to withdraw from the study, without penalty, at any time.

Concurrently, to you receiving this letter, I am submitting the enclosed application to the Institutional Review Board (IRB) for the Protection of Human Research Subjects to the Chair of the IRB at X University. In order to obtain full approval from X University's IRB, I need a written statement from the appropriate official at Hospital A authorizing access to participants of the study. It would be my preference to meet with you to answer any questions that you have and to talk with you about ways in which to access nurses.

I can assure you that I will uphold the highest of ethical principles while conducting this study with great sensitivity to cause no harm and with promise to contribute important research findings to the nursing profession.

You are welcome to contact my academic advisor, (number and name given) to attest to my character and qualifications to conduct this study. I look forward to hearing from you and am excited about beginning this study. I can be reached at work (315)448-5838 or at home . My e-mail address is Ddeppoliti@aol.com

Thank you for your time and consideration.

Sincerely,

Denise Deppoliti
602 Valley Drive
Chittenango, New York 13037

Appendix C

SYRACUSE UNIVERSITY

Higher Education Program/School of Education

My name is Denise Deppoliti and I am a doctoral student in Higher Education at Syracuse University. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask questions about the research if you have any. I will be happy to explain anything in greater detail if you wish.

I am interested in learning more about how nurses formulate their professional identity. You will be asked to participate in an audio taped interview with a possible follow-up interview. This interview will take approximately 60 minutes of your time. I will also request that you write a short description of an experience you have had in your nursing career that has positively impacted on your professional identity. All the information that you share with me will be kept confidential. Your name will not appear on any documents or transcriptions and no one will know about your specific answers other than myself.

I any articles I write or presentations that I make, I will use a made-up name for you, and I will not reveal details or I will change details about where you work. Documents and transcriptions will be locked in an office at all times and upon transcription, all audiotapes will be erased and destroyed.

The benefit of this research is that you will be provided the opportunity to reflect on your experiences in nursing and how these connect to your sense of yourself as a nurse. This will provide a better understanding of how to recruit nurses, educate nurses, and retain nurses in the profession. The risks to you of participating in this study are minimal. I realize that the time you need to take for this interview may be difficult and I will work around your schedule as much as possible as well as meet with you in your work area. You may be concerned with the confidentiality of the information you share. As I explained earlier, I will keep your name and institution confidential as I continue my research. If you no longer wish to continue, you have the right to withdraw from the study, without penalty, at any time.

All of my questions have been answered and I wish to participate in this research study.

_____ _____

Signature of Participant Date

_____

Print name of Participant

Denise Deppoliti _____ _____

Name of Investigator Phone Number Date

Catherine McHugh Engstrom _____ __

Name of Faculty Sponsor Phone Number

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