University of Alberta

LETTING GO: HOW NEWLY-GRADUATED REGISTERED NURSES IN WESTERN CANADA DECIDE TO EXIT THE NURSING PROFESSION

by

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DEDICATION

For nurses everywhere, never cease to persevere

&

To new graduates entering the nursing profession who could not find their way, this work is for you

You can be the change you wish to see in the world

Mahatma Gandhi

ABSTRACT

The Canadian Nurses Association predicts the nursing shortage will rise to an estimated 60,000 Registered Nurses (RNs) by the year 2022. Further compounding this issue is the approximate 14-61% of nursing graduates who will change nursing roles or exit the profession within two years of practice. Using the Glaserian grounded theory method, the purpose of this study was to examine the basic psychosocial process labelled *Letting Go* involved in how newly-graduated RNs in western Canada arrive at the decision to exit the nursing profession within five years of entry into the workforce through semi-structured interviews. The study findings revealed the following themes: *Navigating Constraints of the Healthcare System and Workplace; Negotiating Social Relationships, Hierarchies, and Troublesome Behaviours; Facing Fears, Traumas and Challenges;* and *Weighing Competing Rewards and Tensions.* This study adds to a growing body of knowledge to understand new RN attrition from the profession.

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CHAPTER 1: INTRODUCTION AND BACKGROUND

The image of the nurse has long been associated with Florence Nightingale, the *Lady with a Lamp* (Butterworth, 1839-1854). Please refer to *Figure 1. Florence Nightingale as the Lady with the Lamp* below. Butterworth's illustration immortalized her image in an oil canvas painting whilst Nightingale used an oil lamp to complete her night rounds.

Figure 1. Florence Nightingale as the Lady with the Lamp

In addition, the poem, *Santa Filomena* written by Henry Wadsworth Longfellow (1857) describes the presence of Florence Nightingale who carried her lamp through dark, dreary, and often gloomy hospitals to visit and provide care for

wounded soldiers during the Crimean war, thus uplifting their spirits. With the looming Registered Nurse (RN) shortage in Canada and world-wide, coupled with the exit of newly-graduated nurses from the workforce, we must consider the strength of Nightingale's flame to illuminate the future of the nursing profession.

Engaging in a study to examine the process of newly-graduated RNs who have left the nursing profession is timely and relevant. It is my hope that engaging in this study will provide insights for nurse preparation, curricular reform, and knowledge regarding the current clinical culture to address new RN attrition upon entry-to-practice.

The reasons why a newly-graduated RN exits the nursing profession within the current health care climate are unclear. In 1974, Marlene Kramer first posed the question, 'why do nurses leave nursing?' Surprisingly, few Canadian studies have been conducted on this topic since that time. There have been many changes in health care delivery and in the education of RNs since Kramer's theory was first disseminated. Men have entered nursing and nursing education has transformed by moving from hospital-based training to baccalaureate and graduate level education (Canadian Institute for Health Information [CIHI], 2010). Hospitals have adopted business models replacing the head nurse role, resulting in what some researchers describe as the fragmentation of health care (Coburn, 1999; Coleman, 2003; King & O'Toole-Gerard, 2013). Patient acuity has also increased resulting in greater workplace demands, paperwork, turnover, overtime, and burnout (Reineck & Furino, 2005). Also, for the first time in history, four different generations which include the Silents, Baby Boomers,

Generation Xs, and Millennials comprise the workforce (Foley, Myrick, & Yonge, 2012). There have been significant changes in health care delivery models since Kramer's work was first published. Nearly four decades have passed and nurses continue to exit the nursing profession although the reasons for this phenomenon in the 21st century are not clearly established.

Boychuk-Duchscher (2012a) has extended the work of Kramer in her theory of *Transition Shock*. This theory emphasizes the transition experience of newly-graduated nurses upon entry into clinical practice with a focus on new RNs who stay within the nursing profession. However, neither Kramer nor Boychuk-Duchscher have explored the experience of new RNs who exit the profession of nursing in today's current health care climate.

Problem and Significance

Despite efforts to address the RN shortage in Canada, the Canadian Nurses Association predicts that this shortage will continue to rise to approximately 60,000 RNs by the year 2022 (Canadian Nurses Association [CNA], 2009). It is unclear how many newly-graduated nurses are deciding to leave the profession in Canada due to a lack of data collection and reporting on this occurrence. Canadian data collected between 2005 and 2008 estimate the exit rate of RNs under the age of 30 varied between 11.58-14.51% with an estimated mean of 13% exiting the nursing profession (Canadian Institute for Health Information [CIHI], 2010). It is important to note that this data does not differentiate between nurses who have exited permanently, temporarily, or who have moved between jurisdictional boundaries or countries. Also, with the introduction of university

level after-degree programs in Canadian universities, many new registrants are over the age of 30 and do not fall into the less than age 30 exit category.

Various countries have commenced collating data specific to new nurses who exit the nursing profession. In the United States, 33-61% of new nursing graduates will change employment roles or exit the profession of nursing within two to three years of practice as a nurse (American Association of Colleges of Nursing [AACN], 2010); Boychuk-Duchscher, 2012b). New Zealand estimates approximately 30% of new graduates leave the nursing profession (New Zealand Nurses Organisation, 2011). An Australian report indicates 20% of new graduates leave after 12 months of employment (Armstrong, 2004). In a large European study entitled *Nurses' Early Exit Study* (NEXT) funded by the European Union, researchers found 9.3% of new nurses left the profession with as few as 4.5% exiting in Italy and as many as 14.6% leaving nursing in Germany (Hasselhorn, Müller, Tackenberg, 2005). These findings reveal a significant global issue concerning new RN attrition from the profession. New graduate exit from the profession places further constraints with regard to a global climate of fiscal deficits, financial pressures, increasing patient acuity, and aging populations in Canada and internationally. An increased severity in the nursing shortage results in reduced patient care and poor health outcomes (Twigg, Duffield, Thompson, & Rapley, 2010). For these reasons, further examination of the factors associated with new RN exit from the profession of nursing is warranted in Canada.

Motivation

In my tenure as a nurse, I have considered leaving nursing twice. The first instance occurred during my second year of study as a baccalaureate nursing student. I was challenged by my instructors to embody a traditional image of the nurse, an image that was in opposition to my personal appearance. The decision to leave weighed on my conscience as to whether or not I should continue within a profession that rests its professionalism so heavily on appearances alone. With great hesitation, I conformed to the requisite image, and subsequently was successful in my studies as a student nurse. All the while, I never forgot the power that my instructors held over me with their ideals of nursing professionalism and the pressure to conform to my classmates.

The second instance occurred within one year of entering the workforce. I found that I was employed in an acute setting that I would now consider an inappropriate placement for a new nursing graduate. I was distressed at witnessing great disrespect between nurses, a situation which challenged my perception of nurses being caring and compassionate for others. Dissatisfaction with the work environment, an 'every man for himself' mentality, and an exodus of senior staff to other hospital areas resulted in a lack of mentorship for newly-graduated RNs that included me. Day after day I questioned, is this how it is supposed to be? And, if this oppressive climate is going to continue, do I really want to remain part of this profession? Subsequently, I took a three-month leave of absence to consider my options. In the end, I decided to stay, but I never forgot

my experience as I pursued work in other areas of nursing, throughout my graduate studies, and as a nurse educator.

As I move forward exploring this topic as a nurse educator, it is clear to me that nursing students require not only support, but encouragement to succeed in the nursing profession. This study allowed me to understand first-hand what was needed to help the newly-graduated RNs who left the nursing profession to thrive as novice practitioners. Throughout this study I have made many reflections:

> The seed is planted;
> At times the seed is nourished, and despite the elements, thrives.
> Other times the seed is left to starve and struggles to survive.
> The stalk unsupported, the flower cannot bloom;
> Or the leaves become shorn, frayed by gloom.
> Without the hope of seizing the changing elements,
> A loss of control – the blossom slowly fades.
> Returning to the earth, the seed rests assured.
> What was once deterred, will thrive, be determined,
> And will rise once more.
> (K. Chachula)

As part of utilizing Glaser's grounded theory method, it was important to explore my own assumptions regarding the reasons why newly-graduated RNs might choose to leave the nursing profession. Is it possible that my experience as a new RN continues within the incoming Millennial Generation nurses? Perhaps new RNs are leaving related to workplace injuries? Or, being a female-dominated profession, are new RNs leaving to have children and start families? If so, it is possible that these nurses might return to the workforce after a period of time that is associated with their children starting elementary school. A review of the

literature revealed a paucity of knowledge concerned with the reasons why new nurses leave the nursing profession.

Research Objective

Throughout this study, I seek to explore the factors and basic psychosocial process involved in the decision of newly-graduated RNs who permanently exit the nursing profession.

Guiding Research Questions

1) What is the basic social process involved in the decision of newly-graduated RNs to permanently exit the nursing profession?

2) What contributory factors (internal and external) influence the newly-graduated RN to permanently exit practice?

3) What are the precursors to permanent exit from the nursing profession?

Thesis Structure

I have organized this thesis into five chapters. In the first chapter, I provide an introduction, background, and overview of goals regarding my thesis research. In the second chapter, I present the current state of knowledge through the conduction of a literature review concerning new nurse exit from the profession. In chapter three, I discuss the study design which employs the Glaserian grounded theory method. The research findings and accompanying discussion are revealed in Chapter four. In Chapter five, implications and recommendations are summarized regarding the study findings, which are followed by the study's appendices.

CHAPTER 2: CURRENT STATE OF KNOWLEDGE

A literature search was conducted to identify published studies that examined new RN exit from the profession. Searched databases included Medical Literature Analysis and Retrieval System Online (MEDLINE), Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Health Policy Reference Centre. Search terms included newly graduated nurse, new nurse, novice nurse and retention, intention to quit, intent to leave, and attrition. A total of 422 articles were identified after duplicates were removed. Please refer to Appendix A to view the Search Methods which include the search string, inclusion and exclusion criteria, as well as other search details.

The majority of studies identified in the literature search examined the lateral movement of newly-graduated nurses but neglected to adequately address new RN exit from the profession. Therefore, the findings from the six studies included for review required careful interpretation to distinguish data which measured lateral movement or position changes of RNs, as opposed to findings relating to an RN's intentions to leave the profession. Please refer to Appendix B to view the Quality Appraisal of the five studies and Appendix C to view a synthesis of the studies included for review. Three key themes were identified in the literature relating to new RN exit from the profession. These included level of job satisfaction, exhaustion and burnout, and the quality of the practice environment. Educational preparation specific to new RN exit from the nursing profession was limited within the literature.

Level of Job Satisfaction

Newly graduated nurses who experience dissatisfaction within the workplace are likely to seek alternative employment (Parry, 2008). Conversely, high workplace satisfaction is correlated with intentions to stay in a current position (Suzuki, Tagaya, Ota, Nagasawa, Matsuura, & Sato, 2010). Low levels of organizational commitment and affective commitment to the profession "are antecedents of intention to change professions ... interestingly, the relationship between job satisfaction and intention to change professions are not direct" (Parry, 2008, p. 163). The relationship between job satisfaction and intention to leave the profession remains unclear in the nursing literature. Without conducting a specific study or series of studies central to the newly-graduated RN who exits the nursing profession, these factors and their associated relationships will remain unclear.

Exhaustion and Burnout

Exhaustion and burnout are common themes documented throughout nursing literature. They are often attributed to a nurse's intentions to change job roles; however these themes are seldom related to novice nurses entering the clinical practice environment. A study conducted by Suzuki et al. (2010) provided an extensive review of factors effecting turnover in newly-graduated Japanese nurses using a repeated-measures design. The study included detailed reporting of study participants, data collection points, and findings resulting in a score of 17/18 on the Methodological Index for Non-Randomized Studies (MINORS) scale. See Appendix B: Quality Appraisal of Studies for details.

Suzuki et al. (2010) found that *Maslach Burnout Inventory* scores were statistically significantly higher in newly-graduated Japanese nurses in those who quit their jobs when compared to new graduates who stayed within their current position. Increasing levels of burnout, physical exhaustion, and mental exhaustion throughout the first year of practice were statistically significant contributors for job turnover. New graduates who entered practice environments feeling burnout were more likely to leave their position after a period of approximately 10 to 15 months after practice-entry. Nine point seven percent of participants indicated they wished to leave the profession (Suzuki et al., 2010).

In a Swedish longitudinal study, Rudman and Gustavsson (2011) found that "during the first three years of practice, every fifth nurse is at some point 'burned out', and for the majority of novice nurses, the second year of practice seems especially stressful" (p. 293). Furthermore, the researchers reported that approximately 47% of graduates experienced a significant increase in burnout during their second year of entry into the workforce. Rudman and Gustavsson (2011) reported a significant relationship between study participants with high and increasing levels of burnout reported with intention to leave the profession. Considering these findings, there remains a gap in the literature that fully explores the experience that motivates a newly-graduated nurse from *intention* to leave the profession to *actual* exit from nursing.

Mackusick and Minick (2010) also identified fatigue and exhaustion as a key theme in their phenomenological study. This study was appraised using the Critical Appraisal Skills Program (CASP) Qualitative Research Tool resulting in a

mixed final score. Of the ten questions on the appraisal tool, only five were adequately reported. While Mackusick and Minick's study has a clear purpose with appropriate methodology and research design, it is somewhat misleading. The researchers describe *clinical nursing* as "providing direct patient care in the hospital setting" (Mackusick & Minick, 2010, p. 335). It is widely known that nursing work takes place in a variety of settings that involves direct patient care outside of the hospital environment including outpatient clinics, hospices, primary care networks, client homes, and long term care facilities (Buhler-Wilkerson, 2012; Every, 2007; Munn, 2012). The definition provided by the researchers limits the scope to examine 'why nurses leave' if only hospital environments are considered.

The outcome of the study participants is also not totally clear in the study conducted by Mackusick and Minick (2010). Specifically, the study reveals that only three out of the 10 participants actually left the nursing profession. Interestingly, all three were new nursing graduates who exited the profession after one to two years upon entry-to-practice. Two study participants reported having to find alternative work as a result of their experiences. The reader is left to wonder what happened to the five remaining participants. Taking that into account, the researchers clearly presented exhaustion and burnout as a central theme.

The participants in the Mackusick and Minick (2010) study who described exhaustion referred to experiencing its effects for six months before quitting their positions. Importantly, self-described exhausted participants did not exit the

nursing profession in the study; instead, nurses moved laterally into alternative positions. These findings suggest the potential for newly-graduated RNs to exit the nursing profession in the presence of exhaustion and burnout. Further study of this phenomenon is needed to fully understand the relationship between exhaustion and burnout on exit from the profession as opposed to turnover intentions in new RNs.

Quality of Practice Environment

The quality of the practice environment is a significant indicator of a nurse's intentions to stay or leave a position and contributes to an RN's decision to exit the nursing profession. In a study conducted by Lavoie-Tremblay, Paquet, and Marchionni (2011) in Quebec, Canada, the researchers employed a descriptive correlational design to examine "the intent to quit among new nurses from Generation Y" (p. 39). The study was appraised using the MINORS tool and received a score of 15/18. The authors conducted and reported their study with a high level of clarity. The aim was clearly stated following the literature review which adequately captured concepts by prevalent researchers defining Generations X and Y (Boychuk-Duchscher & Cowin, 2004). The authors reported a 30% survey response rate where they clearly established that the nursing work environment is a factor related to nurse turnover and retention.

Specifically, Lavoie-Tremblay et al. (2011) found that nurses who provided low scores on ability to participate in hospital affairs, ability to provide quality care, and engage in poor nurse-physician relationships were more likely to leave their jobs in the province of Quebec, Canada. Those with severely low

scores indicated their intent to leave the profession. Parry (2008) asserts that intention to change employer is significantly related to the intention to leave the profession in an Australian study which examined newly-graduated RNs. These studies, however, do not reveal the process or the factors of what occurs between the times a newly graduated nurse has intentions to leave the profession to actively exiting from practice.

Newly-graduated RNs frequently face horizontal or lateral violence from their co-workers and hierarchical bullying from managers and physicians (Vessey, DeMarco & DiFazio, 2011). The presence of horizontal and hierarchal violence is a serious determinant of a newly-graduated RN's decision to exit practice. For example, in MacKusick and Minick's study (2010), the three newly graduated nurses who permanently exited the nursing profession reported experiencing verbal, physical, and sexual abuse. While negative practice environments influence an RN's decision to leave their position, it may not necessarily lead all newly-graduated RNs to exit from the profession.

It is important to make a clear distinction between intent to change position and intent to change profession. The outcome for each concept results in a different pathway wherein the nurse who changes roles, continues to practice nursing as opposed to those who exit practice permanently. There are many studies in which *job turnover* is examined (De Gieter, Hofmans, & Pepermans, 2011) whereas few have examined nurses who have chosen to leave the nursing profession other than for retirement purposes or disciplinary action (Nooney, Unruh, & Yore, 2010). We cannot safely assume that the reasons newly-

graduated RNs are leaving the nursing profession are the same as those who decide to change positions without a specific study to examine this phenomenon. Therefore, conducting a grounded theory study which examines the basic social psychological process involved in determining how newly-graduated RNs arrive at the decision to exit the nursing profession within five years of entry into the workforce is warranted.

CHAPTER 3: STUDY DESIGN

This study was conducted using classic, Glaserian grounded theory. Grounded theory is a qualitative research method that examines a basic psychosocial process (Loiselle, Profetto-McGrath, Polit, & Beck, 2011). The historical foundations of grounded theory are described as well as *symbolic interactionism*, the philosophical underpinning of grounded theory. The purpose of the study and the guiding research questions are re-iterated, and the sampling and recruitment strategies are described. Methods for data collection and analysis are outlined, followed by the study's mechanisms to ensure for rigour.

Historical Foundations of Grounded Theory

Grounded theory was developed by the sociologists Barney Glaser and Anslem Strauss in the mid-1960s (Streubert & Carpenter, 2011). Glaser and Strauss published this new method in their book entitled *The Discovery of Grounded Theory* (1967) wherein the researchers explored hospitalized, dying patients. The purpose of grounded theory is to develop a middle-range theory that delineates a basic social problem or process (Glaser, 1992). The basic psychosocial process is characterized by at least two stages which occur and change over time. Furthermore, the process may or may not be perceived by the person experiencing the phenomenon, but can be perceived by others (Glaser, 1992). Streubert and Carpenter state that basic psychosocial processes "transcend time and place without regard to culture, race or place" (2011, p. 125). Grounded theory utilizes an inductive approach to theory development that is 'grounded' in the research data or evidence from which the theory is generated (Streubert &

Carpenter, 2011). Importantly, the grounded theory method is widely used and accepted within nursing research (Artinian, Giske & Cone, 2009; Streubert & Carpenter, 2011).

Grounded theory was later modified by Strauss in collaboration with his graduate student, Juliet Corbin. This modified approach was published in their book entitled *Basics of Qualitative Research* (Strauss & Corbin, 1990). Glaser strongly opposed the book's publication which resulted in a divide between the classic, Glaserian grounded theory and Straussian grounded theory methods (Glaser, 1992). Proponents of Straussian grounded theory aim to describe concepts and their relationships, whereas Glaserian grounded theory seeks to discover an emerging theory (Glaser, 1992). Straussian grounded theory advocates for a thorough literature review, whereas Glaserian grounded theory is opposed (Streubert & Carpenter, 2011). Another difference between each method lie within how data is coded. Glaser utilizes substantive coding (open and selective) and theoretical coding, whereas Strauss uses open, axial, and selective coding (Loiselle et al., 2011). Straussian grounded theory also requires an explicit research question as opposed to Glaserian grounded theory where a specific research question is not needed.

Symbolic Interactionism

As a philosophical underpinning, grounded theory is rooted in *symbolic interactionism* which seeks to understand how behaviour and meaning are associated with particular social symbols or a social process (Aldiabat & Le Navenec, 2011). From this philosophical standpoint, the '*self*', '*me*', and '*I*' are

socially constructed by others (Mead, 1934). In elaboration of these concepts, Mead (1934) asserts that the '*self*' is comprised of '*I*' and '*me*'. The notion of '*I*' interprets the inner self, whereas the notion of '*me*' is defined and reflected by the external '*other*'. Cooley (1902) originally referred to this notion as the '*looking-glass self*'' wherein the perception of oneself is dependent upon the thoughts and actions of others through social interaction. Merton's *Social Theory and Social Structure* (1949) further elaborate on these sociological constructs adding the dimension of socialization. Merton (1949) illustrates that individuals internalize their roles within a social system resulting in acceptance or conformity of the society or institution's goals. Conversely, dysfunction, maladjustment, or rebellion could also result from socialization. Theories that draw upon *symbolic interactionism* are inductively generated and rooted in sociological philosophy, hence the basis for the strong relationship between grounded theory and *symbolic interactionism* (Aldiabat & Le Navenec, 2011).

Purpose of Study

The purpose of this study was to explore the basic psychosocial process involved in the decision of newly-graduated RNs to permanently exit the nursing profession. Glaserian grounded theory is an appropriate method to determine how factors influence a newly-graduated nurse to permanently exit nursing practice.

Guiding Research Questions

1) What is the basic psychosocial process involved in the decision of newly-graduated RNs to permanently exit the nursing profession?

2) What contributory factors (internal and external) influence the newly-graduated RN to permanently exit practice?

3) What are the precursors to permanent exit from the nursing profession?

Sample Selection

Purposive, convenience, and theoretical sampling were used for recruitment into the study. Participant inclusion criteria consisted of newly-graduated RNs who chose to exit the nursing profession within five years of entry-to-practice. Participants are graduates from a Canadian university institution living in western Canada and were taking steps to leave the nursing profession. Individuals were excluded who left the nursing profession after more than five years of entry-to-practice, as well as those who exited related to retirement purposes, or due to disciplinary action. Midwives, diploma-educated RNs, Licensed Practical Nurses (LPNs), and college-level graduates were also excluded as the Canadian Nurses Association has advocated for nation-wide baccalaureate entry-to-practice (CNA, 2004). Please refer to Appendix D to view the Demographic Form.

Recruitment of Participants

After ethics approval was obtained, participants were recruited by means of a poster, email, and Facebook campaign calling for participants. Posters were placed within various buildings and departments throughout two academic institutions in western Canada. Posters were also placed in public areas within eight hospitals and health care facilities in a large western Canadian city. Refer to Appendix E to view the Sample Poster. An email calling for participants was

posted on four faculty listserves throughout a large academic institution in western Canada with the intention of capturing nursing alumni who returned to study in alternate career paths. Emails were also sent to nursing alumni who graduated between the years 2008-2012 through one academic institution. A request to email nursing alumni at a separate academic institution in western Canada was unsuccessful due to a lack of space in an online alumni newsletter. Participants were not recruited through provincial RN regulating bodies due to fiscal constraints. The total number of participants was determined by achieving data saturation.

Demographic Description of Participants

Eight individuals ranging in ages 26 to 34 years participated in the study. Seven participants were female and one was male. Only one participant self-identified as being part of a visible minority. No participants had children or independents. Half of study participants were married or were partnered with a significant other. While the majority of participants worked within one or two practice areas, one participant was employed in four different specialized areas before deciding to exit the nursing profession. Seven participants decided to exit the nursing profession or are pursuing studies that will result in a different career path that does not include nursing work. Participant characteristics are summarized below in *Table 1. Participant Characteristics*.

Table 1. Participant Characteristics

Variable	n	%
Age (years)		
Range = 26 - 34	8	100
Mean = 27.9		
Standard Deviation = 2.6		
Sex		
Male	1	12.5
Female	7	87.5
Married or Significant Other		
Yes	4	50.0
No	4	50.0
Children or Independents		
Yes	0	0
No	8	100
Self-Identify as Visible Minority		
Yes	1	12.5
No	7	87.5
Areas of Practice upon Workforce Entry		
Mental Health	1	12.5
Labour & Delivery	1	12.5
Critical Care/Specialized Area	4[a,b]	50
Community Health	2	25
Full Time Status		
Yes	7[c]	87.5
No	1	12.5
Years of Practice as RN		
Range = 1 - 5	8	100
Mean = 2.4		
Standard Deviation = 1.4		
New Career Path		
Education	2	25
Law	1	12.5
Midwifery	1	12.5
Research	1	12.5
Global Health	1	12.5
Undetermined	2	25

Notes: [a] Specialized areas consisted of Emergency Department, Intensive Care Unit, and Oncology. [b] Most participants held employment in one area of nursing. However, one participant worked in four different specialized areas. [c] One participant's work hours were reduced unexpectedly to part time after gaining full time employment.

For theoretical sampling purposes, one participant who decided to maintain her nursing license was recruited into the study. However, it should be clarified that this individual is not required to maintain a nursing license in her current job, she

does not provide direct nursing care, and has no intentions of returning to bedside practice. Therefore she qualified as an appropriate participant for this study. All participants originated from western Canada and practiced as RNs in the provinces of British Columbia, Alberta, and Manitoba.

Concurrent Data Collection and Analysis

Data were collected through semi-structured interviews that were audio recorded and transcribed per verbatim for data analysis. Transcriptions were 'cleaned' by me, the primary researcher, removing any identifying information. The initial interview allowed participants to freely describe their experiences related to exit from the nursing profession. An interview guide was developed to prompt participants if there was difficulty explaining or recalling their perspectives. Please refer to Appendix F to view the sample interview guide. Subsequent interviews utilized theoretical sampling and semi-structured questions that related to emerging categories within the data to generate a model. Approval was gained to interview each participant up to three times. Participants were interviewed twice, for approximately one hour at a location of the participant's choosing. The shortest interview was only 12 minutes while the longest interviewed spanned three hours in length. A total of 15 interviews were conducted. All but one participant responded to a request for a second interview to review the preliminary findings.

Data collection and analysis occurred simultaneously wherein interview data were analyzed systematically, line-by-line, using Glaser's constant comparative approach (Glaser, 1978). Data were 'fractured' through two types of

coding: *substantive codes* and *theoretical codes* to discover the core variable (Glaser, 1978; Glaser, 1992) that highlighted the experience of the newly-graduated RNs who were in the process of permanently exiting practice labelled *Letting Go*. According to Glaser (1992), drawing upon substantive and theoretical codes result in a theory that fits the data.

Substantive Coding

"Substantive codes are the conceptual meanings given by generating categories and their properties, which conceptually sum up the patterns found in the substantive incidents in the field" (Glaser, 1992, p. 27). Substantive coding consists of two types of coding; open and selective. Substantive codes in this study comprised: (a) *Navigating Constraints of the Healthcare System and Workplace*; (b) *Negotiating Social Relationships, Hierarchies and Troublesome Behaviours*; (c) *Facing Fears, Traumas and Challenges*; and (d) *Weighing Competing Rewards and Tensions*.

Open coding. Open coding is the initial stage of constant comparison analysis. During this initial phase, data were broken down into incidents, and compared for similarities and differences, allowing concepts, categories of concepts, and the properties of each concept to emerge until saturation was achieved. Glaser (1978) encourages the researcher to open code in the margin of the transcript or field note, next to the indicator. This was completed on all transcribed interviews throughout the study. Glaser (1978) identifies several rules for open coding that were followed in the conduction of this study. Glaser (1978) advises the researcher to begin by asking themselves a series of questions such as:

What is this data a study of? What category does this incident indicate? What is actually happening in the data? What is the basic psychosocial process or problem faced by the participant? In this level of coding, the researcher (a) analyzes the data line-by-line; (b) does their own coding; (c) always interrupts coding to memo which involves theorizing and writing an idea about codes and their relationships; (d) stays within the confines of the substantive area and field of study, therefore, this study was focused within the nursing profession; and (e) should not assume the analytic relevance of any demographic variable until it emerges as being relevant in the data. This advice was drawn upon throughout all study activities.

Glaser (1978) identifies two levels of open coding. The first level includes *in vivo coding* which adopts language used by the participant to identify codes and their relevant categories. One such *in-vivo* code generated in the study emerged as *Realizing it will not get better*. The second level of coding includes *sociological constructs* which are identified by the researcher to broaden *in vivo* codes into categories. Identification of the core category, *Letting Go*, signified the end of open coding and shifted to selective coding to generate the substantive theory or model (Glaser, 1978; Glaser, 1992; Loiselle et al., 2011).

Selective coding. Selective coding limits data analysis to one core variable, which is often the basic psychosocial process. Throughout the concurrent data collection and analysis process, both open and selective coding were utilized simultaneously to shape and structure the emerging core variable, *Letting Go*. In accordance with Glaser's (1978) eleven criteria regarding the core

category, *Letting Go* was therefore: (a) central; (b) recurred frequently in the data; (c) took more time to saturate than other categories; (d) related and easily connected with other categories; (e) it was clear with grabbing implications; (f) it had carry-through and relevance; (g) it was variable and readily modifiable; (h) it was a dimension of the problem; (i) the core category fit the data; (j) had explanatory power; and lastly, (k) it evolved from theoretical coding. A combination of substantive and theoretical coding was employed.

Theoretical coding. "Theoretical codes are the conceptual models of relationship that are discovered to relate the substantive codes to each theoretically" (Glaser, 1992, p. 27). Theoretical codes connected the identified concepts and explicated the relationships between identified substantive categories to generate the theory or model. Theoretical codes wove the fractured codes back together, providing integrative scope and new perspectives (Glaser, 1978). An example of a theoretical code that emerged was *Wearing Out*. This theoretical code emerged from theoretical constructs within the *Maslach Burnout Inventory* (Maslach, Jackson, Leiter, & Schaufeli, 1996), thoroughly discussed in Chapter Four (Findings) of the thesis.

Memoing

Extensive memos were noted and sorted regarding important concepts that were discovered through the data. A memo is a sentence, paragraph, or a few pages which function to conceptualize and construct the emerging theory that is central to the core category and the basic social process (Glaser, 1978). Memoing forces the researcher to re-think and re-work global categories to become more

specific to the emerging theory (Glaser, 1978). Glaser (1978) identifies four goals of memo writing: (a) to develop *ideas* that raise data to a conceptual level, identify properties of each category, hypothesize connections between categories and their properties, integrate connections with clusters of other categories to generate theory, and locate the emerging theory with other theories; (b) to write with complete *freedom* to release the memo without concern for grammar; (c) to create a *memo fund* or listing of analytical ideas to generate a rich and dense theory; and (d) to create memos that are *highly sortable* wherein the central category or property of the memo is highlighted or underlined, allowing the memos to be copied or sorted without losing the original idea. Furthermore, Glaser (1978) advises not to memo in the margins of field notes, as this reduces the memo's sortability, therefore memos were completed on coloured pages that were kept separately from the interview data. The use of model-building whilst memoing was the most successful strategy to delineate the emerging model throughout data collection and analysis.

Glaser (1978) identifies twelve rules for writing memos that were adhered to during the conduction of this study. These rules include: (a) keep memos and data separate; (b) always interrupt data coding or recording to write a memo; (c) the researcher can force a memo by starting to write on a code; (d) do not be afraid to modify memos as growth and realizations occur; (e) keep a list of the emergent codes readily available; (f) if too many memos on different codes are similar, compare codes for differences that are being missed between the two codes; (g) problematic digressions should be followed through on a conceptual,

not logical elaboration basis, for the purpose of theoretical sampling or for indicating an area for future research; (h) run the memos open as long as resources allow to develop the rich diversity; (i) write conceptually about the substantive codes as they are theoretically coded without referring to the original participant; (j) if the researcher has two burning ideas, write the ideas up one at a time; (k) indicate in memos "saturation" when the category is saturated; and (l) no matter how well memoing is working, be flexible with memoing techniques.

Throughout the memoing process, many codes and categories were shifted, reviewed, discussed, journalled, integrated and/or collapsed into larger categories, re-iterated, and redrawn to develop the emerging model in accordance with Glaser's grounded theory method.

Journaling

Importantly, Glaser (1992) advises researchers to enter the field with an open mind and to learn from the participants as opposed to drawing on what is already known about the phenomenon. Both memoing and journaling serve to keep the researcher open to ideas and possibilities related to the substantive and conceptual areas (Glaser, 1978). This basic tenet served as a foundation during the data collection and analysis process. Being that the literature is crowded with themes that include burnout, bullying, and horizontal violence, a journal was kept by the researcher throughout all research activities to limit any preconceived ideas regarding the area of study (Glaser, 1978). This activity kept my mind open and true to the data as opposed to referring to my own experience or published knowledge in nursing literature.

Mechanisms to Ensure for Rigour

The resulting model met four criteria outlined by Glaser (1978; 1992). The four criteria include: (a) the theory will *fit* the experiences and data collected from the participants; (b) the theory will *work* in explaining the social process and behaviour of the participants; (c) the theory will have *relevance* if the theory both *fits* and *works* regarding the identified categories, as well as explain, predict and interpret what was and what will happen in the area of substantive inquiry; and (d) the theory will accommodate concepts and properties as new data emerges, referred to as *modifiability*. In achieving the above named criteria, the theory had both *parsimony* and *scope* which are "two prime criteria of good scientific inducted theory" (Glaser, 1992, p. 18).

In addition, mechanisms to ensure for rigour in qualitative research include dependability, credibility, confirmability, and transferability or fittingness (Lincoln & Guba, 1985). Techniques to ensure rigour included investigator triangulation, member checks, as well as audit and decision trails. Investigator triangulation is known as the use of more than one researcher to collect, analyze, or interpret a set of data adding to the *dependability* of the research (Loiselle et al., 2011). Hence, my supervisor reviewed the cleaned, coded interviews to add to the study's rigour. Lincoln and Guba (1985) refer to 'member checks' as a fundamental technique for establishing *credibility* of qualitative data which was achieved during secondary interviews with participants.

Furthermore, data were analyzed concurrently with the data collection process not only to align with the Glaserian grounded theory method, but to

clarify and confirm emerging categories with participants to add rigour to the study. Numerous participant quotations are included in the fourth thesis chapter as findings. This adds to the *confirmability* of the study findings (Lincoln & Guba,1985). An audit and decision trail was also constructed. Loiselle et al. (2011) define an audit trail as a "systematic collection of documentation that allows an independent auditor to arrive at similar conclusions about the data" (p. 269) thus adding to the *trustworthiness* and *confirmability* of the data. Likewise, a decision trail "articulates the researchers' decision rules for categorizing data and making inferences in the analysis" (Loiselle et al., 2011, p. 270). Additionally, adhering to Glaser's four criteria of fit, work, relevance, and modifiability (Glaser, 1978; Glaser, 1992) has added to the study's *transferability* or *fittingness* to outside contexts.

Ethical Considerations

Ethical approval was sought and granted from the University Ethics Committee (see Appendix G to view the Approval Letter). An Information Letter and Consent Form was provided to each participant prior to data collection (please refer to Appendices H and I). I answered any questions about the study and obtained written consent from those interested in participating in the study. Participants were made aware that taking part in this study would not affect the participant's job, current standing as a Registered Nurse, current professional status, or have any effect upon academic courses in which the participant was currently enrolled or may choose to partake in future studies.

Participants were free to withdraw any and all data at any time during the data collection phase of the study. Within one week of the interview, the participant received a copy of their transcript to review the data for errors, clarify statements, or retract data from the interview transcript. At the completion of the data collection phase, all participants were notified that the data collection phase was closing. This provided participants a final opportunity to review their transcripts regarding any data they wanted removed from the study.

Transcripts were anonymized by the researcher, did not contain any identifying information, and any electronic data were password protected and/or encrypted. Only the researcher and research supervisor responsible for the oversight of coding had access to the ‘cleaned’ interview transcripts. Pseudonyms were assigned to participants to ensure for confidentiality and to protect their identity. Transcripts will be kept in a locked, secure location for a minimum of five years on completion of the study as the data may be used for future research upon ethical approval of a secondary analysis.

Owing to the sensitive nature of the topic, the participants’ mental health was considered throughout the interview/data collection process. The only exception to the promise of safeguarding the participants’ identity was that the researcher was legally obligated to report any intentions of harm to oneself or others. This was stated clearly on the Information Letter prior to the initial interview. Although some participants were emotional and verbalized difficulty sharing their perspectives and reflections at times during data collection, no interventions were required.

Limitations

Potential limitations of this study include the sampling and recruitment strategy. Convenience and purposive sampling may exclude participants who fit the inclusion criteria but are not aware of the opportunity to participate and share their experience with the researcher. It was not feasible to recruit potential participants through the provincial regulatory nursing body by placing a call for participants. Furthermore, to place advertisements in nursing journals and local newspapers was beyond the fiscal capabilities of the primary researcher and research supervisor as this study received no funding. Therefore, the researcher was limited to localized potential participants and those with email access to listserves through a large western academic institution due to fiscal restrictions.

The scope of this study was limited to the nursing profession. The researcher recognizes that the educational practices and experiential learning components within the nursing profession are reflective of the educational practices of many other professions that include but are not limited to physicians, social work, dental hygiene, physiotherapy, occupational therapy, teachers, speech language pathologists, and pharmacists, among others. This study focused on the nursing profession; however, the implications of the study may have relevance for other practice-based professions.

Dissemination Strategies

There is a diversity of options available to disseminate the findings of this research study which include journal publications, conferences, and non-traditional methods. This thesis will become accessible through the University of

Alberta and the online database, ProQuest Theses and Dissertations. Publication within a nursing journal will be a primary mechanism for dissemination. Journals that will be considered for publication include the *Canadian Nurse*, the *International Journal for Nursing Education Scholarship*, the *Journal of Nursing Education*, *Nurse Education Today*, and the *Journal for Nurses in Staff Development*, among others. Research findings will be disseminated at conferences locally, nationally and internationally. Specifically, I presented at the International Institute for Qualitative Methodology: Qualitative Health Conference in Halifax, Nova Scotia in October, 2013. I also presented the findings of this research at the Margaret Scott Wright Research Day, a conference supported by the University of Alberta's Faculty of Nursing in November, 2013. The attendees of this conference consist primarily of nursing faculty and students, to whom this research is highly applicable. Conferences hosted by the Western and Northern Region Canadian Association of Schools of Nursing (WNRCASN), Canadian Association of Schools of Nursing (CASN), Canadian Nurses Association (CNA), International Council of Nurses (ICN), and Sigma Theta Tau International (STTI) will also be regarded. Non-traditional methods for dissemination will be considered which include web-blogs, You Tube videos, and Twitter.

CHAPTER 4: FINDINGS AND DISCUSSION: LETTING GO

Through the use of Glaser's grounded theory method, a basic psychosocial process described as *Letting Go* was generated which captured the dynamic involved in the decision of newly-graduated nurses to exit professional nursing practice. *Letting Go* is illustrated as a fading flame depicted below in *Figure 2. The fading flame: Letting Go*. The image of the fading flame echoes the image of Florence Nightingale, the *Lady with a Lamp*, (Longfellow, 1857; Butterworth, 1855), and symbolizes the fading internal light of nursing within those who have decided to exit the nursing profession.

The process of *Letting Go* for participants was a journey fraught not only with challenges, but also insights, rewards, and perceptions into nursing education and subsequently with becoming a nurse. *Letting Go* can be likened to Kübler-Ross' (1969) theory on grief as a five-stage process wherein an individual feels a sense of denial and isolation, anger, bargaining, and depression, followed by acceptance at which point an individual comes to terms with loss. These stages of loss were outwardly present in two participants in which the process to exit nursing was akin to "grieving." A sense of loss was perceived by participants who questioned the decision whether to stay or leave nursing practice as they persevered in spite of many challenges. As one participant stated, leaving nursing will be "less of a struggle" (Blaize) now that she is pursuing an alternate career pathway. One participant stated it was a "cathartic experience" (Kindle) to discuss what prompted her decision to leave nursing.

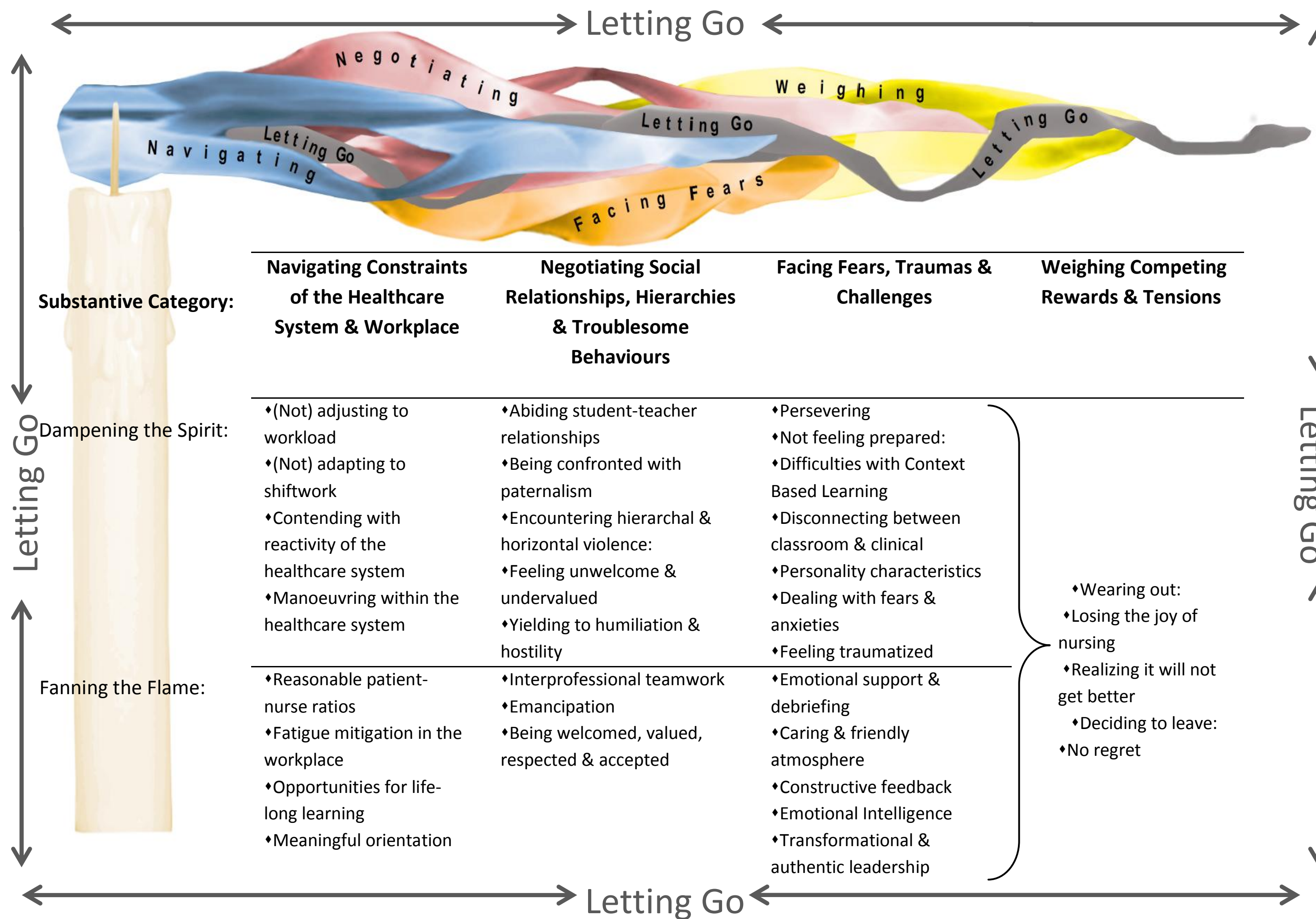

Figure 2. The Fading Flame: Letting Go

For others, *Letting Go* provided a sense of self-actualization knowing that they "made the right choice [to leave] nursing behind" (Aura) and to move on from nursing work. Self-actualization is an individual's process toward self-fulfilment (Maslow, 1943). Through engaging in self-actualization, participants gave themselves "permission to let go" of nursing (Ember) without the fear of "becom[ing] trapped because they are afraid to let go" (Ashley). Arriving at the decision to exit nursing practice allowed participants to rest-assured with the accompanying "freedom" (Ember) and sense of "relief" (Aura) in their choice to exit the nursing profession.

Integral to the core variable were four substantive categories that emerged from the basic psychosocial process, *Letting Go*. Owing to the sensitive nature of qualitative research, the content of the substantive categories naturally overlap (Foley, 2011). This overlapping relates to the interconnectedness with regard to how a single experience has implications for other substantive categories in the process of newly-graduated nurses who decide to exit the nursing profession. These categories include: (a) *Navigating Constraints of the Healthcare System and Workplace*; (b) *Negotiating Social Relationships, Hierarchies and Troublesome Behaviours*; (c) *Facing Fears, Traumas and Challenges*; and (d) *Weighing Competing Rewards and Tensions*.

The final substantive category, *Weighing Competing Rewards and Tensions* involves active engagement in evaluating conflicting contextual elements encountered in nursing practice. This evaluation is comprised of weighing tensions, described as *Dampening the Spirit*, and positive rewards

garnished from nursing practice, referred to as *Fanning the Flame* in the previous three substantive categories in deciding whether or not to stay in the nursing profession.

To further explain, *Dampening the Spirit* emotes the dampened spirit and sense of loss each participant endured throughout the basic psychosocial process of *Letting Go*. This process involved the loss of identity as described by Burke and Stets (2009) in their theory of identity formation. More specifically, participants increasingly dissociated from establishing a role identity as a nurse in relation to the absence of support, de-validation, and lack of legitimization in securing a nursing identity. This process is attributed to the lack of intrinsic and extrinsic rewards specific to the nursing identity in conflict. *Dampening the Spirit* comprises oppressive tensions specific to each substantive category as participants exited practice.

Conversely, *Fanning the Flame* is characterized by positive, reassuring rewards that mitigate wanting to exit the nursing profession. Strategies and recommendations to circumvent exit from the profession are discussed, as well as comments from participants in the study. A summary of recommendations to mitigate exit from the profession is provided following discussion of the major substantive categories. As a result of this process, participants ultimately decided to leave nursing practice. We will first explore *Navigating Constraints of the Healthcare System and Workplace*.

Navigating Constraints of the Healthcare System and Workplace

Today, we live in a market-driven, globalized society, reflected by neo-liberalist and capitalist business venture. The market has permeated government functions, education, the health care system, and many others throughout North America and globally (Hedges, 2010). In this multi-layered substantive category identified as *Navigating Constraints of the Healthcare System and Workplace*, participants experienced a variety of constraints upon entering the health care system and workplace. Boychuk-Duchscher (2012a) argues newly-graduated nurses must learn to navigate the health care environment through high workloads and increasing patient acuity to successfully transition from student nurse to novice practitioner.

Navigating within the system and workplace was influenced by many factors. Participants described working in a health care system that is “backed up everywhere,” “strained,” “rigid,” and “non-responsive” (Ember). Participants discovered a learning curve to operate within the “bureaucracy” and feeling “stifled” in their practice as a nurse (Ashley). Kindle and others described poor “working conditions,” “high patient loads,” and a climate of “cutbacks.” Researchers acknowledge the health care system is a rigidly structured entity that does not permit system changes easily (Hendy & Barlow, 2012). Reflected in *Navigating Constraints of the Healthcare System and Workplace*, many difficulties arose relating to (not) adjusting to workload, (not) adapting to shiftwork, grappling with the reactivity of the healthcare system, and manoeuvring within the healthcare system and workplace.

(Not) Adjusting to Workload

Dampening the spirit. Nurses and other health care providers have not been impervious to the marketization of health care and the changes within the health care system that have resulted. As an effect of capitalist business models, some authors argue that health care delivery has been transformed into a fragmented model of care (Coburn, 1999; Coleman, 2003) and a 'do more with less' mentality. This notion was reflected by Blaize regarding her role as a nurse in which she commented:

> For the most part, I really like my job. I like nursing. My reason to leave nursing isn't because I'm a nurse; I think it's a frustrating climate to work in. I think it's a frustrating industry to work in, I think it's frustrating for patients, I think it's frustrating families, and it's frustrating for staff. Because we are expected to do more with less.

Kindle said, "I felt like when you were on the unit, you had to go go go constantly, and if you were late with something, it was like all hell was breaking loose. It was like the worst thing in the world." In most work environments, participants described 'doing more with less' manifested as having increased patient-nurse ratios in hospital environments and the number of clients nurses are responsible for in community settings. Aura stated:

> The patient-nurse ratio. That's my biggest pet peeve about the health care system is the patient-nurse ratios. Even in [critical care], it's supposed to be one-to-one. But a lot of time it's two-to-one. And I don't think that if a patient is sick enough to be in the ICU they should have one nurse to two patients.

Dawn was unequivocal when she stated "I found the workload difficult to manage" she also found it "physically challenging because of the workload." The expectations for nurses to provide holistic care while being responsible for acutely ill patients and increased patient-loads have contributed to dissatisfaction, absenteeism, burnout, and poor psychological well-being within the nursing

workforce (Burke, 2003). According to Kelly (2007), "hospitals are now built to 'cure' diseases rather than to 'care'..." (p. 29). Cole iterated that it was difficult to look "at a person as a whole rather than the task." Aura expressed a similar sentiment while working as a nursing student:

> You get taught that you should spend time with your patient, and that you shouldn't walk away, and you should take the time to get to know them, and all that stuff. But when you go out there ... in the medicine and surgery areas, you have an obscene amount of patients. And you are just running your entire shift.

Another participant further elaborated how the workload affected her ability to provide the high-level of care expected of her during nursing school and subsequently as a nurse. She stated:

> Nurses are overworked; they have so much to do in so little time ... I think the vast majority of people go into nursing thinking that they are going to be doing compassionate care. And they *do* want to improve the health of people and do what they can to provide comfort and empathy to their clients. But when you have a slate of five clients and they all need quite a lot of attention, it's really hard to build up that therapeutic relationship. And in nursing school, they always talk about building that rapport, build that relationship, active empathy, active compassion. But in reality, when you're that overworked, it's actually really hard to do those kinds of things ... because our health care system is the way it is, and we are understaffed for Registered Nurses. It's just, you *really* can't nurse in the Florence Nightingale model of nursing. (Ashley)

Boychuk-Duchscher warns newly-graduated nurses are "are at risk of buckling under the strain of workload expectations" (2012b, New Graduate Transition Context section, para. 5) as they transition into the workforce which is reflective of the experiences of participants in this study. This was represented by Ember's comment. She stated:

> You are the first person that work gets put upon if there are cut-backs, or layoffs, or someone gets sick, or anything. You're just a mule in the healthcare system and you carry the weight ... It's very depressing because

> you don't have the time to do it, you don't have the energy, and what becomes important when you have a huge string of patients that you have to look after is, it changes very quickly from what you would like to do ideally, versus what it is you're actually capable of doing without burning yourself out in a matter of a few years.

Banks and Bailey (2010) report "high level of stress related to responsibility and high workloads paired with minimum pay compound the effects of reality shock of nurses new to the field" (p. 1491).

A national survey jointly conducted by the CNA and the Registered Nurses' Association of Ontario (RNAO) issued a statement warning of the rising incidence of nurse fatigue. More specifically, they state "fatigue is largely due to the relentless heavy workloads of nurses with ever-increasing cognitive, psychosocial and physical work demands" (CNA & RNAO, 2010, p. 1). Furthermore, "many [nurses] tend to pay more attention to the needs of their patients and colleagues rather than to their own needs" (CNA & RNAO, 2010, p. 1). These statements are reflective of the experiences of the participants in this study who often provided nursing care with little resources and expectations to work overtime hours. As Ember emoted "the way I wanted to do it [carry out nursing work] was not sustainable for me. But it was never the actual patient care that pushed me over, it was the system. It's working in the system." Cole stated "when an emergency happens right at the end of a double shift ... you don't have the time or energy, or love, really, to give to what you're doing." These participants' comments highlight the consequences of high workloads with little to no resources resulting in the push to exit the nursing profession.

Fanning the flame. Due to the efforts made by provincial nursing regulatory bodies and the CNA, there is an increasing awareness being disseminated regarding the negative effects of workload on nurses and the health care system. These organizations have developed solutions to mitigate and to prevent the exodus of nurses from the profession. These strategies include securing adequate funding to prevent staff shortages and an increased workload, developing policy standards to mitigate fatigue, advocating for healthy work environments that includes fatigue management strategies in nursing education programmes, and encouraging nurses to self-monitor for fatigue in the work environment by declining work assignments with regard to fitness to practice and safety (CNA & RNAO, 2010).

Although many of the newly-graduated nurses I interviewed had difficulty managing the workload, Rae described feeling prepared for the realities of the workload a nurse carries. She stated:

> My mom is a nurse. Since I was a kid, I've always known the job is busy and stressful, and you're running around, and I've always known those things. I kind of knew going into it was I was getting into.

Rae added "I was very fortunate to be on a unit that was well staffed, and they were quite firm about how many patients we could have." Likewise, Cole's mother was also a nurse. However, he described his experience with regard to the workload as being surprising as if he was "going in blind;" despite knowing what his mother did as a nurse. In Western Australia and in the American state of California, hospitals have been mandated to set limits on the nurse-patient ratio leading to increased satisfaction in workload amongst licensed nursing staff

(Donaldson, Bolton, Aydin, Brown, Elashoff, & Sandhu, 2005; Twigg & Duffield, 2009). These participants raised other issues that they encountered in the workforce relating to having to adapt to shiftwork.

(Not) Adapting to Shiftwork

Dampening the spirit. In order to adapt to the disruption caused by shiftwork, new graduates must learn to develop a reasonable level of tolerance to accommodate a rotating schedule (West, Ahern, Byrnes, & Kwanten, 2007). According to Clare and van Loon (2003) many new graduates underestimate the impact of full time work upon entry into the workforce. Participants described their personal, social sacrifices they made to accommodate a rotating schedule. This was reflected in many of the comments made by participants in the study. Blaize stated, “I see my work family more often than I see my real family.” Aura reflected her perspective:

> I worked days and nights, and it was killing me. The switching, the nights, ugh it was just awful ... I had a hard time with shiftwork. I prefer to have either days or nights but not both. But I didn’t want to work only days because it’s 12 hour shifts, and that would be hard. I’m not exactly a morning person [chuckles]. I didn’t want to work only nights because again, it’s 12 hour shifts and you feel like you just live [at work], and then you sleep all day, and you’re kind of like a vampire. You never see your friends.

She continued:

> I think I’m a really social person and I need that social aspect of my life. And I think that’s probably the biggest thing that drives me in terms of career choices. I need to be able to have that social aspect. (Aura)

West et al. (2007) suggest that new graduates have a lower level of tolerance to disruptions in social life caused by shiftwork and rotating schedules. The impact

of shiftwork was also described by another participant who reported not being able to keep a regular schedule.

> I found shiftwork very taxing. And I found it really hard to stay connected to the rest of the world, when I don't even know what day of the week it is. And I can't go to a regularly scheduled yoga class because I don't have a Monday to Friday schedule. (Kindle)

Another participant reflected:

> I don't really know if I have the personality to cope with a really rotating schedule. I would like to get something with permanent days, or permanent nights. Those kinds of jobs are few and far between in nursing. (Cole)

Ashley stated the lifestyle of nurses is "very unhealthy – all the shiftwork, not getting to spend a lot of time with your family. I think that's the case for many nurses – definitely not all, but a few. And yeah, I don't enjoy the shiftwork." Rae reflected a stronger aversion when adapting to shiftwork while still attending nursing school stating that "clinicals were brutal. Getting up at five in the morning and going to clinical ... getting into scrubs, and I hated nursing so much ... I just remember driving there, and [thinking to self], oh my God. I hate this."

These participants understood that nursing work often occurs within rotating shifts; however engaging in shiftwork was another matter. Ryle (1945) suggested the difference between 'knowing how and knowing that.' To elaborate, the practice of engaging in shiftwork, or 'knowing how' was a challenging prospect for new graduates as opposed to simply 'knowing that' nurses work in rotating schedules. Cole reflected "I didn't know I couldn't deal with shiftwork until I had got into nursing, really." Interestingly, he further added that "we are Millennials, so we're hyper-educated and kind of entitled ... maybe I'm a little

entitled thinking I don’t have to work shiftwork, and I don’t have to put up with all the things I have to.”

The Millennial generation, also referred to as Generation Y, are perceived and stereotyped in the public purview as being needy, entitled, and disloyal (Thomspon & Gregory, 2012). The Pew Research Centre (2010) argues that the search for work-life balance that began in Generation X has been accentuated in the subsequent Millennial Generation. Thompson and Gregory (2012) state “the same generation that is criticizing Millennials is responsible for shaping who they are today” (p. 242). Further adding to the Millennial debacle is the frequency in which Millennials are known to change employment roles. According to an American study conducted by the Pew Research Centre (2010), approximately 66% of employed Millennials report that it is ‘very’ or ‘somewhat likely’ they will change careers sometime in their working life. While “nearly six-in-ten employed Millennials say they already have switched careers at least once” (Pew Research Centre, 2010, p. 46). It is likely that the nursing profession is not immune to the movement of Millennials into and out of the profession. However, despite the job and career movement characteristics of the Millennial Generation, those within the nursing profession are encountering additional pressures and physical challenges that are intrinsic to the adjustment to shiftwork, thus adding to the push to leave the profession.

Dawn described the physical challenges she encountered adjusting to night shifts upon entry into the workforce. She stated “a lot of nurses get the opportunity to combine their breaks and sleep on nights. That wasn’t possible

where I worked, it *never* happened. It felt physically horrible to work, and unsafe to work all night." She added:

> I just felt exhausted having to be up all night. Working your whole shift, by 4 am you feel like you want to die ... I used to sleep all day after my night shifts and it didn't matter [chuckles]. I was still tired. I definitely preferred day shifts because I felt bad on night shifts. And I felt like I was very tired, and I knew for sure that I was slower, that my reactions were slower ... I would notice that I would make a lot of mistakes that I wouldn't even see.

The exhaustion Dawn encountered was not an issue of feeling entitled, rather one of fatigue. The definition of fatigue proposed by the CNA and RNAO is described as a state in which the nurse's physical and cognitive ability becomes impaired involving physical and psychological features such as emotional exhaustion, compassion fatigue and sleepiness that persist, despite obtaining periods of rest (CNA & RNAO, 2010). In a small survey conducted by the New Zealand Nurses Organisation (2011), approximately 30% of young nurses reported wanting to leave the nursing profession related to poor rostering and a dislike for shiftwork.

Fanning the flame. One participant was able to adapt to shiftwork by avoiding it altogether. After graduating from nursing school, Rae secured a nursing position that was a straight evening shift without having to rotate between days and nights. Rae stated "I don't think I'd want to do that for my life, I don't think I'd want to do shiftwork. It just worked out well that I did the evening shift when I was working [as a nurse]." This raises a key question when recruiting new graduates into workforce positions. Perhaps employers should consider a schedule for new graduates that limit a rotating schedule in the first year of

practice as an RN. West et al. (2007) propose numerous strategies to mitigate the effects of shiftwork including learning how to manage an effective sleep and work schedule. This process involves new graduate self-scheduling, and "socializing rather than supporting" new graduates into shiftwork (p. 29). West et al. (2007) also suggest new graduates ought to learn how to negotiate with management if a particular shift is not suitable for the social requirements of the new graduate.

Thompson and Gregory (2012) propose a different strategy, one that involves encouraging managers to engage Millennials at least once per month to provide them with feedback in their practice. The authors purport that "Millennials have learned to expect feedback" and that managers should see this want as "a willingness to learn and do a better job" (Thompson & Gregory, 2012, p. 241). Meeting with the Millennial would provide an avenue to strengthen the relationship of the new graduate with the workplace. This approach would allow the manager to support the new graduate confronted with any difficulties that arise with regard to adjusting to the workplace, shiftwork, and the health care system itself.

Grappling with the Reactivity of the Health Care System

Dampening the spirit. Participants described how the health care system is based too heavily on a medical model of care and ought to be proactive rather than reactive. According to CNA (2005b), current primary care methods are overwhelmed and unsustainable within a medical model of health care delivery. In the current health care system, physicians often operate within a medical model of curing. Nurses are not educated to cure, rather to promote and optimize health

as per the principles of Primary Health Care (PHC) in Canada. Nurses teach and engage individuals, families, and communities to live well with disease, as well as to prevent injury and illness. Nursing activities are supposed to occur under the auspice of the PHC model of delivery; however that has not been the case with many participants in this study.

PHC includes five interrelated tenets: accessibility, public participation, health promotion and illness prevention, appropriate technology, intersectoral and interdisciplinary communication (College and Association of Registered Nurses of Alberta [CARNA], 2005). Nursing was conceptualized at the centre of this model (Reutter & Ogilvie, 2011). However, there is incongruence between what nursing students are taught and the way the health care system operates. As Ember described, "My nursing education did not prepare me for practice very well at all. I think there's such a huge gap between what you are taught, what you should do, and what actually happens in the hospital setting." One participant expressed disappointment in how the health care system functions when she stated, "We are really good at looking at the medical side of things ... but we are less good at understanding those cultural, sociological, and anthropological influences that are intrinsic to the way that health works" (Ashley). She further elaborated:

> I'm a huge proponent of proactive rather than reactionary medicine and healthcare. Our current political system doesn't put enough emphasis on that ... because we *are* quite lacking in preventative care ... We need to stop using healthcare as a band-aid solution and we need to start focusing on why people are getting sick, who's getting sick, the disparities in healthcare ... To me, that is at the core of what nursing should be, working with a vulnerable population to identify what their risks are in a harm reduction framework. That is the real essence of what healthcare is. It's looking at

> coping mechanisms, and it's looking at harmful health practices, and trying to navigate between the two. (Ashley)

Another participant confirmed the medical model-based nature of the health care system in her comment:

> If what we are actually striving for is better health, we are actually causing worse health, in the big picture. But it's like we don't look at the big picture. We do everything on a reactive basis not on a proactive basis. And I found that frustrating. (Kindle)

Interestingly, Laschinger, Finegan, and Wilk (2009) report that new graduates experience more fulfilling and empowering workplaces that draw upon a nursing foundation of care as opposed to one that draws upon a medical model of care. As Ember stated:

> We focus so much more on giving medications, skills, and physical assessments. I found that patients physically feel better when you just talk to them, and learn a little bit about them, and how they feel ... Do they understand the healthcare team? Stuff like that. And those so-called soft skills are really not encouraged, promoted, or valued very much at all. And my experience has been that they are *very* valuable. And that's something that I'm not willing to give up.

These newly-graduated nurses are educated to uphold the principles of PHC, yet encounter a health care system that does not reflect PHC's core principles of health promotion and illness prevention. When attempting to engage in nursing practice that is not in alignment with PHC principles and are medical-focused, Ember reflected "healthcare is such a huge monstrous machine that it's almost prohibitive to change. And we would all somehow collectively rather keep working in a broken system than try to get over the task of changing it."

In the 1980s and 1990s, many nurses lost their jobs in the wake of health care reform and budget cuts (Burke, 2003; Dingel-Stewart & LaCoste, 2004). It is unfortunate that this trend continues. The current economic climate, ripe with

fiscal deficits, has pressured managers in the health care system to cut costs thus adding to the reactive nature of the healthcare system. In the province of Alberta, 12 Registered Nurses were 'cut' in March of 2013 with the intention to replace these individuals with lesser-skilled staff in effort to save costs (Mertz, 2013) resulting in untoward consequences between health professionals.

Blaize remarked:

> They make it seem like we cost so much money and the reason why the health care system is being buried into the ground is because of nursing and only nursing. And that is the attitude that many nurses feel... it pits Registered Nurses, against Licensed Practical Nurses, against health care aides ... It creates animosity within the hospital, and within health care disciplines. So it's a frustrating industry to work in [whispering voice].

Blaize's frustration with regard to the replacement of RNs with less skilled staff was highly "insulting" to her. The reactionary effects of health care cuts have serious implications for newly-graduated nurses seeking to establish themselves within the nursing profession. Blaize urged for "a better working relationship with our superiors, whether it be your managers, your management team, or [the provincial health board] themselves" to decrease the "animosity" felt between stakeholders of the health care system. Without improved communication between managers, provincial health boards, nurses, and the public, Canada risks losing more newly-graduated nurses from the profession.

Fanning the flame. To date, the CNA has lobbied governments, developed partnerships with physicians (CNA, 2005a), and encourages collaborative practice between all health professional groups within Canada's public health care system (Walker, Olson, & Tytler, 2013). The CNA's National Expert Commission delineates key priorities for change as the nursing profession

moves forward in promoting health and wellness within Canada's health care system. Chief among these priorities is shifting health care delivery to perceive an individual as a whole rather than the sum of their parts and contextual health issues (CNA, 2012). Furthermore, the commission emphasizes educating health professionals as competent practitioners and capable leaders who can navigate patients and their families through the health care system. In keeping with the principles of PHC, the commission advocates for transferring health care delivery outside the realm of hospitals to encourage individuals to live well at home and in the community (CNA, 2012).

As a means to shift power back to new graduates striving to navigate the health care system, it would behoove employers and nursing unions to provide new graduates with committee membership opportunities thus promoting their active involvement in decision making. The inclusion of the new graduate would thus provide the novice practitioner with an authentic voice through opportunities for involvement into workplace affairs as a means for retention (Lavoie-Tremblay et al., 2011) and occupational commitment (Parry, 2008). As well, nursing unions can also play a role in engaging newly-graduated nurses in resolving workplace issues and utilizing effective communication strategies with employers and managers to mitigate exit from the profession.

Manoeuvring within the Health Care System

Dampening the spirit. Many participants were confronted with various difficulties in learning how to maneuver within the rules of the workplace and union with regard to scheduling, requesting leave of absences (LOAs), seniority,

taking vacation, and having adequate orientation. Ember felt discouraged by "all the nitty-gritty rules [of the union] that affect everybody" with particular regard to the perceived mobility available within the nursing profession. Ember elaborated:

> One of the things that I think is really promoted in nursing, and in nursing school as well, is that you have a lot of mobility ... If you end up in a place that you don't like, you can always move around. And I found that once I started working, that's actually not true because of the way that most nursing positions are unionized. Hiring is based on seniority. And so, it's very [sigh] difficult to move from one area to another. Because if you don't have any experience in a particular area, chances are actually quite low that you will get in.

These participants relay a sense of powerlessness akin to Foucault's notion of power relations (Foucault, 1982) with regard to demanding obedience to institutionalized rules while operating within the health care system. Upon an attempt at manoeuvring within the system, these graduates were met with resistance from those who held power and dominion over them thus "clos[ing] the door on all possibilities" (Foucault, 1982, p. 789). The rules regarding seniority affected one participant's ability to maneuver within the health care system to secure a nursing position. Kindle stated:

> There was a nursing freeze on. So for a while, all of the positions available were only open to employees who already had jobs within the system ... I knew that when I graduated, I decided that I couldn't work in a hospital. I just felt that that environment was very stressful and it wasn't something that I was really passionate about. I wanted to be in health promotion, or health education, or public health. And I had applied for some public health positions but no one would look at me seriously because I didn't have enough hospital nursing experience yet ... so I just kind of felt that I didn't have any other options in nursing left, really.

Given the current economic climate, Ritter (2011) reports the misconception that there is no longer a nursing shortage which has resulted in fewer new graduates finding employment. The idea that "the world is your oyster, you can do anything

and everything" (Aura) may no longer be applicable to newly-graduated nurses with respect to the hiring processes currently taking place within the health care system and current economic climate.

Issues relating to seniority were also identified by participants in relation to taking vacation time. As part of the Millennial Generation, these newly-graduated nurses are seeking flexibility to manage a work-life-balance and gain educational opportunities (Boychuk-Duchscher & Cowin, 2004). The following statements capture this perspective:

> I don't like to exist on other people's timelines. I really enjoy doing work when I can do it at my own pace. I like freedom and flexibility ... I wanted to have a bit more flexibility with my hours. I also had a hard time asking for vacation. Because I was so new to [the area] and there were so many senior nurses there, I never got my vacation time approved. Also, not even because of seniority but because of staff shortages, I never got my vacation time approved. For example I would submit for five days, like a stretch of five days. And they would approve the first day and the third day. So it's like, well what's the point of that? ... It's just, I don't know, it's not for me. (Aura)

Similarly, another participant reported:

> The culture was such that unpaid leaves [of absences] were never approved. As a full-time employee, I was often switched off of days of statutory holidays where I was scheduled to work because they just wanted to have the bare minimum staff ... Some things would've made me stay longer [in nursing] or been more conflicted about leaving, was if my management at the hospital I worked at was very supportive of the things like leaves [of absences] and didn't do the kinds of things they did around scheduling. (Dawn)

Hutchinson, Vickers, Jackson, and Wilkes (2006) propose that those in authority use existing institutional structures to engage in hierarchal and horizontal violence. For example, a charge nurse might use the nurse assignment schedule to routinely assign a targeted nurse to heavy-care patients with the intent to deplete

the nurse physically and psychologically until they leave their position. Notably, Brewer, Kovner, Yingrengreung, and Djukic (2012) report that a lack of flexibility in scheduling adds to the new graduate's intention to leave a current position. In a similar vein, Kindle became disheartened from nursing when trying to take educational LOAs within her position in order to carry out her nursing role safely and effectively. She explained to her manager, "I need some continuing education to learn." Unfortunately with budget cutbacks, she was met with resistance from her manager who was not able to accommodate her request that would have supported her in the workplace. Kindle further explained to her manager:

> I'm not going to be able to continue my work because I can't do it in these conditions. And she told me, 'Well, we don't have the funding for this. We can't change this. That's how it's going to be.' So I told her, well, I guess I can't continue.

According to Clare and van Loon (2003), the provision of continuing education opportunities assist the new graduate in their transition from student to novice nurse in the workplace. Education and life-long learning are core values within the Millennial Generation (Boychuk-Duchscher & Cowin, 2004). It is unfortunate that these newly-graduated nurses did not feel supported in their roles as RNs to take LOAs or vacation time to allow a sufficient break from the workplace setting. Being unable to maneuver within the system or gain the support she needed, Kindle left the nursing profession.

According to a Canadian Federation of Nurses Unions (CFNU) study, allocation of vacation by seniority was not always a fair process (Wortsman & Crupi, 2009). Similar findings were noted in this study that is in alignment with

Foucault's assertions on power (1982). One participant voiced frustrations with scheduling and LOAs:

> Our contract says they [managers] may not unreasonably deny vacation or an education request. They can't unreasonably deny you. So if you apply for an education day six months out and they deny you the next week, how is that not unreasonably denied, have you not tried to fill that spot with a casual staff or part-time staff member? ... They do that with everybody ... [Also] if I want an ad hoc vacation, I cannot have it. There's not a single day from now [July] until May [next year] that I can ask for off, because the [staffing] numbers aren't good enough ... You don't get holidays in the summer for the first 20 years, so don't even bother. (Blaize)

The CFNU issued a report stating "[Millennials] are not interested in the concept of 'paying your dues': rather they want to be valued for their contribution and their potential ... they just want and expect to be included in decision-making, team development and life-long learning" (Wortsman & Crupi, 2009, p. 23). It is, therefore, important for managers and senior staff within the health care system to better understand the values that the incoming generation of nurses hold for themselves and of their co-workers upon entry into the workforce, and vice-versa.

Fanning the flame. Clare and Van Loon (2003) emphasize providing new graduates with support, assistance, and a quality orientation while they adjust and adapt within their role as a nurse. Dawn described how "crucial" it was to be properly oriented to her nursing role and the workplace as a new graduate. A direct outcome of her orientation provided her with a sense of feeling "confident to work." She added, "If you want a new grad to be successful in her job you have to support her. And it means that she probably needs a lot of training coming out of nursing school." To accomplish this, newly-graduated nurses require a good, working relationship with their manager in which the new

graduate feels supported in their role as a nurse and orientation to the workplace which is meaningful. As Kindle stated:

> You hear complaints from managers everywhere that they don't like to invest their time and energy in orientation and training when new nurses just leave within a year anyway. And that's true, and I understand that perspective. But any job I've had as a nurse, I've never had any great orientation [chuckles]. That's never ever happened. You just fly by the seat of your pants.

To mitigate the impetus to exit the profession, new graduates who left the nursing profession indicated their need to have an adequate orientation, opportunities for learning, and a manageable workload where they had resources at their disposal to carry out their roles safely and effectively. Wong and Cummings (2009) found that "supportive leader behavior and trust in management are necessary for staff to be willing to voice concerns and offer suggestions to improve the workplace and patient care" (p. 6). Managerial support can subsequently mitigate the stressors experienced within nursing related to patient acuity, workplace demands, paperwork, turnover, overtime, and burnout (Reineck & Furino, 2005). Rae stated having a supportive charge nurse and nurse educator "makes a huge difference." She elaborated:

> They were busy sometimes and couldn't help, but if they had extra time they would love to just take you and teach you things, or help you with a question. It was nice to have that.

Conversely, Rae continued:

> Sometimes you were working on a shift with people who were less eager to help, but you just kind of knew as to who was good, would give you good instruction, and who was not so good.

This comment brings us to the next major substantive category in the study which explores *Negotiating Social Relationships, Hierarchies, and Troublesome Behaviours*.

Negotiating Social Relationships, Hierarchies and Troublesome Behaviours

In this study, the difficulties of newly-graduated nurses with regard to *Navigating Constraints of the Healthcare System and Workplace* coupled with negative social relationships, hierarchal social frameworks, and troublesome behaviours within the nursing profession, were found to heavily influence participants' decision to exit the nursing profession. Clare and van Loon (2003) report "when tiredness, exhaustion, and isolation were compounded with negative feedback and bullying, the balance tipped and almost all graduates began to contemplate leaving nursing (96%)" (p. 28). To contend with the reality of such an environment, often identified as oppressive, newly-graduated nurses are instead choosing to leave their positions (De Gieter, Hofmans, & Pepermans, 2011; Lavoie-Tremblay et al., 2011).

According to Freire (1970), an oppressive experience becomes internalized within those who encounter its detrimental effects. This process ultimately results in the oppressed becoming the oppressors (Freire, 1970) which would account for the spill-over of repression and oppressive modes of thinking and behaviour that are present in the nursing workplace that comprise 'troublesome behaviours'. Diekelmann (1990) reflects that "it seems ironic that we work hard to create caring environments for our patients but not for ourselves as clinicians, teachers, and students" (p. 301). Manifestation of oppressive

behaviour is troublesome within the nursing profession, as its consequences can be far-reaching.

Oppressed group behaviour in nursing was originally delineated by Susan Roberts in 1983. Roberts attributes such behaviour to oppressive societal forces. Building on Freire's assertions (1970), Roberts (1983) suggests that a subordinated group develops an increasing sense of self-hatred, diminished self-esteem, and decreased assertiveness as the oppressed internalizes the behavioral impact of the oppressor. Because the oppressed individual cannot retaliate against their oppressor, hostility against other members of the oppressed group ensues. Perpetuation of oppression ultimately precipitates a vicious cycle. Subsequently, bullying and incivility indicative of oppressed group behaviour manifest in hierarchal and horizontal violence within the nursing workforce.

Newly-graduated and experienced nurses are routinely encountering horizontal or lateral violence from their co-workers and hierarchical bullying from physicians and managers (Vessey, DeMarco & DiFazio, 2011). Horizontal and hierarchal violence is comprised of behaviours with the intent to hurt that include sabotage, intimidation, manipulation, alienation, as well as verbal, emotional, physical and sexual abuse (Craig & Kupperschmidt, 2008;Thomas, 2010; Thomas & Burk, 2009). The Workplace Bullying Institute (2013) defines bullying as 'repeated, health-harming mistreatment' that includes verbal abuse, verbal and non-verbal behaviours that are humiliating, threatening, or intimidating, as well as work interference that includes sabotage. Bullying is characterized by negative behaviours that accumulate over time (Hutchinson, Vickers, Jackson, & Wilkes,

2006). It is estimated that as many as 75-85% of nurses have experienced bullying behaviours during their careers (Ditmer, 2010; Hutchinson, Wilkes, Jackson, & Vickers, 2010; Lewis, 2006).

Experiences with hierarchal and horizontal violence were evident throughout all participants' experiences spanning from their years as student nurses and subsequently as new RNs. Study participants recounted biding their time within oppressive student-teacher relationships, being confronted with paternalism, and encountering horizontal and hierarchal violence amongst nurses which resulted in feeling unwelcome and undervalued, as well as having to yield to humiliation and hostility in the workplace.

Abiding Student-Teacher Relationships

Dampening the spirit. The Oxford Dictionary (2013) defines 'to abide' as to accept or act in accordance with a rule. Inherent in the student-teacher relationship are hierarchal rules governing interactions. In referring to their nursing school experience, participants made several comments with regard to the presence of a hierarchal relationship between themselves and their professors or instructors. Hence, students would 'bide their time' until this hierarchal relationship was terminated at the conclusion of their educational program. The hierarchal relationship between participants and their instructors was evident in the following statements:

> I found that my clinical instructors were often very hard on the students or on me anyways. And I think I wasn't really prepared for that coming out of high school ... they always sort of held it [success] out of your reach. You never really got that real positive feedback when you had done something really well. It was always sort of tempered like, 'Well, you need

> to work on this', and that kind of thing. So I think I kind of got discouraged. (Kindle)

> Coming from the social sciences and the arts where you have really small classes, you go out for coffee with your instructors. On Friday afternoons, your professor would come with you to the campus bar for beer... I *never* felt like that in nursing. I never felt like I could have anything that was even less than formal, I could never really get there... I felt that there was a real a gap between professors and students. (Ashley)

The gap Ashley speaks of relates to the hierarchy and power structure between students and teachers. In opposition to this power structure, Myrick and Tamlyn (2007) advocate for an emancipatory approach to pedagogy, one that is free from oppression. However, adding to the presence of a perceived hierarchy between participants and teachers, many participants reported their professors' and instructors' lack of respect for them as students. A lack of respect was evident in the following statements by Dawn:

> The tone of instruction from the instructors and the faculty was challenging ... speaking to students in lecturing formats in a condescending way, there was a lot of threats if you didn't attend lectures ... We were threatened in more than one lecture that we wouldn't pass ... I had an instructor address the class and state that he hoped he never got sick because he wouldn't want any of us to be his nurse... I reported that to the Dean and I don't think anything ever came of it.

Dawn continued:

> The person who was leading our program at the time, her way of communicating with the group was very much akin to someone teaching a junior high class. And it just did *not* work. And it's kind of hard to explain what that was, but it was like a basic lack of respect. And not really seeing us as adults and future nurses, but rather as like these women's children.

Similarly, two participants reported:

> It's a disastrous program. When students gave feedback, and we're not talking about a group of students who are just out of high school, but a group of mature students – I mean the average age of the student was probably 25. Students who are married, who have families, who all have

> previous work experience, and they are questioning – as they have a right to, and to be threatened, and told that we're just troublemakers. And that we'll never get our RN if we put down any more negative comments on the course evaluation. That's not right. I would have never believed that people in a position of power in a caring profession would treat students who are vulnerable in that way. Unless I had been there that day and heard it with my own ears, I would never have believed that that could have happened. But it did. (Ember)

> There wasn't a lot of respect for the fact that we were all adults. You know, a lot of us had families, spouses, children, etc, were still working in other jobs, had transferred careers. They [professors] neglected that aspect of our personalities, as students. I was a little upset by that, a little let down by that. (Ashley)

The above examples depict a far departure from student-centred education models adopted in nursing curricula since the launch of the curriculum revolution in the 1990s that centres upon student empowerment (Bevis, 1993). The teacher-centred examples provided above portray a behaviourist learning paradigm that empowers the teacher and affords the student little latitude for compromise. The primary focus of behaviourism is mastery of skills and 'training' frequently to exclusion of critical thinking (Lisko & O'Dell, 2010) and praxis (Bevis, 1993).

Behaviourist learning theory was originally developed by Johann Friedrich Herbart (1891) in the late 19th century. Of course, behaviorism as we know it in modern times was not drawn upon in nursing education until the early 1950s by Ralph Winfred Tyler (Bevis, 1989; Finder, 2004). Tyler developed an educational model in which learning is organized into operationalized, specific, measurable, and observable behavioural objectives to guide education and evaluate learner performance (Shane & Shane, 1974). More specifically, "if behavior has not changed, learning has not taken place" (Bevis, 1989, p. 24). The behaviourist paradigm for curriculum development and education has become

deeply entrenched within nursing education (Bevis, 1989; Sellers, 1991). Overall, a behaviourist approach can result in a fragmented, authoritarian, and oppressive learning atmosphere evident in participants' remarks that does not contribute to a safe and trusting learning environment.

Fanning the flame. Behaviourist, teacher-centred learning models have given way to emancipatory, humanist, and student-centred approaches that include constructivism (Mezirow, 1994). Constructivism stems from the work of such philosophers as Kant, Nietzsche, and as recently as Donald Schön (Candy, 1989; Peters 2000; Schön, 1983). Constructivism is based upon the philosophy that knowledge and learning are co-constructed rather than acquired (Mezirow, 1994). Furthermore, it is the construction of meaning and knowledge regarding an experience that is individually or co-created (Appleton & King, 2002; Mezirow, 1994), and draws upon reflection (Schön, 1983; Williams, 2001) in order for learning to occur. Concepts within this philosophical viewpoint include collaboration, constructive feedback, scaffolding, and coaching that occurs between the student and teacher, as well as between peers (Bean, 2011). As one participant stated, "I really liked my [clinical instructors], they were all really knowledgeable and really supportive. Really had our interests at heart ... they were very conscious of the fact that they wanted to guide us rather than show us, or tell us" (Ashley). Kindle advised:

> A lot of learning happens when you are able to talk about what you've done, and be able to ask questions ... I think that's *so* critical because it's how people feel about expressing themselves. If you create an environment where people feel safe to express themselves, then they will. But if you make people feel guilty, or like they haven't done enough, or they're not smart enough, or they didn't perform well enough, then people

> just shut up and they stop expressing themselves. And they feel scared. And I think that that happens too much in nursing.

Similarly, Dawn stated the best instructors “were kind and approachable and created an environment where you felt safe to ask questions ... [they wouldn’t make you] feel like you weren’t very smart or that you should already know this.” The permeation of emancipatory, humanist, and constructivist models of education bolster confidence within students and new graduates thereby creating a welcoming relationship between students and their teachers. Clinical practice areas also require saturation of these principles and philosophies of emancipation to counter the effects of oppression and paternalism.

Being Confronted with Paternalism

Dampening the spirit. It is well known that for over a century the nursing profession has evolved from under hierarchal and suppressive forces. Nursing has endured not only health care reform under managerialist business models and capitalist forces, but also paternalistic relationships; specifically, the traditional, hierarchal relationships between male physicians and female nurses. The *doctor’s handmaiden* is a description of the nurse that has been difficult to shed given the evolution of nursing practice out of hospital-based institutions and into university settings (CIHI, 2010). It is unfortunate that this stereotype continues to be perpetuated within the nursing profession. As one participant stated:

> I remember particularly being taught by someone in nursing school who was like, ‘The role of the nurse is like being a wife in that you have to anticipate the needs of the doctors, just like you would your husband. And make him think that it was his own idea.’ And I remember people were laughing at that and I was just sitting there going oh my God, I do not want to be anticipating the needs of someone who is superior to me. (Dawn)

Dawn further reflected:

> I remember discounting nursing because I did not want to be in such a subordinate position where I would take orders from people ... I think I always wanted to work in something where *I* could be the person making decisions about people's [care] in conjunction with clients, and planning for their care in a more full way.

As a result of Dawn's experiential process, she left the nursing profession to pursue a pathway that would provide "more autonomy, more responsibility, better remuneration, and more variety." Another participant commented:

> The interaction between the nurses and the doctors, that's something that we never ever learned as students. We were told many times that nursing is not just being the doctor's helper. And the nursing profession is one that stands on its own and we all need to be dedicated to elevating it ... A lot of doctors are not easy to work with. And it's very difficult when you want to do more, you want to work to your highest capabilities, you want to increase your knowledge, and you want to become an expert in your field. (Ember)

Many described being "yelled at" (Aura), criticized, and "intimidated" (Dawn) by physicians. Kindle described her relationship with her female manager who was also a physician. She stated:

> There were often nurses who felt like physicians didn't treat them well. I can actually attest to that in my own experience... my manager was a doctor. I would probably say that *was* the reason why left that particular job. And in doing so I left the profession... I felt that I was constantly blamed for things that happened that weren't necessarily my fault. And I didn't really feel like I was never given any positive feedback, or any recognition, or support for anything. But just always sort of like – almost belittled, really. I felt like it was a real abuse of power in the position that she was in. And kind of treating me like she could just walk all over me.

Kindle continued:

> I felt really intimidated by her, like actually scared. I would go into meetings with her and my heart would just start pounding, and I would just feel like, I just didn't know how to cope with talking with her, that kind of thing. So I decided that I would put in writing my concerns for her,

> because when I confronted her, she just yelled at me. And I would just kind of back down.

Through held back tears, Kindle further reflected that “you kind of try to block these things from your memory so that you can move on.” The power physicians hold over nurses continues to exert itself upon the nursing profession as identified by participants in this study. In one place of employment during Blaize’s tenure as a nurse, she commented regarding the lack of “peer-to-peer” between nurses and physicians, only the presence of a hierarchy. She stated:

> There was a hierarchy. So it was physicians, and then about 25 steps down the ladder there was nurses. There was no peer-to-peer ... There’s not as much job satisfaction I don’t think. Because they [nurses] are not treated as an equal. (Blaize)

Findings from Lavoie-Tremblay et al. (2011) reveal a statistically significant relationship in nurses who had poor relations with physicians in the workplace with the intention to quit the nursing profession. This finding is evident arising from the recollections of the participants in this study. Ember shared:

> I’ve had a couple of experiences where I was put-down by a physician in front of a patient. And being humiliated that way, and belittled, I know some nurses say it happens to everybody and that’s just the way it is, but again, over time, I’ve just developed less and less tolerance for that. I don’t accept that, it doesn’t have to be that way. Why are people not being held accountable for that behavior? It’s totally uncalled for. And that’s in every setting; it doesn’t matter whether it’s healthcare or anything. There’s mature, responsible ways to deal with things, and there’s other ways. And just because you are a physician doesn’t mean you can treat people that way, and in front of the patient? That’s inexcusable.

Cole questioned the very essence of advocating on behalf of a psychiatric patient with regard to a medication change when “the psychiatrist looked at me and he said please do your job and let me do mine.” Cole remarked that “we care more

about the doctors and we value them more highly than we do ourselves and that would not happen in another profession."

Fanning the flame. Nursing students and subsequently, newly-graduated nurses ought to understand that nursing practice can be highly autonomous, yet occurs within integrated inter-professional teams to deliver high quality care in many different practice environments beyond the hospital setting. Nursing practice has transformed and is no longer limited to the hospital environment, nor is nursing practice only for women. Furthermore, nursing practice occurs in partnership with physicians and certainly not in their servitude. Current inter-professional curricula reflect this evolution of practice (Accreditation of Interprofessional Health Education [AIPHE], 2011). As one participant reflected:

> I have had *very* positive relationships with physicians, specifically at [an inner-city clinic]. Extremely attentive, very empathetic, [the physicians] *really* understand the importance of an interdisciplinary-collaborative team... I've had very positive experiences personally, and I know that I'm probably the exception to the rule. (Ashley)

Likewise, Rae commented, "The relationships between the physicians and nurses were phenomenal [in the specialized area] ... They [the physicians] worked so much with the nurses that it was such a good cohesive relationship." These participants' reflections highlight that having positive and respectful work relationships with physicians is possible. Thomas (2010) recommends health care providers better understand gender differences as more men enter nursing practice and more women become physicians. For many, however, hierarchal and horizontal violence still appears to maintain its grasp within the nursing profession (Vessey et al., 2011).

Encountering Hierarchal and Horizontal Violence

Dampening the spirit. The nursing literature is replete with examples that describe horizontal or lateral violence, and hierarchal violence within the nursing workforce (Ditmer, 2010; Hutchinson, Wilkes, Jackson, & Vickers, 2010; Lewis, 2006). Horizontal violence is characterized by demeaning actions that are overt or covert in nature that occur between nurses at the same hierarchal level within an organization; whereas, hierarchal violence within nursing occurs between nurses at differing levels within the hierarchal structure of an organization (Thomas & Burk, 2009).

Author, Phyllis Chesler (2003), recounts in her work that women are guilty perpetrators of incivility towards other women. Chesler (2003) purports that this incivility amongst women occurs within a complex dynamic, rooted not only in oppressed behaviours, but also in learned behaviours from childhood. This dynamic generates patriarchal thinking within the female perpetrator and manifests in actions committed against other women that take the form of gossip, slander, exclusion, humiliation, and hostility. These behaviours were evident within this study and are well documented within nursing research, perhaps because nursing is a female-dominated profession (Hutchinson et al., 2006). The process of encountering these behaviours resulted in participants *feeling unwelcome and undervalued*. Participants also described *yielding to humiliation and hostility*.

Feeling unwelcome and undervalued. Being the recipient of and witnessing horizontal and hierarchal violence amongst nurses included incidents

of gossip, withholding skills, and other exclusionary behaviours that made participants feel unwelcome and undervalued in the clinical areas. Aura reported, "That's the problem with the nursing profession, is that it's full of women ... I think they get really catty, gossipy. They just stop being considerate of each other's feelings." Ember stated, "It was a climate of gossiping and back stabbing." One participant described how gossip was used in the workplace as a source of power over others when someone was not well-liked by the group:

> People were like, 'Did you see what she did? Did you see that it was terrible! And oh my gosh, we could have had a huge problem with this! And oh, it could have been so unsafe!' There was a bit of that if someone was targeted as not being liked. (Rae)

Ashley also reported witnessing gossip in the workplace:

> On two units that I was on, I did notice that there was a fair amount of gossip. A fair amount of talk behind another nurse's back. You know, it's very unprofessional and it's very inappropriate in the workplace ... I was really disappointed. Because I think that nursing has a bit of a reputation for that. And I was really hoping that those myths would be dispelled. And so to see that there was basis for those stereotypes was really disappointing to me. And especially because I didn't want to associate myself with the field if that was the true case.

Ember summarized the consequences of horizontal and hierarchal violence in the following way:

> I never had the experience before, of being in a group of only women. And seeing them exhibit all of those stereotypical qualities or characteristics... Different dominant personalities started to come to the top of the group and control other people, you did see them kind of feeding off of each other. The power came from the gossiping and putting other people down. And just doing anything you could to make sure that you didn't get thrown under the bus. Because it could happen from anywhere. From one of your instructors, one of the nurses on the floor, from one of the people in your carpool group. That after a while you felt like you just couldn't trust anybody.

The occurrence of gossip in the work environment conveys a highly unwelcoming atmosphere to students and newly-graduated nurses. Chesler (2003) accounts for behaviours that include gossip as emanating from women who have low self-esteem, poor efficacy, and a lack of optimism that correlate with the conclusions made by Roberts (1983). Furthermore, she describes that women will often surround themselves with "members" to increase their foundations of power (Chesler, 2003, p. 397). This behaviour is exemplified by the following incident described by one participant:

> [Critical care] nurses tend to do the whole wolfpack thing to the nurses who come from other areas ... There's always one person that gets picked on basically, and there's always a group of nurses that pick on that one person... [It's like] being the little goat in the middle, basically. (Aura)

The troublesome behaviours described above within the nursing profession have detrimental effects upon the incoming generation of nurses. Specifically, upon encountering horizontal violence in the workplace, Ashley felt the need to distance herself from the nursing profession, thus adding to the push to exit the profession. These behaviours not only erode the professional image of the nurse, degrade patient outcomes and impact trust amongst the health care team (Cowles, 2008), but also diminishes confidence, self-esteem, and creates oppression in the newly-graduated nurse (McKenna, Naumai, Poole, & Coverdale, 2003; Myrick, Phelan, Barlow, Sawa, Rogers, & Hurlock, 2006).

Participants also reported exclusionary behaviours that impacted a welcoming atmosphere. Rae found that some of the nurses with whom she was paired as a student were not nurturing and had no patience for students. She stated some nurses "did not share their thoughts with you." They would "just

expect you to figure it out and tag along ... as for not welcoming, it's not talking with you, not being communicative with you that makes a difference." Kindle described unwelcoming behaviour in nurses as:

> Not really smiling, often not saying hi in the morning, and just a lot of negative language – sighing ... Negative comments, pessimistic attitudes I would find towards the work environment in general ... I started my first clinical when I was only 19 years old. I think you are not expecting that when you were that age either, it's your first contact with the real work environment kind of thing. So it's kind of hard to adjust to that and to kind of stay positive yourself.

Ashley encountered nurses who "were really rude to [students] or delegated them to do the really low-level skilled tasks." She further stated, "Even in our third, fourth, fifth semester of nursing, they [students] would still be changing bedpans and making beds, rather than actually doing clinical skills." Similarly, Ember reported:

> [Nurses] would deliberately send us students on the worst possible tasks. And keep the more complicated skills away from us that we actually needed to learn. So if we knew a patient had something coming up like an IV start, or tubing change, or a complicated dressing change, or a drain removal, or something like that, we would say, okay I'm ready, I want to do this.' 'No, so-and-so in room five needs to be taken off the toilet.' And then they would force us to do that so that we wouldn't get the experience that we needed.

Ember further reported, "They [nurses] would do really passive aggressive things. For example, if we would go in the day before to do our research, they would deliberately hoard the patient's chart so that we can't access them." The above examples highlight the power differential between student and novice nurses to well-established nurses in the workplace, thus adding to perceived 'tensions' within the work environment. Blaize attributed her understanding of power differentials and tension as follows:

> I see nurses getting frustrated with students whether they be students [on their final practicum] or new grads ... They just become unwilling to teach ... they become less helpful ... their demeanor changes ... you'll see them roll their eyes, or maybe you'll see them get exasperated like – sighs, when explaining [something] for the 17th time ... you can *feel* the tension.

Cole also reported feeling "tension between nurses and nurses" while working as a newly-graduated nurse. According to Horowitz (1996), individuals reciprocate behaviours. More specifically, if a person emits a hostile dominant behavior thereby evoking a returned hostile submissive behavior in the other, hostile behaviours are potentiated adding to a perceived tension between individuals. This tension may be eased if a hostile dominant behavior is reciprocated by a friendly submissive behavior, in this case, submissive behaviours demonstrated by a student or newly-graduated nurse.

Many participants referred to the hierarchal structure present within clinical practice environments. Ember reported being able to sense the "hierarchy of nurses that went by either seniority or the most dominant personalities. And it really was like a pecking order. And I came in at the bottom" when in the clinical practice environment. Likewise, Ashley noted being at the "bottom rung of the ladder." She stated:

> You are a student nurse, you are on their territory, they've taken you in, they have consented to having you there and you are meant to be learning. You really are the bottom rung of the ladder. And so it's just, if you were to say anything, or if you were to butt heads with a superior, with your buddy nurse or another nurse, then it could be seen as just really disrespectful. They have the ability to make your experience on the unit really unsatisfying or really difficult if they wanted to ... We just had to focus on the work that we were actually doing and try to block out the rest of it.

In order to belong, Levett-Jones and Lathlean (2008) report student learners use silence, compliance, and conformity rather than advocating for their own needs rather than risk alienation and rejection. As strategies to fit in, Levett-Jones and Lathlean (2008) report learners will "keep a low profile" and "not ask too many questions" to fit in (p. 344). This tactic was used by Blaize who stated her desire to "fly under the radar" in her practice as a nurse.

Some participants attributed exclusionary behaviour in nurses as stemming from having to prove themselves as a valuable member of the team before being accepted into the group. Blaize explained:

> Nobody trusted the fact that I had five years of experience working in that area ... Like it didn't matter that I'd spent five years and I had all the same skills that they had, it didn't matter because I was new [to that hospital]. So I mean, it took me a while to kind of break into the 'friends' group. But once I was there everyone was super nice, but I guess it just takes a while. And I guess you have to prove yourself.

Ember recounted:

> There is this idea in nursing that you have to suffer to prove that you are worthy of being there. Or that you have to endure a certain amount of hardship. And that's just considered to be a rite of passage. And to some extent that's true in every new job because it's hard when you are learning, people don't know you, they don't necessarily trust you, and you *do* kind of have to prove that you're worthwhile. And I understand that. But, it goes way too far in nursing, *way* too far. How can you expect people to look after others when you treat them that way? And I remember distinctly, many times, going into a patient's room and being almost in tears myself and thinking, I had to pull it together to look after this person.

Thomas (2010) reports it is unfortunate that horizontal and hierarchal violence are seen as a 'rite of passage' within the nursing workforce. These behaviours negate the caring and compassionate values held at the centre of nursing practice. Ember reflected it would be "nice having a team that welcomes somebody new instead of

feeling like you are a burden that people didn't want to deal with." She continued, "Or that people have a bit more patience if you are just learning, rather than just getting frustrated and yelling at you." One participant described seeing a different form of exclusionary behaviour in the workplace. She explained:

> There were some bedside nurses who brought up something not being done on shift by a certain nurse ... And then the other nurses in the same [area] had decided not to do it for this nurse when she was on break. And they had specifically – the line they had used specifically was, 'Let her drown' ... Why would you want to go to work if you think your coworkers are out to sabotage you? (Aura)

Contrary to the above examples, Clare and van Loon (2003) emphasize that being welcomed, valued, accepted and supported are essential elements for positive transition from student nurse to new RN. The lack of professionalism and trust stemming from negative behaviours has severe consequences for newly-graduated nurses gaining entry into the profession. For example, McKenna et al. (2003) found that one-in-three newly-graduated nurses considered leaving nursing because of humiliating incidents.

Yielding to humiliation and hostility. Increasingly detrimental to newly-graduated nurses in the workplace are incidents regarding humiliation and hostility perpetrated by other nurses that include criticizing and accusatory verbal and non-verbal language. Participants reflected being "criticized" (Cole), "blamed" (Ember), demeaned, humiliated, and "laughed at" (Ember) in the clinical practice environment. Dawn reflected that troublesome and criticizing behaviours "always" stemmed from "nurses who were in a position of authority over me and other people." She explained, "I had an incident with her [a charge nurse] where she asked me to do something I thought was unsafe, and I said no.

And she just tore strip off me in front of the patient. I got really upset." Another participant felt chastised by nurses and her clinical instructors. Kindle stated:

> I was always made to feel like I wasn't good enough. Like it was *my* fault if I didn't know something, you know? It was never like, 'Did somebody show you how to do this yet? Okay, then I'll show you how to do it.' It was always, 'You don't know how to do this?! Why did you come to clinical unprepared?! Why didn't you do your research?!' Or, you know, 'You don't know what this adapter is?!' And I just felt like you couldn't win no matter how much time you invested, no matter how much research you did, there was always going to be something you didn't know. And as soon as you didn't know it, somebody was going to chastise you for not knowing.

Being blamed, chastised, and criticized is degrading and erodes confidence (Craig & Kupperschmidt, 2008) in students and newly-graduated nurses. Rae recounted:

> I remember having one awful little nurse that I was buddied with. I had done my assessment, and missed that this person had a yeast infection. I had never seen a yeast infection. I had no idea what it looked like. And she yelled me. She said, 'Why didn't you see this? You didn't give the medication, it was prn for that!' And I cried. It was awful ... I remember being so traumatized by that day... But that day [thinking to self], oh, I hate this! I just want to go home.

Similarly, Dawn described feeling criticized and targeted by the charge nurse on her unit. She stated:

> The challenging part of my work was the unit dynamics with the other nurses. Particularly with the nurse who was almost always in charge who was part of my team on my rotation. I *did* feel like she picked on the more junior nurses of which I was one ... This nurse would criticize you if you were too slow with a task ... She would complain about other nurses at the desk to other nurses. If you resisted your assignment at all ... she would make your life miserable.

Dawn further reflected that "She [the charge nurse] was so, so unpleasant that I really wanted to leave." Dawn ultimately left her position, and in doing so, left the nursing profession to pursue another career pathway. The increasing nursing shortage requires changes be made in nursing management styles and in the work

environment to make conditions more favourable toward achieving nurse satisfaction and nurses' intent to stay within the profession. Quality practice environments in which teamwork, communication, and trust are valued, have been found to foster nurses' job satisfaction and commitment to the organization in which they are employed (Bobbio, Bellan, & Manganelli, 2012; Laschinger & Finegan, 2005).

In another vein, Ember felt like a scapegoat for other nurses throughout nursing school and subsequently as a nurse. She commented:

> As a student, you would always feel that you would be blamed no matter what went on ... It was very black-and-white that it was *your* fault and that was the end of it. And as a student, because you are vulnerable and you don't [exhales], you just don't stand up for yourself as much as you could or maybe you should. And then working as an RN, it's a very similar culture. If you don't have a relationship of trust with your coworkers or with your manager, there is still that fear that if something goes wrong I'm going to be blamed.

These comments highlight the disparity in power and vulnerability of student nurses and newly-graduated nurses in the practice environment. These vulnerable individuals "often remain silent out of fear and embarrassment" (Thomas, 2010, p. 302) and retaliation (Ditmer, 2010). According to Hutchinson et al. (2006), humiliation and belittling contribute to dissatisfaction and poor psychological health, evident in participants who have left the nursing profession.

Another participant explained her perspective of being humiliated after making a drug error as an undergraduate student employee. Aura stated:

> There was an error made and I felt awful ... At the time the nurse educator, instead of pulling me aside and being like, okay you made this error. Here is what we're going to do to deal with it, here's how we do error reporting on this unit. It was like, 'How come you don't know this [voice stern]?! This could have been so much worse! You have to go tell the patient!'...

> So I'm standing there in the middle of this unit and crying hysterically until she finally pulled me into her office where this conversation continued. And then my buddy nurse had come in there and said 'Well, she is supposed to know that by now. You know, she's gone through this many years of school and besides, it's 3 o'clock so it's time for me to go home.' So then, she left.

Aura continued:

> The next morning I was pulled aside by a different nurse who had told me that the patient's family was worried about me. They kept asking about me, instead of their loved one. Because they had seen this whole thing go down in the hallway, and they were so worried about me because they felt so awful that this had happened. And that I was treated that way.

She went on to say:

> The hierarchy and how things can work in this type of environment, and how other nurses can make you feel really bad when you are kind of in a vulnerable position, where you still lack knowledge because you haven't completed your education yet. I feel like that experience could've been handled *so* differently by the educator. Because I think that I was freaking out enough, for everyone on that unit, there didn't need to be a freak out from her.

The process occurring here is not only distressing for the victim, but extends to witnesses of the event, specifically, the patient and their family. Ditmer (2010) reports that quality patient care and safety are compromised in a negative practice environment exemplified in the above participant comments. Another participant exclaimed, "Patients can tell if they are being taken care of by a team doesn't get along, if there's lots of stress. They hear nurses gossiping, of course they do" (Ember).

As we can see from the findings of this study, the consequences of allowing horizontal and hierarchal violence to continue in the workplace can be far reaching. Ashley, another participant, reported that these troublesome

behaviours are “disenfranchising” and “disappointing” for nursing students and newly-graduated nurses. She stated:

> I think people go into nursing because there is that feeling that you want to help people, you want to make a difference. And to have that marred and muddied by these very petty-type things, like the gossip and eye rolling, is *really* disenfranchising. You enter the professional workforce with the intention that I’m going to treat others with respect and I’m going to in turn get respect from others. And so to have those behaviors play out, is I think [sigh], it really makes the nurses who are really astounding, and doing excellent work, and being immensely professional, it reflects poorly upon them as well. And that to me, was really disappointing. I couldn’t really trust the other nurses. I couldn’t really navigate who was quote-unquote a good nurse, or who was not a good nurse. Because you just feel that it’s disenfranchising and it’s also scary that you are not working in a climate of trust, which you would expect in a professional environment.

The findings presented in this study are in keeping with other international studies that explore horizontal and hierarchal violence in the nursing literature. More specifically, with regard to themes of feeling vulnerable, powerless, not valued, and experiencing both a lack of respect and humiliation in both Australia (Curtis, Bowen, & Reid, 2007) and the United Kingdom (Randle, 2003). It is important to note that horizontal violence is not only present within the nursing workforce but other helping professions that include social work, education, and medicine (Myrick et al., 2006). However, Craig and Kupperschmidt (2008) report horizontal violence is highest in the health care workforce, namely, within the nursing profession.

The comments made by participants in this study offer us many ‘lessons to be learned.’ Firstly, we are reminded that students and newly-graduated nurses are a vulnerable group who require a supportive atmosphere. All health care professions are responsible for creating a friendly atmosphere comprised of

teamwork, respect, and inclusivity, as well as one that is free of verbal and non-verbal behaviours that comprise hierarchal and horizontal violence. Secondly, these behaviours have no place in professional health care environments and in learning environments that include university settings. Thirdly, education and clinical settings require strategies and measures to not only stop these behaviours from occurring, but prevent their occurrence altogether.

Fanning the flame. As a means to prevent hierarchal and horizontal violence, "nurses need to develop a positive identity as a critical step in breaking out of the cycle of oppression, towards systematic change in the power structures that create oppression" (Hutchinson et al., 2006, p. 123). Newly-graduated nurses will look to experienced nurses for support and direction in their practice (McKinney, 2011). Bandura's *Social Cognitive Theory* (1977) delineates that human behaviour is learned by observation. If the behaviour being role modeled is one of incivility, horizontal, and hierarchal violence, it is detrimental to the incoming generation of nurses. If nurses are not engaging in respectful, collegial collaboration within and outside the nursing profession, we risk perpetuating the cycle of horizontal violence in the nursing student and newly-graduated nurse who enters in our stead.

Newly-graduated nurses are the future of the profession. Providing this group with tools and strategies while in nursing school will provide a foundation to effectively combat horizontal and hierarchal violence in all practice environments (Curtis et al., 2007). Nursing curricula can be modified to provide students with opportunities and strategies to confront unethical behaviour,

horizontal, and hierarchal violence in the workplace. This can be achieved through classes and workshops that utilize positive communication and role play to engage in respectful confrontation to resolve conflict prior to workplace entry. Griffin (2004) concludes that the use of cognitive-behavioural techniques in nursing education is effective to confront abusive behaviour in the practice environment. Other suggestions in the literature include assertiveness and confidence training for new graduates (Daiski, 2004).

Thomas (2010) proposes numerous strategies to combat hierarchal and horizontal violence in the workplace. Change can begin with a shift in attitude toward student nurses and new graduates entering the workforce toward one of inclusivity and respect. Collaboration between schools of nursing and employers in the workforce is also needed to convey realistic expectations of students and new nurses entering clinical practice environments. Thomas (2010) encourages the use of communication tools such as SBAR: Situation, Background, Assessment, and Response to facilitate communication between health professionals and prevent errors from occurring in the workplace.

Other strategies include transition programming and nurse residency placements to assist newly-graduated nurses (Boychuk-Duchscher, 2012a) in navigating the healthcare system and to more easily negotiate social relationships in the workplace. Adopting policies and procedures for reporting and dealing with troublesome behaviours in the workplace are also needed (Longo, 2007). We must consider the negative effects of workload, overtime, inappropriate staffing mixes, and limited resources when establishing positive work

environments for all health professionals in clinical practice environments (Bobbio, et al., 2012; Laschinger & Finegan, 2005; Ritter, 2011). "Organizational leaders need to be responsive to abusive behavior in the workplace in order to foster a positive workplace environment" (Kisamore, Jawahar, Liguori, Mharapara, & Stone, 2010, p. 594). Managers and health care leaders in clinical practice environments require practical knowledge on how to de-escalate and resolve conflict within the work environment that can be obtained from seminars specializing in conflict resolution and management.

The nursing profession will continue to witness new graduate exit from the profession if negative behaviours contributing to negative practice environments are not addressed with appropriate leadership skills to resolve conflict. Left unchecked, the financial and social cost of these behaviours is immeasurable. The average cost of nurse turnover in Canada is estimated at $10,100.52 (O'Brien-Pallas, Griffin, Shamian, Buchan, Duffield, Hughes, Laschinger, North, & Stone, 2006). One participant stated that being privy to and enduring these behaviours "set me up for a lot of psychological stress and moral stress" (Ember). More consideration must be paid to the challenges students and newly-graduated nurses face as they enter the workforce. This process will be explored more fully in the next substantive category *Facing Fears, Traumas and Challenges*.

Facing Fears, Traumas and Challenges

Participants were found to face and endure many challenges on their journey as nursing students and subsequently as new RNs as they entered the workforce arena. Some challenges have already been explored in the previous

substantive categories, *Navigating Constraints of the Healthcare System and Workplace* and *Negotiating Social Relationships, Hierarchies and Troublesome Behaviours*. Participants reflected on the process with regard to persevering through nursing school which included *not feeling prepared* and *dealing with fears*, *anxieties*, and *emotional pressures*. Combating traumas and critical incidents also emerged as themes from participant interviews.

Persevering

Dampening the spirit. All participants conveyed a sense of perseverance through challenges they encountered, specifically, with regard to completing nursing school. They stated that they "forged ahead" (Ember), their goal was to "just get through" (Rae), "stick it out" (Aura) and, as one participant reported, "I wanted to do well. I wanted to succeed" (Blaize). Interestingly, many verbalized their dislike for the nursing profession as nursing students, yet chose to continue with the nursing degree. Aura stated:

> I didn't enjoy them [clinicals] too much... this is the point where I started realizing that I don't know what I'm doing here... I started thinking to myself, I'm not sure if I should be in this profession. But at the time I kept telling myself, well, this is just a phase. You know, you just have to get used to it.

Rae admitted:

> As a nursing student I was just trying to get by and do the best I could. I didn't love what I was doing ... I just needed to get through, and do the best I could, I just didn't enjoy it ... I had been an A and B student all my life, and then I got C's in nursing school. But that was because I didn't really care that much, which was really too bad. So really, I was just trying to get through and get by.

Rae further reflected:

> I've never not finished, or failed at anything in my life. I'm one of those people that just has to do it right ... If I would have failed something [in nursing school], I would have been mortified ... If I had failed a practicum there's no way that I would have ever come back ... That would have definitely dissuaded me from finishing.

In a similar vein, Dawn stated:

> I had been a fairly average nursing student when I had had excellent grades in my Bachelor of Arts. I was on the honor roll and then coming into nursing, I got like 75% on everything no matter how much work I put into my assignments. So, it felt a bit demoralizing that I hadn't achieved academically what I thought I should.

This notion of getting through relates to the strong sense of internal motivation reflected in study participants. Aura stated, "I didn't want to drop out in the middle [of nursing school] ... It's going to look good on a resume whether or not I actually work as a bedside nurse ... It says you can make a four-year commitment to something." Similarly, Ember described:

> It was cold outside and I was crying, and I just thought to myself, I would do anything if I could just quit right now. I hate this. I just hate it. How can something that started out being so positive turn out like this? It just doesn't seem right ... I guess I learned the value of pride. Because it was such a small class, and such a small hospital, I didn't want to give them [the instructors] the satisfaction of me quitting. So I still showed up every day.

Likewise, Rae recounted:

> I was a strong internal motivation type person, and I wanted to get to the end... There was no doubt in my mind I was not going to get through it. I was always going to get through it, just how to be happy and survive.

From the above comment, it is evident that despite being motivated to complete nursing school, it 'took a toll' on participants' mental health to complete their degree. The presence of dislike for nursing work while enrolled in nursing school could possibly be a precursor to nurse exit from the profession.

All participants reported the challenging nature of their undergraduate nursing programs. One participant summarized “nursing is so intense for those four years... [because] you have to know what you are doing... if you don’t, you are going to get to clinical and you are going to be floundering” (Rae). Other participants reported difficulty with the “demanding pace of the program” (Ember) and described the program as “rigourous” (Kindle) with “a heavy course load” (Ashley). Kindle further elaborated upon her nursing program. She stated:

> It was a very challenging program academically. And also challenging because you are taking classes at the same time that you are taking clinicals. So you are juggling homework, and studying, and being prepared for your classes at the same time as being in that work environment and negotiating your relationships there and what not, and waking up early to go to clinicals because they started at 7 am.

Participants with previous degrees were asked to compare nursing with other educational programs. One responded that nursing school was “the most challenging years of my life... my peers certainly said that nursing was way more difficult than all of their previous degrees put together” (Cole). Likewise, Rae stated:

> Education is *way* easier. I don’t want to say that to an education teacher who goes straight into education, but comparing the two, nursing was harder for sure ... Education, it still takes a lot of time, but it wasn’t as much as a rigorous program as nursing was.

One participant reported, “Being a nursing student is hell. It was just, it was absolutely the worst time in my life” (Ember).

Not feeling prepared. The challenges in which the participants of this study engaged while attending nursing school and subsequently as newly-graduated nurses were found to be attributed primarily to three factors: (a) the

process of engaging in a Context Based Learning (CBL) curriculum; (b) the perceived disconnection between the classroom and the clinical environment; and (c) the participants' self-described personality characteristics.

Context Based Learning (CBL). One challenge of note participants reported was being educated in a CBL classroom, also referred to as Problem Based Learning (PBL). The PBL model was developed at McMaster University (Barrows & Tamblyn, 1980). PBL approaches have become increasingly prevalent within nursing education curricula as the 'new frontier' for the preparation of nurses (Chikotas, 2008; Peters, 2000). This particular educational model is thought to allow increased creativity, critical thinking, and acquisition of knowledge through the act of group problem solving (Barrows & Tamblyn, 1980; Eugene, 2010), as opposed to lecture and teacher-centred behaviourist models. Arguably, the co-operative approach utilized in PBL resembles the clinical practice environment wherein interprofessional teamwork occurs (Eugene, 2010). While two participants "saw value in CBL" (Ashley & Blaize), many preferred lecture-style. As one participant reported:

> I like lecture style, I like to be able to take my own notes, approach the instructors, so-on-and-so-forth, as opposed to relying on fellow students to teach me things. That made me really paranoid as to the quality of my education and what I'd be paying for exactly. (Aura)

Similarly, Rae stated, "I like lecture. I like having information that is concrete and then going to practice it after." Another participant remarked that CBL did not teach her "how to think through decisions, and how to prioritize ... But then again, we didn't have any guidance on how to do it. And that was the idea [behind CBL], you figured it out on your own" (Kindle). One participant

indicated, “It was like the blind leading the blind for problem-based learning” (Dawn). Ember reflected:

> Thank God I knew how to [teach myself]. Because we had no teaching, we had no actual passing on of knowledge. It was all self-taught because ... that was the style of learning that was CBL. I know that there’s lots of research that says CBL works, and I suspect it does work if you do it properly. But CBL doesn’t mean you leave a group of students to figure out a problem and you just walk away, and say if you have any questions email me. That’s not CBL, that is being totally irresponsible. And I remember so many of us saying why are we even paying for this? Who is getting paid? This is a joke! This is an absolute joke!

Other participants also verbalized the lack of guidance from professors in the CBL classroom. When asked to describe CBL, one participant went so far as to report “I hated CBL” (Rae). While the CBL educational style may be constructivist in nature and reflective of the clinical practice environment, for many participants, it was not a favourable method to learn about nursing practice.

Owing to the premise that knowledge is co-constructed in CBL, the teacher must be able to facilitate discussion and foster an inclusive learning environment (Mezirow, 1994). One participant reported that “for people that are quiet or just aren’t confident ... [CBL] may not be the ideal learning environment” (Blaize). Without proper facilitation from instructors, coupled with the “palpable lack of respect from educators within the program” discussed previously in the study by Dawn, a positive learning environment was not achieved and appeared to pose various challenges for study participants.

Disconnecting between classroom and clinical. The second factor associated with not feeling prepared relates to the perceived disconnection participants described between the university and the clinical practice setting.

Ember stated, "My nursing education did not prepare me for practice very well at all. I think there's such a huge gap between what you are taught and what you should do, and what actually happens in the hospital setting." Nurse researchers and educators have indicated the idealistic nature of nursing education which contradicts the reality of the clinical practice environment (Allen, 2004; Clare, 1993a; Clare, 1993b; Eggertson, 2013). This sentiment was reflected in the following comments made by participants with regard to learning nursing skills.

Cole stated:

> The tutors thought that they were brought in to teach us how to do these [nursing] skills. And once we had these skills, the rest would sort of take care of itself. And I think that's where everything fell short for me because the rest didn't take care of itself. You know, I didn't feel prepared.

Similarly, Kindle reported:

> I found I wasn't really that prepared going into clinical, because we would have a lab going simultaneously with the clinical. But often you would get there and you would have to perform skills that you hadn't yet learned to do in your lab.

Ashley stated:

> We would have one lab a week to learn all the skills. And then we would get to the unit and we still didn't really know what we were doing. I think that's just the nature of the beast. Aside from technological advances, and having a standardized patient, or one of the mannequin patients in every room, it's really hard to practice inserting an IV on not a real hand.

Ashley further reflected:

> Nursing education, it is what it is. It's just to get you through, and get you into the field. And it really felt like that. It really felt like they [professors] were just giving us the information that we needed to know and sending us along on our way.

Dawn reported:

> The program I was in was fairly theoretically heavy and not as heavy on skills. I think it would have been more useful to have more specific instruction on nursing skills ... and focusing on specific decision-making patterns ... I think as a new nurse it's really useful to use those kinds of flow patterns of thinking to make decisions about care.

One participant stated, "I was on a very specialized unit, nursing school could never have prepared me for the unit that I was on" (Rae). To counter this occurrence, some Canadian nursing schools, for example, are offering certificates in specializations such as oncology to better prepare new graduates for entry into the workforce (Eggertson, 2013).

Predisposing personality characteristics. The third factor associated with challenges experienced throughout the basic psychosocial process of *Letting Go* refers to participants' self-described personality type of 'being sensitive'. 'Being sensitive' derives from the Latin word *sentire* which means 'to feel' (Sayers & de Vries, 2008). According to Aron (1996) approximately 15-20% of the population have a sensitive personality type which pre-disposes the individual to become 'easily overwhelmed' in highly stimulating environments. Aron (1996) posits that sensitive personality types want to be noticed for their hard work, are affected by others' mood, and prefer work environments that are quiet and calm. Interestingly, when participants were asked to describe their personality, several participants self-described as 'being sensitive.' Note that participants did not complete a personality-sorter questionnaire to objectively determine their personality type. However, the following quotations strongly depict 'being sensitive' (Aron, 1996). Ember described being introverted and its inherent challenges as a member of the nursing profession. She stated:

> One of the things I’ve learned throughout nursing school and practicing as an RN is that, we all have different strengths. And one thing in nursing that’s really unpopular, that I never would have guessed, is being introverted. And I don’t know why people tend to equate being introverted with being weak, or being not very smart, or having nothing to contribute, or anything like that. Because that’s not true.

Ember further described being influenced by a negative practice environment and others’ mood. She reflected:

> Those things take a toll. It’s like you’re walking into a sponge and all day you’re saturated in negativity, anger, anxiety, and fear. Not necessarily that you feel that, but when it’s all around you, it’s very hard not to pick it up in your mentality ... After a while, it starts creeping into your mind.

Ember concluded that being exposed to a negative practice environment while in the workforce “often brought out the worst in me ... it’s not right if you see yourself changing.” This comment reinforces how those with sensitive personality types can be affected by the work environment. Dawn also described herself as a “quiet person.” She further elaborated:

> I’m a quiet person. People tend not to notice me. I was kind of invisible throughout most of my placements and throughout most of the program ... I didn’t feel like people, the physicians, or clients saw me very much, or really noticed the work I was doing. I didn’t receive a lot of thanks for my work directly from management, or my charge nurse, or the physician, or the patient.

This comment emphasizes the need for those with sensitive personality types to be recognized for their contribution in the work environment. Similarly, Kindle also described herself as “a hard worker” who further stated:

> I’m a sensitive person. But I think I also have enough inner strength that I can handle criticism, and it’s not that I wanted the [nursing] program to be easy or that I wanted people to just tell me how great I was all the time. I wanted to know how I could get better, and I wanted to feel like it was actually obtainable.

Fanning the flame. Constructive feedback from faculty, managers, and nurse educators can mitigate these challenges identified by those of a 'sensitive' personality type. Constructive feedback reinforces appropriate behaviour, contributes to professional development, and can assist learners and new nurses to reach their goals (Kabotoff, 2006). One participant not only described himself as being sensitive and a "global learner" but additionally stated, "I was an anxious nursing student" (Cole). Therefore, further adding to the above challenges inherent in being sensitive, is dealing with fears and anxieties encountered in the clinical setting.

Dealing with Fears and Anxieties

Dampening the spirit. Nursing students and experienced nurses alike must cope with stressful and anxiety-producing events in their practice. For students and newly-graduated nurses, this process can comprise of practicing newly-learned skills in clinical practice environments, fear of making errors, feeling traumatized and dealing with emotional pressures.

Practicing newly-learned skills. Participants verbalized feeling "nervous" (Rae), "scared" (Cole), and "overwhelmed" (Ashley) when performing skills in the clinical environment for the first time. Rae stated:

> It's a scary thing having to do all of these things when you were 19 and 20 years old. Going in, trying to do your assessments and dressing changes, and all that stuff you are doing for the first time. I remember the first ostomy. It's really scary. You think you are going to mess up and it's just one of those stressful things that all you want to do is get through the shift, do the best you can, and go go go and feel that stress for so many hours. Then go home exhausted and go do more patient research, and I don't know, it was brutal.

Ashley reflected:

> The nurses that you are buddied with don't want to give you more than you can handle ... Sometimes you get lost between feeling overwhelmed and feeling useless ... I just thought of the actual clinical experiences as a means to an end. You know, I'll just grin and bear it for now, do my clinical pre-work, do my best when I'm on the floor, and just wait for the experiences to come to a close.

Cole reflected on the first time he carried out a male catheterization. He stated:

> I wasn't expecting it to be a particularly painful sort of procedure. I wasn't really prepared for that aspect of it... I passed out as soon as I saw blood. And the nurse was sort of critical of it. She said, 'Didn't you know he was going to be in pain? Didn't you know there was going to be blood?' And I hadn't been prepared for all of those little minute realities. I felt embarrassed, I felt scared, and I was frustrated.

Overtly critical feedback toward novice practitioners can result in resignation from the workplace (Anders, 2001). The Dreyfus model of mentorship (Benner, 1984) delineates five levels of proficiency as a learner acquires and develops skills which move from novice, to advanced beginner, to competent and proficient, toward expert mentee. Assisting novices to become proficient, coaching and mentorship play a key role to enhance confidence through appropriate communication techniques that include empathy for the learner (Redmond & Sorrell, 1996; Reilly, 2007). The presence of a welcoming and warm relationship between mentor and mentee, or a teacher and student allows for learning and identity development to occur. One participant advocated for a different approach. Rae advised:

> 'Fake it till you make it'... Look like you know what you are doing. Even if it's your first IM [intra-muscular] injection, you put on that confidence, you go for it. I remember that really helped me ... It's kind of how I deal with my fears. Just give it a try, do the best you can, and pretend you know what you are doing when you have to do something new.

Fear of making errors. Fear of making errors was also found to be evident in study participants. According to Kim (2003), the most anxiety provoking situations learners encounter include communication with physicians, a fear of making errors, being observed by instructors, and responding to initial experiences which include practicing newly-learned skills. Cole stated:

> I dreaded clinical shifts every single time every single time I went ... There was fear that I was going to make a mistake, and I was afraid of that because I didn't want to fail. And there was a thought that I would fail if I had made a mistake ... I'm worried about poor patient outcomes and if I kill this patient by making a medication error, you know? I hadn't yet developed coping skills ... What I needed in nursing school was somebody to say *calm down*. It's going to be fine. Nobody ever told me it was okay to make a mistake.

Cole further advised, "The way mistakes are handled in nursing school might be the key to keeping some of us in the profession. Because I think mistakes are inevitable, we need to learn how to deal with those." Similarly, Kindle stated:

> I've discovered that making mistakes in the education profession is something that is viewed as critical to learning ... It's something the nursing profession can certainly learn from. I mean, we have to find a way to do things safely in nursing, but that fear that I felt of making a mistake, I know I was not the only one who felt that.

Kindle further reflected:

> There's not a lot of room to grow in nursing. It feels like you have to be good at it when you graduate. You can't just develop over time ... Whether you have no years of experience or 25 years of experience, the bar is at the same level for you. You don't have the luxury of having a time period in which you can develop ... In nursing I often felt that no matter how much work I put in, it didn't matter, I just wasn't good enough for it.

The unrealistic expectation for new graduates to "hit the ground running" remains within the workforce given that nursing education curricula prepares graduates for entry-level practice (Cowin & Hengstberger-Sims, 2006, p. 61; Greenwood, 2000,

p. 17). The above participant comments emphasize the need for supportive feedback and mentorship for students and novice nurses to advance toward competent and proficient practice (Benner, 1984) within a nurturing atmosphere. Myrick, Yonge, and Billay (2010) encourage nurses in practice settings to nurture growth and potential within learners entering workforce settings.

Feeling traumatized. Without proper access to support structures for nurses, research studies indicate nurses are at risk of developing Post Traumatic Stress Disorder (PTSD) relating to increasing complexities, demands of the workplace, and exposure to traumatic incidents that include working in critical care, emergency nursing, and in pediatric areas (Adriaenssens, de Gucht, Maes, 2012; Czaja, Moss, & Mealer, 2012; Mealer, M., Burnham, E.L., Goode, C.J., Rothbaum, B., & Moss, M., 2009). Note that many study participants worked in these specialized areas. Participants described incidents of providing nursing care while being exposed to potentially traumatizing events. Blaize reflected:

> Did I realize that probably a reason a lot of nurses leave critical care, is from PTSD? No ... On my 22nd birthday, I bagged and tagged a 22 year old girl. That's what I did on my 22nd birthday... I think that's why people have PTSD. Because you spend the entire day trying to resuscitate someone exactly the same age as you, born three days before you, and you fail. And you don't necessarily fail because you couldn't do it, but you fail because they're sick. Like, there's nothing you can do.

Dawn stated that on one of her worst days working as a nurse, "I had a baby that died after birth... I mean that's not a good day. It's not something you anticipate and it's profoundly sad and scary." She continued, "On average I worked with one family a month that was having a stillbirth or having a late-term abortion

which is always sad." Similarly, Aura also described a potentially traumatizing event when responding to a code. She stated:

> My first real big code happened ... it was very traumatizing for me... This particular case was a younger patient ... she had been responsive and posturing on one side a little bit... it looked like something from the exorcist. Those were the sounds that were coming out of her ... Check her pulse, nothing. Jump on her, start doing CPR. Teenage daughter was in the room. I'm like almost crying at this point. Because it was such, [inhales sharply], like such a fast thing... We tried to resuscitate her for about 3 ½ hours. She coded twice. We were not successful.

Aura further reflected on the code and decided:

> I just didn't want to ever go through that again. It's not for me. I will remember that for the rest of my life. I don't want to have it become a part of my normal way, part of my work.

Another participant warned, "[When] I go home, I never want to have the weight of someone's coffin resting on my shoulders ... Because if you go home and you have doubts, that's when it eats at you" (Blaize). One participant verbalized her difficulty with being able to cope working as a nurse. She stated:

> I really coped on a day-to-day basis. I saw that it was too overwhelming to look too far ahead into the future and see all of the things that needed to be done. And that feeling of anxiety of what if this happens, or what if that happens? So I really just lived one day at a time. (Ember)

According to the DSM-V, four components are associated with the diagnosis of PTSD. They include (a) Re-experiencing the event which involves prolonged psychological distress; (b) Heightened arousal including sleep disturbances and hyper-vigilance; (c) Avoidance which includes distressing memories, thoughts, feelings or reminders of the event; and (d) Negative thoughts, mood, or feelings (American Psychiatric Association [APA], 2013).

Components of the DSM-V definition of PTSD are evident within participants' comments in this study. As Ember reported in the last substantive category, she experienced "psychological" and "moral stress" related to hierarchal and horizontal violence present in the workplace that is reflective of part (a) of the DSM-V definition. Part (b) of the DSM-V PTSD definition refers to sleep disturbances and hyper-vigilance; these anxiety-indicators were noted in the following participant comments:

> In my fourth year of nursing, I really struggled with the approaching completion of my degree ... I had experienced this real fear of graduating and not knowing what I was going to do after I graduated. And then I had real insomnia. Like *real* insomnia for what felt like weeks that I didn't sleep at all ... Because I wasn't sure about how I was going to deal with it, and I didn't feel ready to be a nurse ... It was very very challenging. (Kindle)

> There were a couple of errors [by classmates] that were made in clinical classes ... That was always a very dramatic moment, nursing students would be leaving the clinical unit crying their eyes out ... That affected the milieu of our class as well, because if this can happen to one of your classmates, it could happen to one of us too. You become very hypervigilant about not making those mistakes. (Cole)

Note the severe insomnia reported by Kindle related to intrusive thought patterns and the hyper-vigilance felt by Cole in their comments that could be attributed to PTSD symptomology. Furthermore, part (c) of the DSM-V definition is characterized by avoidance and reminders of the event are evident in the following quotations. Participants stated they would "try to block out" negative events (Ashley) and "you kind of try to block these things from your memory so that you can move on" (Kindle). Rae was reminded of her challenges every time she dressed in her nursing uniform. She stated, "Getting into scrubs, I hated nursing so much. Scrubs represented to me this horrible nursing school."

Negative thoughts, mood, or feelings in part (d) of the PTSD classification were evident in the following comments made by Ember. She stated, “When I went to nursing school, I lost my self-esteem, I lost my confidence, I didn’t believe in what I was doing. I lost the idea that I had of what it was to be a nurse.” While the findings of this study portray a particular relevance to PTSD, the actual presence of PTSD in the participants can only be speculated without specific measures to investigate and diagnose PTSD in newly-graduated nurses who have left or plan to leave the nursing profession.

Dealing with emotional pressures. Together with ‘feeling traumatized,’ participants also described having to deal with emotional pressures. Cole reported that when emotionally drained “you don’t have the time or energy or love, really, to give to what you’re doing ... you feel ineffective in the sense that you need to remain professional for your patients. You’re not supposed to be the one that’s in crisis, they are.” Kindle noted:

> It’s an emotional profession. You see a lot of things. You experience a lot of things that other people in society never have to deal with, right? Like most people never go to a morgue, or have to bag a dead body, like these are big things to deal with ... You often bring the emotional side of things [home] with you.

Blaize also commented on seeing dead bodies. She stated, “I can’t even begin to count the number of people I’ve seen die, or dead bodies I’ve seen, or families I’ve – you know it I mean? And I guess that’s not a normal thing, I guess.” Participants also commented on the emotional pressures and challenges present within practice environments. Kindle reflected:

> I find education, it certainly has challenges and you still deal with people and families that have tough things going on, but it’s not life and death,

> it's not as serious as nursing is. And I think that is probably just a better fit for me.

Blaize also described her challenge moving between patients in a critical care environment. She stated:

> You go from telling the family 'I'm sorry for your loss', to literally walking around the corner and admitting your next patient and telling them that hopefully everything's going to be okay. You have to turnaround from two most extreme emotions possible: the family losing a loved one to the family having a loved one being admitted into intensive care. It's like you are expected to go from one to the other and not miss a beat.

Similarly, Dawn recounted:

> I found it very emotionally taxing to care for people every day, all day... To always be empathetic and patient ... It takes a lot out of you to do that every day. Particularly when there are so many other stressors playing into that and your work isn't always very valued.

The above comments are indicative of not only primary exposure of traumatic stress, but secondary traumatic stress, also known as vicarious trauma (Stamm, 2013). Secondary traumatic stress derives from providing care to individuals who have been directly affected by trauma or injury, hence its prevalence within the helping professions (Figley, 1995). As one self-described "sensitive" participant noted:

> I'm a person who's very affected by my environment and by the people that I'm surrounded with. And I found that in nursing, I got sad a lot because you are always working with people that are sick, or dying, or going through something very traumatic. I had a hard time letting go of that, and not over empathizing with people. (Kindle)

Note that secondary traumatic stress occurs in various helping professions that include child welfare workers (Sprang, Craig, & Clark, 2011), educators, psychologists, firefighters, police officers, social workers, and lawyers (Papovic, 2009). Secondary traumatic stress also occurs in diverse nursing practice settings

that include pediatrics, mental health, critical care, oncology, and hospice areas (Beck, 2011; Beck & Gable, 2012).

Fanning the flame. Nursing faculty as well as nurse educators and leaders within clinical practice environments can assist newly-graduated nurses and student nurses to cope with stress, traumatic events, and the occurrence of errors in a safe environment through debriefing, effective communication techniques, Emotional Intelligence (EI), and transformational leadership.

A brief dyadic, early intervention can prevent onset of PTSD and trauma (des Groseilliers, Marchand, Cordova, Ruzek, & Brunet, 2013). The authors note that negative support contributes more greatly to PTSD symptoms than the lack of support (des Groseilliers et al., 2013), thus the importance of debriefing after critical incidents (Killian, 2008) which can include making errors. Rudolph, Simon, Rivard, Dufresne, and Raemar (2007) advocate that “mistakes are puzzles to be learned from rather than crimes to be covered up” (p. 358). Errors can provide opportunities for learning in a safe environment free of ridicule. Furthermore, discussing mistakes openly and objectively role models professional behaviour and can ensure patient safety (Rudolph et al., 2007). Note that engaging in effective debriefing requires delivery of effective feedback and communication techniques.

Effective feedback comprises ongoing, timely, specific, simple, purposeful, private, valuable, and most importantly, supportive characteristics (Myrick & Yonge, 2005; Myrick & Yonge, 2011). Engaging in effective feedback contributes to learner or novice confidence, motivation, self-esteem, and

proficient clinical practice (Clynes & Raftery, 2008). Similarly, Rudolph, Simon, Dufresne, and Raemer (2006) advocate for a debriefing and communication approach that does not 'shame and blame' which has ramifications resulting in humiliation and dampened motivation but rather, an approach that is non-judgmental. Furthermore, nursing faculty can facilitate and shape student learning in clinical practice environments through EI and genuine concern for student well-being (Allen, Ploeg, & Kaasalainen, 2012).

The conceptual theory of EI was first developed by John Mayer and Peter Salovey in 1990 in which they describe EI as "the ability to monitor one's own and others' emotions, to discriminate among them, and to use the information to guide one's thinking and actions" (Mayer & Salovey, 1993, p. 433). In 1995, Daniel Goleman revised Mayer and Salovey's theory of EI, adapting the theory to predict personal effectiveness at work and in leadership (Goleman, 1998). Goleman concludes that leaders require EI competencies that comprise emotional self-control, empathy, conflict management, and emotional self-awareness alongside the ability to energize others, network, build partnerships, and have fluent interpersonal skills (Boyatzis & Goleman, 2007; Goleman, 1998). EI not only impacts novice learning, but positively influences patient outcomes and employee retention in the nursing workforce (Smith, Profetto-McGrath, & Cummings, 2009).

In this study, participants described clinical instructors and nurse educators who adopted approaches that showed genuine concern. For example,

one participant's outlook improved after receiving support from a clinical instructor. Ember stated:

> I had one clinical instructor who was very good. And the reason she was good was that she was totally honest when I told her how I felt. And she didn't tell me that it wasn't her fault, or that she couldn't do anything, or it was beyond her control, she just said to me, I know exactly what you mean... And at least then I didn't feel *so* alone. I didn't feel like it was hopeless. That nobody understood or cared at all.

Ashley reflected on the anxiety she experienced the first time she performed venipuncture on a patient. However, with support, guidance, and encouragement from her tutor, she was successful. She explained:

> Word had kind of gotten around to the students on the unit that our tutor was looking for someone to put in an IV on a patient. And I was making myself scarce... I would peek my head into the hallway and if she wasn't there I would go into the next patient's room and hide for a while. And so I was definitely hesitant ... but our tutor was there completely, telling me exactly what to do. And it wasn't as scary as you anticipated it to be. It ended up being *totally* fine.

Fears and anxieties can be diminished within a supportive and non-judgmental atmosphere (Rudolph et al., 2006).

Not only is EI important for faculty, management, and leaders in the health care system, nursing students with emotional competence engage in more effective coping strategies (Por, Barriball, Fitzpatrick, & Roberts, 2011). The authors also found that EI was greater in students with higher levels of education and age (Por et al., 2011). Interestingly, one participant commented, "I started nursing school when I was 22 or 23. And I felt really glad that I wasn't 18 and doing that" (Dawn). This comment suggests that entering nursing with previous life experience and maturity can decrease the amount of stress perceived by students entering the nursing profession. Por et al. (2011) purport that teaching

nursing students principles of EI can diminish the overwhelming effects of stress and anxiety. A similar finding was noted by Smith et al. (2009), who found that students require emotional competence to develop effective coping practices within complex and chaotic nursing practice environments.

Being that stress and anxiety emanate from the clinical environment and not just internal personality characteristics, leadership styles of managers, nurse educators, and nursing faculty can also diminish challenges faced by newly-graduated nurses and nursing students. Faculty and managerial adoption of transformational and/or authentic leadership styles can promote a positive work environment for newly graduated nurses as they enter the workforce.

Transformational practice environments ease transition of newly-graduated nurses into the workforce as evidenced by positive outcomes at Magnet™ hospitals in the United States that employ transformational leadership (ANCC, 2008; Gardner, 2010; Kramer, Maguire, & Brewer, 2011). Without the tenets of fostering collaboration, building teamwork, trust, respect, and innovation emphasized in both the ANCC's framework for Magnet ™ hospitals, the nursing profession risks a continuance of hostile practice environments resulting in compromised patient care, nurse distress (Ditmer, 2010), and new graduate exit from the nursing profession. Weberg (2010) found there is overwhelming evidence that transformational leadership decreases burnout, diminishes exhaustion, increases nurse well-being, and improves job satisfaction.

Transformational leadership was first described by Burns (1978) as "transcending leadership that is dynamic leadership in the sense that leaders throw

themselves into a relationship with followers who feel elevated by it and become more active themselves" (p. 20). Bass (1990) redefined transformational leadership as "a leadership process that is systematic, consisting of purposeful and organized search for changes, systematic analysis, and the capacity to move resources from areas of lesser to greater productivity to bring about a strategic transformation" (p. 34). Wong (2008) defined and differentiated authentic and transformational leadership styles stating, "authentic leaders influence via their strong sense of who they are and where they stand on issues, values, and beliefs; whereas transformational leaders influence though a powerful and positive vision" (p. 82). Authentic and transformational leadership characteristics include "positive role modeling of honesty, integrity, and high ethical standards in the development of leader-follower relationships" (Wong & Cummings, 2009, p. 6).

Adoption of authentic and transformation leadership styles can be accomplished within the nursing profession. Literature that includes *The Leadership Challenge* (Kouzes & Posner, 2007) provides the reader with a working model on how to adopt an authentic and transformative leadership style. Adopting EI skills identified by Goleman (1998) with the leadership skills outlined by Kouzes and Posner (2007) could generate a highly adaptive and transformative nursing practice environments. Adoption of authentic and transformational leadership styles has the potential to sustain and meet the needs of the nursing profession, as well as potentially transform negative practice environments into positive work environments that can serve to mitigate nurse turnover and RN exit from the profession.

Kouzes and Posner state “more than ever there is a need for leaders to inspire us to dream, to participate, and to persevere” (2012, para.1). This statement holds significant weight for the nursing profession. Moreover, the nursing profession ought to develop and foster resilience through positive and supportive working relationships (Jackson, Firtko, & Edenborough, 2007), thereby ensuring a nursing profession that is more attractive, gratifying, and sustainable for the future.

Weighing Competing Rewards and Tensions

Throughout the emergent process, invariably, participants were found to be weighing the positive rewards while engaging in nursing practice, with competing negative tensions. These tensions influenced their ultimate decision to exit the nursing profession and were found to have been a culmination of their encounters while nursing students and subsequently as newly-graduated nurses. In this substantive category, two subsuming categories emerged: *wearing out* and *deciding to leave*. *Wearing out* resulted from *losing the joy of nursing*, *thinking it will get better*, and the accumulating effects of the previous three substantive categories that included: (a) *Navigating Constraints of the Healthcare System and Workplace*; (b) *Negotiating Social Relationships, Hierarchies and Troublesome Behaviours*; (c) *Facing Fears, Traumas and Challenges*. Ultimately, participants made the decision to leave the profession and dissociate from establishing a nursing identity, thus completing the basic psychosocial process, *Letting Go*.

Weighing Competing Rewards and Tensions was characterized as both a ‘tug-of-war’ and a balance in determining the decision whether to stay in the nursing profession or leave altogether. See *Figure 3. Weighing Competing*

Rewards and Tensions below. As one participant stated, "I don't think I'm getting the reward from the direct patient care that I require in order to keep going...it's sort of a push and pull...if they were to balance, I would still consider wanting to be a nurse" (Cole). Ember stated, "If I could find a team that I felt I belonged in, then I feel like I could just take off, and be very happy. I don't know how to find it. And I feel so tired." One participant weighed positives (rewards) and negatives (tensions) in her work environment and described what she would have needed to remain in nursing. Kindle stated:

> I didn't have any support, and I would say that [my] work environment was actually a toxic work environment ... It was very negative ... If I would have had more support, if I had been in a place where I felt like I could be given the resources that I needed to grow, I probably *would* have stayed.

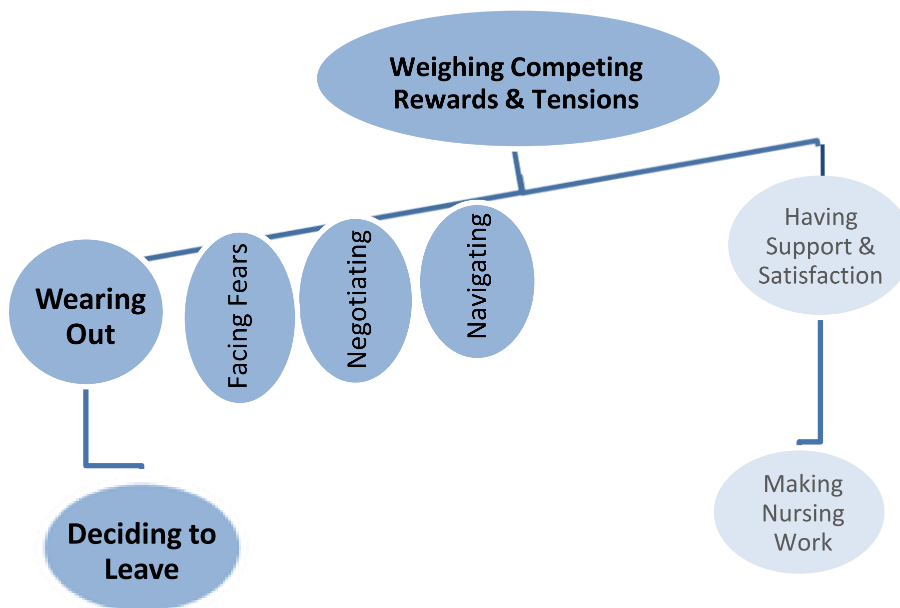

Figure 3. Weighing Competing Rewards and Tensions

According to *Identity Theory* (Burke & Stets, 2009), it is suggested that support and feedback, as well as gaining internal and external rewards are essential toward establishing identity. Without this "feedback loop" (Burke & Stets, 2009, p. 50),

an individual risks disruption in identity formation through disturbances within the feedback loop. These disturbances comprise the tensions identified in the three previous substantive categories under *Dampening the Spirit*.

Wearing Out

As participants accumulated both positive rewards prompting them to stay in the nursing profession, with opposing antecedent experiences prompting them to leave, it is clear that many of them were *wearing out*. Participants made various comments stating that they felt “ground down” (Rae), “drained” (Cole), felt “dragged under” (Ember) and referred to “deteriorating” (Ember & Kindle). Aura commented, “I felt like if I was going at the pace I was going, that probably in a few years’ time, I would not be able to work as a nurse at all.” Cole questioned:

> How much longer can I do this? ... I’m anticipating that if I were to do this indefinitely, I don’t know if there would be a breakdown, or I would become physically unhealthy, or what would happen ... I’m so close to the brink.

Ember also questioned:

> Why do I have to keep doing this? Who says that I have to keep doing this? ... I just said to myself, *you* are the one who is making yourself do this. I mean, there’s a lot of circumstances that are outside of my control, and that’s true, but at the very end of all these arguments, the fact is, I am the only one who is forcing myself to go every day, and put myself through all these stresses. And so, it gave me more of a sense of empowerment. And I think as a nursing student, I had virtually all of my powers stripped. I felt so powerless. And so to have gone through all of that, and then just say to myself, you know what? I am in charge of my life. And if I say I don’t want to do this anymore, then I don’t need anyone’s permission other than my own. And I gave myself that permission. And I’ve definitely felt a lot better.

Wearing out was further evident in the following participant statements:

> I got to a point where it was just so stressful, and things were just deteriorating more and more with my manager ... I got to a point where I felt like I just *had* to get out of it [nursing]. And I just didn't feel like I could keep going on with it any longer because I had been holding on for so long. (Kindle)

> It [nursing] was like running a marathon. You know you can't do it forever, but you just need to get to the end kind of thing... I couldn't have kept going forever because, oh my gosh, it's tiring. It's like when you don't like something, it's really hard to get yourself going and keep yourself motivated. (Rae)

Similarly, Ember stated:

> I distinctly remember having this feeling that I couldn't bounce back anymore ... At that time, it was a really fundamental shift that for the first time I felt in my physical body, there is no energy. There's nothing to run on anymore. It's just not there. And I realized I had [been] depleted ... that there's nothing left ... I just needed every spare moment just to collect myself to get up the next day and do it again. And at that point I realized that this can't be worth it. And I don't want to be a nurse to the exclusion of everything else in my life, unless I compromise my own standards.

While research indicates that as many as 66% of new graduates experience severe burnout associated with negative practice environments (Cho, Lashinger, & Wong, 2006), it is not clear if burnout was experienced by all participants in this study. The concept of *burnout* is defined as "a state of exhaustion in which one is cynical about the value of one's occupation and doubtful of one's ability to perform" (Maslach et al., 1996, p. 20). The *Maslach Burnout Inventory* (MBI) is comprised of three components that include *Exhaustion*, *Cynicism*, and *Professional Efficacy* (Maslach et al., 1996). While participants in this study displayed and described characteristics of emotional exhaustion and decreased amounts of personal efficacy, two key measures of MBI, participants did not display or describe elements of cynicism. On completion of member checks with

participants, members agreed with the subsuming category *wearing out*, however, not all members agreed with the MBI definition of burnout. As Rae explained:

> I was never exhausted when I was a nurse ... I'm more exhausted as a teacher than I ever was as a nurse ... I think I never hit the exhaustion point because I knew that I would find an out. I always saw education as a way to get home [return to home community] – it was my light, it was my carrot ahead of me ... So I didn't ever feel exhausted. I knew I would find a way to get home no matter what it was. So I ended up changing fields.

Furthermore, participants described 'getting out' of nursing before they were too depleted of energy to pursue another career pathway. Ember stated:

> How long can I keep going? And being depleted on one hand by a system that doesn't give me what I need, versus the rewards of the patient care. And how long do I wait before I decide? I don't want to wait until I'm so depleted that I feel like I don't have the strength to find another job or, I don't have the mental resources anymore to start being more creative in terms of thinking about things I can do that I would find rewarding.

The process of participant experiences and descriptions are more in alignment with the theory of *Compassion Fatigue* outlined in the *Professional Quality of Life Scale* (ProQOL) (Stamm, 2009). According to Stamm (2009) *Compassion Fatigue* comprises of secondary trauma (discussed under the substantive category *Facing Fears, Traumas, and Challenges*) coupled with a revised definition of burnout that includes the presence of exhaustion, frustration, anger, and depression. Note that cynicism is not included in this definition of burnout. Opposing *Compassion Fatigue* is *Compassion Satisfaction*, gaining positive rewards through the action of helping others.

Participants of this study were not assessed using ProQOL, however, the conceptualization of the major substantive category, *Weighing Competing Rewards and Tensions* draws similar parallels. If an individual in the nursing profession reaps a satisfactory amount of reward to sustain helping others, it is

likely the individual will remain in the nursing profession. Conversely, if fatigue perpetuates, *Compassion Fatigue* may be a valuable measure in the exit of newly-graduated nurses from the profession.

Losing the joy of nursing. Participants described the lack of rewards and a diminishing level of enjoyment in nursing as determinants of *wearing out* and wanting to exit the profession. Some participants came to the realization that performing nursing work provided them with little enjoyment. As Rae stated, “I don’t have interest in giving medications, doing assessments... I don’t think I was ever really interested in the whole nursing process. It just never really appealed to me ... it’s just not something I wanted to do my whole life.” Cole also arrived at the conclusion that “the work that nurses are doing now is very technical, and no, I don’t like that stuff. No, I don’t like nursing work.” Similarly, Aura stated, “I didn’t like doing the morning routines, gathering the meds, getting people out of bed.” She further reflected, “I don’t think I can do this.” Ashley questioned:

> I’m doing *all* this work, and I’m putting in *so* much energy and effort in, and just, you know, studying all the time, doing *so* much work, and all for what? Because I’m not going to do this in the future.

Two participants garnered some enjoyment from the work environment and the tasks embedded in nursing practice; however they hoped the challenging aspects inherent in the three previous substantive categories would resolve. As Blaize explained, “I think what I do is rewarding. Some days you win some, you lose some. You often lose more than you win them in my unit.” She continued:

> I’m not leaving because I don’t like being a nurse. I’m leaving because I don’t like what nursing means to the public ... and to our managers. That we are expendable, that we are dispensable, that we are replaceable. That is not how you get good employee morale, and that is not how you create

> job satisfaction. And the only way that I can change that behavior is if I further my education so that's what I'm going to do.

This comment highlights that although Blaize was able to garner rewards from direct patient care, the challenges surrounding management and working within the health care system were to outweigh the benefits of staying within the nursing profession.

Realizing it will not get better. For many participants, the challenges encountered in nursing school and subsequently within professional nursing practice, did not improve. Participants explained how they hoped 'things would get better', however, without supports and rewards to 'fan the flame,' the push to exit the nursing profession further escalated. Ember reflected:

> My priority was to graduate and become a nurse. And I always hoped that things would get better ... But again, as things just got worse and worse, I just wanted to graduate and get out, and never look back ... And you wonder how on earth am I ever going to do this for a living if this is how I'm handling it [the challenges] as a student. But you always think that things will get better.

Cole reflected on conversations between himself and his classmates. He stated:

> Things are going to be different once we graduate. They really aren't that different ... in many ways for me it got worse. It wasn't any better, certainly, the things we were doing were the same, but the patient load just increased and the support that we had decreased ... There was that myth that things were going to get better once you graduated.

Participants expressed disappointment with regard to the lack of social and emotional support in the work environment. Laschinger et al. (2009) emphasize the importance of decreasing emotional exhaustion in new graduates through civil working relationships, supportive environments, and a sense of empowerment to decrease nurse turnover and exit from the profession.

Deciding to Leave

As participants worked through *Weighing Competing Rewards and Tensions*, deciding to leave nursing was concluded. Although participants described losing the joy in nursing as students, two participants endeavoured to work as nurses before deciding to leave. Rae described her decision as follows:

> I needed to know for sure that it was just nursing school I didn't like, and not the job that I didn't like... I didn't love the nursing aspect... I really just did not want to do that. I had hated it during nursing school; adult care just dragged me down. And I just felt that nursing was not for me. So, I decided I would go back to school, and take [a fast-tracked education] program ... and then I let my RN license lapse when I got my teaching job.

Similarly, Aura also described trying nursing after graduating:

> It [nursing] is not the job for me... having gone through all of that schooling, I don't want to be a bedside nurse. But upon graduation, I thought I might as well try it... I didn't really like the people that I worked with ... at that point I had already kind of made up my mind and moved on, and thought I don't want to be at the bedside.

When participants were asked to describe their emotional state regarding their decision to exit, their reflections were positive. As Ember explained:

> It's a very special thing when you have that rapport with the patient and they open up to you. And you feel so privileged to be involved in their care. And that's what I'll really miss the most [tearful]...There is a very great sense of freedom that I can choose what I want to do that's best for me. And maybe nursing is just a chapter in my life that's going to end soon. And if that is the way it goes, then I'm okay with that.

Similarly, Rae reported:

> I had worked so hard for four years of my life. But on the other side, I was able to look at it, like that was life experience. And that now I'm moving on to something else... it's okay to let it go... it was kind of like this feeling like you're on the edge of the cliff. And I'm like, I'm going to let this go.

> And here it is! This is it! I'm going to let it go... it was kind of like, one chapter closes and another opens. And it's okay. So it was good.

No regret. As participants reflected on their choice to leave nursing, many expressed no regret in their pursuit to become nurses and their subsequent decision to leave. Dawn stated, "I don't really have any regrets about leaving." Another participant noted, "I'm glad I went into the nursing program ... I learned so much, and I got so many experiences ... I miss the people and the patients I had. I don't miss the nursing itself" (Rae). Ashley stated:

> I don't regret the decision to go into nursing. I don't regret finishing the degree. I don't regret the job that I had as a nurse. But it's just that metamorphosis... this is the chapter I'm leaving now, and I'm going on to something different – for better or for worse.

Final Participant Reflection

The data generated in the substantive category *Weighing Competing Rewards and Tensions* revealed an invested amount of emotion and reflection as participants chose to exit the nursing profession. The knowledge generated in this study reveals a disheartening process that could have been mitigated by the presence of adequate support structures in educational institutions, workplace settings, and policy that reinforces healthy work environments (Ritter, 2011). To summarize the process of *Letting Go*, please reflect on the following comments described by Kindle as she reflected on her decision to leave the nursing profession:

> I am starting to be able to let go of nursing ... I still feel a combination of guilt about not continuing to practice. And I don't know what it is exactly, maybe shame or just discontent with the fact that I'm not somehow using my nursing. And so, it *is* still a challenge in that way for me. I always felt with nursing, it *is* a really beautiful profession. And what nurses do is so critical, because we need nurses so much.

She continued:

> I wish I could have found myself in nursing, enough to keep going with it. But as we discussed before, I just personally, I found the stress probably more than anything, just *so* much, that I was concerned that it would just eat me up entirely and I would become *so* anxious or unable to function that it just wouldn't be worth it in that way... I'm happy now because I'm also in a profession where I feel like I can make a meaningful contribution that reflects my skills and personality a little better. But it's still something that I would probably say that I grieve a little bit. The loss of that. And the fact that I didn't feel that I had the support that I needed to make it through that time as a beginning nurse, and to really feel like I could find a meaningful career in nursing.

CHAPTER 5: IMPLICATIONS AND RECOMMENDATIONS

Numerous strategies and recommendations to mitigate newly-graduated nurses from exiting the profession have been discussed in this study under *Fanning the Flame*. The strategies to circumvent the exit of nurses from the profession are reflected in the nursing literature, and in this study, also emerged from participants. These strategies were related to each substantive category: *Navigating Constraints of the Healthcare System and Workplace*, *Negotiating Social Relationships, Hierarchies and Troublesome Behaviours*, and *Facing Fears, Traumas and Challenges*. The basic psychosocial process of *Letting Go* that emerged from the data in this study has implications for educational institutions, workplace settings, and policy that reinforce healthy work environments (Ritter, 2011). In becoming aware of the factors associated with the basic psychosocial process of *Letting Go*, this process can be interrupted to prevent the further exodus of nurses from the profession.

Upon being asked to consider what advice participants in this study might have for nursing students entering the profession, participants offered their own recommendations. Rae stated:

> Sticking it out makes you a tougher person ... The best advice is that no matter how frustrated or hard it is, just get through it. And then work for a little bit just to have the experience ... I needed to know for sure that it was just nursing school I didn't like, and not the job that I didn't like. And I would say just get through, anyone can get through if you can just work hard enough, and put in the time and lack of sleep, and do the best you can. And I think you should try before you should decide not to do it.

Aura cautioned, "I think everything that you get taught in school is like some sort of crazy ideal. And that nothing happens like that in the real world." Cole

recommended "find a way to spend time with nurses before starting nursing school." Blaize advised to be aware of the 'trade-offs' being a nurse. She stated:

> You think as a student that making $90,000 is good money, but what you trade off physically, mentally, and emotionally, is half the compensation right there. You miss birthdays, you work every other Christmas, if your husband is a teacher, he gets the whole summer off, you don't. Getting time off in the summer is not going to happen. And that nursing overall, you get out of it what you put into it ... pick an area that you like.

Other advice for nursing students from participants included pursuing your passion. As Kindle described:

> I would tell them [nursing students] to try and figure out early on in their degree what area of nursing it is that they are passionate about. Because I think that it's important, it's such a big field, and there's so many different areas you can work in, it's important to know what it is that interests you so that you can set up your final practicum in that area ... And be able to find employment there later on.

Ember recommended students who are considering nursing to "get feedback from graduates [of the program you are considering], don't go by what they say on their website, don't even go by what the professors tell you, get feedback from people who've actually lived through the experience." Another participant stated:

> It's [nursing is] a huge amount of work, it's really difficult. And it's not something to be taken lightly ... When you are a Registered Nurse working on the unit you *are*, in charge of people's lives. And you *do* need to have a high level of education and a high level of skill. So expect the program to be challenging. And another piece of advice would be that when you get to clinical, you won't be prepared ... Go into clinical on the first day and say, I *don't* know how to do every skill, and that's okay. (Ashley)

One participant also offered advice for nursing faculty. Kindle advised faculty to allow their students to pursue their passion:

> I felt like throughout my degree, I was sort of told that I had to work in medicine when I graduated. And when I graduated, that was the only way to build my career at all as a nurse... It's better for the nursing faculty to

> take advantage of the abilities of the students, and the interest that they bring, so they can harvest those, and do something useful with them.

Nursing education is the first point-of-entry into the profession for many nursing students. Achieving greater professional satisfaction and increasing nurses' intent to stay can be attained through caring teacher-student relationships that reflect the caring and compassionate values fostered within the nursing profession. This includes nurturing novice learners through emancipatory pedagogy, role modeling, providing constructive feedback and engaging in positive communication techniques to ensure successful development of newly-graduated nurses (Benner, 1984; Bevis, 1989; Myrick et al., 2006; Myrick & Tamlyn, 2007).

Nursing educational curricula ought to embed valuable learning experiences that connect education in university settings to the clinical practice environment (Eggertson, 2013; Myrick & Yonge, 2005). This goal can be accomplished through the adoption of simulation (Jarzemsky, McCarthy, Ellis, 2010) as a source of learning for students that reflect the clinical practice environment within the confines of university settings. Other strategies include transition programming, preceptorship, and mentorship programs (Olson-Sitki, Wendler, & Forbes, 2012) to prepare and foster positive socialization for new graduates entering the workforce. This must include adequate supports that comprise individual assistance through feedback and positive communication techniques, as well as a supportive workplace environment for the novice to develop confidence, proficiency, and competency (Johnstone, Kanitsaki, & Currie, 2008).

To mitigate new nurses from exiting the profession, those in clinical practice environments ought to adopt transformative leadership practices. Transformative leadership offers an emancipatory approach within the workplace which acts as a powerful strategy to circumvent the stressors within nursing related to patient acuity, workplace demands, paperwork, turnover, overtime, and burnout described by Reineck and Furino (2005). These changes can also serve to diminish hierarchal tenets that have given rise to oppressed group behaviour as well as hierarchal and horizontal violence within the nursing workforce.

Conditions in the work environment ought to be made more favourable through the adoption of policy and health care models that permit nurses to practice to their full scope of skills and abilities (CNA, 2012). Furthermore, with increasing patient acuity and complexity, staffing mixes and appropriate nurse-patient ratios must also be considered to permit a safe workload for newly-graduated nurses entering the workforce (Duffield, Roche, Diers, Catling-Paull, & Blay, 2010). Adequate senior staffing ought to be made available to assist the novice practitioner should the need arise (Johnstone et al., 2008).

It is in nursing's best interest to acknowledge our professional history and clarify misconceptions that demote current nursing practice. Nursing has outgrown paternalism of the medical model as the public sees increasing value in primary health care, empowering the public through illness prevention to achieve healthy outcomes (CNA, 2012). Nursing practice can be highly autonomous, yet occurs within integrated inter-professional teams to deliver high quality care in many different practice environments beyond the hospital setting (AIPHE, 2011).

If such awareness is fostered and role-modeled in all practice environments, we can interrupt the process of new nurses choosing to leave the profession to ensure for a sustainable, illuminated, supportive, and invigorated profession.

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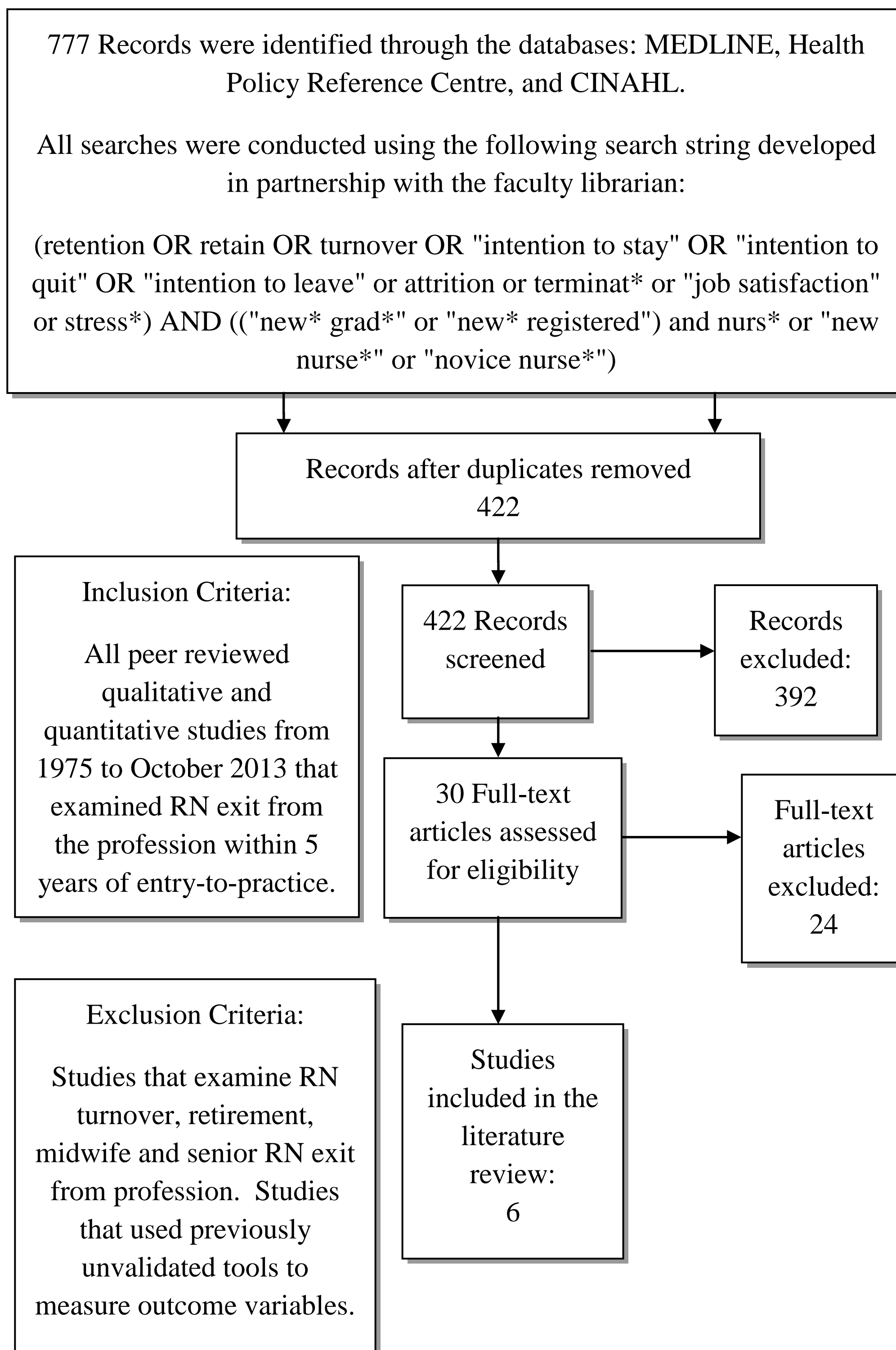
APPENDIX A: SEARCH METHODS



APPENDIX B: QUALITY APPRAISAL OF STUDIES

CASP: Qualitative Research Tool											
Reference:	Questions:										Total
	1	2	3	4	5	6	7	8	9	10	
Mackusick & Minick. (2010). Why are nurses leaving?	Y	Y	Y	P	Y	N	P	Y	P	P	5-Ys 1-N 4-Partial
Cleary et al. (2013). Recent graduate nurse views...	Y	Y	N	Y	Y	N	P	P	Y	P	5-Ys 2-Ns 3-Ps
Items scored 'Y' (adequately reported), 'N' (inadequately reported), or 'P' (Partial) did not meet all criteria).											

MINORS Tool													
Reference:	Questions:												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Lavoie-Tremblay et al. (2011). Turnover intention...	2	2	1	2	N/A	2	0	N/A	2	N/A	2	2	15/18
Nooney et al. (2010). Should I stay...	2	1	0	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2	6/10
Parry (2008). Intention to leave the profession...	2	1	2	2	N/A	2	0	N/A	2	N/A	2	2	15/18
Suzuki et al. (2010). Factors affecting turnover of Japanese nurses...	2	2	2	2	N/A	2	1	N/A	2	N/A	2	2	17/18
Items scored 0 (not reported), 1 (reported but inadequate), 2 (reported and adequate), or N/A (not applicable).													

APPENDIX C: SYNTHESES OF ARTICLES

Author(s)	Citation	Design	Sample Size	Sample Characteristics	Findings
Cleary, M., Horsfall, J., Jackson, D., Muthulaks-hmi, P., & Hunt, G.E.	(2013). Recent graduate nurse views of nursing, work and leadership. *Journal of Clinical Nursing*, *22*, 2904-2911.	Qualitative thematic analysis via qualitative interviews	17	▪Unclear if all participants originated from Singapore. ▪All participants university educated at baccalaureate level in a Singapore university	4 themes emerged: ▪Skills and qualities required for positive nursing achievements (emotional, intellectual, interpersonal, and psychosocial qualities). ▪Being supported after graduation (only 7 participants reported 'good' transitional support in the workplace, heavy workload, prevalence of patriarchy). ▪Role models/leadership in clinical setting (majority of participants reported lack of 'constructive leadership'). ▪Retention of nurses (need for 'non-blaming culture,' more autonomy, freedom to pursue postgraduate studies). ▪1 participant resigned from nursing workforce – not clear how long individual worked as nurse. ▪2 participants intended to quit current position.

Author(s)	Citation	Design	Sample Size	Sample Characteristics	Findings
Lavoie-Tremblay, M., Paquet, M., & Marchionni, C.	(2011). Turnover intention among new nurses. *Journal for Nurses in Staff Development*, *27*(1), 39-45.	Correlational-Descriptive ▪Surveys prior to entry into workforce; repeated at 8 months into first placement using the *Practice Environment Scale of the Nursing Work Index* (PES-NWI).	145	▪All participants from Quebec, Canada. ▪85.5% were female. ▪58.3% were 24 years old or younger (Gen Y). ▪40.7% were between ages 25-44 (Gen X). ▪64.8% attended a college-level nursing program. ▪34.5% graduated from a university nursing program. ▪0.7% (1 person) with master's degree. ▪22.4% worked FT, 35.7% worked PT, 42% worked PT-Casual. ▪55.3% worked rotating shifts. ▪49% worked in a teaching hospital, 43.4% worked in a health or social services centre, 11.7% worked in a university hospital.	▪49% intended to quit current position. ▪9.7% intended to quit profession. ▪Significant correlations found in those intending to quit the profession and in all 5 domains of PES-NWI: (Nurse participation, Quality care, Nurse manager ability, Leadership and support, Collegial nurse-physician relationships). ▪There were no significant differences between new nurses in the age groups (Gen Y and Gen X) on the intention to quit categories.

Author(s)	Citation	Design	Sample Size	Sample Characteristics	Findings
Mackusick, C.I., & Minick, P.	(2010). Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *MEDSURG Nursing*, *19*(6), 335-340.	Interpretive Hermeneutic Phenomenology ▪Semi-structured interviews ▪Purposive and snowball sampling.	10	▪1 participant under age 30; 1 between 30-39 years; 8 between 40-59 years. ▪80% female. ▪70% Caucasian. ▪5 practiced in Medical-Surgical areas; 3 in Critical Care; 1 in a psychiatric setting; and 1 in labour and delivery. ▪Years of practice ranged from 1-18 years. ▪5 were baccalaureate prepared; 5 with an associate degree. ▪3 participants held a bachelor degree in another field. ▪1 held an MBA.	3 themes emerged: ▪Unfriendly Workplace (lack of support, sexual harassment, verbal and physical abuse occurring from managers, co-workers, and physicians). ▪Emotional Distress (conflict between the wishes of patients and their families) ▪Fatigue and Exhaustion (physical and emotional). ▪3 participants left nursing after 1-2 years of practice. ▪Many participants cried during the interviews. ▪"Horizontal Hostility" and bullying occurred in those participants who left nursing

Author(s)	Citation	Design	Sample Size	Sample Characteristics	Findings
Nooney, J.G., Unruh, L., & Yore, M.M.	(2010). Should I stay or go? Career change and labor force separation among registered nurses in the U.S. *Social Science & Medicine*, *70*, 1874-1881.	Cross-Sectional, Retrospective Analysis ▪Data was drawn from the 2004 National Sample Survey of Registered Nurses in the United States of America.	29,472	▪Survey included nurses still practicing (did not include those who left the profession). ▪Majority of participants were white (90%) and female (94%). ▪73% were married. ▪38% had children in the home.	▪Attrition commences 5 years after entry to practice with 80% of nurses remaining in the workforce until age 51. ▪The rate of nurse attrition increases between age 51 and 61, and increases substantially between age 60 and 70 corresponding with retirement. ▪Nurses with higher incomes were significantly more likely to make a career change. ▪Those with an Advanced Practice or Master's education were less likely to make a career change. ▪Nurses with children at home were 2.5 times more likely to make a career change. ▪Married nurses were 2 times more likely to leave the labour force. ▪Women are much less likely to leave nursing than men. ▪Nurses' satisfaction with work environment not measured.

Author(s)	Citation	Design	Sample Size	Sample Characteristics	Findings
Parry, J.	(2008). Intention to leave the profession: Antecedents and role in nurse turnover. *Journal of Advanced Nursing*, *64*(2), 157-167.	Repeated measures ▪Surveyed prior to (or soon after) entry into the workplace and again after 6-8 months using: the Blau occupation measure, job satisfaction, organizational commitment, and turnover intentions scale. ▪Path analysis utilized to test a theoretical model of relationships affecting intention to change employer and profession.	131	▪Participants were entering the RN profession during the year 2005 from Queensland, Australia. ▪All participants were baccalaureate prepared.	▪Higher levels of affective professional commitment are related to higher levels of job satisfaction and organizational commitment. ▪Lower levels of affective professional commitment are related to lower job satisfaction and organizational commitment. ▪The relationship between job satisfaction and intention to change professions is not direct. ▪Organizational commitment and affective professional commitment after a period of work are antecedents of intention to change professions (they are statistically significantly and negatively related to intention to change professions). ▪Job satisfaction and organizational commitment are statistically significantly and negatively related to organizational turnover intention. ▪Intention to change professions is statistically significantly and positively related to intention to change employer.

Author(s)	Citation	Design	Sample Size	Sample Characteristics	Findings
Suzuki, E., Tagaya, A., Ota, K., Nagasawa, Y., Matsuura, R., & Sato, C.	(2010). Factors affecting turnover of Japanese novice nurses in university hospitals in early and later years of employment. *Journal of Nursing Management*, *18*, 194-204.	Repeated measures ▪Novice nurses surveyed at 3-9 months & at 10th-15th month of employment regarding: Assertiveness, Stressful life events, Reality shock, Ward assignment, Wish for transfer, Wish for leaving nursing, Workplace satisfaction, Workload, Social support and Coping profiles. ▪Logistic regression between 2 groups (those who quit their jobs and those who did not quit).	762	▪All participants Japanese. ▪96% female. ▪53.3% graduated from a diploma program, 25% with an associate degree, and 19% with baccalaureate preparation. ▪Workplaces ranged from surgical areas (27.6%), medicine (21.1%), critical care (10.4%), operating room (7.3%), pediatrics (6.2%), and others (5.6%). ▪The majority of participants lived alone (73.8%). ▪37.8% of new grads worked in Tokyo, 62.2% practiced in other sites.	▪4% of new nurses quit jobs during first 3-9 months of employment compared to 4.6% during the 10th-15th months of entry-to-practice. ▪The total *Maslach Burnout Inventory* score was significantly higher in 'quitters' than 'non-quitters' (no differences in scores for *assertiveness* and *personal accomplishment*). ▪9.7% indicated they wished to leave profession. ▪18.9% wished to change workplace. ▪Significant associations for turnover in those with diploma education, working on an undesired ward, and lack of peer support during the first 3-9months. ▪Factors affecting at 10-15months included increased workplace dissatisfaction, working at a Tokyo hospital, and high levels of physical and emotional exhaustion. ▪Novice nurses that depended on alcohol and medicine (measured as part of *Coping Profile*) tended to burnout more easily. ▪Burnout (physical and emotional exhaustion) at baseline affected turnover at 10-15 months more so than during 3-9 months.

APPENDIX D: DEMOGRAPHIC FORM

Data	Indicator
Code/Pseudonym	
Sex	Male/Female
Birth Year	Month-Year
Graduation Date Must have graduated between April 2008- November 2012	Month-Year
Graduated with Baccalaureate Degree from Canadian Institution	Yes/No
Entry-To-Practice Date	Month-Year
Last Date Worked as RN Cannot have worked within 6 months (November 2012)	Month-Year
Type of Workplace ie] Medicine/Post-Surgical Unit/Pediatrics/ER/ICU/Community	
Full-Time Status	Yes/No

How did you hear about this study:

____

____

Do you self-identify as a visible minority:______________________________

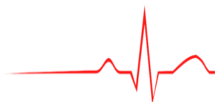
Contact Information:
Email ________________ Phone/Cell___________________ Skype __________
Other____
Additional Notes:

____

____

____

APPENDIX E: SAMPLE POSTER



Seeking Participants

Are you, or is someone you know, a

Registered Nurse
who has decided to leave the profession?

I would like to hear about your experience as a Registered Nurse and how you decided to leave nursing practice. If you have graduated from a Canadian university with a baccalaureate degree within the last five years and have not practiced as a nurse within the last six months, please consider participating in this study.

Contact Kathryn Chachula:

780-492-8913

chachula@ualberta.ca

http://www.facebook.com/RNExit

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FACULTY OF NURSING

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APPENDIX F: INTERVIEW GUIDE

In the initial interview, the following questions may be used to guide the researcher in exploring the process involved in the participant's decision to leave the nursing profession:

1) How did you arrive at your decision to leave the nursing profession?

2) What would you say contributed to your decision to leave?

3) How do you perceive nursing education and its preparation for nursing practice?

4) In retrospect, how would you describe yourself as a nursing student?

5) Is there anything that you wish other nursing students knew about working as a nurse that you did not know?

6) How would you describe working as a nurse?

The subsequent interview(s) will be conducted to confirm or extend the interpretations drawn from the research data generated from the initial interviews. I will begin by presenting participants with an overview of the study themes:

1) Thinking back to our first conversation, is there anything that comes to mind that you would like to discuss or elaborate upon? Do you have any additional comments as to why you decided to leave the nursing profession?

2) What are your thoughts regarding the themes I have identified? Do these accurately capture your perspective?

3) Can we review the themes together and discuss our interpretations?

APPENDIX G: NOTIFICATION OF ETHICAL APPROVAL

Date:	May 23, 2013
Study ID:	Pro00039073
Principal Investigator:	Kathryn Chachula
Study Supervisor:	A Myrick
Study Title:	Exploring Newly-Graduated Registered Nurses' Decision to Exit the Profession
Approval Expiry Date:	May 22, 2014

Approved Consent Form:	Approval Date	Approved Document
	23/05/2013	Participant Consent Form.docx
	23/05/2013	Participant InformationLetter

Thank you for submitting the above study to the Research Ethics Board 1 . Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Sincerely,

Dr. William Dunn
Chair, Research Ethics Board 1

Note: This correspondence includes an electronic signature (validation and approval via an online system).

APPENDIX H: INFORMATION LETTER

Exploring Newly Graduated Registered Nurses' Decision to Exit the Profession

Research Investigator:
Kathryn Chachula RN BN
4-288A 11405 – 87 Avenue
Edmonton Clinic Health Academy
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780-492-8913

Research Supervisor:
Florence Myrick RN BN MScN PhD
4-238 11405 – 87 Avenue
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780-492-0251

Background

You have been asked to participate in this study because you are a Registered Nurse who has graduated from a Canadian university institution within the last five years who has chosen to exit the nursing profession. You may have been nominated to participate by a friend, family member, or colleague related to a poster, email, or advertisement campaign calling for participants.

Purpose

Few studies have investigated Registered Nurse exit from the profession that are not related to retirement or disciplinary action. This study aims to understand the circumstances that led to your decision to exit the nursing profession. Your participation may help nurse educators better prepare newly-graduated nurses through curricular reform, and provide both insights and knowledge into the current clinical culture to address new RN attrition upon entry-to-practice.

The results of this study will be used in support of Kathryn Chachula's Master of Nursing thesis.

Study Procedures

Your participation is your choice. You may choose to withdraw at any time during the data collection phase of the study. Should you choose to no longer participate; any data collected from your interview(s) will be destroyed.

Participation involves being interviewed to describe how you arrived at your decision to exit nursing to the research investigator for one hour up to three times at a location of your choice. Each interview will be audio-recorded. The final interview may be used to verify data collected by the researcher.

Your identity will be anonymized and protected as it will *not* be linked to the research data or any subsequent reports. Any electronic data will be password protected and/or encrypted. Taking part in this study will *not* affect your job, your current standing as a Registered Nurse, your current professional status, or have any effect upon academic courses you are currently enrolled in or choose to partake in the future.

Data will be kept in a locked, secure location for a minimum of five years and may be used for future research upon ethical approval.

Possible Benefits and Risks

Participating in this study may have no direct benefits to you. However, the researcher hopes that through your participation, future nursing students may be better prepared for entry into the workplace. The researcher is aware that this topic may be sensitive in nature and respects your choice to participate.

The only exception to the promise of safeguarding your identity is that the research investigator is legally obligated to report any intentions of harm to yourself or others.

For crisis intervention or emotional distress, contact:
Health Services Crisis Line: 1-877-303-2642
Adult Mental Health Crisis Response Team: 780-342-7777

Further Information

If you have any further questions regarding this study, please do not hesitate to contact the Research Investigator, Kathryn Chachula, or the Research Supervisor, Dr. Florence Myrick.

For questions regarding participant rights and ethical conduct of research, contact the Health Ethics Research Office at 780-492-2615 or the Faculty of Nursing Research Office at 780-492-3769.

APPENDIX I: CONSENT FORM

Exploring Newly Graduated Registered Nurses' Decision to Exit the Profession

Research Investigator:
Kathryn Chachula RN BN
4-288A 11405 – 87 Avenue
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Research Supervisor:
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Edmonton, AB, T6G 1C9
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780-492-0251

To be filled out and signed by the participant	**Please check**	
Do you understand that you have been asked to participate in a research study?	Yes	No
Have you received a copy of the information letter?	Yes	No
Have you had the opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw without giving a reason during the data collection phase of this study?	Yes	No
Has the issue of anonymity, confidentiality, and use of pseudonyms been explained to you?	Yes	No
Do you consent to being interviewed?	Yes	No
Do you consent to having the interview audio-taped?	Yes	No
Do you consent to have your data reviewed at a later date?	Yes	No
Do you understand who will have access to your information and interview data?	Yes	No
This study was explained to me by:	Date:	

I agree to participate in this study.

____________________ ____________________ ____________________

Signature of participant   Printed name   Date

As the Research Investigator, I believe that the person signing this form understands what is involved in the study and has freely chosen to participate.

____________________ ____________________ ____________________

Signature of investigator   Printed name   Date

*** A copy of this consent form must be given to participants.**