NURSE EDUCATORS' PERCEPTIONS ABOUT THE CULTURE OF NURSING

AND HOW THEY BRING STUDENTS INTO THAT CULTURE:

A FOCUSED ETHNOGRAPHY

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By

Susan M. Strouse

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Approved March 19, 2012

_____
Carolyn J. Nickerson
Professor of Nursing
(Committee Chair)

_____
Rick Zoucha
Professor of Nursing
(Committee Member)

_____
Patricia Underwood
Assistant Professor of Music
(Committee Member)

_____
Name of Professor
Assistant Professor of History
(Committee Member)

_____
Name of Dean
Dean, School Name
Professor of Chemistry and
Biochemistry

_____
Name of Department Chair
Chair, Department Name
Professor of Mathematics

ABSTRACT

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May 2012

Dissertation supervised by Professor Carolyn J. Nickerson

Purpose: The purpose of this study was to discover nurse educators' perceptions about the culture of nursing and how they bring students into that culture. Background: Although the extant literature addresses the process of socialization to the profession, literature exploring socialization as enculturation is scant. Nurse educators' perspectives on the culture of nursing needed further exploration, as their voice on this topic is relatively silent and they provide the first formal enculturation to the profession. Viewing nursing as a professional culture may more effectively enable faculty to clarify and explicate for students the values, behaviors, symbols, and beliefs inherent in the profession.

Methodology: This study was a focused ethnography, utilizing Leininger's Four Phases of Data Analysis.

Conclusion and Implications: Four main themes emerged from the data. These themes are *the culture of nursing is multifaceted, multivalent and at times contradictory; multiple factors both internal and external to the culture influence the culture of nursing; nursing faculty believe that the right conditions facilitate the enculturation of students; navigating the subcultures (academia, service and organizational culture) is challenging for faculty.* Theme One reflects faculty participants' views of the diverse characteristics and roles attributed to nurses and the absence of a composite, well-articulated characterization of the culture of nursing other than by value of caring. Theme Two reflects faculty participants' perceptions of the many internal and external factors that influence the culture of nursing. Theme Three captures faculty participants' strong beliefs about what was necessary to bring students into that culture.

Theme Four illustrates the many cultural negotiations required daily of faculty participants as they participate in multiple, and at times conflicting subcultures within the culture of nursing. This study has implications for the preparation of nurse educators, curriculum development in nursing education, the education-practice gap, and the role of nurse educators in shaping the culture of nursing.

DEDICATION

The journey to earning a PhD in Nursing is not a singular journey. It would not be possible without the assistance of many people along the way. I dedicate this dissertation to those who have walked this journey with me. I would like to especially thank my husband Robert Strouse for his unconditional love, support, encouragement, listening, belief in me and patience during yet another one of my educational journeys during our marriage. I would also like to dedicate this to my children Rev. Anthony Strouse, Amanda and Dan Surdenik, and Allison Strouse, for their encouragement, love, support and patience through this educational endeavor. I dedicate this dissertation to my parents, Jesus and Odilla Perez, who instilled in me a love of learning, the value of doing the best you can regardless of the task, and the beauty of experiencing multiculturalism in our home.

I owe a special debt of gratitude to my committee members, Dr. Carolyn Nickerson, Dr. Rick Zoucha and Dr. Patricia Underwood. I greatly appreciate their insights and assistance. I would especially like to thank Dr. Carolyn Nickerson, who has been my advisor since my first day of orientation at Duquesne University and served as my dissertation chair. I cherish our discussions, deliberations, and conversations. You encouraged me to think deeper and from multiple perspectives, which has made me a better nurse educator and person. I humbly thank you for your mentorship and wisdom.

I also dedicate this dissertation to Dr. MaryJo Arndt, my former mentor at Michigan State University who died January 2010. It was MaryJo's encouragement that

led me to Duquesne University School of Nursing and earning my PhD. Her memory lives on through this work.

There are countless others who have walked this journey with me, including those in my cohort (Cohort 14 forever!), my co-workers and friends. Thank you for the gifts of your time and presence, which made this journey doable.

Most importantly, I dedicate this dissertation and give thanks to God, the author of all wisdom. By His grace I came to Duquesne and through His graces I persevered. To Him be the glory and honor.

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Chapter 1

Introduction and Overview

Introduction

Socialization of students to the profession of nursing is a responsibility of nurse educators. According to Leininger (1994), the process of socialization is one of learning and transmitting culture from one generation to another. A limited amount of research exists regarding the professional culture of nursing. There is some convergence of literature available on the professional culture of nursing and that on the socialization in nursing. Research addressing nursing faculty's perceptions on the professional culture of nursing and their role in bringing students into this culture is lacking. This study seeks answers to the questions of nursing faculty perceptions on the culture of nursing and how students learn that culture. This chapter explores the background concepts of culture and professional socialization, underlying assumptions, limitations, and operational definitions in the study, and background of the researcher.

Background

Culture

The study of culture has its roots in anthropology, though it is difficult to find a universally accepted definition of culture even within the world of anthropology. According to the anthropologist Bodley (1994), culture is learned and includes what people think and do, the materials they produce, and is "shared, learned, symbolic, transmitted cross generationally, adaptive and integrative" ("Definitions and discussions on culture", ¶ 4) . This is a descriptive approach to culture, as opposed to the Neoplatonic perspective on culture taken by Arnold, as quoted by Bodley (1994) that

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culture includes "contact with the best which has been thought and said in the world"
(Definitions and discussions on culture, Bodley) and that culture is necessary for a
healthy democracy. The most succinct definition is that culture is shared meanings
within a group (Tutton, Seers, &Langstaff, 2007). Crow (1993) takes a more detailed
perspective of culture and defines it as "a way of life, interrelated in various facets, not
inherited but learned, that shares and defines the boundaries of different groups" (p. 199).
Culture is amenable to social processes, is always in a state of change, and leads to
uneven relationships that result in imbalances of power (Street, 1992).

How the construct of culture is employed depends, in part, on the perspective of
the individual, organization, or profession defining culture, and their philosophical
backgrounds. For example, one common contemporary but narrow use of the construct
of culture focuses on ethnicity and race. Culture is larger than these two elements and
most social scientists agree that the construct of culture also includes values, beliefs,
language, rituals and lifeways that may or may not be homogeneous in groups of people
of a given race or ethnicity. Nurses comprise a professional group with distinctive
values, beliefs, language, rituals, and practices, thus it has been suggested that nursing is
a distinctive professional culture (Leininger, 1994).

Professional culture. Professions are composed of a group of people with
similar values, attitudes and beliefs working toward a common goal. Cohen (1981)
defines professional culture as "the values, norms, motivational attributes, and ethical
standards held in common by other members of the profession" (p. 15). Hong (2001)
provides a more contemporary definition of professional culture as "a form of
professional life organized around a body of specialized knowledge, shared by a group of

qualified practitioners" (¶17). This professional culture includes "job responsibilities, day-to-day service delivery, role differentiation, status hierarchies, [and] communication channels" (Hong, 2001, ¶ 17). Schőn (1987) recognizes different values, norms, and ways of thinking and problem solving among the various professions. Taken altogether, these definitions and observations suggest that each profession has its own unique culture, with each profession shaping and forming those who seek membership in the culture. While limited research exists on professional cultures in medicine (Cadogan, Franzi, & Osterweil, 1999), physical therapy (Stiller, 2000), occupational therapy (Bennett, 1999), and dietetics (Lordy & Taper, 2008), limited research exists on the professional culture of nursing.

Nursing as a professional culture. The majority of research to date addresses nursing and culture from the perspective of the need to provide culturally competent or congruent care to patients (Hong, 2001). However, many authors (Hall, 2005; Hodges, 1997; Horton, 1998; Leininger, 1994; Locsin, 2002; Pecukonis, Doyle, & Bliss, 2008; Raines, 2006; Rassin, 2008; Spector, 2009; Suominen, Kovasin, & Ketola, 1997) recognize nursing as a distinctive culture. Four decades ago, Leininger asserted, "Nursing, too, is a sub-culture which has its own norms and practices that make it a special and distinct group" (Leininger, 1970, p. 51). Leininger later defined the culture of nursing as "the learned and transmitted lifeways, values, symbols, patterns and normative practices of members of the nursing profession of a particular society" (1994, p. 19). Lifeways refers to "shared or similar life experiences of a group of people that reflect the cultural context or totality of the situation" (Horton, 1998, p. 276). Rituals, artifacts,

symbols, physical context, and social context all help to reveal the lifeways of members of a culture (Wolf, in Munhall, P., 2007).

Some researchers also suggest that subcultures exist within the culture of nursing. These subcultures are based on geographic location (Leininger, 1995), specialization (Cashin, Newman, Eason, Thorpe, & O'Discoll, 2009; Horton, 1998; Tutton, Seers, & Langstaff, 2007), roles (Hodges, 1997), and ethnicity (Spangler, 1991). Crow (1993), Hodges (1997), and Shriner (2007) suggest that nursing education may be a subculture within nursing but no studies could be located that explored the perspectives of nursing faculty regarding nursing as a culture or the subcultures of nursing.

Socialization into a Professional Culture

Joining a profession requires socialization of prospective members into that professional culture so that they may learn the lifeways of that profession. One term associated with bringing people into a profession is professional socialization. A variety of definitions of professional socialization exists in the literature. Benner, Sutphen, Leonard, and Day (2010) refer to the process of socialization as formation or re-formation. Formation is "a way of being and acting in practice and the world. Formation occurs over time with the transformation from the well-meaning lay person to the nurse who is prepared to respond with respect and skill" (Benner, et al, 2010, p. 166). Clark (1997) proposes a commonly cited definition of professional socialization. "Professional socialization can be defined as the acquisition of the knowledge, skills, values, roles, and attitudes associated with the practice of a particular profession" (Clark, 1997, p. 272). Howkins and Ewins (1999) expand on that definition to include the process of socialization, and suggest that nursing may have a culture which is different from popular

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culture: "Professional socialization is the complex process . . . In the process, a person gives up the societal and media stereotypes prevalent in our culture and adopts those held by members of that profession" (1999, p. 42).

Howkins and Ewins (1999) also note that professional socialization is an active, non-linear process that engages the student and involves more than knowledge acquisition. "Changes a student will make during a course will depend on the student's past experience, the type and form of educational provision, the opportunity to reflect on practice, and the beliefs and values promoted in the course" (Howkins & Ewins, 1999, p. 48). Weis and Schank (2002) confirm that development of the affective domain is a necessary part of socialization for students to provide holistic, humanistic nursing care and make clinical judgments.

The American Association of Colleges of Nurses (AACN) (2008) regards professional socialization as necessary to become a professional. "The use of the term 'professional' implies the formation of a professional identity and accountability for one's professional image" (AACN, 2008, p. 9). Professionalism is an expected outcome achieved by a graduate of a baccalaureate nursing program, and is included as an essential element in these programs (AACN, 2008). Professionalism is defined by AACN as "the consistent demonstration of core values evidenced by nurses working with other professionals to achieve optimal health and wellness outcomes in patients, families, and communities by wisely applying principles of altruism, excellence, caring, ethics, respect, communication, and accountability" (AACN, 2008, p. 24). Being a professional also includes an awareness of the social contract and trust that patients place in nurses.

Facilitating professional socialization of nursing students is a competency expected of nurse educators (Cohen, 1981; Halstead, 2007). "Nurses educators must possess a solid understanding of the dynamic health care environment, principles of teaching and learning, and the purposes of higher education to effectively socialize students and help them develop to their highest potential" (Halstead, 2007, p. 52). The design of the curriculum also influences how a nurse educator socializes a student to the profession (Halstead, 2007).

There is some convergence in the literature on the concepts of socialization and enculturation. "Professional socialization is "the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge—in short, the culture—current in groups of which they are, or seek to become a member" (Merton, Reader, & Kendall, 1957, p. 278). Bosher and Pharris (2009) also acknowledge that professional socialization of nursing students involves learning the culture of nursing, taught within the culture of higher education. One goal of professional socialization is for the student to "internalize the professional culture of nursing" (Cohen, 1981, p. 15). This professional culture includes common values and ideas, as well as motivational attributes and standards of practice.

Enculturation to a professional group is "a process by which individuals learn about and identify with their own professional culture" (Hong, 2001, ¶19). Enculturation does not happen all at once rather, this process occurs over time. More experienced members of the group guide the novices. "Through the process of enculturation, a nursing student learns philosophical, epistemological, ideological, and ethical foundations and meanings of proper professional activities (i.e., culturally shared, valued

symbolic actions)" (Hong, 2001 ¶ 22). The individual must reconcile his or her

individual cultural norms and practices to those of the group, leaving behind commonly

held conceptions and beliefs and accepting "what to think and how to view the world,

what to expect and how to experience it, as well as how to act in relation to other people

and aspects of the environment" (Hong, 2001, ¶20). Once a member is enculturated into a

professional group, acculturation occurs as the member interacts with members of other

professional cultures. These ongoing interactions shape and change their respective

professional cultures.

<div align="center">**Problem**</div>

Definitions of professional socialization in the literature converge with

established definitions of enculturation, that is, a process of acquiring what one might

regard as a professional culture. Socialization to the nursing profession is known to be

challenging. Students recognize "discrepancies between what is presented in the

classroom and what happens in practice" (Benner, et al, 2010, p. 88). These

discrepancies become more evident after graduation, with students experiencing conflict

as they transition from education to practice, often to the point of leaving the profession

(Duchscher & Cowin, 2004), which creates financial burdens to health care agencies

from the resulting high turnover rates (Dracup &Morris, 2008). Those who remain in the

profession often experience frustration, burnout, and increased stress, which in turn lead

to decreased quality care and general dissatisfaction among nurses (Mooney, 2007).

The transition for new nursing faculty from practice to academia also suggests a

cultural transition that is just as challenging (Gazza & Shellengarger, 2005; Schriner,

2007). These challenges lead to frequent job change, or leaving academia during a time

of a national nursing faculty shortage (AACN, 2005), and the call from national organizations for nurse educators to have a greater consciousness of the context in which they practice. The dissonance experienced during the transition from practice to academia for nurse educators; and from academia to practice by nursing students, suggests that within nursing, there may be subcultures of practice and academia.

Altogether, nursing's distinctive values, behaviors, language, and tools could be thought of as the culture of professional nursing. Nurse educators must prepare nurses for professionalism and socialize students to the profession in a rapidly changing practice environment at a time when their own environment and responsibilities are changing (AACN, 2008; Halstead, 2007). The problem that this study addresses is that there is little evidence regarding nurse educators' perceived role in bringing students into a professional culture. Nurse educators' voices are silent on their perceptions of nursing as a culture and their role regarding students in relationship to this culture.

Purpose

Nurse educators' perceptions of the world of nursing influence, often subconsciously, how they educate students of nursing and how these students go on to practice. The purpose of this study is to explore nurse educators' perceptions and meanings of the professional culture of nursing and their role in enculturating students into this professional culture. Knowledge gained will contribute to greater cultural consciousness that will contribute to improved communication and interactions between nurses and other health care professions, as nurses are called to lead and interact with interprofessional teams in the provision of heath care (Institute of Medicine, 2010. A greater consciousness of the culture of nursing will also inform interactions between

professional nurses and the recipients of their care. Understanding one's professional culture will also lead to improved and more culturally respectful interactions and client care by informing the practice preparation of nursing students who increasingly face a culturally diverse, complex and dynamic health care environment.

Research Questions

The study will consist of the following research questions:

Question 1: What are nurse educators' beliefs and perceptions about the professional culture of nursing?

Question 2: Given their perceptions of the culture of nursing, what do nurse educators perceive as their role with students?

Assumptions Underlying the Study

One of the assumptions underlying this study is that nursing academia and nursing practice are distinct sub-cultures in nursing. While there is no specific research to support this assumption, there is some evidence to support that not only do students have difficulty moving between these two areas of nursing, but practicing nurses who take faculty positions also have difficulty in moving between these subcultures. These studies form the basis for this assumption.

The second assumption rests on the first. It is that the culture of academe influences nurse educators' perceptions on the culture of nursing. Existence within a particular culture leads to exposure of different alternatives, including new perspectives, rituals, and values, as well as differences in power and status. These differences often serve to challenge the initial cultural impressions of those joining the culture, and subsequently reshape them to the new culture. Nurse educators live and practice within

the culture of academe. The culture of academe can therefore shape and change nurse educators' perspectives on the professional culture of nursing.

A third assumption is that a greater understanding of the professional culture of nursing and the perceived role that faculty play in bringing students into that culture will have a positive impact on providing culturally congruent care to patients. This assumption is based on literature, which proposes that nursing, as a health care profession is a culture foreign to many patients, a factor that may have a negative impact on care. Awareness of one's professional culture could assist in providing culturally congruent care (Hong, 2001; Spector, 2009).

Definition of Terms

For the purpose of this study, the following definitions of terms will be utilized.

1. Culture is the shared beliefs, values, attitudes, knowledge, norms, and assumptions transmitted from experienced members of the group to novices.

2. The culture of nursing is the learned and shared life experiences, values, symbols, patterns and normative practices of members of the nursing profession of a particular society. This definition is based on Leininger's (1994) definition of the culture of nursing (p. 19).

3. Professional socialization is the acquisition of the knowledge, skills, values, roles, and attitudes associated with the practice of a particular profession (Clark, 1997, p. 272).

4. Nursing faculty are licensed RNs who have earned a minimum of a Master's Degree in Nursing, and who teach primarily in a BSN program.

Significance to Nursing

The overall significance of this study to nursing practice is the greater knowledge of one's professional culture, which in turn can enhance interactions with others, including those from other cultures (Hong, 2001; Leininger, 1994; Leininger, 1995; Spector, 2009) and professional cultures. Leininger (1995) proposes that a gaining a greater understanding nursing's professional culture will reduce the tendency of biases and prejudices of nurses towards people of other cultures. "Gaining knowledge about the culture of nursing can be enormously helpful to guide nurses in their interactions with clients and health personnel whose personal culture values may be quite different from those of the nurses" (Leininger, 1995, p. 207). Spector (2009) posits that patients view health care providers as having a separate culture, including a unique language, cultural norms, and rituals, and often find it difficult to understand, or accept aspects of this professional culture. One of the first steps in providing culturally congruent care is an awareness of one's own culture (Camphina-Bacote, 2010). This includes understanding one's own professional culture.

Nurses are called to increasingly interact with and lead interdisciplinary teams to facilitate the delivery of high quality patient care (Institute of Medicine, 2010). However, interdisciplinary education seldom occurs. "Nurses and physicians—not to mention pharmacists and social workers—typically are not educated together, yet they are increasingly required to cooperate and collaborate more closely in the delivery of care" (IOM, 2010, p. 1-10). One requisite to interdisciplinary education and teamwork is knowledge of the professional cultures of team members (Almas & Odegard, 2010). A greater understanding and articulation of nurse educators' perceptions on the culture of

nursing can lead to an improved interface with other professional cultures, both in the educational and later in practice setting. Thus, knowledge gained from this study can contribute to improved professional cultural interaction between health professionals especially as during professional education as that is the setting for this study.

Another area of significance to nursing is the development of evidence to guide nursing education. Given the call for increased research on nursing education (Benner, et al., 2010), this study will provide a beginning level of evidence for nurse educators to utilize in their practice as they interact with students from a wider diversity of backgrounds. It will also assist those who prepare future nursing faculty on the role of faculty in enculturation into the profession. This includes knowledge gained by making nurse educators' perceived aspects of the professional culture of nursing explicit which will in turn make for a more deliberate enculturation process. It also facilitates discussion on the faculty role in the enculturation process, which is not currently known. Improved knowledge on the enculturation process will also provide knowledge which can assist in the transition from education to practice for nursing students, and from practice to education for nurse educators. Given that "thirty percent of new nurses left their jobs in the first year and 57% resigned in their second year" (Tourangeau, Cummings, Cranley, Ferron & Harvey, 2010, p. 23), this knowledge can help provide stability to the nursing workforce and also the number of nurse educators at a time of nursing faculty shortages (AACN, 2005).

Nurse educators face challenges in preparing a more diverse workforce nurses who are ready to practice in a rapidly changing arena. "Knowledge of the culture of nursing can assist newcomers to the nursing profession in understanding some of the

dominant, recurrent, and patterned features of nursing" (Leininger, 1995, p. 207).

Hodges (1997) and Suominen, Kovasin, and Ketola (1997) discuss the challenges facing

nursing education today which includes teaching styles, and the explosion of information.

"The question is whether the culture is educating practitioners for change or for the status

quo" (Hodges, 1997, p. 364). This study will help illuminate progress to date on this

challenge, and bring to light nurse educators' tacit understanding of the culture of

nursing. Diversity in nursing students includes age, ethnicity, gender, geographical

location, and learning styles (Lindeman, 2000). "A greater understanding of the culture

and worldview of nursing education/academia and the diverse people entering nursing is

needed (Crow, 1993, p. 198). Bosher and Pharris (2009) agree with Crow, and

acknowledge that the culture of nursing education exists within the subcultures of the

United States, health care, and higher education. Examining the perspective of nursing

faculty, who live at the intersections of nursing practice and higher education will provide

this type of understanding. "When practitioners respond to the indeterminate zones of

practice by holding a reflective conversation with the materials of their situations, they

remake a part of their practice world and thereby reveal the usually tacit processes of

worldmaking that underlie all of their practice (Schőn, 1987, p. 36).

Iwasiw, Andrusyszy, and Goldenberg (2007) advocate the promotion of the value

of teaching as necessary for the health of the profession, which in turn will influence the

health of our patients. "The potential for nursing to come to terms with the conflicts and

contradictions of health care for a high-technology and pluralistic society will increase

only if educators begin seriously to call into question how the 'knowing of' nursing is

transmitted and reproduced" (Hodges, 1997, ¶44). Findings from this study can

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contribute to the "knowing of" nursing and how that knowing is transmitted from nurse educators to students.

Aspects of Personal Biography of Researcher

I have been a Registered Nurse for 28 years. Throughout these 28 years, I have worked in a variety of inpatient and community settings, while continuing my education from my initial Associate Degree in Nursing (AD) to the current PhD level. The last 20 years of my practice have been primarily in the area of nursing education, teaching at both the AD and BSN level, and in a variety of courses including fundamental skills, medical surgical nursing, and leadership and management for undergraduate nursing students. During the past 28 years, I have witnessed dramatic changes in health care, including increases in technology used in health care, organizational impact on the professional practice of nursing, changes in the role of the RN and the use of evidence as the basis for nursing practice.

As a nurse educator, I also have experienced challenges preparing students for practice. These challenges include the increasing amount of knowledge included in nursing curriculum, changes in teaching strategies and philosophies, and the changes brought about by advances in technology. One challenge that has become more evident is preparing students for the professional nursing role. The changing demographics of student nurses, as well as the changing values of society compound these challenges.

In my own attempt to address this challenge from an evidence-based perspective, I turned to the literature. Much is known about professional socialization, but the voice of the nurse educator is silent on this topic, even though socialization of students is an expectation of nursing faculty. This gap in the literature, when combined with the

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convergence of definitions of enculturation and socialization and my growing conviction that viewing nursing as a culture may be quite valuable, led me to this study. Naturalistic observations of other nurse educators contributed to the research questions.

As a nurse educator, I will need to bracket my assumptions regarding the culture of nursing. Assumptions regarding the role of the nurse educator in bringing students into the culture of nursing will also need to be bracketed, along with my own personal experiences and thoughts regarding the research questions. This is congruent with practices recommended for ethnographic research methods, and will be accomplished through journaling and discussions with the dissertation chair during data collection and analysis. Through this bracketing process, I will be more open to what the informants are sharing about their perspectives in interviews, and the cultures revealed during time spent observing as part of the research study.

Summary

This chapter explored the concepts of culture, professional socialization, and possible intersections between these two concepts. The need for and purpose of this study of nursing educators' perceptions of the culture of nursing and their role in enculturating students to this culture were provided. Research questions, assumptions, limitations, and definitions of key terms are also stated. The significance to professional nursing and nursing education are also reviewed. Background on the researcher was included, as the researcher becomes the research instrument in ethnographic studies. In subsequent chapters, a review of the literature and discussion on the ethnographic method will provide further foundational knowledge for this study.

Chapter 2

Introduction

This chapter will review the research and conceptual literature that ground the claim for the existence and salience of a professional culture of nursing, and the influence that nursing practice and nursing education have on that professional culture. The philosophical impact of nursing education's move historically from service to academic settings is also included because of its influence on the current professional culture of nursing and this study.

The proliferation of ways that the term *culture* is used in nursing is in part due to the recognition of the significance of culture for our changing society and profession. As the population in the United States becomes more diverse, society in general and nurses in particular realize the importance of cultural influences on behaviors and health practices. A greater understanding of cultures allows for greater understanding and communication between individuals and groups. This in turn leads to improved communication between health care professions and interdisciplinary teamwork, and the provision of care that is more individualized, culturally congruent, and more likely to result in improved patient outcomes.

Across the research literature in nursing, higher education, and organizational sociology and psychology, some common attributes of culture have been the focus of inquiry. They include beliefs, values, attitudes, knowledge, norms, and assumptions. The study of these attributes of culture contributes to a deeper understanding of the nature of professional groups within health care. Three decades ago, Cohen (1981) defined professional culture as the "values, norms, motivational attributes and ethical standards

held in common by other members of the profession" (p. 15). More recently, Hall (2005) asserted that each profession has its own culture: "Each health care profession has a different culture, including values, beliefs, attitudes, customs and behaviours [sic]. This culture is passed on to the neophytes in the profession" (p. 188). Pecukonis, Doyle, and Bliss (2008) concurred, asserting that "each health discipline possesses its own professional culture that shapes the education experience; determines the salience of curriculum content, core values, customs, dress, salience of symbols, the meaning, attribution, and etiology of symptoms" (p. 420). Professional cultures have also been found to influence the distribution of power within groups, and the way professional groups relate to and work with other professions (Pecukonis, et al., 2008). Gaining a better understanding of the professional culture of nursing will provide insights into the profession itself as well as nursing's relationships with other professionals within the healthcare arena, and nurses' perceptions of their role an interdisciplinary team (Hall, 2005).

Facets of Culture in Professional Nursing

There is a limited body of research both in nursing and other health professions that address professional culture. Three studies address these facets of professional culture evident in nursing, including the values, beliefs, attitudes, customs, and behaviors of members of the nursing profession. On the basis of their descriptive study conducted in New Zealand and Australia, Horsburgh, Perkins, Coyle, and Degeling (2006) assert that nursing has a professional culture distinct from that of medicine and pharmacy as evidenced by differences found among the beliefs about care collaboration held by students in each of those professional programs. Medical students tended to believe that

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individuals are responsible for patient care in a clinical setting, whereas nursing students believe in a more collective, team or systems approach to accountability for patient care. Pharmacy students demonstrated a balance of accountability between individuals and a team.   The authors suggest that these differences in orientation to the provision of care may exist prior to starting professional education, and are reinforced by role models students observe in practice. These differences can impede interdisciplinary team work among these professions. It is not known if these differences exist among medicine, nursing, and pharmacy students in the United States. While the total response rate for this study was small (total n = 88 from 311 surveys distributed, with the response rate from nursing students being 28%), the findings from this study point to the need for further research on how different professions are socialized into their professional culture. This is especially significant given the call for increased cooperation and team work between various health care professions (Horsburgh, et al., 2006)

Hilden, Honkasalo, and Louhiala (2006) used discourse analysis to analyze end of life decision-making beliefs and behaviors among nurses and physicians in Finland. Their findings indicate that the professions of nursing and medicine have distinctive cultures made evident in their respective approaches to end of life care. Given the differences in the health care system and beliefs on end of life care between Finland and the United States, these particular differences may not exist between the professional cultures of medicine and nursing in the United States, but they have not yet been studied. Cadogan, Franzi, Osterweil, and Hill (1999) studied perceptions of effective telephone communication between physicians and nurses in long term care settings in the United States. The authors found differences in perceptions of communication barriers between

physicians and nurses, and relate these findings to differences in these two distinct professional cultures.

Studies of professional cultures in other health care professions include a focused ethnographic study that examined the professional culture of the occupational therapy (OT) classroom, (Bennett, 1999), and dieticians (Lordly and Taper, 2008). Bennett (1999) found that the professional culture of OT, the cultures of the students, faculty and academia all contributed to the culture of the classroom. The classroom culture reflected the broader compositional aspects of culture of the profession, including the strongly dominant female gender and Caucasian race which in turn influenced who was admitted to the program, the shape of their socialization and learning experiences, and who completed the program. Lordly and Taper (2008) used a mixed method approach to examine the effect of internship placement on socialization of students into the professional culture of dieticians. The researchers found that students perceive long-term care settings negatively, and do not value them as much as they do acute care setting placements, which are seen as more desirable and conducive to developing skills and knowledge. Based on their findings, Lordly and Taper (2008) call for "individual and professional efforts . . . directed toward creating a professional culture that fosters the values of all practice areas" (p. 81).

The research findings cited above suggest that various disciplines in health care, including nursing, have distinctive professional cultures. Hall (2005) asserts that the professional culture of various health disciplines contribute to difficulties in interdisciplinary teamwork, as members of each professional culture have a unique worldview from which they approach health care and their patients. A greater

understanding of the distinctiveness of the professional culture of nursing can facilitate deeper insight into the unique contribution made by nursing within the practice arena. Heightened cultural consciousness will make it possible for nurses and other health care professionals to exercise greater cultural sensitivity in interacting with health care professionals in interdisciplinary teams, as well as patients from other cultures.

Greater cultural awareness will also provide insights that will inform strategic decisions within the profession regarding contextual factors that impact nursing practice as well as the ongoing development of professional nursing culture. This is a pro-active stance to defining the profession of nursing. Knowledge of nursing's professional culture will also provide strength and resilience when professional or organizational cultures with more power attempt to threaten, marginalize, or change the professional culture of nursing. In light of the increasing demands on the health care professionals and the economic struggles of health care organizations, this becomes particularly important. Each professional group is challenged not only to a find a greater effectiveness and efficiency within the overall health care system, but to define its value or worth (Institute of Medicine, [IOM], 2010). A better understanding of the professional culture of nursing will strengthen nursing's ability to meet these demands.

Facets of Culture Characterizing Nursing Research, Practice, and Education

Nursing is often thought of in three subcomponents: research, practice, and education. To gain a better understanding of the overarching culture of nursing, it is important to examine the facets of culture unique to each of these three subcomponents, the subtle differences between them, and how the facets of culture of each subcomponent

may influence the overall culture of nursing. Following is review of the research literature on nursing research, practice, and education.

Nursing research. As nursing education moved from the hospital to academia, and the number of nurses with advanced degrees has increased, the call to produce nursing research has grown, in part to establish nursing's place in the academic world (Clare & Hawes, 2001; Cooke & Green, 2000; Gething & Leelarthaepin, 2000), and in part to foster growth as a profession (Polit & Beck, 2008). Recently the term "research culture" has been used in reference to increasing research in nursing (Clare & Hawes, 2001; Gething & Leelarthaepin, 2000; Parse, 2007), and the growing emphasis on evidence based nursing practice (Bonner & Sando, 2008; Chan, Gardner, Webster, & Geary, 2010, Corchan, Watson, Arantzamendi & Saracı´bar, 2010). Parse (2007) defines a "research culture" as "a lived worldview grounded in values and beliefs that surface in a dedication to the pursuit of excellence in discovering and defining knowledge for the betterment of humankind" (p.197). A brief overview of the literature on research culture in nursing over the past decade follows.

Developing a research culture in nursing is an important step in being accepted as an academic discipline. Developing this research culture is often valued, but difficult to establish for faculty in nursing education. Gething and Leelarthaepin (2000) conducted a needs analysis at a university in Australia to determine faculty perceptions of needs and barriers to creating a research culture. The authors found that nursing faculty did not meet the university standard of spending 20% of work time on research and that faculty did not feel confident in their ability to conduct research (Gething & Leelerthaepoin, 2000). Based on this needs analysis, strategies to promote research were implemented.

These strategies included development of a faculty research management plan, faculty research performance indicators, research workshops and mentoring, funding opportunities, initiation of a faculty research day, scholarship support for faculty to pursue doctoral degrees, and a reduction in teaching workloads. The authors conducted a repeat analysis two years after the initial survey and found that these multiple strategies contributed to a substantial increase in time spent conducting research as well as confidence in conducting research. Cooke and Green (2000) in a literature review on developing and sustaining a research culture and Clare and Hawes (2001) in their description of increasing the research culture in a school of nursing concur with the findings of Gething and Leelarthaepin (2000). All of these studies were conducted outside of the United States.

Creating a research culture among nursing faculty is important, but creating a research culture among nurses in practice is also vital for improved patient outcomes, and for health care agencies to achieve Magnet designation. Fink, Thompson, and Bonnes (2005) conducted a descriptive, cross sectional, pre and post intervention survey among practicing nurses in an acute care Magnet status hospital in the Western United States. After conducting an initial survey, the authors initiated the intervention of providing information on research utilization, institutional support and recognition of research based practice. After a period of two years, the researchers conducted a post intervention survey. Findings from the post intervention survey revealed that nurses' attitudes were positive towards using research in their practice. Barriers to a research culture cited in the post survey in this practice setting include lack of institutional and organizational support, time constraints, and knowledge deficits. The authors assert the importance of

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"organizational commitment to the use of research in practice" (Fink, Thompson, & Bonnes, 2005, p. 128) for fostering a research culture in practice settings.

Other studies confirm the findings of Fink, Thompson, and Bonnes (2005). In the United Kingdom, McNicholl, Coates, and Dunnn (2008) used case study methodology and Bonner and Sando (2008) used a descriptive quantitative study to examine attitudes and barriers of nurses in practice to a research culture. The results of their studies were consistent with those of Fink, Thompson, and Bonnes (2005) on the need for a strong research culture in health care agencies and the barriers nurses experience in creating this culture.

Nurses in both practice and academia generally agree with the importance of a research culture but face many challenges in contributing to this culture. For nurses in practice, challenges include cultural role expectations, socialization to the role of a nurse, and education level. Similar cultural challenges exist for nurses in academia, including the cultural role expectation and value for nurses in academia is to remain current in their practice as well as teach and conduct research. These findings are consistent across geographic locations.

Nursing practice. Professional nursing practice refers to the provision, management, or design of patient care (AACN, 2008). Study of the rituals and worldview of members of a particular culture, including values, beliefs, attitudes, and social norms, as well as the many roles played out in everyday life, has provided anthropologists with important insights into the nature and workings of specific cultures. In order to begin to understand the professional culture of nursing practice, it is necessary to examine the research focused on aspects of nursing that are also facets of culture. Facets of culture

evident in nursing practice include the values, beliefs, attitudes, knowledge, norms, and assumptions of nurses as they provide, manage, or design care for others. Research on these facets of culture in nursing practice is limited. Specific areas of nursing practice culture that have attracted the interest of nurse researchers include nursing rituals, the practice environment of the organization especially as it relates to Magnet Status, and the specific knowledge among specialty practice fields in nursing. The process of enculturation into the profession through formal education and beginning practice is another aspect of nursing that has been studied. A review of the research on these facets of nursing culture follows.

Rituals. One facet of the culture of nursing practice evident in the research literature is rituals. The earliest study on rituals in nursing is an ethnograpahic study by Wolf (1988), who defines a ritual as "patterned, symbolic action that refers to the goals and values of a social group" (p. 60). Rituals reflect standard practices of a culture, and allow for transmission of cultural knowledge and practices (Suominen, Kovasin, & Ketola (1997). In his study, Wolf (1988) specifically examined some of the more common nursing rituals of "post mortem care, medication administration, admission to and discharge from the hospital, change of shift, and the bath, and other aseptic practices" (p. 60). Wolf concludes, "nurses pass on their subcultural knowledge by word of mouth and demonstration" (1989, p. 67). Holland (1993), in a subsequent ethnographic study of nursing rituals found that putting on the uniform, containing sickness, and giving report were rituals nurses use in their daily practice. The most recent ethnographic study on rituals in nursing examines the ritual of answering call bells (lights). Dietrich, Bokovoy, and Panik (2006) undertook this study as a means to understand this aspect of patients'

responses to satisfaction surveys. The authors found that the ritual of answering call bells

varies somewhat among health care providers, with differences in opinion existing among

hospital staff on the implementation of this ritual, including who should answer the call

light, and the timing in answering the call light.

Investigators involved in each of the studies above utilized ethnographic research

methods, and examined rituals from the perspectives of practicing nurses. None of these

studies includes nursing faculty's perceptions on rituals as part of the culture of nursing.

However, Holland (1993) argues persuasively for the need to study the culture of nursing

in more depth: "It is imperative that we understand its [nursing's] cultural existence to

enable it to survive through change" (p. 1469).

Magnet culture. The term "magnet culture" is used in the literature by many

authors (Pierson, Miller, & Moore, 2007; Poduska, 2005; Schlag, 2005; Speagle, 2009;

Upenieks & Abelew, 2006) to refer to the culture of organizations that have attained

Magnet certification by the American Nursing Credentialing Center (ANCC). Magnet

certification focuses on the professional practice culture of nurses. In recent nursing

practice literature, documentation of its implementation and effects is plentiful. Initially,

Magnet status developed in response to the nursing shortage of the mid 1980's. While

many hospitals experienced difficulty recruiting and retaining nurses, other hospitals had

very low vacancy and turnover rates (Poduska, 2005), hence the term "Magnet" was used

to designate institutions that attracted and retained nurses.   Hospitals experiencing higher

turnover and vacancy rates also had less collaboration between physicians and nurses,

and nurses reporting less control over their practice, autonomy, support for continued

professional education, and support from management. In short, the practice culture was oppressive and hindering to professional nursing practice.

Magnet status is one way to designate health care organizations that exhibit a positive nursing practice culture that frees nurses to shape their professional practice. Health care organizations meeting the criteria established by the ANCC can use the term Magnet organization. The credentialing criteria for Magnet status include promoting a "professional practice culture in all aspects of nursing care" (Marquis & Huston, 2009, p. 283). This professional practice culture includes self-governance, autonomous practice, flexible staffing, and clinical career opportunities for nursing.

As the number of health care organizations achieving Magnet status increases, so does the amount of research on the professional practice culture in these organizations. Research on professional cultures in Magnet status organizations include quantitative studies examining variables such as nurses' responses to the changes necessary to achieve Magnet status (Caldwell, Roby-Williams, Rush, & Ricke-Kiely, 2009, Upenieks & Abelew, 2006), and as the role of the Clinical Nurse Specialist (CNS), (Walker, et al., 2009).   Caldwell, Roby-Williams, Rush, and Ricke-Kiely (2009) studied nurses' perceptions of the "change in research culture that accompanies the designation of Magnet status" (p. 1413). The authors found that acceptance of change by full time Registered Nurses is facilitated by nurse managers with a transformational leadership style who prepare staff for change and participate in the change process (Caldwell, et al., 2009).

Tutton, Seers, and Langstaff (2007) also used an ethnographic methodology to explore patient and nursing staff perspectives of being on a trauma unit within a hospital

in the United Kingdom. The authors found three themes that emerged as part of the culture of the trauma unit: closeness, therapeutic care, and working as a team. Nurses strived to maintain a professional practice and fostered a culture of caring, but also found work on this unit to be emotionally draining. The researcher established trustworthiness for this study by spending time on the nursing unit and interacting with the staff. Credibility was established by sharing preliminary findings with the staff, maintaining an audit trail, and including sample quotes in the report of findings.

All of these studies explored aspects of a professional practice culture of nursing. Commonalities across study settings include the use of rituals, and values, beliefs, and norms that reflect the desire to provide high quality care to patients. A variety of research methodologies were used but ethnography was the method used most frequently. None of the studies utilize nursing faculty as informants, or sought the perspective of nursing faculty on professional practice culture.

Nursing education.   Within the larger culture of professional nursing, studies on the aspects of culture in general nursing practice, the practice environment, and in various specialty practice areas have revealed that nurses practice distinctive rituals, and that practice is influenced by the culture of the organization. Before a person can enter the practice culture of nursing however, entry into the profession must occur through education and socialization. Nursing education provides the beginning socialization and formation for professional nurses. "Nursing as a culture transmits its survival through nursing education/academia" (Crow, 1993, p. 199). Formation "occurs as students develop knowledge, skilled capacities, and insights into the notion of the good that are central to nursing practice" (Benner, et al., 2010, p. 177). Formation occurs over time, as

the student experiences transformation from a layperson to a member in the culture of professional nursing, taking on "a way of being and acting in practice and in the world" (Benner, et al., 2010, p. 166).

During the socialization and formation period, students learn the ideal culture while they are simultaneously confronted with the manifest culture of professional nursing in their clinical rotations. The ideal culture was characterized some time ago as the "beliefs, practices, and feelings which the people hold as desirable, although they do not always live by those norms" (Leininger, 1970, p. 50). The ideal culture is what nurse educators tend to pass on to their students. According to Kramer and Schmalenberg (1977), this ideal culture is often thought of as the "ivory tower" view of nursing. More recently, the ideal culture has come to mean spending time with patients, providing holistic care, and using knowledge and research to plan and direct patient care (Clare, 1993).

In contrast, the manifest culture of nursing "refers to the pattern of actions, beliefs, and feelings which can be readily identified by any person, since they are visible to outsiders" (Leininger, 1970, p. 50). This culture emphasizes efficiency, cost effectiveness, and working within the system, even when nurses do not have much power within that system (Clare, 1993). This manifest culture is the general portrayal of nursing in popular media, and what students often think of as the nursing profession prior to their clinical experiences (Leininger, 1970). The manifest culture is often referred to as "real world nursing" by staff nurses, and is acknowledged to often be quite different from the ideal culture (Leininger, 1970; Benner, et al., 2010; Kramer & Schmalenberg, 1977).

Facets of culture in nursing education. In three studies, the construct of culture was utilized to explore nursing education. In her case study, Crow (1993) compared the culture of nursing education to Native American culture. Crow bases her description of the culture of nursing education on the predominately white, Euro-centric culture of nursing and draws upon the culture of academia in describing the culture of nursing (Crow, 1993). One weakness of this study is that Crow did not state whether her findings are based on interactions with nurse educators or nursing students. Schriner (2007) used a phenomenological method to examine values and beliefs of new nurse educators, looking for similarities and differences between nurse educators and nurses in practice, and how those differences might affect the nurses' transitions to the nursing faculty role. She identified four common themes in the experiences of these novice nurse educators: a student culture where the values and beliefs of the students differ from those of the faculty, especially in regards to grading; deficient role preparation; hierarchy and reward; cultural expectations vs. cultural reality; and stressors and facilitators of transition. Schriner (2007), after completing a qualitative study on nurses who transition from the service sector, also echoes the call to close the cultural gap between nursing education and nursing practice. Hodges (1997) also examines nursing education from the faculty perspective. Hodges uses narrative analysis to focus on philosophical tensions in the existing culture of nursing education and the introduction of innovative teaching strategies. Hodges concludes that it is vital for nursing to "position itself philosophically with regards [sic] to educating its newest members and fostering a broad spectrum of views from its faculty" (Hodges, 1997, ¶44). Hodges acknowledges the competing epistemologies in nursing education of empiricism and humanism, and questions whether

the cultural tensions between the two can co-exist in a practice discipline centered on the human experience. This study does not address nurse educators' perceived role in transmitting the culture of nursing to students. However, it does affirm the need "to call into question the context through which the professional culture is transmitted and reproduced is an appropriate debate for nursing" (p. 349). Inquiry into the transmission of nursing's professional culture is complicated yet necessary to nurse educators' ability to philosophically situate themselves as they prepare students to enter into increasingly complex health care as well as professional practice arenas.

Culture of academia. According to Clark (1980), the culture of the academia is composed of the cultures of the discipline, profession, educational system, and enterprise. The culture of the discipline provides bonding and identity to its members through shared paradigms and ideals, and provides the name of the academic unit. The discipline provides the idols that embody the values and ideals of the members, who in turn hold these values and ideals in high esteem. From the discipline comes the code of ethics, entry requirements, and boundaries. The culture of the profession provides a more general identity and secondary culture. The culture of the profession, which extends across academic units, transmits cultural heritage and provides the ideals of knowledge (Clark, 1980). The culture of the educational system contains those elements that do not belong to the previously mentioned academic cultures, and originate in the way the national educational system is organized. A great deal of variation can exist in national education systems, as it does in the United States, but there is still some over-arching organizational structure among academic institutions within the country (Clark, 1980). The culture of the enterprise is that of the university or college. This culture varies in

strength and content and is affected by history and organizational size and unity. Organizational saga is part of the culture of the enterprise.

The cultures of the discipline and professional nursing practice have been addressed in a previous section. What follows is a discussion of the culture of the educational system and the institutional enterprise that provide the larger context of nursing education.

Culture of the educational system. The culture and organization of the national educational system in which the university exists influences the culture of academia, as well as the social status of the professoriate, approaches to education, and scope of scholarship and application (Clark, 1980). In a case study involving colleges and universities in the United Kingdom and Scotland, Deem and Lucas (2007) examine influences on the academic culture created by political and societal differences. Gender, national education and research priorities are all differences found by Deem and Lucas (2007) to influence departmental academic cultures for teaching education units. Adams (1998) describes the impact of changes in the national education system in Australia on the culture of academics and higher education. Changes in the national education system, including funding, philosophical changes regarding higher education, demographic shifts, and structural changes, were found by Adams (1988) to be influential on the culture of academia. The current emphasis of federal funding for nursing education and the call for a more highly educated nursing workforce noted by Benner, et al (2010*),* changes in student expectations and demographics (Giddings, 2005; Schriner, 2007), and differences in educational philosophies among nurse educators (Kinsella, 2007; Pratt, et al, 2007;

Tabak, et al, 2003) are examples of external influences on the culture of a higher education system that impact nursing.

Culture of educational system and the culture of academia. The culture of the educational system also shapes the culture of academia, and serves as a means to create change within the system. "On one hand, schools are to provide for cultural continuity though the transmission of traditions, customs, and symbols" (Popkewitz, 1985, p. 429). Conversely, schools serve as mean for creating change within cultures through the generation of new ideas and exposure to novel concepts, with an eye towards changing the future, hopefully for the better. Giroux (1998) points to this interplay between culture and education, stating, "education as a moral and political practice always presupposes for particular forms of social life, a particular view of community and a particular version of the future" (p. 15).

The intrusion of corporate culture in all areas of education demonstrates this interplay, as educational spaces and places are increasingly sold to the highest corporate bidder in return for equipment, lesson plans, and facility improvements. Students are subject to constant marketing messages and the unspoken cultural message that anything is for sale, if the price is right. At the collegiate level, this is most evident in athletic corporate sponsorships, but is also present in the naming of buildings or laboratory facilities for donors, or collaboration with industry, economic institutions, or corporate professional partners. Nursing education has not escaped the power of this influence, as evidenced by the naming of buildings, centers or scholarships after benefactors, and the high use of brand name simulators within practice labs.

The increase in corporate culture within academia is the focus of many research studies. In one study, Mendoza and Berger (2008) use a case study method to examine increased capitalism found in modern universities, and its impact on the culture of academia. Three main themes found by the authors of this study are sponsorship of department research, faculty protection of academic values in collaborating with industrial sponsors, and implications of funding by industry on academic culture. The case study demonstrates that academic culture can remain intact even with corporate sponsorship if faculty remain true to the mission of the university, are aware of possible conflicts of interest posed by corporate sponsorship, and protect students from these conflicts. Increased funding from corporate sponsors can enhance the mission of the college or department, especially during a time of limited federal or state sources of external funding. Mendoza and Berger (2008) do caution that findings of their study "are highly context-dependent and may not transfer to other academic settings" (p. 18).

The culture of education can also influence the culture of academia, and can create changes from within. Bruner (1997), an advocate of change in the culture of education, views education as embedded in culture. This is a different view of the culture of academia, which is often seen as an "ivory tower," separated from the world, and a place where faculty impart knowledge to students in a certain area or topic with minimal interaction between faculty and students. Facts, meaning, and values are not separate from culture, but rather embedded in culture. How an individual learns cultural meaning and values is in part dependent upon the culture in which learning and living occur—the culture of academia and the larger culture in which the academic unit exists.

Educational philosophies in educational system culture. The culture of education tends to focus on the transferring and development of knowledge that is empirical and developed by the scientific method, often referred to as technical rationality. However Schőn (1987) and Johns (1997) question technical rationality as the proper epistemology. They advocate for reflection on, and reflection in practice. Reflection on practice occurs after the practice has ended, and provides a chance to review and learn from looking back in preparation for the future. Reflection in practice occurs "in the moment" while the practice is in process, regardless of the length of time the moment takes. Reflection in action reviews behaviors and skills, reveals tacit knowledge and assumptions, and reveals affective aspects of practice such as feelings or values. Reflection in action is required when novel cases present themselves and "practitioners sometimes cope with the troublesome 'divergent' situations of practice, when the phenomenon at hand eludes the ordinary categories of knowledge in practice" (Schőn, 1987, p. 62). Novel or divergent cases often present themselves to nurses, with the patient presenting unique needs and symptoms which defy the "typical" or expected findings and treatments. To prepare nursing students for this reality of practice, faculty must assist students to practice reflection in action as well as reflection on practice, in addition to the more empirical forms of knowledge gained from the application of technical rationality. Benner, et al (2010) state that nursing faculty

> must be open to the possibilities for teaching in each particular clinical situation, unpredictable and varied it might be …(and) points out what is salient and what needs immediate attention, and helps students to integrate and use their knowledge (p. 44).

Hidden curriculum in the culture of educational systems. The hidden curriculum is another aspect of the culture of academia that is influential but not often researched. According to the Institute of Medicine (IOM) (2003) report, the hidden curriculum is the "observed behaviors, interactions, and the overall norms, and culture of a student's training environment [that] are extremely powerful in shaping the values and attitudes of future health professionals" (p. 16). The hidden curriculum is a subtle form of socialization, "teaching initiates how to think and feel like nurses [and] colors perceptions, independence, initiative, caring, colleagueship, and the mores and folkways of being a nurse" (Bevis & Watson, 1989, p.73). The hidden curriculum pervades the entire educational experience, influencing the scheduling and location of classes, the amount of time spent on a particular subject, evaluation methods, and interactions between faculty and students. Though hidden from view, this aspect of learning is "much broader in scope than the implicit learning normally associated with the concept of socialisation [sic]. It is a prominent feature of educational institutions . . . and it occurs in both formal and informal settings" (Eraut, n.d. p. 2). This hidden curriculum contributes to the education-practice gap (Eraut, n.d.; IOM, 2003), and must be explored and revealed to be fully understood, as all learning is culturally contextual.

Baccalaureate nursing students learn nursing from nursing faculty, in part, in the cultural setting of higher education. Residing or working within a culture for a period can lead to assimilation of cultural values and beliefs. As such, the culture of academia may influence nurse educators' perceptions on the culture of nursing. Yet research from this perspective is lacking. Since bringing students into the profession is a primary role of nurse educators, and that role includes passing on the norms, values and practices of the

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profession, it is important to know the perspectives of nurse educators on the professional culture of nursing. A well-developed body of research literature investigating this aspect of nursing education is lacking.

Culture of the institutional enterprise. The culture of the enterprise provides a sense of loyalty and sense of belonging and serves as a "bridge to the outside world across which resources flow" (Clark, 1980, p. 14). The culture of the enterprise varies depending on the development, size and scope of the university, and the organizational saga. "An organizational saga is a collective understanding of current institutional character that refers to the historical struggle of the group and is embellished and romanticized and loaded with meaning to the point where the organization becomes very much an end-in-itself" (Clark, 1980, p. 12). The organizational saga distinguishes one university from another, varies in intensity among institutions, and is transmitted to new members of the organization by long tenured faculty. Rhoads and Tierney (1992) refer to organizational saga as institutional history. Understanding institutional history implies recognizing the importance of knowing faculty-student interaction norms, rituals, traditions, institutional values and beliefs, and symbolic meaning. Symbolic meaning exists in day-to-day and major ceremonial observances, and "refers to events and practices that have an underlying significance which extends beyond their obvious or explicit purpose," (Rhoades & Tierney, 1992, p. 13).

Educational institutions in general, and nursing programs in particular, risk losing organizational saga and the culture of the enterprise because the current demographic of nurse educators shows the majority of long practicing nurse educators nearing retirement age and a relatively small number of younger, or junior faculty prepared at the

doctoral level. Observing day to day interactions between nursing faculty and students and major ceremonial events at the research sites will help make explicit this tacit institutional knowledge of experienced nurse educators to junior faculty, and serve as a mode for cultural preservation or negotiation.

      Culture of nursing education within higher education. Nurse educators practice within the culture of higher education. Although nursing education resides in higher education, an underlying tension still exists between faculty of academic disciplines and professional practice disciplines such as nursing (Moody, Horton-Deutsch, & Pesut, 2007; Schőn, 1987). Higher education is a place of research and education, of knowledge development and knowledge dissemination. Professional education, though located in universities, often applies knowledge gained through research to practice. "Quite simply, the professions are to give their practical problems to the university, and the university, the unique source of research, is to give back to the professions the new scientific knowledge …to apply and test" (Schőn, 1987, p. 36). To ameliorate this tension, nurse educators often attempt to take on characteristics of the culture of higher education, including imitating accepted types and methods of research, and endorsing the values of discipline specific knowledge generation.

      Existing and working within this overarching academic culture can influence how nursing faculty view their professional culture and how they introduce students to the discipline. Yet the research literature regarding this influence is very sparse. Rossetti and Fox (2009) used a hermeneutic methodology and studied faculty, including nursing faculty, within the culture of a public university in the Midwest to identify factors associated with successful teaching. Faculty reported that presence, promotion of

learning, viewing teachers as learners, and enthusiasm are the main factors believed to be associated with successful teaching. Holkup, et al. (2009) reported a synthesis of four unrelated research studies conducted by professors at a university involving Native Americans, and acknowledged the differences between the culture of academia and the culture of Native Americans. The authors found that reciprocity, respect, and rapport are essential when navigating the differences between the two cultures.

Given the paucity of research inquiring into the influence of the culture of academia on the practice of nursing education, it is difficult to know if this culture influences the perceptions of nurse educators on enculturating students to the professional culture of nursing. However, gaining nurse educators views on the culture of nursing and their role in the enculturation of students into this professional practice can serve as a foundational step to future research in this area. Given the call for an increase in domain specific research in nursing education (Benner, et al., 2010), this is an appropriate first step to add to this body of knowledge.

Socialization to Professional Culture

Socialization is the process of providing the circumstances and experiences to enable new members of a group or profession to learn the established norms, values and behaviors of that particular group. One valuable approach to illuminating the cultural facets of the nursing profession has involved inquiry into the transition of students and practicing nurses between the culture of academia and the culture of professional practice culture. Recently, that transition has been conceptualized not only as a process of socialization, but a journey of enculturation.

To understand the culture of a profession well, it is important to learn how those who aspire to membership in the profession learn its science, values, and practice norms. Based on his expertise in organizational culture, Shein (2004) asserts, "we are aware that being a …professional involves not only the learning of technical skills but also the adoption of certain values and norms that define our occupation" (p. 10). The development of common values and norms occurs when individuals who have or desire membership in a group mature and come to share visions, assumptions, goals and beliefs until there is agreement among the individuals regarding the desired characteristics and practices of the group.

In addition to revealing values and norms of a profession, the socialization process that brings a person into a group can also reveal assumptions shared by established members of the group. While individuals can learn some aspects of the culture on their own, well-established members of the group, such as nursing faculty, pass on critical information about the group culture through modeling behaviors and providing feedback to new members. This often occurs subconsciously, as established members may not be aware of the elements of culture they role model and affirm (Eraut, n.d.; Hong, 2001.).

Socialization as Enculturation

Socialization into the profession is one accepted function of nurse educators. This process is also referred to enculturation in the literature (DeBellis, et al, 2001; Hong (2001). According to Hong, enculturation is "a process by which individual professionals learn about and identify with their own professional culture" (2001, ¶19), which occurs during nursing education and is most strongly influenced by nurse educators. Rush,

McCracken, and Talley (2009) apply the term acculturation to the enculturation process both nursing students and graduates experience. Acculturation is related to, but not the same as enculturation. Acculturation is the "process by which individual professionals, enculturated in one professional field, assimilate selected aspects of another professional culture through the experiences of professional interactions" (Hong, 2001, ¶19). Among traditional nursing students, acculturation occurs as they transition from the culture of the academia to the culture of practice.

Hong (2001) considers student nurses cultural neophytes who learn the "philosophical, epistemological, ideological and ethical foundations and meanings of proper professional activities" (¶22) through nurse educators, certification requirements that reinforce culturally congruent practices, and other training experiences within the enculturation process. Brown, Collins, and Deguid (1989) also consider learning a profession as enculturation, as learning a culture occurs *in situ,* as "communities of practitioners are connected by more than the ostensible task. They are bound by intricate, socially constructed webs of beliefs, which are essential to understanding what they do" (p. 33). Students learn the culture of professions by immersion in that culture, and the guidance of experts (teachers) within that culture.

Transition from Nursing Educational Culture to the Nursing Practice Culture

Multiple challenges exist when student nurses experience acculturation, or transition from the ideal culture of nursing they absorbed in their educational experiences to the manifest practice culture. Based on a synthesis of seventy-nine critical incidents of nursing students in Sweden, Andersson (1995) concludes that the term "marginality" best describes this nursing student transitional experience. In an ethnographic study

conducted in England, Holland (1999) found the transition from student to nurse ill-defined and laden with role conflict. Based on the findings from their phenomenological study in Australia, Kelly and Ahren (2008) concur with Andersson (1995). DeBellis, Longson, Glover, and Hutton (2001) conducted a qualitative study in South Australia focused on the many difficulties experienced during this time of transition for new nurses; they call for nurse educators to better prepare students for their role after graduation. Viewing socialization as enculturation may be one way to help nurse educators answer this call.

Kramer and Schmalenberg's sentinel work (1977) focused on the nursing student transition experience in the United States. They also viewed the socialization process as one of enculturation and address the challenges of enculturation as it relates to the transition of nursing students from academia to practice. Kramer and Schmalenberg (1977) used the term "biculturalism," defined as "being as competent and effective in the new subculture as in the old" (p. ix), to refer to the situation students and new graduates faced in their efforts to be as competent in the practice setting as they were in the educational setting. Achievement of biculturalism results in "competence in the new work subculture while retaining values from the old nursing school subculture" (Kramer & Schmalenberg, 1977, p. ix).

If one concurs that professional socialization is enculturation, as posited by Kramer and Schmalenberg (1977), one could logically infer that the findings reported above suggest that nursing education and nursing practice may be subcultures within the culture of nursing. However, all of these studies on the transition from education to practice focus on the viewpoint of the student or the practice organization. While two

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studies conducted with nursing faculty have examined the transition from practice culture to the culture of academia (Hodges, 1997; Schriner, 2007), no studies on the enculturation of nursing students examines the perspective of the nurse educator on the culture of nursing. The majority of studies on enculturation to the profession culture of nursing to date have also been conducted outside of the United States. This is important to note, as socio-cultural and political factors have been shown to be powerfully influential contexts that shape the ethos and structure of both health care education and practice (Giddings, 2005; Lordly & Taylor 2007; Stiller, 2000).

Understanding how a person learns the culture of his or her desired professional group can be very important to understanding the culture of that group. "Studying what new members of groups are taught is, in fact, a good way to discover some of the elements of culture" (Schein, 2004, p. 18). Previously cited studies on the enculturation of nursing students to the professional culture of nursing all focused on the perception of nursing students. A gap exists in the literature regarding nurse educators' perceptions on the professional culture of nursing and how they participate in the enculturation of students into the profession. As nurse educators provide the first formal enculturation to professional nursing, gaining their perspective is vital to understanding the nursing practice culture vis a vis the nursing educational culture.

One area of the professional culture of nursing that is evident in the research literature is that of rituals. Research on other aspects of culture in the nursing literature refers to the areas of practice as in Magnet Culture, and developing a research culture within nursing. While research studies to point to the idea of nursing as a separate

professional culture among the health care disciplines with sub-cultures, a consensus on the definition or description of the professional culture of nursing is lacking.

There is limited research that supports the process of socialization to professional nursing as a process of enculturation. The challenges of this enculturation process for both students moving to practice and nurses moving from practice to academe are documented. However, research on this process of enculturation from student to practitioner from the nurse educator's perspective is lacking.

The other potential influencing factor in the enculturation process that is not well addressed in the literature is the influence of the culture of academia on nurse educators. While conceptual and some limited research exists to support the notion of nurse educators being influenced by the setting of academia, the perceptions of nurse educators is absent. Given the multitude of gaps in the literature surrounding the professional culture of nursing, enculturation to the profession, and the influence of the culture of academia on how nurse educators perceive their role, gaining nurse educators' insights on the professional culture of nursing and their role in the enculturation process is an appropriate first step in developing this body of knowledge.

It is also recognized that the historical context of nursing and nursing education can influence nurse educators' perceptions on the culture of nursing. A brief overview of both follows to provide context for this study.

Historical Context of Nursing and Nursing Education

Historical context influences current cultural perspectives. Past events and experiences help explain behavior within a culture over time (Leininger, 1995). Leininger's (1995) work on the historical context of nursing, as well as work by Bevis

and Watson (1989) regarding the development of nursing education and curriculum provide the necessary insight into historical context as they are recognized as sentinel sources in these areas. In what follows, a brief overview of the history of nursing practice, nursing education, curriculum within nursing education, and legal authority for nursing practice and education is provided.

Eras in Nursing Practice

In exploring the development of the culture of nursing in the United States, Leininger (1995) identifies differences in values, beliefs and practices in the Early Era of Nursing, from 1940 to 1974, and the Recent Era of Nursing, from 1975 to 1994. In the Early Era, Leininger (1995) describes nurses as having "a deep sense of pride and commitment to provide comprehensive and total care to patients" (p. 212). During this era, nursing care occurred in the hospital, but also quite often in the home. Private duty nurses were part of the family unit. As limited technology existed, nurses used innovation and resourcefulness, making the best of materials present. Qualities such as altruism, self-sacrifice, hard work, caring, compassion, and dedication to patients and their work are associated with nurses in the Early Era. In this era, nursing was considered a calling, or vocation, instead of a profession. Nurses deferred to and valued authority, most often-male physicians, and were viewed primarily as handmaidens to physicians. However, strong nursing leaders such as "Lillian Wald, Isabel Hampton Robb, and Mary Brewster" (Leininger, 1995, p. 225) emerged in the Early Era to advance nursing, in spite of dominant physician authority and oversight. Nurses during this era worked together, valued teamwork and cooperation, and engaged in little to no competition. This can be attributed in part to the subservient position of nursing in the hospital.

In the Recent Era of nursing from 1975 to 1994, according to Leininger, nurses were expected to be "technologically competent and confident in their technical skills especially in acute care settings" (1995, p. 215). Qualities that describe Recent Era nurses include the following: independent, autonomous, competitive, politically active, and having socio-political ties (Leininger, 1995, p. 213). Nursing was viewed as a profession instead of a vocation, yet many nurses worked in hospitals where these qualities were not valued or promoted. Specialized or critical care units allowed nurses to specialize in patients with complex physiological problems and in need of technology. Nurses in this era found providing care in these critical care units rewarding but taxing, often leading to burnout. As a core function of nursing, caring became an area for research instead of an assumed attribute during this era. Values of nurses in this era were based mainly on the Anglo-American culture, and included patient self-care. These values of the Anglo-American culture also included self-interest, competition among group members, and self-improvement through advanced education. Even though 15 years have passed since the last update, during which changes in many aspects of the health care culture have occurred, such as in communications, technology, epidemiology, and nursing practice, the current era of nursing has not yet been analyzed and described in quite the same insightful ways offered by Leininger.

Changes in the historical context of nursing also reflect the changes occurring in the socio-political culture of the United States. These changes include an increase in attention to women's rights, equality in pay and authority, and political activism. Nurses are now active in elected positions, in leadership positions in healthcare and hospitals,

and in other positions of power and authority. In some respects, changes in the culture of nursing practice mirrors the cultural changes within the United States.

Nursing Educational History

As nursing education moved from an on-the-job training model to take its place in higher education, changes in nursing education began to both mirror and influence the historical changes in nursing practice. A brief overview of the history of nursing education follows.

Religious orders of nuns provided the initial nursing education in the United States, as they did in Europe, by training young women in hospitals. Physicians served as directors and faculty for schools of nursing, with student nurses working long shifts with little to no education, direct oversight or pay (Kalisch, & Kalisch, 1975; Leininger, 1995). The student nurses served as staff for the hospital, providing basic hygiene for the patients, as well as performing general housekeeping duties (Kalisch, & Kalisch, 1975).

In 1893, the first organization for nursing in the United States—The American Society of Superintendents of Training Schools for Nursing—was created (National League for Nursing [NLN], 2007), with the purpose of "the establishment and maintenance of a universal standard of training for nurses" (NLN, 2007), as nursing education began to move out of the hospital and into higher education. In 1912, the name of the organization was changed to National League for Nursing Education (NLNE), and in 1917, the organization released the first standard curriculum for nursing education. These standards were devised in response to inconsistencies among quality of content taught in nursing schools (Bevis & Watson, 1989). In the early 1900's, following the standardized curriculum was optional for schools of nursing. However, it did provide a

framework for the rapidly growing number of college and university schools of nursing to build their educational programs.

In 1939, the National League for Nursing Education completed its first accreditation visits, in an attempt to address the quality of nursing education programs. All programs, regardless of length or degree granted (Associate or Baccalaureate) followed the same accreditation criteria. Until 1997, the National League for Nursing (a new name for the National League of Nursing Education) was the only accrediting body for nursing education (Zerwekh & Claborn, 2006). Also in 1997, the National League for Nursing Accrediting Commission (NLNAC) was established. The NLNAC assumed responsibility for all accrediting activities, and accredits nursing education programs from the licensed practical nurse (LPN) level through post baccalaureate programs. The NLNAC is accountable to the NLN through its board of governors.

In 1996, the Commission on Collegiate Nursing Education (CCNE), an autonomous branch of the American Association of Colleges of Nursing, began offering accreditation to baccalaureate and graduate nursing programs (Mexibov, 2000). "In April 1999, CCNE's Board of Commissioners issued the agency's first accreditation decisions on 40 nursing programs located at 27 4-year colleges and universities" (Mexibov, 2000, p. 142). Currently, the United States Department of Education approves the accrediting branches of both organizations (NLNAC and CCNE) as accrediting agencies for schools of nursing.

Another large influence in the historical development of nursing education was the advent of the Associate Degree in Nursing. In 1951, in response to the post-war need for nurses, Mildred Montag "designed a 2-year course of study for 'technical nurses'"

(Bevis & Watson, 1989, p. 23) to be housed in community colleges. Between 1950 and the 1970's, the number of community college or technical schools of nursing increased, with a corresponding decrease in the number of hospital based nursing programs (Bevis & Watson, 1989).

As nursing education moved to colleges and universities, nurse educators began to obtain advanced degrees, most commonly in education, as very few advanced degrees in nursing exist (Bartels, 2007). Earning Master's and Doctoral degrees assisted nurse educators in their effort to legitimize nursing as a profession. These advanced degrees also prepared nurses to conduct research. Early nursing research focused on nursing education and nursing administration. By mid-century, nursing research turned more deliberately to nursing practice and clinical phenomena of interest to nurses, leading to the development of specialized, abstract knowledge, a hallmark of a profession (Abbott & Meerabeau, 1998). The research and knowledge development achieved by doctoral prepared nurses also legitimized the university as a proper place for nursing education.

Nursing curriculum. The evolution of nursing education curricula is another historical aspect of nursing education that bears consideration as it is relevant to understanding the perspectives of nurse educators today. As nursing education moved out of hospitals and into schools, the Tyler approach to curriculum, based on a behaviorist philosophy, dominated nursing education. Nurse educators who earned advanced degrees in education, which promoted this curriculum model, reinforced the Tyler approach.

The number of schools of nursing currently using the Tyler model of curriculum is unknown. However, it is now evident that a more caring, humanistic curriculum model

is the desired model for schools of nursing to follow. "The central task of health professions education must be to help students, faculty and practitioners learn how to form caring, healing relationships with patients, and the communities and with each other, and with themselves" (Tresolini and the Pew-Fetzer Task Force Report, 1994, p. 39).

> This shift from behaviorist to a caring, humanistic approach reflects a shift from a focus on training to education, from technique to understanding, from strict content to critical clinical decision making, from product line thinking to value-based human caring education for an educated person, as well as an educated values driven professional. *(Bevis & Watson, 1989, p. 40).*

A model for nursing education developed by Raines (2006) promotes a relational approach as a means of "transforming the general culture of nursing education, so that self-actualization and enactment of caring-humanistic nursing becomes possible" (p. 3). Complex patient health problems, advanced health care technology, changing health care systems, and a more mobile and diverse patient population requires nursing students to be educated in this manner, as they grapple with constant change within both the profession and the culture they practice (Benner, et al., 2010).

Legal Authority

The legal authority to practice nursing is yet another influence on the historical development of nursing and nursing education in the United States. In the early 1900's, the legal status of nursing in the United States was established. State laws, though varying in some respects, provided for more consistent inspection and evaluation of nursing education and training facilities. Evaluation criteria for educational programs

consisted primarily of documentation regarding the prerequisite number of days and hours spent on the various functions of nursing such as surgical, medical, maternity, and pediatrics. State boards of nursing were created and "empowered by state laws to govern and regulate the quality of nursing schools" (Bevis & Watson, 1989, p. 27). The result was a somewhat standardized nursing curriculum with specified content, and the elimination of the weakest of the programs. The laws also entitled graduates of nursing education programs who passed the licensing examination to call themselves "Registered Nurses" (Kalisch & Kalisch, 1975).

This review of the history of nursing practice and nursing education provides the context for understanding the current culture of nursing, nurse educators' perception of that culture, and their perceptions on bringing students into that culture. Nursing practice and nursing education have changed over time, in part influenced by the changing sociocultural-historical context of the United States. Although it is certain that the professional culture of nursing has changed over time in response to the changes in practice or education, the degree of the profession's collective consciousness of that cultural change is more ambiguous. Gaining nursing faculty's perceptions on the culture of nursing and bringing students into that culture will address this gap in knowledge.

Summary

This chapter reviewed the literature on the professional culture of nursing: the nursing research culture, the professional practice culture including rituals, specialty practice culture and Magnet culture and nursing education culture. In addition, a review was made of the culture of academia in higher education and the history of nursing and

nursing education. All of the aforementioned provide the context for the practice of nurse educators and shape their perceptions on the culture of nursing.

One role of the nurse educator is to socialize students to the profession of nursing. There is support in the research literature for viewing socialization as enculturation. There is also support in the research literature to suggest that both nursing education and nursing practice are two sub cultures, as evidenced by the challenges faced in moving between the cultures of academia and practice for both students and faculty. Recent research on the current professional culture of nursing is lacking, even as the emphasis on collaboration in interdisciplinary teams grows. Gaps also exist in the perception of nursing faculty regarding the culture of nursing, the perception of nursing faculty on their role in bringing students into the professional culture of nursing, and the possible influences of the culture of academia and nursing practice on faculty's perceptions on the culture of nursing. Another gap exists in that the majority of recent studies on enculturation were conducted outside of the United States. This study examining nursing faculty's perceptions on the culture of nursing and their role in bringing students into this culture is the first step to address these multiple gaps in our understanding of these important phenomena.

Chapter Three

Introduction

This chapter provides an overview of the focused ethnography method that were used for this study. The research methods and key components of focused ethnography are described and a rationale for using focused ethnography provided. The study design, including setting, entry into the community, informants, data collection and analysis are presented. Ethical considerations for this research study and means to establish rigor within this study are also discussed.

Method

Ethnography helps "make explicit the common-sense knowledge of the culture studied by revealing what the social worlds mean for the persons within the worlds, and what they mean as insiders acting within them" (Wolf, in Munhall, 2007, p. 293). Ethnography has its roots in anthropology, and the examination of various cultures. With ethnography, researchers live with the participants, immersing themselves in the culture, and participating as able in the rituals and activities of the people in that particular culture. The researcher attempts to gain knowledge of the emic or insider view of a culture from the etic perspective, or the perspective of an outsider looking in at the culture. This may require bracketing of assumptions or biases on the part of the researcher through journaling.

The method used for this study was focused ethnography. Focused ethnography is "widely used particularly in the investigation of research fields specific to contemporary society which is socially and culturally highly differentiated and fragmented" (Knoblauch, 2005, para 2). Focused ethnography involves examination of a particular

aspect of a culture, and generally involves a shorter, more intermittent immersion in the culture (Knoblauch, 2005). In a focused ethnography, the researcher typically has some knowledge of the culture before entering it. This shorter time frame is compensated for "by the large amount of data and the intensity and scrutiny of data analysis" (Knoblauch, 2005, para 2). For the purposes of this study, focused ethnography was an appropriate method. The researcher had a beginning knowledge of the culture to be studied, sought to gain knowledge on a specific aspect of culture, and remained in the culture for a shorter time frame than is required for an ethnography.

Setting

Two public schools of nursing within one Midwestern state served as the settings for this study. Neither setting were sites where the researcher had been, or was currently employed. Both schools of nursing were accredited by the Commission on Collegiate Nursing Education (CCNE), the autonomous accrediting arm of the American Association of Colleges of Nursing (AACN), assuring that they met the same curricular standards. However, there were unique elements to each school that provided broader perspectives on the domain of inquiry, nurse educators' perceptions of the culture of nursing.

The first school, identified as school A, was in an urban setting. The school of nursing was 37 years old, and offered a traditional undergraduate degree, as well as an advanced generalist Master's degree program and newly established Doctor of Nursing Practice program. The traditional undergraduate program was last accredited in 2007, and required 130 credits for graduation with a Bachelor's Degree in Nursing (BSN). A minimum overall grade point average of 2.8 was required for admission to the program.

Forty-eight credits in the nursing major were included in the program. Forty-four faculty members were on staff at program A, with 15 faculty members at the rank of affiliate faculty, eight at the rank of assistant professor, 12 at the rank of associate professor, and three at the rank of professor. There was one visiting professor position and one associate visiting professor position. The administration of the college consisted of one dean and three associate deans. Enrollment was approximately 1500 students for both undergraduate and graduate programs and students completed the undergraduate program at the conclusion of fall, spring, and summer semesters.

School B was located in a more rural setting. The nursing program had been in existence for 32 years, last accredited by CCNE in 2005. It offered a traditional BSN program, as well as Master's degree in nursing with concentrations in health system specialist (with role concentrations in Clinical Nurse Leader, manager, educator, or informatics), as well as nurse practitioner preparation.   The BSN program required 124 credits for graduation, 57 of which were in nursing. Forty-eight students were admitted to the nursing program twice a year, with a minimum grade point average of 2.5 required for admission consideration. Seventeen faculty members were on staff, seven with earned doctorates, two with an MSN as the highest level of education; four faculty members had an MSN and were currently enrolled in a PhD program, and one faculty had a DNP. Two faculty members had no credential information on their web page. This information was obtained once access to the site was granted. There was one director for the entire program. No other titles (professor, associate professor) are provided for faculty.

Entry Into the Community

Once approval from the Institutional Review Board (IRB) at Duquesne University was obtained, entry into the community was initiated by contact with the directors or deans of the nursing programs, who served in the capacity of gate keepers. Initially, inquiry regarding the feasibility of conducting research at the proposed sites occurred via email contact with the gatekeepers. Included in this initial email was an introduction of the researcher, a brief description of the study purpose, the activities included in the research study and the proposed time frame for conducting the research. Follow up contact via phone occurred as necessary.

Once the gatekeepers granted permission to enter the setting, and all institutional requirements for conducting research on site or IRB approval from study sites were met, an initial meeting with the gatekeepers occurred. During this meeting, the researcher discussed the best method for introducing the researcher to faculty and students, and time and setting parameters for naturalistic observation. The researcher also asked the gatekeeper to identify possible key informants and the best way to contact the informants.

Informants

For this study, informants from two different sites included nursing faculty whose self-defined primary teaching assignment was in the undergraduate pre-licensure initial degree nursing program. Faculty members eligible to participate in the study had a minimum of a Masters in nursing degree, possessed an unrestricted license to practice as a Registered Nurse within the state, and one year's teaching experience in the undergraduate program. This allowed for data collection from faculty with a range of experience as both a Registered Nurse and a Nurse Educator. Inclusion criteria was

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based on the potential ability of faculty participants to provide rich, detailed descriptions when interviewed, and was not limited by content area or level in program taught, highest degree earned, or gender.

Data Collection

One of the goals in qualitative research is obtaining thick, rich data (Munhall, 2007). Collecting data from a variety of sources within the culture facilitates this. It also facilitates confirmability during data analysis, which occurs simultaneously with data collection. The sources of data for this study included field notes from observations, transcribed interviews, and the examination of documents and artifacts. While it is philosophically incongruent with qualitative research methodologies to reduce data to variables, systematically documenting findings does facilitate revelation of what was once hidden (Munhall, 2007). While data collection and data analysis occurred simultaneously with this study, they are discussed as separate topics for clarity and ease in describing.

Participant observation is "the method by which investigators join the insiders of a culture so that human relationships, events, patterns, and sociocultural [sic] contexts in which people live and work can be studied" (Wolf, in Munhall, 2007, p. 297). During fieldwork, the researcher's observations were recorded as field notes to provide context for the domain of inquiry. Data from naturalistic observation in the form of field notes included date, start and ending time of the observation period, location, general comments on the participants observed, and activities (Wolf, in Munhall, 2007) as well as notes from the observation period. This allowed the researcher to systematically record notes, and yet remain intuitively open to what should be recorded (Emerson, Fretz, &

Shaw, 1995). Field notes were recorded in a two column notebook, which allowed for both recording of observations and the thoughts and feelings of the researcher. After leaving the site, any additional thoughts or reflections regarding the observation were recorded and labeled as a memo in the field notes.

While observing at both sites and throughout the study, the researcher also reviewed artifacts and documents that were publicly available or offered by the informants. "The way insiders use artifacts informs ethnographers about the culture" (Wolf, in Munhall, 2007, p. 310). Within a culture, documents are a source of data that "instruct ethnographers about what is going on and who is doing it" (Wolf, in Munhall, 2007, p. 310). Documents and artifacts therefore revealed meaning and context about the culture, and roles within the culture. Artifact and document examination during this study included noting the location, appearance, and use of an artifact or document in field notes. Documents included but were not limited to syllabi or curriculum documents. Artifacts also included pictures, awards, posters or other wall hangings, and tools used within the education setting such as computers or other technology devices. Whenever possible, confirmation by the participants regarding the importance or relevance of the document or artifact to the culture was obtained and connected to the data via a memo in *NVivo* © version 9.

Another part of focused ethnography and source of data that helped promote holistic understanding of the domain of inquiry and rigor of the study was semi-structured interviews (see Appendix A). "Ethnographers depend on interviews to gain understanding of informants' worlds during participant observation opportunities… Cultural understanding and interpretation are chief on the agenda for all types of

ethnographic interviews" (Wolf, in Munhall, 2007, p. 308).   Participants were informed

about the study, and asked to sign informed consent (Appendix B), which included

consent to audio-record the interview prior to the start of the interview. Audio recording

the interview increased credibility of this data source. The interview started with broad,

general questions, and progressed to more specific questions. Probes and prompts, such

as "tell me more about that," or "can you think of another example similar to that one"

were used to help augment the information provided, or to clarify content. The use of

semi-structured interview guides allowed for consistency in data collection and the ability

to explore new areas as they became evident in the process. During the interview, the

researcher took notes, noting non-verbal cues and the setting. The semi-structured

interview guide was modified as data collection and analysis progressed, which allowed

for confirmability of previously revealed content, or the exploration of new phenomena

made evident in earlier interviews.

Process of Data Collection

After receiving permission from Duquesne University Institutional Review Board

(IRB) and then all site-specific institutional requirements such as IRB requirements to

protect human research subjects were met, naturalistic observation began. The gate

keepers and participants introduced the researcher as a PhD student conducting research

by observing at the school of nursing and interviewing faculty. Initial data collection

focused on the physical setting, and day-to-day interactions between people in those

settings. Observation of events identified as key to those in the culture also occurred.

After an initial period of naturalistic observation in the settings, formal contact was

made with the potential participants that were suggested by the gate keepers.

Gatekeepers informed possible participants of the study, and provided contact information of possible participants to the researcher to facilitate communication (Appendix C). After possible participants contacted the researcher, participants were provided with further information regarding the study, and consent forms (Appendix B).

The snowball method of data collection was used. The snowball method of recruitment facilitated access to future informants who could readily address the research questions, and is congruent with ethnographic research methods. Referral from a known colleague also facilitated trust between the researcher and new informants, which is key in obtaining accurate and rich descriptions and data. After obtaining informed consent and completion of the initial interview, these informants were asked to identify other possible informants, and to share information about the study and the researcher's contact information with them (see Appendix D). The researcher followed up with all contacts in a timely manner. It was anticipated that between 20 to 30 interviews would be conducted, however, the total number of interviews conducted was dependent on when saturation was reached. The researcher continued to take field notes of events and day-to-day activities and examined documents and artifacts as the study progressed. Though described separately, data collection and data analysis occurred concurrently. As data analysis occurred, member check also occurred, including returning to participants from each site for confirmation interviews.

Ethical Considerations

All participants signed a consent form (appendix B) prior to any interviews. Signed consent indicated their agreement with the interview and the recording of the interview. Transcription of interviews were conducted by a secure third party who met

criteria for protection of human subjects, protection of identities, and had signed a confidentiality statement (Appendix E). All interview transcripts were de-identified. All recordings of interviews were in digital format, and stored on a secure, password protected hard drive. The use of the *NVivo© version 9* data management system provided for secure storage of all electronic data, with further protection provided by use of a password protected external hard drive stored in a fire-proof secure location separate from the research sites. All data relating to the study, including printed and electronic formats, were kept in a secure storage system at an office of the researcher. Data was only shared with members of the dissertation committee and had all identifiers removed prior to being shared. Deans, directors, or those in a supervisory role did not have access to any data except in final analysis form (final findings, etc.). Participants were informed that they may withdraw from the study or ask for their data to be deleted from the study at any time, with no retribution for withdrawal.   All data was destroyed upon completion of the study. When conducting field observations, the researcher fully cooperated with any request to refrain from observing.

To further protect the rights of human participants, the researcher completed the Collaborative Institutional Training Initiative (CITI) training course "Biomedical Responsible Conduct of Research".   Successful completion of this course demonstrated an understanding of the rights of human research participants, and the responsibilities of the researcher in protecting those rights (Appendix F).

Researcher as Research Instrument

In qualitative studies, the researcher is the research instrument. This is particularly true in ethnography, which has its roots in anthropology (Lincoln & Guba,

1985). "The human as a [research] instrument is inclined towards methods that are extensions of normal human activities: looking, listening, speaking, reading, and the like" (Lincoln & Guba, 1985, p. 199). The researcher as a research instruments has certain advantages according to Lincoln and Guba (1985), which include the ability to adapt and respond to cues, to preserve a holistic emphasis, to process data as it became available, and to immediately summarize and clarify. These qualities make the human an excellent instrument for ethnographic study. Specific qualities of this researcher which contributed to being an instrument for this study included past experience with qualitative data collection and analysis, and experience in keeping ethnographic field notes.

Another aspect of the researcher as a research instrument that is key to a focused ethnography is a prior knowledge of the culture (Knoblauch, 2005). The researcher had been a nurse for 30 years, and a nurse educator for 22 years, and completed course work and an advanced degree in nursing education. Thus, the researcher had the necessary experience and knowledge required for conducting a focused ethnography.

The researcher's experience and knowledge in nursing education also served as drawbacks to the researcher as the research instrument. These included biases, values, and past experiences. Reflective journaling, which included bracketing assumptions, biases and values prior to and during data collection and analysis, helped reduce these liabilities. Since the researcher was currently a nurse educator, this was especially important. Peer debriefing with the dissertation chair was another means used to reduce researcher bias.

The establishment of trusting relationships with members of the culture is crucial to obtaining thick and rich data. These relationships can also have a negative effect on

data analysis. The researcher can become too close to the informants and immersed in the culture to remain objective or see the culture with an etic eye. To decrease the possibility of this occurring, the researcher developed rapport and not friendship (Wolf, in Munhall, 2008). Peer debriefing with the dissertation chair also assisted the researcher in maintaining the proper relationship with informants.

Ethical considerations also arise when the researcher is the instrument. This includes the need to preserve privacy, confidentiality, and trust (Hollaway & Wheeler, 2010). Privacy was addressed by conducting interviews in a location that protected the participant's privacy and was agreeable to them. Confidentiality was afforded the participants by removing all names or identifiers. When the researcher is the instrument, trust must also develop between the researcher and the participant. This trust was maintained by preserving fidelity to the research plan, entering and leaving the setting in a respectful manner, and keeping appointments with informants. Once acceptance was gained to a culture, the researcher may be asked to participate in events, or take on roles of the members of the culture. While this may provide unique data, the researcher remained remain true to her role as researcher and assisted only to the point where the "native" members of the culture were still the primary faculty members.

Data Analysis

Data analysis in ethnography occurs concurrently with data collection, requires intimate knowledge of the data, begins with the recording of the first field notes, and ends only after saturation is achieved and the final report is written. Saturation is reached when new data reveal redundant information, and no new information is obtained (Polit & Beck, 2008). Although participants and their information are unique, redundancy in

general themes and concepts becomes evident with ongoing data analysis. The number of participants needed to reach saturation varies based on the research question and quality and types of data provided. Polit and Beck (2008) suggested conducting a total of 25-30 interviews with informants. Given the total number of faculty at each institution (60), it was the intention to seek 20-30 interviews, or to seek and conduct interviews until saturation was reached.

In data analysis for qualitative research, the researcher attempts to answer the questions "What is going on here? What does this mean? Why do the participants behave this way?" (Jacelon & O'Dell, 2005, p. 217). In focused ethnography, data analysis is cyclical and follows the pattern of participation observation, reflection and observation. Data is deconstructed, then reconstructed using induction to develop a new theory or understanding of a phenomenon that was not previously apparent.

Leininger's four phases of data analysis for qualitative research (1991) were used to analyze the data generated from this study. Multiple nursing researchers have used this method of data analysis, and it is a method that "provides rigorous, in-depth, and systematic analysis" (Leininger, 1991, p. 94) of qualitative research. Data analysis began with the start of data collection, and continued simultaneously with data collection until all data was collected (Leininger, 1991).

The first phase included "collecting, describing, and documenting raw data" (Leininger, 1991, p. 95). This included data from naturalistic observation, interviews and notes taken during interviews, and identifying symbols. The researcher focused on the emic perspective but was also attuned to her preliminary interpretations and etic perspective.

The second phase of data analysis involved coding and classifying data as they related to the research questions. "In Phase II, the researcher identifies the descriptors, indicators, and categories from the raw data in Phase I" (Leininger, 1991, p. 96). Descriptors were reviewed for similarities and differences. If descriptors or categories reappeared, they were evaluated for meaning (Leininger, 1991).

During Phase III, the researcher examined the data for recurrent patterns from Phase I and II.

> Data are scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meaning-in-context" (Leininger, 1991, p. 95).

Throughout the different phases, the researcher traced the various levels of analysis back to the raw data, established an audit trail from data to analysis and back to the data. This preserved the emic nature of the data.

Phase IV was the highest level of data analysis. In this phase, the researcher developed "major themes, research findings, theoretical formulations, and recommendations" (Leininger, 1991, p. 95). This phase involved synthesizing themes, interpreting findings from previous phases, and presenting major themes and recommendations. This phase required the researcher to know the data well, as she must "carefully preserve relevant verbal statements, meanings and interpretations from informants in a meaningful way and not reduce data to spurious or questionable themes" (Leininger, 1991, p. 97). Leininger (1991) views this phase as the most challenging to novice researchers, as it involves critical analysis and creativity. For novice researchers,

a research mentor is crucial for data analysis and the development of findings that are credible and meaningful. For this study, the dissertation chair and methods expert on the committee served as mentors.

As with all research studies, the research was not complete until the findings were presented. The findings included excerpts from interviews, or other forms of raw data to substantiate the findings. Reporting the findings also fulfilled an ethical obligation to the participants who invested their time, and insights to the study. When participants recognize the findings as presented, the researcher is assured that the data analysis was accurate and rigorous (Munhall, 2007).

Management of the Data

N-Vivo ©version 9 was used to manage the data, and assisted with data analysis. This data- management software tool allowed for maintaining confidentiality of participants, ease in coding, the retrieval of quotes from transcripts, and the ability to record and track decisions. It also allowed for ease in sharing data between researchers, facilitating dependability and substantiating themes, all which contribute to the rigor of the study.

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Establishing Rigor

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Rigor

Rigor in qualitative research differs from that in quantitative research, but still refers to the overall strength and quality of a study. Debates abound on how to determine if a qualitative study is rigorous (Holloway & Wheeler, 2010; Polit & Beck, 2008), but Holloway and Wheeler (2010) suggest using the term trustworthiness (p. 298) instead of rigor for qualitative studies, as it "means methodological soundness and adequacy" (p.

302). Trustworthiness is evaluated based on the dependability, credibility, transferability, and confirmability of a study. These terms are appropriate to use as they are consistent with the naturalistic philosophical orientation of qualitative research to establish the rigor of a study, and are based on the work of Lincoln and Guba (1985). All of these criteria contribute to a qualitative study that is both rigorous and trustworthy.

Dependability

Dependability refers to the stability or consistency of findings over time, and is seen as the equivalent of reliability in quantitative research (Lincoln & Guba, 1985). Record keeping of the decision trail was one method suggested by Lincoln and Guba (1985) of maintaining dependability. Decision trail is the recording of decisions made throughout the study. The use of *N-Vivo* © version 9 data management software during this study allowed for easy retrieval and recording of decisions made regarding data analysis. A review of decision trails during data analysis by the dissertation chair and committee further enhanced dependability of the study, as it attested to the consistency of decisions throughout the study.

Lincoln and Guba (1985) also suggests assessing researcher bias and the overall design of the study as methods to assess dependability. In this study, evaluation of all aspects of the process, including methodology, data collection, and analysis by the dissertation chair and committee contributed to the dependability of this study. The use of a reflective journal by the researcher, and regular consultation with the dissertation chair during data collection and analysis were additional steps to ensure dependability of this study.

Credibility

Credibility is a crucial component in qualitative studies. Credibility is "confidence in the truth of the data and interpretations of them" (Polit & Beck, 2008, p. 539). Credibility is established by conducting a study so that the findings are believable and the researcher ensures credibility in each step of the research process: planning, data gathering, data analysis, and reporting findings (Polit & Beck, 2008). Credibility in the planning step was assured by careful review of study method and design by the dissertation committee.

The three main hallmarks of credibility in the data collection aspect of qualitative study are prolonged engagement, persistent observation, and triangulation. In this study, these qualities were addressed in the completion of naturalistic observation and collecting data from multiple sources (observation, interviews, and artifact and document examination). Keeping a reflective journal during data gathering also enhanced credibility and rigor of this study, as this journal facilitated the bracketing of biases, feelings, and values (Polit & Beck, 2008).

During data analysis, credibility was facilitated by the continued use of triangulation of data sources, as well as the use of transcription rigor, development of a codebook, peer debriefing, and member check. Transcription rigor was achieved through verbatim transcription of interviews, minus identifying information. Checking transcripts against the audiotapes of interviews for congruency helped ensure transcription rigor. The compilation of a codebook to record coding decisions made during the coding process was another tactic used in data analysis to enhance credibility during this phase of research. *N-Vivo* © version 9 data management software facilitated the development of a

codebook. Peer debriefing occurred with the dissertation chair at regular intervals throughout data analysis. Member check is a process in which "data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected [and] is the most crucial technique for establishing credibility" (Lincoln & Guba, 1985, p. 314). Member check occurred by returning to selected participants at each site for clarification or confirmation of data and findings, and occurred both formally and informally.

Credibility in reporting the findings was ensured with the help of the dissertation chair and committee. The chair assisted the researcher in preparing findings for the final dissertation defense. After making corrections or modifications based on the review of the committee and public defense, findings from this study were published in accordance with Duquesne University standards for dissertations in an electronic database of dissertations.

Transferability

Transferability in qualitative research is the ability to transfer findings to another setting (Polit & Beck, 2008). Providing thick descriptions, especially of time, place and setting, is essential for transferability as these thick descriptions allow other researchers to determine if the study findings are transferable to other settings. The final judgment on whether or not to transfer conclusions to other settings is the responsibility of future researchers, but future researchers rely on the rich and thick descriptions provided by the researcher to make that judgment (Lincoln & Guba, 1985).

For this study, the provision of thick descriptions facilitated transferability, and the application of findings to other settings. Thick descriptions provide "the widest possible

range of information for inclusion" (Lincoln & Guba, 1985, p. 316), and include rich and detailed descriptions of settings and interactions (Polit & Beck, 2008). Digitally recording interviews, and taking detailed notes during field observations during this study facilitated the inclusion of thick descriptions in the findings and contributed to the ability of future researchers to decide whether findings are transferable to other settings.

Confirmability

Confirmability deals with objectivity, and addresses the accuracy of the data and its meanings. It refers to "congruence between two or more independent people about the data's accuracy, relevance, or meaning" (Polit & Beck, 2008, p. 539). Establishing confirmability ensured that data represent the voice of the participant, and not the voice or bias of the researcher. Digital recording of interviews, and confirming transcription of interviews by simultaneously reading and listening to interviews confirmed that the data was true to the participant's words. Assessing for confirmability included assessing for appropriate linkages between data and findings, logic of inferences, analysis techniques, and appropriateness of interpretations and labels, and any evidence of researcher bias (Lincoln & Guba, 1985). In this study, the dissertation chair and committee assisted in assessing for confirmability.

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Summary

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This chapter provided background information on ethnography. Information on focused ethnography as well as the rationale for using it in this research method was also provided. A review of the study design, including setting, entry into the community, informants, data collection and analysis were described, along with ethical considerations

involved in this study. Means to establish rigor and credibility in this study and in all

qualitative studies was also provided.

Chapter 4

Introduction

This chapter describes the method of data collection and data analysis, along with the reporting of findings from this study. Categories, patterns and themes are presented with quotes from participants are given to substantiate the findings. The setting, entry to the field, and ethical considerations during data collection are also discussed.

The Setting

The setting for this study was two schools of nursing in a Midwestern state. Both schools of nursing are accredited by the Commission on Collegiate Nursing Education (CCNE). During the course of data collection, it was revealed that both sites were undergoing curriculum revision in their baccalaureate programs. While the reasons for curriculum revision varied between the sites, both were at similar stages of the process. The two sites were in separate regions of the state, with variances in social demographics.

Site A was located in a newer building in an upscale downtown location, which was approximately a half hour drive from the main campus of the university. The School of Nursing shared building space with other allied health professions programs, such as Physical Therapy, Occupational Therapy and Radiological Imaging Sciences. An academic nurse managed family practice clinic (staffed by Nurse Practitioner faculty) and major health care agencies in the regions were within close proximity of the building.

Site B was located in a more rural, middle class setting. The building was less than a year old, and on the main campus of the university. The Nursing Department was part of the Health and Human Services College, and shared building space with other departments within the college such as Athletic Training, Occupational Therapy, and

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Social Work. There is a contracted urgent care facility on campus that is physician based. Major health care agencies are scattered throughout a tri-county area surrounding the university.

Both study sites had nursing related and other art/pictures in the building. There was a large amount of natural light and windows at both sites, making the atmosphere open and inviting. Both sites were clean and well maintained.

Classrooms at both sites were arranged similarly with tables and chairs situated in rows with a center aisle, and projector screens and smart carts for technology at the front of the rooms. White boards were also available in all classrooms, and were utilized by the majority of faculty. The capacity of the classrooms available varied from 30 to 60 students. Site B had an amphitheater style classroom which had seating for 36 students. The front of the amphitheater had a wall set up to simulate a hospital room (oxygen port, electric plugs, blood pressure cuff, suction canister, etc.) and other equipment such as a tube feeding and intravenous pump, as well as a sink to wash hands, sanitizer and soap, disposable gloves, paper towels, and a cart covered with a sheet. Site A had a large auditorium style room in which orientation was held that seated approximately 250 people. A smaller, reception or meeting room was attached to the auditorium.

The simulation lab at site B was adjacent to the amphitheater and had 32 hospital bed stations with an over-bed and bedside table, and a cabinet attached to the wall at each bed station. Each bed station also had oxygen, suction, an IV pole, a clock, electronic blood pressure and thermometer machines. Laptop computers were on rolling carts at each bed station, which, according to the faculty present in the lab was for electronic charting. Curtains could separate each bed station for privacy. There were large and well

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stocked supply rooms at both ends of the lab and a smaller supply room and office in the middle of the labs. A wooden rectangle desk with a chart rack and electrical outlets and wiring for computers were also present in both half of the labs. I did notice very few students present in the lab when I observed, and only one faculty member present. During a faculty interview, it was confirmed that this was the largest simulation lab in the state, but the school lacked the financial resources at this time to hire the necessary faculty and staff to fully utilize these facilities. The simulation lab at site A was also fairly large in size and also well stocked, and seemed to have multiple students in whenever I walked by. It appeared more crowded with less storage space than the lab at site B. Mannequins and other bedding and supplies appeared a bit older in this lab but in good repair.

Both sites had multiple computer terminals for students to use outside of the classrooms, and site A had a snack and coffee bar. Parking for students, faculty and guests was free and in close proximity to the building at site B. At site A, parking for guests was in an attached, gated, covered ramp and accessible only through advanced request. It is not known if this is where faculty also parked, but it was noted that parking for students was minimal at best. Both sites were served at frequent intervals by city buses.

Entry into the Field

The dean or director of the nursing programs acted as the gatekeeper for both study sites. Once Duquesne University IRB approval was granted, the gatekeepers at each site were contacted individually via email with information about the study and a request for permission to conduct the study at their site. Follow up phone calls with the

individual gatekeepers clarified questions regarding the study. Both gatekeepers

independently gave their permission to use their schools as a study sites once their site

specific IRB requirements were met. The researcher notified each gatekeeper when IRB

approval was granted for her respective site. The gatekeepers then sent an email to

potential participants who met the inclusion criteria, noting their approval and the

approval of the university IRB, and introducing the study and the researcher. The

gatekeepers also provided the researcher with a list of prospective participants and their

email contact information. The researcher then began contacting prospective

participants via email. The emails contained general information about the topic of the

study, specific requests to observe and/or interview the participant, and the contact

information for the researcher. Final arrangements for observations and interviews were

made either by email or phone based on the preference of the prospective participant.

Ethical Considerations and Data Collection

The researcher followed ethical guidelines for this study including obtaining

permission from all necessary IRB units before proceeding with the study, obtaining

signed informed consent prior to conducting interviews, and protecting the anonymity

and confidentiality of the participants. Additional ethical considerations in regards to the

methodology were establishing a trusting relationship with the participants, and notifying

students present during observations of the purpose of the researcher's presence and

study.

Per the study protocol, the rights of the participants were respected in multiple

ways. Each participant gave verbal and/or written approval for naturalistic observations.

At the start of each naturalistic observation, participants read a statement to the students

informing them of the approval of the study by both the originating and local IRBs, the purpose of the study, the role of the faculty in the research study, and that no identifying information about the students would be recorded. Each participant provided informed written consent prior to the start of each interview. A business card with the researcher's contact information and a copy of the informed consent were left with each participant in case the need arose to contact the researcher at a future date.

All interviews were audio-taped. The audio tapes were transcribed verbatim by a transcription service. A representative of the transcription service guaranteed confidentiality by signing a confidentiality statement. In addition, each transcriptionist employed by the company signed an individual confidentiality agreement upon employment with the company. To further protect the identity and confidentiality of faculty participants, identifying information was removed from all transcripts before sharing them with the dissertation chair. Participants in interviews or observations were only referred to by an alphanumeric identifier. All transcripts and recordings were stored on a secure, password protected hard drive in a fire-proof secured location separate from the research sites. The dean and director of the programs did not have access to any of the raw data. Confidentiality and privacy were also maintained by conducting the interviews in a private location of the participant's choice.

The researcher also took care to establish rapport and a trusting relationship with participants. The researcher kept appointments and was on time for all observations and interviews, introducing herself to the participants when meeting for the first time, asking preferences for observing and interviewing, and thanking the participant when leaving the study site. The researcher also dressed in a professional manner that was congruent with

the cultural expectations of the settings, and did not interrupt or contribute to the classes or orientation sessions. The researcher kept all contact with the gatekeepers and participants at the professional level and respected the boundaries of those professional relationships.

Data Collection

Naturalistic observation occurred during regularly scheduled class times at both sites, with the additional observation of program orientation at site A, all with the permission of the participants conducting the class or orientation. Participants also informed students that the focus of the study was on the participants and not the students, per the request of the IRB at both sites, and that the study had met institutional IRB approval. All of the participants greeted the researcher warmly at the beginning of the observation period, and often chatted with the researcher during a break or at the end of the observation period. Students acknowledged the researcher when she was introduced by smiling and turning to look at the researcher, but otherwise never interacted with the researcher at any time during the observation. During naturalistic observation, the researcher sat at the back and side of the room and did not interact with faculty or students during class or orientation. Naturalistic observation at site B started approximately one month after data collection at site A due to differences in IRBs at each site. In total, data collection took place during over a six month time period, over the span of two semesters.

Prospective interview participants were contacted via email or in person after the researcher conducted observations in their classrooms.   Interviews were conducted with individuals who agreed to participate after written informed consent was obtained.

Naturalistic observation continued at both sites during the period of time that interviews were conducted.

Two prospective participants who were contacted from site A declined to be observed, stating that they didn't have time to participate. One participant at site B declined to be observed but did agree to be interviewed. During the interview the participant noted that this was her last semester teaching before retirement, and that she felt she did not have good rapport or connection with the students anymore, which is why she declined to be observed.

A total of sixteen nurse educators from the two study sites provided informed consent and signed the consent form. These participants were interviewed and audio-taped in a private location that ensured the participants' confidentiality. The completed transcriptions of the audio tapes were then checked against audio tapes to ensure transcription accuracy, adding to the rigor of the data collection procedure. De-identified verbatim transcripts of each interview were shared with the dissertation chair and discussed at various intervals during the study as a form of peer debriefing.

Participants represented varying ages, years in nursing, years teaching at the Bachelors of Science in Nursing (BSN) level, years spent teaching in current BSN program, experience in multiple practice settings, and educational preparation. Participants ranged in age from the 30-39 years age group (one participant) to the over 60 age group (six participants), with three in the 40-49 years age group and six in the 50-59 years age group. The number of years participants had been Registered Nurses ranged from 21 to 48 years, with the average number of years as a Registered Nurse being 31.75 years. Years spent teaching in a BSN program ranged from one year

teaching experience (two participants) to 41 years teaching experience with the average length of time teaching in a BSN program being 18.875 years and only five participants had fewer than 10 years' experience teaching at the BSN level. All of the participants at site B had spent their entire career in nursing education at the BSN level at that site. Five of the seven participants at site A had spent 75 percent or more of their career in nursing education at the BSN level at that site. Educational preparation ranged from a Masters in Nursing (with a focus in nursing education) (five participants) to Doctorate of Nursing Practice (one participant), Doctorate of Philosophy (six participants), Doctorate in Family and Child Ecology (one participant), and Educational Doctorate (three participants). Of those with Masters in Nursing degrees, two were Doctorate of Philosophy candidates, and one was starting a Doctorate of Nursing Practice program in the fall. Only one participant was African American; all of the other participants were Caucasian. Practice or education specialty areas taught by the participants included nursing fundamentals, adult health, medical-surgical, critical care, end of life, ethics, maternal-child, community/public health, emergency department, mental health, nursing research, nursing history, pharmacology, and professional issues.

While being interviewed, two participants (one from each site) mentioned that they perceived their answers to the interview guide questions were most likely different from most nurse educators regarding the culture of nursing. Both of these participants had a background in mental health nursing. Data analysis revealed that these two participants did indeed give answers different from other participants when describing the culture of nursing. Although their descriptions were largely positive, these participants also offered descriptors that were more critical of the culture of nursing.

Both participants addressed the culture of nursing as one that needed to be more inclusive and open to the thoughts and ideas outside of the mainstream beliefs in the culture.

During the interviews, all participants responded affirmatively when asked if nursing had a culture. When asked to describe the culture of nursing, the participants gave varying responses. Some participants described nursing, while others described nurses. Some participants described both nursing and nurses. It was difficult for the researcher to separate out descriptions of nurses vs. the culture of nursing because the same word could be used to describe both, and also because individual nurses contribute to the overall culture of nursing. All participants were able to answer the question regarding influences to the culture of nursing and, when prompted, often provided examples of those influences.

One of the interview questions asked faculty participants whether they viewed nursing students as part of the culture of nursing. There was disagreement among participants in their replies to this question. Replies ranged from the negative to the affirmative, with some participants stating that students were becoming part of the culture, but not officially part of the culture until they began working as a nurse after graduation. When asked, all participants were able to easily describe their role in bringing students into the culture of nursing and share what helped students learn the culture when asked.

The participants' responses to all of the interview questions were analyzed; results of data analysis are presented below.

Presentation of the Categories

Leininger's (1991) four phases of data analysis were used to analyze the data. Phase I is data collection; data collection occurred during naturalistic observation and interviews. Transcriptions of interviews were checked against audio-recordings to ensure transcription accuracy and identifying information was removed from the transcriptions. As the de-identified data were reviewed, *NVIVO 9 ©* software was used to record descriptors or indicators of the culture offered by participants. Descriptors or indicators were named using the most commonly used words or ideas presented. According to Leininger (1991), data analysis begins as soon as the initial data are collected.

During Phase II, the descriptors and indicators were further analyzed and evaluated for commonalities or repetitions, leading to the identification and coding of 15 categories. Categories were named using the most commonly occurring words or ideas. Coding decisions were also documented in *NVIVO 9*, adding to the credibility of the study. The resulting 15 categories of responses to the researcher's questions included aspects of *expressions of caring*, *nurses eating our young*, *interdisciplinary team members*, *sub cultures in nursing*, *student sub culture*, *internal influences*, *external influences*, *changes in the culture of nursing*, *becoming a nurse*, *internalizing the identity of a nurse*, *how students learn the culture of nursing*, *mentors and role models help students learn the culture of nursing*, *faculty knowing students*, *class size*, *and curriculum*. A full description of these categories follows; quotes and observations are provided that supports their identification as categories.

Expressions of Caring

In response to the researcher's request to describe the culture of nursing, the first category that emerged was *expressions of caring*. The word caring was used to describe the culture of nursing by all participants. Other words used by faculty participants in connection with caring included nurturing and empathy. Nurturing was used in conjunction with the word caring by two midlife doctorally prepared faculty participants (one EdD, one PhD), both of whom had greater than 10 years' experience in nursing education and more than 37 years as a registered nurse. Empathy was used by 5 faculty members who represented all age groups and years' experience in both nursing and nursing education, and who were educated at the PhD or PhD Candidate level. Caring referred both to students caring for patients and to faculty caring for students. Participant 4A said,

> I think the whole caring ethic is a real strong theme in nursing for whatever age group, or wherever nurses work.

Faculty participants perceived that some nursing students come to the program with a caring nature, but others need to be taught caring. Participant 2A shared this example of what she has told students.

> And sometimes when you're at a funeral, and you don't know what to say. This is what I want you to say. Mrs. Smith, I don't know what to say. But I want you to know that I care…You gotta care.

Regardless of the setting, or who was involved, it was apparent to the researcher by the tone of voice and emphasis of the words care or caring that this was a very important aspect of the culture of nursing for the participants.

Nurses Eating our Young

A second category of participant descriptors of the culture of nursing was *nurses eating our young*. The term lateral violence was used by participants in conjunction with the phrase eating our young. Both of these terms were described by participants as more experienced nurses giving new nurses a difficult time, being harsh with new members, or not demonstrating empathy or compassion towards novice or new nurses. One faculty saw these terms as evidence of established nurses in an institution not valuing the contributions of newcomers, and wanting to maintain the status quo or established ways of performing. While lateral violence or *eating our young* was viewed by many participants as the antithesis of caring, it was still seen by multiple faculty as part of the culture of nursing. Eating our young and lateral violence were mentioned as a part of the culture of nursing by half of the participants from both sites, representing all age groups and a wide range of experience, both as Registered Nurses and nurse educators. Eating our young was perceived to occur not only between nursing staff and students, but also between junior and senior faculty and among various levels of students such as between senior and newly admitted nursing students. Faculty 1B's statement best summarized the pervasiveness of eating our young as part of the culture:

> We sometimes get into situations where that whole reputation for eating our own, it plays itself out in the department. It plays itself out in whatever agency we're a part of that we tend to get into that behavior. And unfortunately, our students get into it real early on when they break into groups and these people are ostracized. We need to do a lot more to be that caring.

While faculty participants expressed disapproval of eating our young and wished it would stop, it still appeared to be pervasive in the culture of nursing.

Interdisciplinary Team Member

The third category of descriptors of the culture of nursing was *interdisciplinary team members*. This description of nursing was offered by five participants when asked to describe the culture of nursing. Participant 4B spoke of this in terms of being part of the health care team.

> I think we do see ourselves as collaborative with other professions, that we're very much a part of a healthcare team.

Participant 5B saw all professionals on an interdisciplinary team, including nurses, as having different cultures.

> They [other healthcare professionals] each have their own culture and being sensitive to those cultures too …I mean, really knowing where they're coming from, just as much as we want them to know who we are.

Overall participants spoke favorably of being a member of interdisciplinary team as a part of the culture of nursing.

Other words used less frequently by participants to describe the culture of nursing that reflected additional aspects of caring included matriarchal, holistic, and concerned with quality and safety. Matriarchal was used in both a positive and negative manner as both a way of being domineering yet caring at the same time. Holistic was used in reference to nursing being uniquely concerned with multiple dimensions of the patient—psychological, social, and spiritual as well as physical. Participants deemed

quality and safety as qualities characteristic of the work of nursing that received major emphases in the provision of care.

When asked to describe the culture of nursing, some participants used words that were more characteristic of nurses. These words included innovators or change agents, systematic, and going above and beyond. The word trustworthy was used by one participant to describe the culture of nursing, and by another participant to describe a characteristic of individual nurses.

Subcultures Within the Culture of Nursing

The fourth category of descriptors of the culture of nursing was *subcultures within the culture of nursing*. Participants described different subcultures within nursing that included the subculture of academia and the subculture of service. The subculture of academia was described by faculty as having a unique set of values that often reflected the values of the individual university, and the promotion of education, research, and service among its members. This subculture was also seen as more formal, with a high priority placed on a educational background. The formality believed to be characteristic of the subculture of academia was addressed by participant 2B, when she shared

> I'm having a really hard time as being referred to as Professor Xxxxx, because I would rather not be so formal. But it is an expectation of the college, the university, that I am addressed as such.

The stress of participation in the rhythm of the university culture was shared by participant 5B.

It happened the tenth week of the semester, and I know that's the most stressful

time… there's a pattern to a semester and that – and it's like we're going like this

[making a climbing motion with hands], the tenth week, you reach that crescendo.

Nine participants addressed the subculture of service. The culture of service

involved those elements that related to direct patient care, such as length of the work day,

patient care assignments and acuity of patient populations, policies and procedures, and

unions. Participant 7B contrasted the subculture of service with the overall culture of

nursing and used the terms "the culture of the profession" in reference to the subculture

of service and the terms "professional culture" for the overall culture of nursing and to

differentiate between the two different cultures.

I think there is the professional culture, clearly outlined in literature and

professional organizations. They [sic] help the framework of the culture [and] the

people that are within that; whereas the culture of the profession of nursing [is]

where the majority of the people are working or employed… I feel that that is a

different culture because you have different variables.

Student Culture

The fifth category to emerge from participants' responses to interview questions

was *student culture*. The student culture included the time demands and stresses of being

a student nurse, the experiences students encountered and their relationship with faculty.

One of the interview questions probed faculty participants' views about students in the

culture of nursing. Faculty participants' responses to this question and questions about

other aspects of the nursing students' experience compose this category.

Participant 5B definitely saw students as part of the culture and was enthusiastic in her belief that students have something to contribute to the culture.

These students are definitely part of our culture and, wow – what they've got to share with all of us!

Participant 5A also agreed that students were part of the culture, but in a different way than in the past.

They aren't the way they used to be but I think that they are part of the culture…Back in the old, old days, you talk to old nurses they'll talk about how they ran the hospitals in the evenings and definitely they were part of the culture. Now I think it's – well, they are to some degree and sometimes they're just not, sometimes they're pretty annoying, I think, to the folks who are out there. But that makes them part of the culture too, annoyances.

Participant 1B thought students can be a source of change in the culture if allowed.

We end up [admitting] a whole group of people who are somewhat the same. So trying to create diversity by allowing ourselves to select people [to enter the nursing program] who are very different than the others… It [could] change the culture.

Participant 3B saw students as in the process of becoming part of the culture. When asked by the researcher, participant 3B attempted to clarify when student nurses make that transition and said it happened between their junior and senior years.

Yeah. Well, yeah, after they've passed out of the junior two, [second semester junior year] I think…they've got enough information that they've accumulated that now they can see how it fits together.

Participant 3B addressed the stress of being a nursing student.

Many of them are absolutely overwhelmed with the reality of nursing. I think many

of them come with …beliefs and attitudes and what they think this is all about. But

when they actually get here and find out that it's very difficult – it's hard work,

probably harder than you've ever done before.

Faculty participants also believed that the stress experienced by student nurses also

emerges from the desire to obtain good grades, as reported by participant 3B.

I had a student send me an email the other day and she was apologizing for the

behavior of the students when they got their test results back. And she said, you

have to understand that we are grade driven, that grades are how we get our

scholarships.

Internal Influences

The sixth category to emerge from faculty participants' responses to questions

about what influences the culture of nursing was *internal influences.* Internal influences

were those that originated from within the nursing profession. Participants identified

multiple factors within the profession of nursing that they believed influenced the culture

of nursing. Internal influences included educational differences, history of the

profession, gender, generational differences, and a sub culture of nursing service

(practice).

Participant 4B discussed educational differences and the challenge that they pose

to cohesiveness in the culture of nursing.

Well I was just going to say here a big problem here … for years and it's not

better – there's a big divide between ADN and BSN – education – a big divide.

The students will hear…the staff nurses tell us ADNs are better and then,

somebody else will say, no, the BSN are – that goes back and forth and I think

that very much affects our culture. We can't present ourselves as a united force.

The impact of the history of our profession on the culture of nursing was addressed by

participant 9B.

Well, I mean, if you start off, historically, you start off linked to a profession, it's

kind of hard to set yourself apart from it. And I think we do a decent job of

explaining and understanding how we're different from physicians, but I don't

know that the lay culture or the lay community really understands that.

Participant 1A described a quality of the culture of nursing that she believed has been

present historically, and still endures somewhat to this day.

I think there's still an overlay, a bit of an overlay, of perfectionism from the '50s

and '60s, maybe some '70s.

Participant 3A discussed how the current and historical influence of nursing as a

predominantly female profession influences the profession and culture of nursing yet

today.

We're still predominately a female profession. Yes we've made strides with males

but . . . we just haven't moved that much. So our history is still predominately

female and some of that comes from the culture of American society – society at

large. The fact that [in] society still, it's great for a female to be a physician but

people are still uncomfortable with male nurses. No matter what you say the guys

still have that bias against them.

Participant 3B acknowledged that the generational differences within nursing can

cause problems, but that all have something to contribute to the culture.

Problem is that the older nurses, experienced nurses, however you want to put it, don't see the amazing contributions that these really young kids have as far as technology and new ideas, and that the young people see the older, experienced people as archaic, and don't value them for their experience.

Participant 3A identified the subculture of service as very different from the subculture of academia, and shared her belief that these differences influence the overall culture of nursing.

I think that there are these big differences in our – big differences in the subcultures that the education service gap is the result of the difference in the cultures… they [service] are very comfortable with change. So I think that two different cultures have such a different way of approaching it [change] and I don't think that we have a lot of people in nursing that bridge those cultures, those subcultures. So it's hard because we don't even understand each other. . . I knew coming out of a baccalaureate program that people felt like I wasn't as well prepared as a diploma nurse… But it didn't seem like it was quite as negative as it is now in terms of – on both sides… so now it seems like it's a bigger split.

External Influences

The seventh category to emerge from faculty participants' responses to questions about what influences the culture of nursing was *external influences*. External influences to the culture include those that originate outside of the culture of nursing. These external forces included the interdisciplinary teams, the media, perceptions of others, organizational culture, and the sub-culture of academia.

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Interdisciplinary team work is one external influence to the culture of nursing. Collaborating with other health professions and whether nurses are part of a team influences the culture of nursing. Participant 4A addressed nurses working in interdisciplinary teams when she said

I also think working with all the different disciplines that we work with in nursing is helpful in getting that [nursing] culture. And I think nurses are such an important part of the team.

Participant 7A also addressed learning interdisciplinary team work and collaboration when she said

I like to believe that respect for different professionals that we work with, and knowledge of those who interact with the environment in terms of providing health services is also vital within our culture. We need to create a force that is an understanding and a respect for other professionals that we work with.

Changes in the composition of interdisciplinary teams and the role of the Registered Nurse were addressed by participant 5A.

When I graduated there was a real sense that there were these four main professions [in mental health]. There was psychiatry, there was social work, and psychology and nursing was one of those professions. We really aren't there anymore.

Participant 5A went on to say that a lack of advanced degrees contributed to nurses not being part of the interdisciplinary team. She also advocated for nurses to advance their education to facilitate their participation in and contributions to interdisciplinary teams.

Participant 4B described how the media influences how nursing is perceived by others.

I think how others speak and write about nursing is an influence, like in the movies,

how nurses are portrayed many times, you know, as just being there for sex with

doctors, or to find a husband…

Participant 3A believed that the media helps to shape the perception of the profession for

nursing students.

Certainly the media has a role in molding their [students] beliefs and attitudes and

what they think this [nursing] is all about.

Participant 1B described what seemed like her dismay about a somewhat less desirable

viewpoint held by others about nursing.

When you look at the way that we're presented through the media and through

even what high school counselors tell kids, it's like, you're really smart. You

shouldn't be a nurse. You should be looking at medicine.

Participant 1B went on and described how her significant other who worked in discipline

not related to health care viewed nursing.

Because [to him] anybody's a nurse. You take care of your kid who fell down,

what are you doing? You're out there nursing. You're putting a Band-Aid on

them. And he said, It's not a professional title. A nurse is a nurse kind of thing.

Participant 8B addressed how organizational culture can influence the local culture of

nursing.

I go to all the different hospitals in Xxxxxx for various committees… and all of them

have their own culture. We have the culture of nursing, which probably provides the

foundation for the nurses that work within those agencies, but then, there's a culture

of the agencies, too… some of it has to do with the leadership within agencies, I'm

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thinking of one particular agency that doesn't have a Chief Nursing Officer. They have somebody in finance or something that actually is over nurses. And I think the culture within that agency is different in terms of even nursing.

Participant 4A discussed how the assumptions and expectations in the subculture of academia can influence the culture of nursing.

They've [university administration] told the nursing faculty we want you [doctorally prepared nursing faculty] to lecture. We want you to do the classes and somebody else do [sic] the clinical almost like it's [clinical] a throwaway. And we're [doctorally prepared nursing faculty] saying, no it's not. Almost [doctoral] faculty should be in the clinical more than they should be in the classroom because that's where the application part comes. There's some difference in our culture here because administration sees us [nursing faculty] in a classroom. And I'm saying no.

Participant 1B also described how the conventions of the subculture of academia influence students' perceptions of the contrasts between the cultures of nursing in both academia and service.

Now you [students] have to start calling us by our title the same as engineering or anywhere else. The students saw that as, well, that's not – that's not close. That's not bonding anymore. So again, our clinical instructors, these adjuncts, who are out there floating around, go by first name. But you're back here in the classroom, now it's Dr. Xxxxxx. So does that not create some kind of a distinction between here's real world, where they're warm, friendly, and cozy. And here's your didactic lecturer, who is this know-it-all from above.

Participant 4B described support from the subculture of academia as a positive for the culture of nursing. The support involved the willingness of an academic administrator to underwrite the cost of taking gifts to present to high ranking national nursing officials when she took nursing students on a study abroad trip.

> I contacted the vice president and I said, look, it's traditional that we now have to take really nice gifts because gift giving is their culture, and it has to be something with a plaque on it, something very nice, and he said do what you have to do and just send me the bill. And, you know, I can kind of rely on them for that. So I think that helps with the culture.

Changes

The eighth category to emerge from indicators of the culture of nursing was *changes*. The changes and the types of changes in the culture of nursing mentioned by participants included generational differences in the student nurse population, changes in teaching and learning strategies, and the change inherent in nursing practice.

Participant 2A recognized that current nursing students were different from when she was a student and forecast the impact that they would have on the culture of nursing.

> And they are not the passive school of nursing person I was… but I think they're part of the culture because they're going to be what is going to be change. They are not going to get their Ph.D. when they're 50…They're going to go right on, and accumulate the debt, and not worry about it.

Participant 2A also spoke of her belief that traditional approaches to teaching nursing students about the concept of patient vulnerability need to change due to the increased knowledge base and rapid changes in knowledge inherent in nursing.

I think we spend far too many times with our outlines. And probably not as much time with giving students examples of how they could change practice. And I think, again, it goes back to the curriculum where we had to get through this content. Oh my gosh, I got through all 72 slides. When you maybe didn't need those 72 slides. What you needed was a dialogue about, really, what is vulnerability? Talk to me about what you think vulnerable populations are, and how they got there. And what you can do as a nurse. So, and I think the culture's changing, but it's changing slowly.

Participant 2B talked about how change is inherent in nursing and the necessity for nurses to continually learn to keep up with the changes.

Because if you're not willing to learn, everything's changing every day, and [if] you're not willing to learn, or change, then this isn't the career for you.

Becoming a Nurse

The ninth category to emerge from faculty participants' responses to inquiry about their role vis-à-vis students was *becoming a nurse*. Faculty participants spoke of becoming a nurse as a process undertaken by students as they learned the culture of nursing. This happened as they as they progressed in course work, and gained knowledge about the culture of nursing. Participant 6B talked about the process of becoming a nurse.

So part of the becoming process is that ability to pull all those different pieces of knowledge together and integrate it. Part of that is they're also at this point in the process of learning what is the culture of nursing? How do I fit? Where do I fit? How do I actually become a member of this culture?

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Internalizing the Identity of a Nurse

The tenth category to emerge from the data in response to questions about faculty role related to students was internalizing the identity of a nurse. This is different from becoming a nurse, as it meant the pervasiveness of the identity of being a nurse. For a few of the faculty participants, internalizing the identity of a nurse meant always being a nurse, regardless of the setting. Participant 4A described the goal of internalizing the identity of a nurse and gave her own experience as an example.

> And I'm a nurse when I go to church with the elderly people in my church, and I'm a nurse to my kids. You're always a nurse once you're a nurse. You're always a nurse once you're a nurse. Interviewer: The nursing culture is kind of ingrained in you. Participant 4A: Yes.

One other participant shared this same perspective. Both participants thought it was appropriate for students to obtain this perspective and internalize the identity of a nurse.

How Students Learn the Culture of Nursing

The eleventh category to emerge from faculty participants' responses to inquiry about their role vis-à-vis students is *how students learn the culture of nursing*. This category included faculty participants' descriptions of experiences believed necessary to learn the culture of nursing and included clinical experiences and simulation. Clinical experiences and simulation were often mentioned by participants as the primary ways students learn the culture. Learning the culture through clinical experiences was addressed by participant 4A.

> I would bring the students in [to clinical]… I could see they didn't see themselves as a nurse… I'd tell them, by the end of the semester my goal is for

you to feel like a nurse.   I think clinicals are a really important part of their

enculturation… Usually by the end of clinical, during that semester of clinical,

they start off terrified, and by the end, if they can do it and they have more and

more responsibility, then they start feeling a part of the culture.

Learning the culture through simulation was addressed by participant 6B.

We do the high tech simulation in the Sim lab a couple of times in the semester

where we put them in a difficult situation. It's difficult clinically …Then we do a

number of very low tech role plays in the classroom where we talk about how

would you solve this problem?

During naturalistic observation, the researcher noted that participants often used

story telling as a way to help the students learn the culture. Storytelling by the faculty

participants varied between sharing stories from their own personal experience of caring

for a patient with a particular disease process or nursing intervention being discussed in

class, to reading from a popular book in the genre of children's literature. The researcher

noted that when the participants used storytelling, the students were very quiet and

attentive to the story, and became actively involved in discussion following the story.

Mentors and Role Models Help Students Learn the Culture

The twelfth category to emerge from descriptors of the culture of nursing was

mentors and role models help the students learn the culture of nursing. This category is

related to the research question: Given their perceptions about the culture of nursing,

what do nurse educators perceive as their role with students? Assistance in learning the

culture of nursing comes from mentors and role models. Mentors and role models guide

students' formation and help the students learn a different way of thinking. The ways

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faculty members experienced socialization to the profession was also identified by participants as influencing how they help students learn the profession and culture.

Participant 6B addressed the importance of role modeling by faculty and preceptors during clinical in students' learning the culture of nursing.

I think they get a ton by observing in their clinical settings to see how does their practicum instructor help them understand what happened in the clinical setting. How did the bedside nurse that they worked with help them to understand it … so they have a lot of opportunity to see the culture and the identity of an RN as different individuals embody it.

The important role of mentors and role models in learning the culture was also addressed by Participants 8B and 2A. Participant 8B addressed the importance of mentors and clinical faculty in learning the culture of nursing.

I think it's important that they have good mentors or good people in clinical settings that help them with that. That's why it's really important that we choose our clinical faculty well.

Participant 2A described the role of and shortage of good mentors.

Do you have the wherewithal to let that student bloom? And find something good in the worst presentation ever? And room for improvement in what is a really sterling presentation? And can you be fair in your evaluations? Those are what make mentors. And that's what nursing doesn't have enough of.

Participant 4A described one way faculty assist students learn to think like a nurse, which was part of learning the culture.

So we have them write papers, for example, and those I think can be really good for them to kind of think about, and we help direct those as far as their thinking goes, we help them – it's exhausting the amount of probing sometimes that we have to do to get them thinking like a nurse.

Participant 2A stated that mentors and role models helped her learn the culture of nursing. When asked how she learned to be a mentor, participant 2A stated

Well, I've had really wonderful mentors in my life …And xxxx is just a wonderful role model of a mentor …And she really took me along, and said, "You can do this."

Participant 4A also confirmed that her role models helped her learn the culture of nursing and taught her how to interact with students.

I was socialized that you contributed to your profession… I mean, I got involved in the Xxxxxxx Nurses Association immediately. I was thinking about graduate school immediately. There were people there who definitely were strong role models as far as the culture of what a professional nurse should be. Interviewer: Do you think that influences how you interact with the students today?

Participant: I think so. I think those role models that were my teachers along the way. Definitely.

During naturalistic observation, this researcher observed participants helping students think and role modeling thinking processes. The participants would ask students for their input on a test-like question or scenario. After the students gave their thoughts and answers, the faculty participants would then share their thinking process with the students, including what they saw as important or unimportant in the question or

scenario. One participant told the students that this was the type of thinking required as a practicing nurse and on their licensure exam.

Faculty Knowing Students

The thirteenth category to emerge from faculty participants' responses to inquiry about their role vis-à-vis students was *faculty knowing the students*. Multiple participants spoke of the importance of faculty knowing the students. The word knowing was consistently used and emphasized by faculty when discussing their relationship with the students and what influenced their ability to share the culture of nursing with students. This was expressed by participants from both study sites. Participant 1A felt strongly about this.

> They don't know me. I mean, I tell them my professional background, but they
>
> don't <u>know</u> me. So if you think about culture being imparting values and beliefs
>
> and rituals, I don't think you can do that by one or two exposures very effectively.

Participant 3B also spoke of how she came to value knowing the students as individuals and how that was no longer possible.

> Not only their abilities but who they were as a person. I knew their names, I
>
> knew what was bothering them, I knew when they had a family member who was
>
> sick. But I don't know that anymore.

During each naturalistic observation, this researcher noticed that the faculty also seemed to establish some kind of relationship with the students during class. This included calling the students by name, talking with them during breaks about events important to the students or current events. Calling the students by name was facilitated by students having name cards at their seats. Topics discussed included talking with the

students about a local sports team, spring break or their upcoming graduation.

Conversations were often initiated by faculty before class, or during break. When

students initiated conversations with faculty the discussion focused mostly on course

content or upcoming assignments.

Class Size

The fourteenth category to emerge from faculty participants' responses to inquiry about

their role vis-à-vis students was *class size*. Ten out of 16 participants discussed class size

and the impact class size had on helping students learn the culture. Participant 4B

described the change from a smaller class size to a larger class size.

> Yeah, 24, and I knew every single student, and I knew all about them, and I know
>
> their strengths, and I knew their weaknesses, and I knew – I – there was just such
>
> – a very personal approach to it. Now we have two classes of 32 that we're
>
> dealing with. So it went from 24 to 64. That's a large jump and nobody really
>
> helped us make the transition. So for a while, we were unhappy, they were
>
> unhappy.

Participant 4B also discussed how the increase in class size impacted teaching strategies.

> Yeah, so we had to really change our approaches, and I think I feel comfortable
>
> with it now, but when they first made that changeover it was very hard, but I very
>
> much miss knowing the students at the level I used to.

During naturalistic observation it was noted that class size varied at each location. The

smallest class size was at site B, which had class sizes of 24 and 35 students. Class sizes

at site A were usually in the 60-64 student range but would be increasing to 80 students

per class when the curriculum changed.

Curriculum

The fifteenth category to emerge from faculty participants' responses to inquiry about their role vis-à-vis students was *curriculum*. Curriculum refers to the courses and content in the nursing programs, as well as the way content and courses are organized and taught. As previously mentioned, each school was in the process of revising its respective curriculum. Participant 7B discussed the potential changes in their curriculum in general terms.

> And we're looking at that in a curriculum revision of ways to not have so much …they need to give evidence of learning about as much as [of] evidence of practice about their senior semester.

Participant 6B described the large amount of content contained within the curriculum and the problems that creates.

> We cover basically an 1,800 page med-surg textbook, so there is so much material. At the same time that we're covering the clinical material that I feel so passionately that they have to understand, and yet, we're going to try to talk about how to develop a relationship with your patient.

Participant 4A talked about her frustrations and hopes for the curriculum changes at their site.

> So I get an hour and a half and [in] the whole curriculum to talk about end of life care, so that shows you – something that every nurse will be participating in, they are ill equipped to deal with it, and it's frustrating because I like to spend more time. So hopefully with our new curriculum, as we're going to concept base,

we'll be able to pull these concepts, the important concepts through. That's our

goal.

Participant 2A stated that the curriculum has to change due to changes in health care and in the culture of nursing.

Because the culture of how we change, how we prepare healthcare providers has

got to change.

During naturalistic observation, this researcher observed that all participants at both sites knew the content they were teaching well, as they made minimal or no reference to their notes. Participants who had the least teaching experience used notes more often than those with more teaching experience; the participants who had taught the longest never referred to notes. Power Point presentations were used more often by the less experienced participants; three participants did not use any Power Point Presentations. The length of Power Point presentations ranged from 10 slides during a two hour class to over 100 slides during a three hour class.

Participants consistently seemed aware of the students' needs and took those into consideration. This included giving frequent breaks during long class sessions, or altering the delivery pace of the content to maintain student engagement. Participants did this by alternating between pure lecture formats and having a discussion period, small group learning activities, or movie/visual clips. The two participants who had the least experience teaching used more lecture and had less student interaction, but still monitored student engagement and needs. Participants were also cognizant of the taxing schedule of the students, and acknowledged the need for breaks between classes.

However, none of the participants dismissed the students early by more than 10 minutes so they could have a longer break.

In summary, fifteen categories emerged from the data. These categories include of *expressions of caring, eating our young, interdisciplinary team members, sub cultures in nursing, student sub culture, internal influences, external influences, changes in the culture of nursing, becoming a nurse, internalizing the identity of a nurse, how students learn the culture of nursing, mentors and role models helps students learn the culture of nursing, faculty knowing students, class size, and curriculum*. After confirmation of the categories with key informants, further data analysis revealed seven patterns.

Presentation of Patterns

Once the dissertation chair and the researcher agreed upon the fifteen categories, the categories were presented to participants identified as key informants at both sites as a form of member check. Key informants were selected based on the richness and depth of information they provided during the initial interview, along with the ability to articulate their knowledge related to the interview questions. The confirmation interviews were reviewed by both the dissertation chair and the researcher.

After further analysis, the fourteen categories were condensed into seven patterns. The seven patterns included

1. *Pattern of contradictory descriptors of the culture of nursing,*

2. *Pattern of learning the culture of nursing*

3. *Pattern of faculty student relationships*

4. *Pattern of shaping the culture of nursing*

5. *Pattern of subcultures operating within nursing*

6. *Pattern of transforming into a nurse*

7. *Pattern of continual evolution of the culture of nursing*

Each of these patterns will be presented with quotes from participants to substantiate the pattern.

Pattern of Contradictory Descriptors of the Culture of Nursing

The first pattern revealed upon further analysis of the categories was the pattern of *contradictory descriptors of the culture of nursing.* The data to support this pattern came from analysis of the categories of caring as part of the culture of nursing, nurses eating our young, and descriptions of the culture of nursing. At times, the data in these categories revealed contradictory behaviors within the culture of nursing, manifested most clearly in the categories expressions of caring and nurses eating our young. Participant 4A shared the caring aspect and descriptors of the culture of nursing:

I think values – caring values as far as I think most nurses put that first. You know, some nurses would say they value health, or whatever, but I think the whole caring ethic is a real strong theme in nursing for whatever age group, or wherever nurses work. Probably honesty, you know. I know nurses are one of the most trusted people in the profession. I think the whole responsibility part, being responsible and accountable and having to provide care for people who are vulnerable. . . anybody can do the tasks, but the nurses that really love what they do are the ones that go that little extra step and hold the hand or rub the feet or do those things… That's really what nursing, to me, is all about.

This same participant (4A) saw eating our young, or lateral violence, as emanating from the imperative of caring for their patients.

Sometimes I've worked with nurses before, and they're a little hard on the students, but that even sometimes comes out of that culture of caring, where they're very protective of their patients, and it's hard for them to let a novice student in – but sometimes it makes it seem like they're not always so welcoming or encouraging to nursing students. But I do think it can be a very stressful job.

Pattern of Learning the Culture of Nursing

The second pattern to emerge from analysis of the categories was *learning the culture of nursing*. This pattern was supported by data from the categories of how students learn the culture of nursing, role models and mentors help students learn the culture, and curriculum. All three of these categories addressed students' learning the culture of nursing. Participant 7B's comment best reflects this pattern:

They learn it from the people around them. As a student, it's what we ex – what we hopefully have them participate in, experiences that they have. Definitely the experiences that they have… It's really based on the way they interact, the relationships that they have with either faculty or working nurses, mentors, preceptors. I think that that – it's – to coin that silly phrase it's a lived experience. I really think that it is.

Pattern of Faculty Student Relationships

The pattern of faculty student relationships was the third pattern to emerge from the data, supported by the categories of faculty knowing students and class size. A smaller class size was seen as essential to faculty knowing students. This pattern is best described by participant 3B.

I have the students for three hours for class time, and I have two groups of those. I've got 64 students. I come out at the end of the semester not knowing all their names, and that really bothers me. …. I don't know anything about them. . . . Not only their abilities but who they were as a person. I knew their names, I knew what was bothering them, I knew when they had a family member who was sick. But I don't know that anymore.

Pattern of Shaping the Culture of Nursing

The pattern of *shaping the culture of nursing* emerged from analysis of the categories of internal and external influences on the culture of nursing. The multiple factors that shape the culture of nursing were best addressed by participant 1A.

Externally. Well, there's all kinds of things that are going on right now that are influencing; Benner's book, the Carnegie book, the Institute of Medicine's report, and RWJ's report about the future of nursing education, legislation, public policy. We've been trying for so long to get… prescriptive authority and advance practice. So the external things are that we have enemies, I guess (laughing). People that don't want us to practice at the full scope of our knowledge and our practice. So now we have the DNP, we are trying to come being a change agent and being at the executive levels to be able to influence health care reform from a different angle with different skill set than some of us have. I think we're still trying to figure out ways to be change agents. The clinical nurse leader at the bedside, not a CNS, but trying to influence at the unit based in a generalist way, the quality of patient care and the continuity of patient care. [Interviewer:] You mentioned enemies, can you specifically? [Participant 1A:] Medicine (laughter).

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Pattern of Subcultures Operating Within the Culture of Nursing

The fifth pattern to emerge from analysis of the data was *subcultures within the culture of nursing.* The data to support this pattern came from further analysis of the categories of subcultures and student subculture. Upon further analysis, the category of student culture was seen as a subculture within the culture of academia. Organizational culture, which was originally conceived of as part of the category of external influences to the culture of nursing, seemed, upon further reflection, to be a significant aspect of the pattern of subcultures within the culture of nursing.

Participant 3A identified the unique subcultures of academia and service.

Well first of all, I think there is a culture for the profession of nursing and then I think even within that there are sub-cultures so I'm gonna try to stay at the broad professional culture of nursing. I think for example one of those subcultures is the academic world and the service world and that kind of thing so I think there are these subcultures.

Later in the interview, this same participant addressed these different cultures again.

I think that there are these big differences in our – big differences in the subcultures that the education service gap is the result of the difference in the cultures.

Participant 3A also spoke to student nurses as part of the culture of nursing.

I think nursing students both form the culture and then hopefully take on some of the aspects of the culture that are the good parts, the socialization that we talked about.

Organizational culture was described as influencing the culture of nursing by participant 8B.

> I go to all the different hospitals in Xxxxxx for various committees, and all of them have their own culture. I mean, we have the culture of nursing, which probably provides the foundation for the nurses that work within those agencies, but then, there's a culture of the agencies, too.

Pattern of Taking on the Identity of a Nurse

The sixth pattern to emerge from analysis of the categories was the pattern of *taking on the identity of a nurse*. This pattern emerged from further analysis of the categories of becoming a nurse and internalizing the identity of a nurse. Taking on the identity of a nurse is an internalization of the identity and role of being a nurse, which is separate from learning nursing as a profession. Participant 6B further described this pattern of taking on the identity of a nurse.

> Boy. It's so abstract. It's so abstract, but the ability to, I think, unlike many other professions, it's they're realizing that you're a nurse all the time, that it's not something you can take off. You don't take it off. When you go home from work you can't just take off the uniform of nursing and now I'm not a nurse anymore. . . I think you realize that you see people on the street and you may nurse them. You certainly nurse your family. You certainly nurse your friends, the people around you, your neighborhood individuals may come to you and ask for help because you are a nurse. So I think the becoming is that realization that you really are this. You really embody this particular profession.

Pattern of Continual Evolution of the Culture of Nursing

The seventh pattern to emerge from analysis of the categories is continual

evolution of the culture of nursing. This pattern emerged from further analysis of the

category of changes in nursing culture. This category included generational changes in

the students, changes in teaching learning strategies, and the change inherent in nursing

practice. Participant 3A saw the changes in nursing culture as positive.

I see the culture as evolving. This is a good thing…I think we should always

evolve. So I see it's a culture that in some ways for some people it's being forced

to evolve and then for other people it's a wonderful evolving so I see it changing

and I see it here changing so I like that. And I don't like change any more than a

regular person but sometimes I do I guess.

In summary, further data analysis of the 15 categories revealed seven patterns.

They are *pattern of contradictory descriptors of the culture of nursing*, *pattern of*

learning the culture of nursing, pattern of faculty student relationships, pattern of

shaping the culture of nursing, pattern of subcultures operating within nursing, pattern of

taking on the identity of a nurse, and pattern of continual evolution of the culture of

nursing. Further reflection and analysis of these seven patterns revealed four themes

which are described next.

Presentation of Themes

The fourth phase of Leininger's four phases of data analysis is the identification

and presentation of themes. This phase involves synthesizing patterns, interpreting

findings from previous phases, and presenting major themes and recommendations.

After completing additional analysis and consulting with the dissertation chair, the seven

patterns were condensed into four themes. These themes are: *the culture of nursing is multifaceted, multivalent and at times contradictory; multiple factors, both internal and external to the culture, influence the culture of nursing; nursing faculty believe that the right conditions facilitate the enculturation of students, navigating the subcultures (academia, service and organizational culture) is challenging for faculty.*

These themes are the result of interpreting what the participants were saying from an emic perspective, and presenting the findings using phrases or words that would make the tacit more visible to the etic world. The themes are presented below with supporting patterns and quotes.

Theme One - The Culture of Nursing is Multifaceted, Multivalent and at Times Contradictory

The first theme is *the culture of nursing is multifaceted, multivalent, and at times contradictory.* This theme can best be described as there is no one consistent definition or characteristic to describe the culture of nursing other than the attribute of caring. At times the descriptions of the culture of nursing contradict each other. This theme is supported by data from the pattern of multiple and sometimes contradictory descriptors of the culture of nursing.

While faculty participants concurred overall that the culture of nursing was caring, they also used multiple other terms to describe the culture of nursing. The multiple terms used by faculty participants to describe the culture of nursing include being harsh to newcomers (nurses eating our young), change agents, concerned with quality and safety, and members of interdisciplinary teams. Values expressed as part of the culture of nursing include caring, being holistic, trustworthy, and matriarchal.

Faculty used terms to describe the culture of nursing that at times conflicted with each other and reflected behaviors inconsistent with espoused values, such as caring and nurses eating our young, or being change agents and wanting to preserve traditional teaching practices. Faculty participants were not always aware of these conflicting values.

Half of the faculty participants acknowledged that harsh behaviors and intimidation of newcomers, commonly referred to as nurses eating our young, was part of the culture of nursing, even though they did not approve of this practice. Examples of nurses being change agents provided by participants included the use of simulation and technology as teaching learning tools. Membership on interdisciplinary teams was mentioned by five participants as part of the culture of nursing in addition to being concerned with quality and safety in providing patient care.

During naturalistic observation in the classroom, the exercise of the value of caring could be observed between participants and students, students and students, and participants and the researcher during naturalistic observation in the classroom. Participants demonstrated caring towards students when they asked how students were doing or discussing events important to them such as sports teams or what students did over spring break. They also demonstrated caring when acknowledging that students needed a break during a long day of classes. Students showed caring for each other when they helped their fellow students by providing copies of Power Point presentations or notes, or spending time with fellow students during breaks between classes. The researcher experienced caring by the participants when she was offered a cup of coffee by them, or when they touched base with the researcher during breaks in a class to make

sure the researcher was comfortable. The researcher bracketed these interactions in an attempt to limit the influence of these interactions on data collection and analysis.

Half of the participants spoke of nurses eating our young and saw it as pervasive in the culture of nursing. Faculty saw this practice of intimidation and harsh behaviors occurring between experienced and novice nurses in the service sector as well as between established and new faculty members in the academia, and senior and junior nursing students. While many of the faculty recognized that this practice was in conflict with the espoused value of caring, some just acknowledged the existence of this practice.

Participant 1B described the pervasiveness of the practice of nurses eating our young and how that conflicted with the value of caring.

We sometimes get into situations where the whole reputation for eating our own, it plays itself out in the department. It plays itself out in whatever agency we're a part of that we tend to get into that behavior. And unfortunately, our students get into it really early on when they break into groups and these people are ostracized. And we need to do a lot more to be that caring, unifying body without putting our thumbs on people.

An example of conflicting values was the cultural values of nurses being change agents and the participants' strong desire to maintain established practices of educating nursing students. Multiple faculty spoke of how they tried to maintain established nursing education practices even in the face of changes such as using name cards to know students' names when class sizes increased and maintaining established acute care clinical sites when an increased emphasis on outpatient or community based nursing is evident in the service sector. Two faculty participants acknowledged these

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incongruencies and the need to acknowledge, accept, and work with current changes in the culture of nursing. Participant 3A was aware of these conflicting values and noted the possible origin and result of conflicting values.

> One of the things I see now is in the service subculture because of the economic pressures that they've been under because of the development what's [sic] happened in service over the last ten to fifteen years, tremendous change that they had to move through but they are very comfortable with change. Change is their name. You got to keep changing in the service world. So they've got this whole culture of change and when we look at the subculture of education, of academia, there is not this focus on change. So instead what we value is the tradition of longstanding growth and depth of understanding, that kind of things. So I think that two different cultures have such a different way of approaching it and I don't think that we have a lot of people in nursing that bridge those cultures, those subcultures.

Two participants spoke to the variety of definitions and dimensions in the culture of nursing as almost confusion within the culture. Participant 3B stated

> We can't really separate our group out from the others. I mean, we're so intimately involved with other professions that that certainly shades our perception in our own culture.

Participant 3B had taught in the same BSN program for 28 years, had been a Registered Nurse for 48 years, and had a PhD in an area outside of nursing or education. This same theme is present in this quote from participant 9B, who has taught in a BSN program for only 5 years and has been a Registered Nurse for 10 years.

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I don't think we do a good enough job of explaining why what we do is unique and different from medicine just at a basic bedside level, why is it important to hold somebody's hand while they're dying? Why is it important to swab the mother's head as she's birthing?

Theme Two- Multiple Factors, both Internal and External to the Culture, Influence the Culture of Nursing

The second theme is *multiple factors, both internal and external to the culture, influence the culture of nursing.* This theme can best be described as the social and historical factors originating both within and outside of the culture of nursing that influence the evolution of the culture, within the societal context in which the profession exists. At times, there is tension between these factors. This theme evolved from the patterns of shaping the culture of nursing and continual evolution in the culture of nursing. Social factors included generational differences and demographic changes found in current students.   Historical factors identified by faculty participants included persistence of multiple educational levels for entry to practice, enduring patterns of instruction in nursing education, the tradition of nursing as a female occupation, changes in nursing practice over time, and evolution of the medical profession and its work. Participants also identified the impact of the IOM's *The Future of Nursing* (2010)*,* and *Nursing Education: A Call for Radical Transformation* (Benner, et al, 2010). The identification of these multiple factors reflects participants' acknowledgement of the social context in which the profession of nursing exists, the as well as tension these factors can at times produce. Perhaps more importantly, faculty participants did not address the need for greater diversity in nursing, the direction that the culture of nursing

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should be taking, or that nurse educators could provide leadership for the changes to occur. They simply reflected that the culture of nursing was influenced by various factors.

During naturalistic observation, the researcher noted that changes in teaching strategies recommended by Benner, et al. (2010), including the use of case studies and a move away from traditional lecture format, were slow in occurring. Both study sites were in the process of revising their curricula. Participants at site A mentioned that during the process of revising the curriculum, faculty verbalized a commitment to not using long Power Points and to moving towards conceptual and engaged learning. Participants at site B mentioned how students expect Power Point slides to accompany lecture and sometimes complain when they are not available. While a transition in teaching strategies seems to be in progress, traditional lecture techniques and content laden curricula are still very evident at both study sites and appear to be areas that will be slow to change.

While participants did monitor student participation during class and adjusted their teaching strategies during class to keep students engaged, multiple faculty participants largely employed traditional methods and some used long Power Point presentations; student engagement in those sessions was limited. The researcher observed one faculty participant who used more than 100 Power Point slides in a three hour class session. Participants with more teaching experience were noted to use fewer Power Point slides per class session, but Power Point guided lecture with minimal student engagement was still the predominant teaching strategy used.

Participants also addressed the increasing proportion of men who have entered the ranks in nursing, and how their presence may impact the culture of nursing. However, faculty did not elaborate on what influence a greater proportion of men in nursing might have on the culture. One participant did mention the difference in recruiting men to nursing, such as the Johnson and Johnson nursing ads that show females primarily in nurturing roles such as holding a baby, or caring for the elderly, while recruitment materials for men ask if they are "man enough to be a nurse" (allnursing.com) and show men in various sports attire as well as in scrub uniforms and business suits. The participant wondered aloud how those different messages might impact the values, and in turn, the culture of nursing in the future.

While increasing gender diversity was mentioned as a factor influencing changes in the culture of nursing, racial diversity was not mentioned. During naturalistic observation, both gender and racial diversity were noted to be slow in changing. The majority of students at both study sites appeared to be Caucasian. In classes ranging from 28 to 60 students, fewer than three students per class appeared to be from diverse racial or ethnic backgrounds. This pattern was consistent with the pattern observed in the graduation composite pictures for the last 10 years, which were displayed in the hallway of site A. No graduation composite pictures were seen at site B. There were fewer than five men in each of the aforementioned classes. This lack of racial and gender diversity was also evident among the participants, as all participants who met established inclusion criteria were female, and only one participant who agreed to participate in the study was African American. Based on the websites for each school, site A had one female African American associate dean and one female African American tenure/tenure

stream faculty. One male was listed as an adjunct faculty. At site B, no men and one African American female were listed as faculty in the undergraduate programs. Based on the researcher's review of student posters at site B that were developed during a summer study abroad course, it seemed likely that faculty did encourage the students to learn about racial and ethnic diversity for the provision of culturally competent care. No posters related to racial or ethnic diversity were noted at site A.

Tensions that these factors produced and noted by the researcher during naturalistic observation and interviews included those primarily related to social and historical factors. None of the faculty participants taught the clinical aspect of the course, yet nursing is a practice profession that values professional ownership of one's practice. Participants from both sites stated that university administrators wanted doctoral prepared faculty teaching in the classroom reaching a larger number of students than would be possible if they were assigned to smaller clinical groups. This practice neglects the importance of the practice aspect of the discipline and defers to the preferences of non-nursing academic administrators on a decision that should made by members of the discipline. Participants also did not overtly acknowledge their role as leaders in influencing the culture of nursing. Several participants acknowledged the challenges involved in maintaining active involvement in nursing practice while teaching; they also verbalized strategies they used to overcome this limitation, such as being active in service over the summer when classes were not in session, or only on weekends.

Other examples of tensions between historical and societal factors noted by the researcher related to gender and racial diversity within the profession of nursing and teaching strategies. While society values aspiring to a profession regardless of gender or

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race, and the number of male nurses is slowly increasing, nursing continues to be influenced by a historically dominant Caucasian female population. This was seen in both the student and faculty population. Participants did not mention racial diversity as a factor influencing the culture of nursing though it is one advocated by both society in general and by leaders in professional organizations such as the AACN. Advances in technology have provided multiple formats and strategies to educate students successfully, yet during observation, technology was noted as a secondary aspect in teaching strategies with lecture the still predominant format used in the classroom.

Participant 2A captured many of the values and factors that influence the culture of nursing in this quote:

So a lot of the young little candidates that we have are from very, very conservative environments… they are much more saucy student. Much more self-directed. Many of them can put our faculty, without technology skills, in a spin because they can do all these do-dads. And it's just a different world… they're going to be what is going to be change. They are not going to get their Ph.D. when they're 50. . . And they are not going to stand up, when physicians come into the room. They're not going to do that because that's culturally not the norm anymore. And it's certainly not the culture.

Theme Three: Nursing Faculty Believe that the Right Conditions Facilitate the Enculturation of Students

The third theme is *nursing faculty believe that the right conditions facilitate the enculturation of students*. This theme can be described as an overall agreement that bringing students into the culture of nursing is part of the role of nurse educators and that

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the right conditions are necessary to fulfill this role. The right conditions reflect a fairly traditional perception about the culture of nursing. This theme evolved from further analysis of the patterns of learning the culture of nursing, faculty knowing students, and taking on the identity of a nurse. Faculty asserted that the right conditions were necessary for them to fulfill this role. If the right conditions were not available, faculty participants developed strategies to overcome what they perceived as those deficits. The right conditions necessary for students to learn the culture of nursing effectively include the right learning experiences, mentors, role models, curriculum, and class size, as well as the ability of the faculty to know the student, the personal characteristics of a student, and students being able to take on the identity of a nurse.

Life experiences believed by faculty participants as necessary to share with students who are learning the culture of nursing included an awareness of the gradual process that occurs in "becoming a nurse," consciousness of their membership and role in interdisciplinary healthcare teams, the importance of faculty knowing the students and students knowing faculty, the impact of class size on these relationships, and the curriculum. The faculty participants also spoke of the necessity for these shared experiences to be the correct ones. They talked of the right faculty-student relationship, the proper class size, the desired learning experiences, the right curriculum, the desired personal characteristics of the students, and the correct type of mentors and preceptors as elements for students to learn the culture of nursing.

Gradual process of "becoming a nurse." The participants shared that becoming a

nurse was a gradual process that evolved over the time the students were in the nursing program. Participants believed that some students arrived with 'the right characteristics' to become a nurse, while others needed more help in developing the right characteristics to become a nurse. Caring was the most frequent characteristic mentioned by faculty participants that students needed to possess. Participants did acknowledge that more people were entering the profession of nursing for reasons other than being altruistic, yet were still successful in becoming a nurse. Intelligence was also a desired characteristic mentioned frequently by the participants that was necessary to become a nurse. Two faculty participants spoke of the need to admit students who did not fit the expected or ideal characteristics of faculty, as a means of changing the culture of nursing. One of these two participants was explicit in stating that admitting students who had a more questioning or entrepreneurial spirit would help change the culture and produce more leaders in nursing.

The proper learning experiences were also seen by participants as required in helping the students become a nurse, or learn the culture of nursing. The most frequently mentioned experiences were in the acute care setting, though a quarter of the participants did mention the importance of including experiences in out-patient or community based settings. Participants were not explicit in what constituted the right learning experiences, other than that the experiences helped the students learn the content of the course, but did acknowledge the difficulty in finding clinical sites that provided the right experiences. Participants placed more emphasis on having the right mentor or preceptor for the students, and acknowledged that the finding a good mentor for the students was difficult. One participant shared that faculty could be mentors, but not all faculty were good

mentors. Overall, faculty did value and acknowledge the important role clinical preceptors played in the student becoming a nurse and learning the culture of nursing.

Roles in interdisciplinary teams. Faculty participants also thought it was important for students to learn about their role in interdisciplinary teams as part of learning the culture of nursing. The right mentor or preceptor and the right learning experiences facilitated this process. Participants did not mention that interdisciplinary teamwork was part of the right curriculum, and the researcher did not have access to curricular documents. However, it was highly valued by participants and deemed a necessary concept for students to master. One participant from each site stated that it was important to know your own professional culture (i.e. nursing) when working with other professional cultures on an interdisciplinary team. Two different participants, one from each site, mentioned that respect for other members of an interdisciplinary team was important. The value of respect could also be considered one of the 'right characteristics' of student nurses and one of the 'right learning experiences' students should have in the nursing program. Having the 'right mentor or preceptor' could facilitate the student learning the importance of the role of the nurse on interdisciplinary teams.

Faculty/student relationships. The right faculty student relationship and the right class size are inter-related, with faculty participants speaking of them together. Faculty participants consistently valued and believed that the right class size and relationship between the faculty participants and students were necessary for students' learning. Participants saw both of these as essential to the student learning the culture of nursing. Class sizes that were too large hindered the ability of participants to know the students at a personal level, which they saw as a necessary part of their role in

enculturating nursing students. When asked, participants thought that 24-28 was the right

class size. They also all affirmed that a class size of 60 was too large to adequately know

the students and having the right relationships. Knowing the students included knowing

something about them outside of their role as nursing students, such as knowing about

their families, their background, and how students spent their time outside of the

classroom. Participants frequently mentioned how much they missed the smaller class

sizes, and how helpful it was to know the students as individuals and be able to establish

relationships with them. During naturalistic observation, the researcher noted

participants using name cards at the students' seats, and participants chatting with the

students as a means to know the students as individuals.

Participants also spoke of having the type of relationship with students that they

had with their nursing faculty, and students of today learning in the same way that they

had learned. Faculty participants expressed the importance of seeking the same qualities

that they found beneficial in mentoring relationships when looking for mentors or

preceptors for their students. These appeared to be practices and experiences considered

normative by faculty. They did not refer to any expressed philosophy of nursing

education guiding these decisions but appeared to rely more on their own past experience

to determine what constituted what was "right."

Participants shared their perceptions that nursing students should have the right

characteristics. Faculty participants are more able to establish the right relationships with

students who had the right characteristics. Students with the right characteristics included

those who were caring and altruistic, liked working with people, and intelligent.

Participants at both study sites acknowledged the high grade point average required for

students to be considered for the competitive admission process to the nursing curriculum. During naturalistic observation the researcher noted that students seemed very concerned about their grades, and would ask for a review of exam or quiz questions for an increase in their scores. While students appeared to be comfortable challenging faculty participants about their grades, they seldom disagreed or questioned comments made by faculty participants regarding topics or concepts.

The right curriculum. Unbeknown to the researcher during site selection, both schools of nursing were undergoing curriculum revision during the period of naturalistic observations and interviewing. Multiple participants spoke of the additional stress this created for them, and the need to have the "right" curriculum to facilitate students learning the profession and culture. While revising the curriculum was challenging and time consuming, faculty participants expressed their awareness that this was necessary to adapt to social and professional influences impacting both students and faculty. The social influences participants perceived to be important included generational characteristics, related changes in learning style and preferences of the students, the vast amount of rapidly changing knowledge in the discipline, and input from the students and their perceptions of preparation for practice.

It appeared that faculty participants had input into deciding what the desired curriculum was, and were able to verbalize what constituted the right curriculum. Participants did not elaborate on whether there was just one right curriculum or what determined if the curriculum was right. However, there was some dissension among faculty on how to design the new or "right" curriculum. One participant expressed dismay that more of the new curriculum was not community based. She shared her

observation that the majority of faculty resisted moving certain content, especially pediatrics and mental health, away from an acute care setting to a community based setting. Another participant spoke of the struggle but necessity to move from a medical model of presenting content based on medical specialty, to one based on nursing concepts. A nursing concept based curriculum was viewed by this participant as recognizing and promoting the unique body of nursing knowledge and better representing nursing's role in health care. This demonstrates that while nursing faculty are open to changing aspects of how students learn the culture of nursing, there is still a strong tendency to hold onto aspects of the culture that traditional, highly valued and cherished, or deemed "right" by faculty members.

During naturalistic observation, the researcher also observed storytelling was a teaching strategy frequently used by faculty participants. Participants would often share clinical examples from their own practice to demonstrate a concept being discussed, and included their thoughts and feelings in addition to facts surrounding the incident. Students listened attentively to the stories and often asked questions about the outcome of the story as they appeared to enjoy learning from these stories. The stories included both positive and negative outcomes from the participants' perspective. It appears that storytelling was considered an appropriate teaching strategy within both curricula.

Multiple participants also discussed the importance of having the right mentors and preceptors for students. None of the participants interviewed were currently teaching in a clinical setting, but almost half had in the past. Participants saw developing a strong relationship with clinical preceptors, who often worked under the supervision of onsite clinical faculty, as critical. These preceptors and adjunct clinical faculty served as a role

model for students, though they did not always role model what was taught in the classroom. Faculty participants spoke of preceptors "taking shortcuts," or telling the students "this is how we do it in the real world," which often conflicted with what was taught in the classroom or while learning a nursing intervention in a skills lab on campus. The fact that students were exposed to this conflicting information troubled participants, however most appeared accepting of it and tried to explain to students how these differences could co-exist.

Participants noted that nursing faculty also served as role models, though one participant said that not all nursing faculty were good role models. Role modeling of expected behaviors and decision making strategies was observed during naturalistic observations. Participants demonstrated respect, care, and concern for students, and started class on time in the classroom. They also would ask students questions, solicit their input, and then share how the participant would approach the question or problem. The researcher heard some faculty make their thinking explicit, explaining why they considered some information but ignored other available information when deciding on a course of action or answer. This is a practice endorsed by Benner, et al. (2010) as a method of enhancing student learning and reforming nursing education.

Participant 3A alluded to what the faculty perceived as the desired way to learn the culture of nursing when discussing what she shared with nursing students at orientation.

I say this is what the nursing program is like and the expectations here are not like the expectations in your English classes and I want to let you know, not because that's better or worse, but because it's different… because many times the difference is due to what we see as the importance in the profession. That when

you go in the hospital, for example, when you're dealing with someone that [sic] is dying, you need to be able to act a certain way and this helps prepare you for that. So I try to be very deliberate in that this is what the profession means.

Participant 7B best summed up this theme when she said

We're working on a new curriculum and we're saying it's …about trying to help them be a nurse, not just do nursing. And I think that that comes from within, but it's up to us to somehow create that.

This was reinforced by participant 7A who stated

When somebody comes in, they're not aware of certain things. But as you teach them, or you provide them with facilitation on how to look at things in certain perspectives, you help them change their opinions. So you are helping them to change the way of perceiving things. You're helping them to view things with different lenses, and you're helping them to learn to be adaptable to various situations.

This participant had been a nurse educator for 30 years, and had earned a PhD in nursing.

Theme Four: Navigating the Subcultures (Academia, Service and Organizational Culture) is Challenging for Faculty

Theme four *is navigating the subcultures (academia, service and organizational culture) of nursing is challenging for faculty*. This theme describes the frustrations and challenges faculty experience as they function and exist between various subcultures within nursing. These subcultures include the subcultures of academia, service and organizational culture. This theme is supported by the pattern of the subcultures within nursing. The many subcultures identified by faculty participants include the subcultures

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of academia which includes a subculture of students, practice, and to a lesser extent, the varying yet distinctive characteristics of organizational culture. When asked to describe the culture of nursing, faculty participants often asked which culture the researcher was referencing, or identified subcultures they saw within the larger culture of nursing. Faculty also expressed frustration and challenges as they discussed their attempts at balancing the cultures of academia, students and service in fulfilling their role as nurse educators.

As they were trying to explain these various subcultures, faculty participants manifested some difficulty expressing their ideas. They often hesitated and made gestures with their hands trying to show how the subcultures they perceived might be related. During interviews, the participants would verbalize uncertainty or confusion regarding which culture they would address, or state how stressful it was to consider the influence of all of these subcultures on the role of a nurse educator.

During their interviews, the subculture of academia was mentioned most often by faculty participants. This seemed to be the primary subculture of which the participants were conscious. The subculture of academia held some common attributes of the culture of nursing, and differed in others.

During naturalistic observation, the researcher noted what appeared to be normative practices in the academic cultures of both sites. Participants referred to normative practice of holding office hours for appointments with students and others, the ebb and flow of the pace of the semester for both faculty and students in academic settings, as well as the academic social conventions calling for students to address them as professor or doctor when appropriate. Participants observed that students felt free to

call adjunct clinical faculty by their first names and did not have to use the term professor; one participant believed this strengthened the dichotomy between service and education.

The student subculture in academia was evident to the researcher, and addressed by faculty participants at both settings. The student subculture included attire, foods consumed, use of technology, and general behaviors of students. Some faculty participants related differences in the student subculture to how the younger generation viewed authority, their preferred learning styles, and the experience of being a college student. Participants acknowledged that very few students were same as the "traditional" student of years past. According to the participants, students in years past seldom had work or family responsibilities, and devoted the majority of their time to learning and school related activities. This perception is confirmed by Astin (1998). Participants also observed that many students today had multiple responsibilities outside of school, including work and family or childcare matters. These outside responsibilities were seen as adding stress to students, which participants observed in their classroom behaviors and how they approached faculty. The experience of being a college student involved using a great deal of technology, being focused on their own needs, and a less formal relationship with faculty.

Students at both study sites dressed in casual attire. The majority of students wore jeans and some type of shirt or sweatshirt, often with the name of the university on one piece of clothing. Students all carried backpacks and many carried lunch bags and had bottles of sports drink, water, or juice at their seats. Frequently, men in the class wore baseball caps, with the names of sport teams or the university on the caps.

Occasionally, students would be wearing khaki or dress pants and a dressy top, especially if they were giving a presentation. Students would often put their cell phones on top of their table at the beginning of class but the researcher seldom heard the phones ring. Approximately 1/3 of the students used laptop computers, and at times had social networking sites on the computer instead of course documents. Students appeared to take pride in the appearance of their settings, disposing of trash and returning tables and chairs to the original positions when finished with the class.

The attire of the students contrasted with that of the faculty participants. Participants were dressed professionally when teaching, wearing skirt sets, dresses, dress slacks and blazers, and dress shoes. The researcher never saw a cell phone used or handled by participants but did note that participants at both schools often wore lanyards around their neck with keys and/or name badges identifying them as faculty. During Summer Semester, participants were noted to dress in a slightly more casual manner, wearing lighter weight dresses, skirts and tops. When faculty participants had trouble with technology during a class, students were often the first to offer suggestions on how to correct the problem. Participants would sometimes follow the suggestions, but often called for assistance from the university technology departments.

The subculture of service was addressed by faculty participants in both positive and negative terms. Virtually all faculty participants also spoke of the time demands and expectations of academia, including teaching, service, and research and the difficulty of balancing these multiple demands on their time. Participants who spoke of the service subculture the most were either educated at the MSN level or had a DNP. Those with a MSN had the shortest amount of experience as a nurse educator, and still worked

weekends or summer in the service sector. The participant with a DNP was educated with an emphasis on practice, and had taught at the BSN level for 10 years. The shorter time frame in academia and type of degree may have influenced these participants' relatively stronger connection to the subculture of service over the subculture of academia. Participants educated at the PhD level did not teach any clinical courses and tended to speak of service in more general terms, or mentioned that they had not been in the service setting for a long time. One participant at each site mentioned that it was the wish of university administrators that PhD prepared faculty teach lecture content and not teach clinical. Faculty participants stated that administrators' rationale for doctoral prepared faculty teaching primarily in the classroom was the lower faculty/student ratio there, as opposed to the higher faculty/student ratio required in clinical.

The subculture of organizations or of organizational culture was mentioned the least by participants. Two participants, one from each study site, compared the organizational structure and culture of the service sector to the organizational structure and culture of academia, comparing the dean or director to the chief nurse officer in a service agency. Participants mentioned the organizational culture of academia more often that the organizational culture of service. Participants also saw the recent economic recession as influencing the organizational culture of both academia and service. Organizational culture within academia was also seen as a factor in how participants communicated with fellow faculty members, dean or directors, and students. The organizational culture within the academic unit was evident to the researcher when making provisions for naturalistic observation, from arranging parking to interaction with

other staff such as secretaries. Participant 7B best addressed these multiple perspectives with her statement,

> You have – in a university setting you have service and scholarship and students. And so you have all of these things that you have to get done and committees that you have to get done.

 Participant 9B shared her thoughts on how students might see the faculty in these multiple subcultures.

> A lot of it seems like they're [students] almost discrediting you because you're not a full-time practitioner and you're not a full-time bedside nurse. You're just in your ivory tower with your research doing that sort of thing ….well, I do practice, but I only practice in the summer because you consume my time in the winter. . . To go into work at 12 and to not be available by email or phone call or to go to a clinical site when stuff is happening, is not possible for the role that I have at this point in this program.

Summary

Sixteen participants from two BSN schools of nursing participated in this study. Their recorded and transcribed interviews were analyzed, along with data from naturalistic observations in an attempt to answer the research questions: What are nurse educators' perceptions on the culture of nursing and how do they bring students into that culture? Leininger's (1991) four phases of data analysis were followed, with data analysis occurring simultaneously with data collection. Fifteen categories were revealed in the raw data. These fifteen patterns included expressions of caring as part of the culture of nursing, nurses eating our young, interdisciplinary team members, how

students learn the culture of nursing, mentors and role models help students learn this culture, becoming a nurse, internalizing the identity of a nurse, internal influences to the culture of nursing, external influences to the culture of nursing, subcultures within the culture of nursing, student culture, faculty knowing students, curriculum, class size, and changes in the culture of nursing.

The categories were then further analyzed, revealing seven patterns. The patterns included the pattern of contradictory descriptors of the culture of nursing, pattern of learning the culture of nursing, pattern of faculty-student relationships, pattern of shaping the culture of nursing, pattern of subcultures operating within the culture of nursing, patterns of taking on the identity of a nurse, and pattern of continual evolution in the culture of nursing.

Upon further analysis, these seven patterns revealed four themes. These themes are: the culture of nursing is multifaceted, multivalent and at times contradictory; multiple factors, both internal and external to the culture, influence the culture of nursing; nursing faculty believe that the right conditions facilitate the enculturation of students, navigating the subcultures (academia, service and organizational culture) is challenging for faculty. The implications of these themes and findings will be discussed in chapter five.

Chapter 5

Introduction

Analysis of the interview transcripts, artifacts, and field notes followed Leininger's four phases of data analysis. Analysis of interview transcripts included the identification of categories, patterns, and themes. This chapter discusses the findings and themes revealed during data analysis in greater detail, including how the themes relate to the culture of nursing, current nursing literature and the research questions. Discussion of the conceptual connection of the themes, and the implications of the findings for nursing theory, education, practice, research, and policy follow.

Discussion of Themes

This focused ethnography examined a particular aspect of nursing culture- nursing faculty perceptions about the culture of nursing and the work role of academic nurse educators vis-à-vis their students. It was undertaken to answer the following research questions:

1. What are nurse educators' beliefs and perceptions about the professional culture of nursing?

2. Given their perceptions of the culture of nursing, what do nurse educators perceive as their role with students?

During analysis of interview data, four themes emerged. These themes were: *the culture of nursing is multifaceted, multivalent and at times contradictory; multiple factors, both internal and external to the culture, influence the culture of nursing; nursing faculty believe that the right conditions facilitate the enculturation of students, navigating the subcultures (academia, service and organizational culture) is challenging for faculty.*

Each theme is presented below in more detail in relation to the attributes of culture, and the extant literature.

In this study, culture was generally defined to be the shared beliefs, values, attitudes, knowledge, norms, and assumptions transmitted from experienced members of the group to novices. The culture of nursing in this study was identified in terms of the attributes of culture and of the nursing profession in a particular society (Leininger, 1994). These attributes of culture were further defined as follows:

- Patterns and normative practices: "learned behaviors and …accepted characteristics of a culture that are today generally accepted" (Freed, & Freed, 1992, p. 476). Leininger (1995) defines norms as rules (1995, p. 209), so in addition to being learned and accepted, normative practices are also those caused by either formal or informal rules.

- Values: "enduring ideals or belief systems to which a person or society is committed" (Ludwig, & Silva, 2000, vol. 3).

- Learned and shared life experiences: those experiences that are passed on from established members to novice members (Leininger, 1994).

- Symbols: physical representations of value or beliefs

Although each attribute of culture is defined separately, all of the attributes are intimately connected, with overlap between the various attributes of culture. Each of the four attributes of culture (patterns and normative practices, learned and shared life experiences, values, and symbols) that are inherent in Leininger's definition of culture was reflected in the interview responses of the faculty participants and in the course of naturalistic observation, as described in chapter four. Further, faculty participants'

agreed without exception that the field of professional nursing qualifies as a unique

culture because these attributes of culture are manifest in a distinctive way in nursing.

Following is a discussion of theme one as it relates to the various attributes of the

definition of culture used for this study.

Theme One: The Culture of Nursing is Multifaceted, Multivalent, and at Times

Contradictory

   Patterns and normative practices. The first theme that emerged from analysis

of interview data, *the culture of nursing is multifaceted, multivalent and at times*

contradictory, reflects the participants' awareness of the various attributes of culture,

particularly the patterns and normative practices and values of the members. Normative

practices identified by study participants included caring, eating our young, going above

and beyond, focusing on the safety of patients in their care, and being a part of

interdisciplinary teams.

   All participants stated that caring was characteristic of the culture of nursing.

Other words similar to caring, such as empathy and nurturing were also used in

conjunction with caring. Participants saw caring as pervasive, occurring between nurses

and patients, faculty and students, students and their patients, and students and students.

Caring is certainly part of the heritage of the nursing profession and a word often used to

describe nursing (Wagner & Whaite, 2010). "Nightingale's attributes of a 'good nurse'

and the caring relationship are continuing threads woven throughout the current

profession of nursing" (Wagner & Whaite, 2010, p. 231). Leininger (1991) and Watson

(2008) also claim caring to be central to the identity of nursing. According to the AACN

Essentials (2008), graduates of a baccalaureate nursing program should "practice from a

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holistic, caring framework" (p. 8). As such, it is not surprising that the word *caring* surfaced so frequently when participants were asked to describe the culture of nursing.

However, the notion of caring as the primary identity of nursing is contested in the nursing literature. Lysaught (1970) asserted that the idea of caring as the central construct of nursing de-emphasized the vast amount of knowledge and skill required in the profession. He did not believe that a nurse could possess the scientific knowledge and skills necessary to be a nurse and still be caring; these were two opposing skill sets. Caring was also seen by Lysaught (1970) as a feminine characteristic that kept the nursing profession oppressed by the male dominant medical profession and reinforced the handmaiden image of nursing. However, others observe that the assertion that nurses can only be either caring or knowledgeable-skillful neglects the fact that both are required of modern nurses and the growth of the profession over the years (Benner, et al., 2010). Nurses need extensive knowledge of science, technology, communication and relational skills to provide safe quality care to their patients. "Typically in professional fields, as the technical and instrumental nature of the knowledge and skilled know-how increases, so does the need for effective communication and relational skills" (Benner, et al., 2010, p. 24).

"Eating our young" was the second most frequent term used by participants to describe a common practice in the culture of nursing. Eating our young is a concept addressed in the literature and refers to more experienced members of a group (nursing) harassing or intimidating newer members of the group. One participant viewed eating our young as a demonstration of nurses caring for their patients, and protecting them from potential mistakes of students. However, this harassing or intimidating behavior

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was also observed by participants to extend beyond the clinical setting. Participants noted that it occurs among senior and junior faculty, and between senior and junior students.

Other descriptors of patterns and normative practices in the culture of nursing used by participants seem to be related conceptually to the core practice of caring. Some participants characterized the culture of nursing as matriarchal; a term that traditionally embodies the orientation to caring that is ubiquitous in cultures everywhere. Others observed the consistent concern of nurses for the safety of patients and the quality of their care, another attribute of the culture of nursing since Nightingale and re-energized by the IOM's inquiry into factors affecting the quality of contemporary health care (IOM, 2001). Several participants observed that nurses are known as trustworthy individuals and that nursing is a trusted profession. Finally, participants characterized the culture as composed of members who "go above and beyond" by which they meant they do more than expected or required in a given situation.

Interprofessional teamwork, communication and collaboration are included in the AACN's *Essentials for Baccalaureate Education* (2008). The Institute of Medicine (2003, 2011) also calls for interdisciplinary team work and education as a way to improve the quality of patient care. However, the education of the various health professionals often occurs in isolation.

There is generally a great lack of understanding among the professions for what each profession does, its level of training and education, and its existing or potential competencies …This situation is exacerbated by the fact that in the vast

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majority of educational settings, health professionals are socialized in isolation. (Institute of Medicine, 2003, p. 79)

A collaborative effort by the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges and the Association of Schools of Public Health led to a 2011 report listing core competencies for interprofessional collaborative practices. These competencies also call for Registered Nurses to be educated with other health disciplines to facilitate effective communication and collaborative practice. Faculty participants' interview responses reflected their endorsement of interprofessional team work as part and parcel of the culture of nursing, however this aspect of the culture was not observed.

This multiplicity of terms used to describe patterns and normative practices in the culture of nursing reflects the multiple aspects of the culture of nursing perceived by the faculty participants. However, many of these terms relate more to the role of the nurse, or "what nursing does." While "what nursing does" can and should change to adapt to changes in environments, demographics and advances in technology and practice, "who nursing is" or the core culture of nursing, should stay fairly constant. Cultures can and do change over time, usually in response to events within the culture or forces outside the culture. While caring seemed to be the constant description of the culture of nursing, the question that remains is whether caring alone is the most effective descriptor of the current culture of nursing.

Values in the culture of nursing. Another dimension of the definition of culture used in this study is values. "Cultural values refer to enduring ideals or belief systems to

which a person or a society is committed" (Ludwig, & Silva, 2000, vol. 3). The values central to a culture can be discovered in a number of ways that include listening to members tell of values they espouse. The patterns of behavior observed or the normative practices of members of the culture provide more persuasive evidence of the values being lived out in any culture. Values of a culture can also be inferred on the basis of behaviors that are repeated and seen as typical or acceptable. In this study, faculty participants identified several normative practices, some of which were consistent with the values believed to be espoused by members of the culture, and some of which were not. These values were observed during faculty-student interactions in the classroom and were also shared by faculty participants during interviews.

Caring was seen as the one endearing value to which every faculty participant was committed. Yet half of the participants also described the normative practice within the culture of nursing of "eating our young." This would seem to be a practice contrary to the value of caring, representing either a behavior inconsistent with the central value of caring or a conflicting ideology. There was some evidence that the prevalence of this practice represents the embeddedness of a contrary value in the culture of nursing, and as such, a conflicting ideology. The majority of participants spoke disapprovingly of the practice of "eating our young," and stated that this behavior needed to stop as it was the opposite of caring. But one participant wondered aloud if lateral violence was a type of rite of passage within the culture of nursing that everyone needed to experience to be included in the culture.

Rites of passage are considered rituals in cultures (Leininger, 1995), with life cycle rituals being especially important as they "provide a sense of cultural identity, self–

esteem, and often reflect new roles or status for people in the culture" (Leininger, 1995, p. 133). If "eating our young" is indeed seen, even subconsciously, as a rite of passage, nurses may consider these behaviors as a means of bringing novice members into the culture, and therefore an essential cultural practice to continue. This may explain why "eating our young" continues to exist in a culture that is largely characterized as caring.

The only normative practice that participants identified that was not observed in practice was interprofessional teamwork. It is possible that this espoused value was put into practice at times other than when the researcher conducted naturalistic observation. The fact that there is such a high congruency between values mentioned in interviews and those seen during naturalistic observations confirms that the values espoused by participants are true values which are not only part of the ideal culture but also part of the manifest culture (Leininger, 1994). The fact that faculty participants did not consistently identify other values considered essential for baccalaureate prepared nurses, such as social justice, human dignity, autonomy, and integrity (AACN, 2008) was a noteworthy omission and points to an area for possible future investigation.

Symbols in the culture of nursing. Symbols are objects or arrangements of objects representative of the values and beliefs of a culture. Patterns of behavior can also be considered symbolic. Symbolism is one way that cultures are shared, communicated and guide how people interact (Kaminski, 2006). The symbolism apparent to the researcher during naturalistic observations varied. It included teaching-learning strategies such as Power Point slide presentations and the use of smart carts, as well as characteristics of the work environment, such as classroom arrangements, wall hangings, and documents that faculty participants considered important.

Faculty participants consistently voiced a desire for interactive and engaged learning by the students as espoused by Benner, et al. (2010). This expressed value was at times in conflict with the instructional behavior observed that involved the use of lengthy Power Point lectures during which students would passively take notes and exhibit minimum interaction with the instructor or with their classmates. While classroom arrangements often included a middle aisle, faculty participants, especially the less experienced faculty, would often stay to the front of the classroom close to their notes and not use the middle aisle to interact with or engage students.

The composition of a group can also be interpreted as symbolic. While faculty espoused the value of more men in nursing, graduation composite pictures hanging on the hallway walls did not reveal that this value had been actualized. The gender distribution of the faculty, current students, and alumnae/-i of both programs could be symbolic of the historically prevalent cultural and professional assumption that females are more capable of enacting a core value of the profession, caring.

Faculty participants often referred to recent major books and reports related to nursing education in a way that suggested they would become symbolic. Publications by Benner, et al. (2010) and the IOM (2011) were hailed as important documents embodying expressions of a desired future for nursing, yet the based on the researcher's observations, the suggestions and values promulgated by these authors were not consistently implemented.

Summary. Some of the cultural patterns and normative practices identified by participants and the values reflected in those practices are the same role characteristics deemed essential for the registered professional nurse in the AACN (2008) *Essentials of*

Baccalaureate Education. These include caring, an orientation to safety and quality, and membership on interdisciplinary team members. Both study sites were schools of nursing accredited by the Commission on Collegiate Nursing Education (CCNE), the accrediting body of the AACN. None of the participants used the language of the American Nurses Association (ANA) *Social Policy Statement* (2010) which defines nursing as "…the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (p. 10).

One glaringly contrary value to those defined essential by the profession and also very contrary to the highly esteemed value of caring is "eating our young," which seemed not only prevalent, but persistent. "Eating our young" appeared to be an enduring normative practice in nursing. Multiple faculty participants commented on this aspect of the culture of nursing. Interdisciplinary team work can also be seen as a normative practice, based on the importance placed on this by faculty participants. It also appeared to be something that faculty participants valued, as they spoke of interdisciplinary team work as a desirable and indeed necessary part of the nursing role.

Theme Two: Multiple Factors, Both Internal and External to the Culture, Influence the Culture of Nursing

The second theme is *multiple factors, both internal and external to the culture, influence the culture of nursing.* Historical and current contextual factors represent the societal influences on a culture, as well as the influence of a culture on society. The persistence of multiple educational levels for entry into practice, the history of nursing,

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the strong influence of medicine, and the still dominant female composition of the nursing profession represent the values, normative practices and shared life experiences of the faculty participants

Faculty participant interviews revealed that they represented the many entry points to the profession of nursing. Though there is evidence to support that baccalaureate prepared nurses have positive effects on patient outcomes (Aiken, et al, 2003; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005), the varying educational levels for entry to practice have been a topic of debate in nursing that began in the mid 1960's and continues to this day (Benner, et al., 2010) in spite of the fact that the ANA supported the BSN as the preferred level of education for entry into practice in mid 1960s and reaffirmed this position in 1985. The persistence of this practice suggests that requiring the BSN for entry into practice is not yet a common value within the culture of nursing.

Participants expressed their beliefs that the culture of nursing overall and that nursing education in particular were changing, and specifically mentioned two recent publications regarding nursing education such as *The Future of Nursing* (IOM, 2011) and *Educating Nurses: A Call for Radical Transformation* (Benner, et al., 2010). During interviews, the researcher noted that participants accepted the analysis offered in and the challenges posed by the authors of these publications and affirmed the need for the culture of nursing as well as nursing education to change. One of the changes recommended by Benner, et al. (2010) included moving away from content laden lectures and Power Point presentations and towards using unfolding case studies to teach nursing practice. While participants from both sites acknowledged this recommendation and

verbalized a desire to change from a passive to a more active teaching strategy, naturalistic observation revealed that the use of content heavy lecture and Power Points was still a pervasive practice.

Another teaching/learning strategy advocated by Benner and colleagues (2010), the use of case studies, was implemented on a limited basis. Faculty participants often shared stories related to the day's topic that was based on the faculty's experience. These stories lacked the qualities of an unfolding case study proposed by Benner, et al., (2010), and involved more passive listening on the part of the student than active engagement in solving the problems presented in the story. The one transformation in nursing education recommended by Benner, et al. (2010) that was observed by the researcher was faculty reminding students of the growing emphasis on the need for lifelong learning. However, based on teaching learning strategies observed, the researcher wonders if students were learning the skills necessary to achieve this outcome.

The enduring female, Caucasian demographic within nursing, as noted in composition of the current classes of students and historically in graduation class composite photographs at site A, reflects normative practices of the culture of nursing as this practice still occur. Men constitute only 6 percent of all Registered Nurses in the state of Michigan (Michigan Center for Nursing, 2009).

The need for increased diversity of students in baccalaureate nursing programs has been identified by leadership in the AACN (2011) as well as Benner, et al. (2010) and the IOM (2011). Increasing the diversity among nursing students leads to an increased diversity in the service sector, creating a nursing workforce that more closely resembles the population it serves. Increasing the diversity of the nursing workforce is also a

standard cited in the National Standards on Culturally and Linguistically Appropriate Services (2007) to improve culturally competent care. Both schools of nursing that served as the setting for this study were located in areas of the state with diverse populations, including minority populations (Asian, African American, Hispanic) that ranged from 33% to 53% of the total population (Quick Facts, US Census Bureau, 2010). Though the CCNE as a credentialing body of the AACN has had significant influence on baccalaureate nursing education policies and procedures including a policy statement on diversity in nursing education (2001), it appears that this is one area where participants have not yet responded to the call to change course.

Among the many influences to the culture of nursing, the value of providing holistic care and considering the needs of the patient from multiple perspectives has evolved in importance (AACN, 2008). Although enriching to nursing, assuming these multiple perspectives can lead to an overlap of interests and between nurses and providers from other health care disciplines such as medicine, social work, and physical therapy. Medicine in particular has historically had and continues to have a strong influence on nursing, as physicians were once the educators of nurses. Medicine has also been criticized roundly as restricting the ability of nurses to practice to the full extent of their knowledge (IOM, 2010). Frequent interaction with and the overlapping of areas of responsibility of nurses and other health care professions may account for the sense participants expressed that there are multiple influences to the culture of nursing (Fawcett, 2007).

Faculty participants' interview responses reflected their view that the culture of nursing was more reactive or responsive to various influences or factors rather than

proactive. In this study, faculty participants, overall, did not provide a clear statement of or communicate a sense of the direction that the culture of nursing should be taking, or where the profession should be going. They also did not describe the leadership role of nurse educators in promoting change. In their responses, they simply reflected that the culture of nursing was influenced by various factors.

Summary. Cultures are always in a state of evolving, though core values and beliefs change more slowly than the more surface aspects of culture (Kaminski, 2006). The faculty participants in this study acknowledged and named many factors that influence the culture of nursing and are part of its cultural evolution. These factors included multiple educational levels for entry into practice, the history of nursing, the strong influence of medicine, and the still dominant female composition of the nursing profession.

When studying cultures it is important to note not only what is said or observed, but what is also not said or observed. It is interesting to note that nurse educators did not name themselves as a factor that influences the profession of nursing, nor did they name the impact of growing racial or ethnic diversity or health care reform on the culture of nursing. The majority of observations revealed an orientation to acute care nursing practice, though outpatient and community settings are increasingly areas where nurses are employed and practice. Faculty participants did name two recent major publications, *The Future of Nursing* (IOM, 2011) and *Educating Nurses: A Call for Radical Transformation* (Benner, et al., 2010), as important factors stimulating change in the culture of nursing; however, implementing the changes and adopting the values set forth by these works is not yet complete.

Theme Three*:* Nursing Faculty Believe That the Right Conditions Facilitate the Enculturation of Students

The third theme is *nursing faculty believe that the right conditions facilitate the enculturation of students.* Faculty participants appeared to want to maintain long established practices and preserve traditional cultural values associated with nursing, as well as traditional experiences and practices within nursing education. Conditions to which faculty participants alluded included a wide variety of factors. Participants valued the traditional characteristics of students, continuation of established learning experiences and environments for students, and sought out preceptors and mentors who shared the same common, traditional values espoused by faculty participants. Without the correct learning experiences, mentors, and preceptors, the students may learn values and practices that are different from those the faculty desire to pass on.

Traditional characteristics. Faculty participants appeared to maintain long established values associated with nursing when speaking of students having the right characteristics, such as being caring and altruistic, and having a desire to help others (Leininger, 1994). One value identified by faculty participants as necessary but only recently associated with the profession of nursing is intelligence (Leininger, 1994). This is a value associated with the pursuit of higher education, the environment in which these particular nursing programs are situated.

Some values espoused by the faculty participants and identified in the first theme were important to their relationships with students. They included the value of a trusting and respectful relationship between faculty and students, and the values believed to be desirable characteristics of students such as caring and altruism. These were desired

aspects of nursing education that faculty participants did not want to change. Gillispie (2005) acknowledges the importance of mutual knowing between nurse educators and students. According to Gillispie (2005), mutual knowing results in transformational learning for the student. "The student–teacher connection foster[s] development of students' professional identity" (p. 212). Benner, et al. (2010) also address knowing the student. Knowing the student's "abilities, background and character" (Benner, et al., 2010, p. 104), helps faculty develop the student's critical thinking, clinical reasoning, and know how to best coach a student in mastering skills and knowledge.

Only two of the sixteen participants voiced their belief that we need to also consider nursing school applicants who exhibited different personal philosophies regarding nursing, including those with an entrepreneurial spirit or willingness to challenge the status quo. The participants saw the potential for these changes becoming means to change the profession and culture of nursing. Kalisch and Begeny (2010) support the need for recruiting and admitting students to schools of nursing who "are able to think outside of the box to find creative solutions and a willingness to change" (p. 165).

The desire expressed by faculty participants for students to have the desired characteristics is similar, in part, to the belief prevalent from 1854 - 1919 that an ideal nurse is an "angel of mercy" and the image of nurse as "mother" popular between 1945 - 1965 (Kalisch & Kalisch, 1983). As such, some of the desired characteristics such as caring stated by faculty participants could be thought of as dated and limiting. The current emphasis on being intelligent is the one exception to the historical ideal. "To act

appropriately, nurses now need sophisticated understanding of chemistry, physiology, pathophysiology, microbiology, physics, genetics and more" (Benner, et al., 2010, p. 27).

Traditional learning experiences and environments. Traditional learning experiences and environments valued by participants included small class sizes, appropriate learning experiences such as clinical sites and teaching strategies, and curriculum. Faculty participants strongly valued smaller class sizes, and changed their practices as class sizes increased to preserve opportunities for achieving the strong faculty-student relationships which they believed were essential to learning. Participants also expressed their beliefs that the proper learning experiences in clinical settings assisted them in fulfilling their roles as nursing student educators. Providing the desired learning experience meant selecting the best possible agencies for students' clinical experiences. With the increased enrollment in pre-licensure nursing programs, and the downsizing of acute care hospitals, finding the appropriate number of clinical sites is a challenge. As emphasis on health care moves to the outpatient setting, community clinical placements are another viable option. "While efforts are being made to expand placements in the community and more care is being delivered in community settings, the bulk of clinical education for students still occurs in acute care settings" (IOM, 2011, p. 189). Ensuring the quality of learning experiences may lose priority in the face of the challenge to simply provide sufficient clinical sites for all of the nursing students.

Even when clinical sites are available, the quality of student learning during clinical experiences is difficult to ensure. "Many of the clinical hours fail to result in productive learning. Students spend much of their clinical time performing routine care tasks repeatedly, which may not contribute significantly to increased learning" (IOM,

2011, p. 189). While faculty participants may strive to provide students the "proper" (presumably high quality) learning experiences, they have some level of awareness that this is difficult to ensure.

Storytelling was one teaching strategy noted during naturalistic observation and appeared to be a desired teaching learning strategy. Storytelling, or the oral tradition, is a well-known way of passing on a culture. Through storytelling, new members of the culture learn the history of a culture, current issues and practices, values, and identity of the group (Locke, 1998). Storytelling provides a context for the delivery of an important message or concept which is helpful for students in learning the context in which they must use knowledge (Flaming, 2003). More recently, Benner, et al. (2010) also promoted storytelling as a way of providing context for nursing students. Sharing stories is also part of narrative pedagogy, a powerful way for students to learn when faculty experiences are shared (Ironsides, 2003). Narrative pedagogy also increases reflective and interpretive thinking in nursing education (Scheckel, & Ironside, 2006).

The influence of technology on approaches to instructional design and teaching strategies within the curriculum was also noted during naturalistic observations at both sites and appeared to be a desired method of instruction. This included the use of smart carts in the classroom, and "clicker" or user response devices incorporated into various presentation formats. Participants taught 28-60+ students at a time in classes lasting two to four hours, and used a variety of methods to share knowledge including Power Point presentations, videos and discussion, small group projects, and traditional lectures. Both the IOM (2011) and Benner, et al., (2010) call for a move away from content heavy, medical model curricula to ones that promote active engaged learning, clinical reasoning,

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and the ability to apply knowledge in a variety of settings, including community health--in essence, a change to how students learn the culture of nursing. It also allows nursing to make explicit their unique body of knowledge and properly communicate that to stakeholders. "All too often nurses make… skills and knowledge invisible or describe nursing practice in terms that are far too limited" (Gordon, 2006, section 2).

Enculturation to the profession is strongly influenced by the hidden curriculum (Allen, Smith, & O'Driscoll, 2011; Browning, Meyer, Truog, & Solomon, 2007). Faculty participants from each site spoke of changing their respective current formal curriculum to one that is more desirable, but no mention was made by participants of the hidden curriculum. The hidden curriculum is defined as "observed behaviors, interactions, and the overall norms, and culture of a student's training environment [that] are extremely powerful in shaping the values and attitudes of future health professionals" (IOM, 2003, p. 16). The hidden curriculum is what occurs to students; it may well include the formal curriculum but is not limited to the formal plan of what should be taught. Unless the hidden curriculum is recognized, acknowledged and modified, changing the formal curriculum will have minimal influence on the enculturation of students to the culture of nursing. Faculty participants at site A hinted at this realization when they mentioned they had socialized students to be passive learners, and were going to avoid that with the new curriculum as it did not foster the active, on-going learning required of professional nurses. However, teaching/learning strategies are only one aspect of the hidden curriculum. Other aspects of the hidden curriculum that faculty participants did not address when discussing changing the curriculum included expected behaviors, norms of interactions, and the environment in which students learn.

Class size can be thought of as part of the hidden curriculum. The desire expressed by faculty participants to preserve or return to smaller class sizes is not misguided; both in terms of the importance of class size to faculty's ability to know their students, but also in terms of what best facilitates learning. In their review of literature on the effect of college on student learning, Pascarella and Terenzini (2005) proffer that larger class sizes lead to decreased learning:

> The weight of the evidence from a body of research using course grade as the dependent measure is reasonably clear in suggesting that, other factors being equal, increasing class size has a statistically significant, negative influence on subject matter learning (p. 94).

It is important to note that the research is not conclusive on this topic, and that there are many forms of summative assessment in higher education other than course grades. As an example, from a student perspective, a study by Lee, Dapremont, and Sasser (2011) found that students reported improved satisfaction, learning and discussion in smaller class sizes (58 students) than those in larger class sizes (98 students), though test scores were not significantly different between the two groups.

Mentors and role models. Mentors and role models can be thought of as cultural guides. As cultural guides, mentors, role models and nurse educators assist students in learning cultural norms that help students make sense of the unpredictability of the day to day events nurses face. Cultural norms serve as a means to reduce the amount of anxiety faced by novices when they become involved in new or uncertain events; cultural norms provide a framework of reference to refer to and make sense of the ordinary and unordinary (Leininger, 1994). A greater consciousness of nursing as a culture and nurse

educators' roles as cultural guides or brokers can evolve through reflection in practice (Schőn, 1983). This development may facilitate a greater understanding by nurse educators of their role in bringing students into the culture of nursing. This, in turn, can influence both teaching strategies selected by nurse educators and the learning experienced by nursing students.

It is possible that faculty participants desire to pass on their somewhat dated perception of the ideal culture, yet struggle with reconciling the ideal nursing culture with the manifest nursing culture more apparent in service settings. This was evident when faculty acknowledged and attempted to reconcile the differences perceived by students in nursing practice between education and service. Only two faculty participants' spoke explicitly of needing to change aspects of the culture of nursing, the remainder seemed to strive more for preservation of the established values and normative patterns of practice in nursing culture. The participants' own beliefs and behavior contradict their valuing of nurses' roles as change agents.

An important aspect of the theme, "nursing faculty believe that the right conditions facilitate the enculturation of students," is that it conveys their belief that there is a single complex or set of educational practices that is most effective in transmitting the culture. This philosophical orientation to teaching and learning is distinctively dualistic, positing the existence of right and wrong, desirable and undesirable instructional methods and learning experiences. Such an orientation limits the possibility of learning from many different kinds of experience and negates the multiple ways students learn. It also limits the way nurse educators view their students and their role in teaching them (Pratt, Boll, & Collins, 2007). Pratt, Boll, and Collins (2007) point to the

danger of using a limited set of teaching strategies as no one strategy or tool is effective

for all students in all settings all of the time, nor for all faculty. Continuing to educate in

traditional or desired formats also excludes the possibilities offered by adopting novel

strategies or those which have the research evidence to substantiate their implementation

and continued use (NLN, 2005). It also does not free its subscribers to demonstrate the

same degree of adaptability and inclination to use evidence to guide practice that nurse

educators ask their students to use in caring for patients. The NLN (2005) also calls for

nurse educators to "question those assumptions and traditions upon which education had

been based" (p. 2). This requires openness on the part of nurse educators to multiple

desired means to educate students and transmit the culture of nursing. Having an

openness to different or new perspectives is also necessary if the radical transformation in

nursing education posited by Benner, et al (2010) will actually occur, or if the changes

will be less substantive and more of a tweaking than transformation.

Theme Four: Navigating the Subcultures (Academia, Service, and Organizational Culture) Is Challenging for Faculty

Theme four is n*avigating the subcultures (academia, service and organizational culture) is challenging for faculty.* The time demands of academia reportedly made it

quite difficult for the faculty participants to stay active in the subculture of service. Three

participated in the subculture of service on the weekends, or during the summer when

classes were not in session. Participants believed that staying active in a clinical role

helped them to remain credible in the eyes of the students, yet the majority of

participants, and indeed all of those educated at the PhD level did not teach clinical

courses. One participant educated at the PhD level viewed her research as her practice

since she interacted with patients while conducting research and one participant practiced to a limited extent in a nurse run family practice clinic associated with the college. Viewing research as practice reflects the partnership between research and education advocated by Donaldson and Fralic (2000) as a way to reduce the practice-education gap.

Faculty participants did identify changes in the organizational culture at their universities that they attributed to current economic strife, showing their awareness of the power of the greater societal culture to have an impact on the organizational culture (Giroux, 1998). The fact that participants applied concepts of organizational culture more often to the university setting than to practice settings again suggests that faculty participants exist more from day to day in the culture of academia than the culture of service. According to Schőn (1983),

> professional practice represents a way of functioning in situations of indeterminacy and value conflict, but the multiplicity of conflicting views poses a predicament for the practitioner who must choose among multiple approaches to practice or devise his own way of combining them (p. 17).

It appears that faculty participants resolved the, at times, conflicting subcultures of academia and practice by combining them with a stronger emphasis on the culture of academia.

Another contrast that lies between the subcultures of academia and practice in nursing is the difference in values characteristic of each subculture. One value that differs between the two subcultures is the value of economy. Nursing education is costly, due in part to the smaller faculty-student ratio required for clinical (Benner, et al., 2010). In the service setting, cost efficiency is a high priority, as health care organizations strive

to operate as cost effectively and efficiently as possible during a time of reduced reimbursement for services provided. Another value that differs between the two subcultures is the value of change. As is typical in academia, change in nursing education takes a long time. Even beneficial changes are slow to be implemented. In service, change occurs over a much shorter period of time as organizations adapt to a rapidly changing health care system. Conflicting values can be a source of conflict between these subcultures and contribute to the education-practice gap.

The move of nursing education from hospitals to higher education was to effect a slow change in the culture of nursing education (Donaldson, & Fralic, 2000). This move to an academic culture brought with it new stressors for nurse educators, including the need to justify nurses' inclusion in the academy of higher education by establishing a research based distinct body of theoretical knowledge. The three pronged responsibilities (scholarship, research, and service) of faculty in higher education placed additional time and new intellectual demands on nurse educators, who were more accustomed to the traditions in the service sector (Gazza & Shellenbarger, 2005). New faculty once again experience the situated learning described by Benner, et al (2010), but often at a pace that is much more rapid and in a more high stakes setting than what they are accustomed. While faculty participants echoed the stress and time demands of being a faculty member (Gazza & Shellenbarger, 2005), it appears that they more closely identify with the subculture of academia than the subculture of service.

The subculture of students is influenced a great deal by the social and technological changes that they experienced during their formative, pre-collegiate years. The current generation of students, also known as the "millennials" (Mangold, 2007),

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generally see technology as a necessity, learn mostly by trial and error, value diversity, public service and public safety, and like to enjoy themselves. They tend to be more informal in both appearance and interactions. This is in sharp contrast to nurse educators, who tend to be from the "baby boomer" generation and value hard work and getting ahead, whose education was almost entirely by lecture format classes, and who were introduced to computers later in life (Mangold, 2007). These generational differences alone necessitate a shift in the teaching learning philosophy, environment and a change in expectations of both educators and students. "Traditional approaches to delivering nursing education do not fit the needs and desires of today's student and tomorrow's workforce" (Mangold, 2007, p. 23). Thus, adapting teaching philosophies, strategies and formats to meet the needs of today's students is a necessity for nurse educators.

While faculty participants did discuss the subculture of service in their interviews, it is interesting to note that none of the faculty addressed the current changes in health care practices or reimbursement brought about by recent health care reform laws. During naturalistic observation, this researcher also did not observe them being discussed in the classroom. The researcher only observed in campus classrooms, and did not observe in the clinical setting or have access to curriculum documents where health care reform may have been addressed. However, the absence of discussion of the impact of health care reform on the profession and practice of nursing is notable. The education-practice gap was evident, and confirms the concern voiced by Benner, et al. (2010) that the education-practice gap is now about the ability of education to keep up with practice, rather than practice keeping up with education.

Another interesting omission in participant interviews relates to organizational culture. None of the participants mentioned Magnet status as it influences organizational culture and in turn, nursing practice. There are three Magnet designated hospitals within approximately a 15 mile radius of site A; the closest Magnet designated hospital to site B is approximately 95 miles away. The organizational culture at a Magnet designated agency continually proves to be more favorable for nurses than that of an agency that does not have Magnet designation (Kelly, McHugh, & Aiken, 2011).

In light of the assumed definition of the culture of nursing, the theme of *navigating the subcultures (academia, service and organizational culture) is challenging for faculty* seemed to demonstrate that the faculty participants struggled with a bi-cultural existence. The values espoused by the participants reflect the values of the nursing profession and those of academia but more strongly reflect those of nursing education or academia. Faculty participants' life experiences, normative practices, and to a lesser extent symbols reflect those of their new culture, that of higher education. Participants spoke of the rhythms of the semester, but did not talk about shift changes, or length of shifts. They also spoke of the normative practices of academia including teaching, research, and service to the academic institution that are not part of the normative practices of nurses in the service sector. Educational preparation and years teaching appear to have an influence on how closely faculty identify with one culture or another, with those having fewer years' experience teaching and those without a PhD identifying more closely with the culture of service.

The apparel worn is also reflective of the culture which one identifies. Wearing scrubs is often a symbol associated with being a nurse in the acute care service culture.

Indeed, nursing students wear scrubs when they are in acute care clinical settings. None of the faculty participants was seen wearing scrubs. All dressed more formally as one would expect in a business or academic setting. While maintaining some of the values of the service culture, faculty participants had taken on more of the normative practices and symbols of the culture of academia.

The differences between the subculture of service and academia are even stronger when one considers nursing as a profession increasingly composed of knowledge workers. "As professionals, nurses are knowledge workers who use a well delineated and broad knowledge base for practice" (AACN, 2008, p. 10). Knowledge workers are those whose "synthesize a broad array of information and knowledge from a wide variety of sources and brings that synthesis to bear on nursing work" (Porter-O'Grady, 2003, p. 6). However, the general public generally recognizes the manual labor and technological aspects of nursing—the tasks or interventions nurses do and the tools that assist them in completing those interventions, which is often associated with the subculture of practice. The thinking, processing and synthesizing of knowledge is internal, less visible, and often associated with the subculture of academia. Nurse educators stand at the intersection of these two subcultures, with the subculture where they spend the most time and perhaps have the greatest influence.

Summary. Faculty participants more closely identified with the culture in which they spent the majority of time; that is the culture of academia. This was evident in their attire, in what they shared in interviews and in what was not shared in interviews. Participants applied elements of organizational culture to the culture of academia, but did not address influences of organizational culture on service. Those participants with a

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higher educational degree identified more closely with the culture of academia and those who had not yet attained a doctoral degree struggled more in navigating between the cultures of service and academia. This may reflect a longer immersion in the culture of academia required to attain a doctoral degree in both the student and faculty role. Faculty struggled with the multiple demands placed on them by the various subcultures within nursing, which includes the subculture of students. These multiple demands were challenging to their bi-cultural role as nurse educators operating at the intersection of academia and service.

Discussion of the Meaning of the Four Themes Together

The four themes that emerged from the interview data, *the culture of nursing is multifaceted, multivalent and at times contradictory; multiple factors, both internal and external to the culture, influence the culture of nursing; nursing faculty believe that the right conditions facilitate the enculturation of students; navigating the subcultures (academia, service and organizational culture) is challenging for faculty* together reflect a greater understanding of the culture of nursing. The theme, *the culture of nursing is multifaceted, multivalent and at times contradictory* reflects participants' view that there is a diversity of characteristics and multiple roles attributed to nursing. At the same time, the theme also reflects the absence of a uniting or composite, well-articulated characterization of the culture of nursing other than the value of caring. Participants did not refer to any standard, well established definitions of nursing derived from theory or articulated by those in leadership in professional organizations. Faculty participants' responses themselves seemed to lack cohesiveness. Collectively, what faculty participants' responses had in common seemed only to be their agreement on the many

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facets of nursing culture and that the culture emphasized caring. Without a collective

sense of the core norms, values, and life-ways of nursing, the ethos of nursing in the

larger culture of health care remains vulnerable to cultural imposition by other

professional cultures and risks having other professional cultures determine the identity

of the culture of nursing. It places the culture in a position of being reactive instead of

pro-active.   This also leaves the culture of nursing vulnerable to the many other

influences to the culture of nursing (Leininger, 1994). This vulnerability can in turn

hinder the evolution of a strong cultural identity.

Theme four, *navigating the subcultures (academia, service and organizational*

culture) is challenging for faculty demonstrates the multiple cultures and cultural

negotiations nursing faculty experienced on a regular basis, as they belong to multiple,

and at times conflicting subcultures within the culture of nursing. Belonging to multiple

subcultures is stressful and challenging for nurse educators as they constantly are

required to navigate between these different subcultures, resulting in cultural dissonance

(Duphily, 2011). Cultural dissonance, or "an uncomfortable sense of conflict or

uncertainty experienced by those undergoing change in their cultural surroundings"

(Clarke, Leininger, & McFarland, 2002) could contribute to the lack of unified cultural

identity, or even be the hidden source of the first theme that emerged from this study of

nurse educators' perspectives on the culture of nursing: *the culture of nursing is*

multifaceted, multivalent and at times contradictory. Faculty participants may be having

difficulty identifying with multiple subcultures within nursing, while still identifying with

the central culture of nursing. Theme four also relates to the theme two, *nursing faculty*

believe that the right conditions facilitate the enculturation of students as cultural identity

may depend on which subculture is the more dominant influence in the professional life of each study participant. It is interesting that while faculty had difficulty managing a bicultural experience between service and academia, students are expected and assumed to be able to manage this bicultural experience with both clinical and didactic elements of course work.

While participants were not able to identify a core or unifying attribute of the culture other than caring (*the culture of nursing is multifaceted, multivalent and at times contradictory*), there was remarkable consistency in their belief that there are "right ways" to bring students into that culture (*nursing faculty believe that the right conditions facilitate the enculturation of students*). When changes occurred that forced a change in one of the ways faculty deemed as more desirable, as in class sizes and relationships between faculty and students, participants tried using strategies that maintained what they perceived as necessary and desirable for enculturation. An example of this was the use of student name cards so participants could get to know student names in a large class, and storytelling to pass on aspects of the culture that the participants valued. Changes in the curriculum could also be seen as an effort to have the desired factors to learn the culture of nursing and accommodate the rapid changes in the science of nursing and teaching strategies, though these changes are slow in happening. However, holding on to traditional values, practices, and curriculums within the subculture of academia prevents the truly radical transformation that Benner and colleagues (2010) call for, and perpetuate the problems identified in nursing education, and nursing by Benner et al (2010) and the IOM (2011).

Discussion of Themes in Relation to the Research Questions

Research Question 1: What are nurse educators' beliefs and perceptions about the professional culture of nursing?

The first and second themes that emerged from analysis of the data from both naturalistic observation and participant interviews address the first research question. The attributes of culture in this study were patterns and normative practices, values, learned and shared life experiences and symbols. Patterns, normative practices, values and shared life experiences can be difficult to separate from each other as they all interrelate and weave together in the context of the culture.

Generally, when one is immersed in a culture it is more difficult to identify these attributes as the attributes are so intimately woven into their lives (Leininger, 1995). Therefore, the etic perspective is needed to examine the patterns, normative practices, values, learned and shared life experiences and symbols. When gaining the etic perspective, a researcher can find contradictions between what is espoused and practiced, or place value judgments upon the findings. It is important to remember to not judge the findings, and to state noted contradictions as they are seen (Leininger, 1995).

When asked, faculty participants unanimously agreed without hesitation that nursing had a professional culture. The way this culture was described varied among faculty participants, and at times the normative practices and patterns contradicted themselves such as caring and eating our young; or voicing strong preferences for certain ways of transmitting the culture and simultaneously stating that nurses were open to change and new ideas. One attribute of the culture of nursing stated by all participants was the attribute of caring. However, many other words were used to also describe the

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culture of nursing with a varying amount of consensus among participants on those terms. So while faculty participants believed that nursing had a unique professional culture, it was at time challenging to name attributes of the culture. The data from the interviews, along with normative practices and patterns seen in naturalistic observation all revealed varying perceptions about the culture of nursing (theme one: the culture of nursing is multifaceted, multivalent, and at time contradictory).

All cultures undergo change over time and are influenced by many factors; however, enduring qualities and values of a culture are slow to change (Schein, 2004). Factors that influence change can come from within due to proclamations from esteemed members of a culture, or they can come from forces and factors outside of the culture. This is especially true when one culture is exposed to the ideation of other cultures (Leininger 1995).

The faculty participants in this study also saw the culture of nursing evolve over time and were able to name specific factors that contributed to this evolution (theme two: multiple factors, both internal and external to the culture, influence the culture of nursing). Some of these factors included those from within the culture, and some were from external influences. Multiple faculty participants expressed the historical influences on the profession of nursing as well as the influence of a predominately Caucasian female composition of the profession. The effects of these factors were evident in some of the normative practices observed but did not seem to influence the predominate value of caring.

Second Research Question: Given their perceptions of the culture of nursing, what do nurse educators perceive as their role with students?

The third and fourth themes that emerged from analysis of the data speak more directly to the second research question. It is typical for a more experienced member of a culture to assist a novice or outsider in joining the culture. Generally, a person wishing to join a culture looks to a more experienced member for guidance, wisdom, and teaching of accepted behaviors, beliefs, and values (Hong, 2001). The more experienced members of the group encourage "the cultural novice to observe and experience the material and symbolic practices valued by the cultural group" (Hong, 2001, para 3.1.1).

One of the four attributes of culture is shared life experiences among members of the culture. Shared life experiences are defined as those experiences that are passed on from established members to novice members (Leininger, 1994). In nursing education programs, the more experienced members of the profession are the faculty. In the literature, nurse educators have long been recognized as role models, mentors for nursing students during the socialization process or as cultural guides in an enculturation process (Benner, et al., 2010). Thus, their perspectives on the learning and life experiences that must be shared with students are important because these beliefs influence choices about what should be passed on from established members to novice members (Leininger, 1994). Indeed, one of the first steps in curricular design is formulating a philosophy of nursing and teaching/learning. This requires clarification of beliefs of individual faculty and coming to some consensus about what the nursing educational program philosophy will be. Furthermore, core values of the general culture of the profession and program sponsoring agencies are important aspects of the program philosophy.

As experienced members of the group, nurse educators are cognizant of their role in bringing students into the culture of nursing and do not take this role lightly. Indeed, faculty participants have established some consensus about desirable ways of transmitting the culture because they have come to believe that these ways are more effective in fulfilling this role (theme 3: *nursing faculty believe that the right conditions facilitate the enculturation of students*). A resistance to changing or trying new methods of bringing students into the profession was noted, revealing that nurse educators have strong beliefs about the proper way to fulfill this role.

Nurse educators also encounter multiple subcultures within the culture of nursing that can influence their perceptions of their role in bringing students into the culture of nursing. Living among these multiple subcultures is challenging to faculty (theme 4: *navigating the subcultures (academia, service and organizational culture) of nursing is challenging for faculty*) as they try to develop a sense of what aspects of each culture should be passed on to students. These multiple subcultures also contribute to multiple beliefs and cultural encounters experienced by faculty which challenge their ability to come to a consensus regarding established values, beliefs, practices, and educational philosophies.

Limitations

The limitations of this study revolve around generalizability of findings to other groups. This study was conducted at two public universities in a single Mid-Western state. The study focused on pre-licensure undergraduate programs. Therefore, others should use caution in trying to generalize these findings to private universities, Associate Degree programs, post licensure BSN (RN to BSN), second degree, or MSN pre-

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licensure programs, or those in a different geographical region of the United States. Another limitation to this study is the fact that the researcher herself is a nurse educator. While the researcher did not use her place of employment as a study site, she did not bring a purely etic perspective to this study. Bracketing assumptions by keeping journal notes and frequent discussions with the dissertation chair throughout the study helped to decrease this limitation, but it is one that still should be noted.

Summary. Analysis of the data revealed four distinct yet related themes. These themes were *the culture of nursing is multifaceted, multivalent and at times contradictory; multiple factors, both internal and external to the culture, influence the culture of nursing; nursing faculty believe that the right conditions facilitate the enculturation of students; and navigating the subcultures (academia, service and organizational culture) is challenging for faculty.*

. The relationships of these themes to the definition of the culture of nursing, as well as to current literature and to each other were explored and discussed.

Nursing Implications

This study has multiple implications for nursing. These implications include those on nursing theory, education and practice, and policy. As with any research study, findings from this study lead to more research questions which need to be answered. Implications related to each of these aspects of the profession of nursing follow.

Implications for Nursing Theory

This study supports that caring is a central construct for the nursing profession, as posited by nursing theorists Watson (1998) and Leininger (1995). Watson's Theory of Human Caring places caring at the center of nursing-patient interactions. According to

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Watson (2008), caring both distinguishes nursing from other professions and facilitates

interactions between nursing and interdisciplinary members of the health care team

(Foster, 2006). Watson's Theory of Human Caring is "an ontological and theoretical-

philosophical-ethical framework for the profession and discipline of nursing and

[clarifies] its mature relationship and distinct intersection with other health sciences"

(Watson, 2008, para 3). Watson acknowledges that caring as a central construct to

nursing dates back to the time of Nightingale, but also sees the science of caring as a

means for nursing to advance as a profession. "Nursing cannot move forward with any

sense of survival and maturity as a distinct discipline and practicing profession if it does

not ground its evolution in a meaningful philosophical-ethical foundation for its science

and practices" (Watson, 2007, p. 14).

The other nursing theory most aligned with caring is Leininger's Theory of

Culture Care Diversity and Universality. While Watson viewed caring from a

philosophical, transpersonal and spiritual perspective, Leininger viewed caring from an

anthropological and cultural perspective, examining "both the universal aspects of

human care as well as the specific care particular to an individual, family, institution or

society" (Cohen, 1991, p. 908). Leininger (1995) sees care as "the essence of nursing

and what the profession [nursing] should be focusing on" (p. 59). Leininger's theory has

become increasingly relevant to nursing with the increased mobility of people of diverse

cultures, leading to nurses' interaction and caring for patients with a wide range of

cultural beliefs. "Nurses are realizing the importance of culturally based care and that is a

powerful means to promote and maintain health in different cultures" (Leininger, 2007, p.

12). Leininger (1995) envisions her theory advancing the profession of nursing as it is

centered on caring and not curing, and it "provides practicing nurses with an evidence-based, versatile, useful, and helpful approach to guide them in their daily decisions and actions regardless of how many clients they care for or how complex the care needs" (Clark, 2009, p. 234). Other health care professions have adapted and utilized and adapted Leininger's theory to their own professions, including social work, physical therapy, and occupational therapy (Clarke, 2009), but Leininger believes that "epistemologically and ontologically care is the essence of nursing and makes the profession what it is"(Clarke, 2009, p. 234).

Another aspect of Leininger's work (1995) that is supported by the findings of this study and the understanding of nursing as a professional culture is her description of the tribes and eras of nursing. The tribes of nursing represent differences in the culture of nursing in the United States based on geographic location. The attributes of the Blue Collar Tribe, located primarily in the midlands and Mid-west region of the United States (Leininger, 1995) were confirmed by this study. Participants in this study manifested those attributes of accomplishing tasks while having multiple other responsibilities, and being economically and politically astute. This was evident in their efforts and increased workload required to revise the curriculum, and in their ability to negotiate for new buildings and technology for their programs and schools of nursing during a time of economic downturn.

The Eras of Nursing, as described by Leininger (1995) include the Early (1940-1974) and Recent (1975 – 1994) Eras. According to Leininger (1995), characteristics of the Recent Era include using high tech skills and equipment to care for patients, being clinically competent and capable leaders, and emphasizing self-care and efficiency.

Recent Era nurses also focus on political, personal and economic gain, the empowerment of women, and assertive behavior (Leininger, 1995). This shift in skills, values, and priorities accompanied the gradual move of nursing education into higher education settings. However, there have been many changes in the larger culture and in health care since 1995. These changes include the economic and political influences cited by faculty participants in their interviews, and the impact of those influences on health care and the profession of nursing. It is important that additional research be undertaken to see if there is a more modern (postmodern) era of nurses over that has developed over the past 16 years.

One important change in the scientific knowledge of nursing over the past 16 years is the acceptance of qualitative research as a means of knowledge generation. Nursing has historically valued quantitative research and the development of an empirical body of knowledge, due in part to the attempt to prove that nursing had a unique knowledge base and a place in academia through identification with the then-dominant scientific paradigm. More recently, however, in a paradigmatic shift in which there is growing recognition of the truth of multiple realities, as chronicled and advocated by Kuhn, qualitative research methodologies have gained acceptance in the academic community in general and specifically in nursing (Stajduhar, Balneaves, & Thorne, 2001). The growing call to

> yield to a postmodern approach in the development of nursing science has been
> solidly embraced as a way to move beyond a reductionistic,[sic] rationalistic
> world view and to instead, conceptualize science as a fundamentally human and
> creative enterprise (Stajduhar, Balneaves, & Thorne, 2001, p. 73).

Both Leininger (1995) and Watson (2007) concur with the proposition that nursing is a human centered, creative profession that embodies multiple realities.

Qualitative research studies such as this also contribute to the development of nursing theory. Specifically, this study also has implications for the development of a theory of enculturation as it relates to nursing education. Faculty participants in this study confirmed that nursing has a professional culture. Nurse educators serve as cultural brokers for students wishing to enter the professional culture. The process of enculturation included sharing life experiences, norms, and patterns of behavior, and demonstrating values esteemed in the culture. As cultural brokers, faculty participants used storytelling to pass on the culture to students, and also identified rituals as students learned the culture of nursing.

Development of a theory of nursing education as enculturation could contribute to a greater understanding of nursing as a culture, and the nurse educators' role as a cultural broker. This is important for multiple reasons. A greater understanding of nursing education as enculturation will make more explicit the "underlying values, philosophy, and ideology" (Godfrey, 2003, p. 2) that will assist nurse educators in bringing students into the culture. It can also makes more explicit cultural norms in the subculture of nursing education that differ from those in the subculture of service and contribute to culture shock for new graduates, and the education-practice gap. A greater understanding of nursing education as enculturation can also allow nursing education to navigate or negotiate the multiple influences impacting the culture of nursing while maintaining highly valued beliefs and practices (Godfrey, 2003).

Additional benefits from a theory of nursing education as enculturation relate to faculty-student interaction and interaction between members of healthcare disciplines. A greater self-awareness of their own professional culture can improve relationships between nurse educators and students from different ethnic or racial cultures, and result in less cultural imposition. This can lead to an increasingly diverse body of nursing students successfully completing their nursing education and becoming actively engaged in professional nursing practice. Students and nurses who have a greater understanding of nursing as a culture can also contribute to improved interaction with other health care professional cultures. For nurse educators, a theory of nursing education as enculturation can also give an overall context and framework for how they educate and interact with all students, as well as provide a framework for the preparation of nurse educators. Additional research is needed to further explore and develop a theory of nursing education as enculturation. It is the hope of this researcher to contribute to that development.

Implications for Nursing Education and Practice

There are multiple implications for nursing education and practice from this study. There are implications in a variety of areas, including class size relative to increasing enrollment in nursing education, the impact of the hidden curriculum on the ongoing negotiation of the culture of nursing, the preparation of nurse educators, strategies to decrease the education-practice gap, and increasing the diversity within nursing education and practice. Each of these implications will be addressed in greater detail.

In an attempt to deal with the shortage of baccalaureate prepared nurses, the AACN has called for an increase in enrollments to BSN programs. "For the ninth consecutive year, enrollment increased in entry-level baccalaureate nursing programs with the total student population growing 3.6%" (AACN, 2010, p. 3). At a time when student enrollment is increasing, a nursing faculty shortage still exists. As schools of nursing admit more students and have less than adequate numbers of nursing faculty to educate these students, the potential increases for increasing class sizes as a means to accommodate this influx of student. This is especially true in the current climate of fiscal restraint in higher education, due in part to decreased funding at both the federal and state levels. However, based on a review of research literature by Pascarella and Terenzini (2005), increasing the class size can have a negative impact on the ability of the faculty to enculturate the student into the profession and establish the necessary relationships with students to foster the enculturation process. This stance is also supported by Benner and colleagues (2010).

Findings also revealed that the hidden curriculum has an impact on the enculturation process of nursing students in a very tacit manner. In part, the hidden curriculum involves the social lessons learned from teaching strategies used by faculty and in faculty student interactions. Teaching strategies such as storytelling serve as a way to not only pass on content specific information, but also the culture, as they convey values that the culture deems important. Information laden Power Point presentations enables passive learning, and represents an essentialist philosophy of education at a time when a more "existential/humanistic, holistic, subjective, intuitive, phenomenological and human experience oriented" (Csokasy, 2009, p. 113) philosophy is encouraged and

desired in nursing education. The value of caring was noted in faculty student

interactions, giving the message that caring is an important part of the culture of nursing

However, all of these areas of the hidden curriculum need to become more visible, and

nurse educators need to become more aware of the impact of the hidden curriculum on

learning the culture of nursing. Making the tacit aspects of the hidden curriculum more

visible will foster congruency between the hidden and formal curriculum, through either

affirmation or change of practices previously not recognized by well-established

members of the culture. A better understanding of all aspects of the culture, including the

tacit and overt, facilitates the ability of the cultural novice to learn and navigate the

culture of nursing and lessen the culture shock or burnout experienced by the novice in

the enculturation process.

One way that nurse educators can become more aware of the impact of the hidden

curriculum on enculturating students to the culture of nursing is to address the

preparation of nurse educators.   Currently, the credential required for teaching nursing in

higher education is a master's or doctoral degree with preference given to the doctoral

degree. However, "faculty and administrators of graduate nursing programs have

focused most of the attention for the past thirty years on developing nursing research"

(Benner, et al., 2010, p. 6), and have not focused on preparing nurse educators. An

awareness of the philosophical foundations of nursing education, and the impact of all

areas of the curriculum, including the hidden curriculum, needs to be considered an

essential aspect of the preparation of all nurse educators through formal course work, post

master's certificates, or certification. Improving the preparation of nurse educators is

supported by both the AACN (2010), the NLN (2012), and Benner, et al. (2010).

The education-practice gap, or "the ability of practice settings to adopt and reflect what was being taught in academic institutions" (Benner, et al, 2010, p. 4) still exists in nursing (Benner, et al, 2010; Burns & Poster, 2009). One concern of Benner, et al., (2010) is that the "the tables are turned: nurse administrators and this research team [Benner, et al] worry about the practice-education gap, as it becomes harder and harder for nursing education to keep pace with rapid changes in practice driven by research and new technologies" (p. 5). When asked about possible influences on the culture of nursing, none of the nurse educators interviewed in this study identified nursing education or nursing faculty as influential in shaping the culture of nursing. Neither did they (the faculty participants) express a sense of their own agency in that regard. However, it is the belief of this researcher that the active collaboration of experts in both nursing education and practice will continue to influence the culture of nursing through re-negotiation and redefinition of values, beliefs, and practices. The development of dedicated education units, and increased partnerships between nursing education and practice which require nurse educators and nursing practice to share their unique expertise, will hopefully address this gap. Even with these new partnerships, nurse educators must realize and take ownership of their ability to influence nursing practice, and, in turn, the culture of nursing.

All of the nurse educators interviewed for this study taught didactic content, and only two of the nurse educators interviewed still worked in a clinical setting. Yet, a common theme found in the data revealed that it is challenging for nurse educators to exist within the multiple subcultures of academia and service. The demands of faculty in academia often preclude an active clinical practice. However, one means to ameliorate

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this tension and the nursing education-practice gap is for faculty who teach didactic to also teach in a clinical setting, or have some relationship with a clinical agency. DNP prepared nurse educators may be able to more easily establish a relationship with a clinical agency as the DNP curriculum has a stronger clinical focus. This would require a change in how nursing education administrators view the workload of doctorally prepared faculty. The inclusion of a clinical teaching assignment for doctorally prepared faculty could serve to decrease the tension experienced by nurse educators teaching at the baccalaureate level, help bridge the education-practice gap, and provide more authentic enculturation experiences for nursing students

Implications for Nursing Research and Policy

The findings of this study have implications for nursing research and policy. Further research is needed on the perceptions of preceptors and practicing nurse, as well as graduate nurses about the culture of nursing. Research is also needed on effective class sizes for teaching didactic nursing content and the pedagogical knowledge of nurse educators. Nursing students have a great deal of contact with nursing faculty during their educational years, making nurse educators the primary agents of enculturation. However, preceptors and staff nurses who interact with students in the clinical setting also help bring students into the culture of nursing (Benner, et al, 2010). Their perspective is also important to obtain and compare to nurse educators' perceptions to increase knowledge of both the enculturation process and a greater cultural consciousness of the profession. A greater cultural consciousness allows the profession to make its tacit values more explicit to those both within and outside of the culture. A better understanding of what is important and valued by the profession can facilitate awareness and negotiation of

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conflicts or contradictions that arise due to the multiple influences on the culture of nursing, and strengthen the position of the profession when other entities and professions attempt to re-design or re-negotiate the values, beliefs, and practices of the culture of nursing.

The viewpoint of the graduate nurses on the culture of nursing may provide insights to the "culture shock" experienced by new nursing graduates as they transition from education to practice. Once the enculturation process for traditional undergraduate students to the culture of nursing is better understood from multiple perspectives, it would also be helpful for nurse educators to have knowledge of similarities and differences between the enculturation process of traditional undergraduates and second degree nursing students to guide their educational practices.

Kramer and Schmalenberg (1977) conducted a very thorough analysis of culture shock and how new nurses can achieve biculturalism; however, much has changed in both nursing practice and education in the last 35 years. New insights from updated research on this topic can shed light on the current reasons behind the high rate of attrition among new nursing graduates from their places of employment or from the profession. This would be an important contribution considering the high cost nursing education as well as orientation of graduate nurses to a health care agency, and the stiff competition for a limited number of seats available in nursing education.

According to Pascarella and Terenzini's (2005) review of the literature published from 2000 to 2011, there is evidence suggesting that increasing class size has a negative impact on student learning and faculty student relationships. It is not known if this body of research holds true for nursing education, which has a combination of larger lectures

and smaller clinical groups. One variable that may influence the effect of class size on student learning and faculty student relationship is the faculty's preparation in effective instructional methods. This leads to the last implication for research from this study; that is the preparation of nurse educators in philosophies and theories of learning. Grounding nursing educational practices in a philosophy or theory of education can guide nurse educators' decisions about cultural norms and practices, including faculty-student interaction, and allow for conscious, deliberate decisions regarding possible changes to the culture. As various philosophies and theories of nursing education are implemented, research to test or expand the effectiveness or appropriateness of these philosophies or theories is necessary to add to the body of science on nursing education. This claim echoes the calls of Benner, et al. (2010) and the IOM (2011) for further research on nursing education as a means to advance both the education of the profession of nursing and in turn the delivery of nursing care and health of patients.

The findings of this study also indicate the need for a review of policies that effectively increase the diversity of student nurses and individual school of nursing policies regarding qualifications required to teach nursing. Increasing the diversity of nursing students was not mentioned by faculty participants as holding the potential to positively influence on the culture of nursing. Naturalistic observation in the classroom and of graduation cohort pictures also did not reveal an increase in student diversity based on ethnicity. Increasing the diversity of nursing students is an important means to provide culturally competent care to patients (AACN, 2011; Benner, et al, 2010; IOM 2011). Given the increasing diversity of the general population within the United States, this is an important area for future inquiry.

The AACN (2008) states that the desired level of educational preparation for faculty teaching in baccalaureate programs is the doctoral degree (research or practice), and that "individuals who desire a role as an educator should have additional preparation in the science of pedagogy to augment their ability to transmit the science of the profession they practice and teach" (AACN, 2010, p. 4). Being clinically competent is not enough; nurse educators must also demonstrate competency in teaching skills (Little, & Milliken, 2007). Research on educational preparation of nurse educators, both from a philosophical and practical perspective, will identify the progress nursing education is making in meeting the needs of the goal stated by the AACN.

Conclusion

This study examined nurse educators' perception about the culture of nursing and their role in bringing students into that culture. Data analysis from naturalistic observation and sixteen interviews with nurse educators revealed that they perceive the culture of nursing to be characterized predominantly as caring, but also multifaceted. There was some disagreement among participants as to whether nursing students were part of the culture of nursing, or whether they became part of the culture as their education progressed or upon graduation. Faculty participants saw the role of nurse educator as one focused primarily on bringing students into the culture of nursing, being a role model, or being a facilitator of learning. All participants thought bringing students into the culture was an important aspect of being a nurse educator, and cited class size and their relationship with the students as being important to helping that process. The results of this study help inform nurse educators about the professional culture of nursing and their role of bringing students into that culture, how that culture can influence

working on interdisciplinary teams, and importance of preparation for practice as a nurse educator. This study also has implications for future study of factors contributing to the education-practice gap, including the subcultures of nursing academia and service and how a better understanding of the culture of nursing and various subcultures can help reduce that gap.

Four main themes emerged from data analysis. These themes are 1) *The culture of nursing is multifaceted, multivalent and at times contradictory 2)Multiple factors, both internal and external to the culture, influence the culture of nursing 3) Nursing faculty believe that the right conditions facilitate the enculturation of students, and 4) Navigating the subcultures (academia, service and organizational culture) is challenging for faculty.*

Participants presented the emic perspective on the culture of nursing, as seen through the lens of nurse educators. The overall culture of nursing is perceived by the participants as caring; this affects their perspectives on their interactions with students and teaching strategies. Nurse educators are also heavily influenced by the subcultures of academia and students as part of the culture of academia, the subculture of service, and, to a lesser extent, organizational cultures. Nurse educators believe that bringing students into this culture is one of their responsibilities about which they have strong viewpoints, though others assist with this enculturation process. The culture of nursing is constantly changing, and influenced by many factors originating both within and outside of nursing.

References

Abbott, P., & Meerabeau. L. (Ed.). (1998). *The sociology of the caring professions.* (2nd.

 ed.). London, England: UCL Press.

Adams, D. (1998). Examining the fabric of academic life: An analysis of three decades of

 research on the perceptions of Australian academics about their roles. *Higher*

 Education, 36(4), 421-35

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003).

 Educational levels of hospital nurses and surgical patient mortality. *JAMA: Journal*

 of the American Medical Association, 290(12), 1617-1623.

Allan, H., T., Smith, P., & O'Driscoll, M. (2011). Experiences of supernumerary status

 and the hidden curriculum in nursing: A new twist in the theory-practice gap?

 Journal of Clinical Nursing, 20(5), 847-855.

American Association of Colleges of Nursing. (2005). *Faculty shortages in*

 baccalaureate and graduate nursing programs: Scope of the problem and strategies

 for expanding the supply. Washington, DC: American Association of Colleges of

 Nursing.

American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate*

 education for professional nursing practice. Washington, DC: American Association

 of Colleges of Nursing.

American Nurses Association. (2010). *Nursing's social policy statement: The essence of*

 the profession.. Silver Springs MD: American Nurses Association.

Andersson, E. P. (1995). Marginality: Concept or reality in nursing education? *Journal of*

 Advanced Nursing, 21(1), 131

Astin, A. W. (1998). The changing American college student: Thirty-year trends, 1966-96. *Review of Higher Education, 21*(2), 115-35.

Bartels, J. E. (2007). Preparing nursing faculty for baccalaureate-level and graduate-level nursing programs: Role preparation for the academy. *Journal of Nursing Education, 46*(4), 154.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.

Bennett, O. M. (1999). *Cultural dynamics in the occupational therapy classroom.* State University of New York at Buffalo). , 217 p. (UMI Order AAI9918187.).

Bevis, E. O., & & Watson, J. (1989). *Towards a caring curriculum: A new pedagogy for nursing*. New York: National League for Nursing.

Bodley, J. (1994). *What is culture?* Retrieved March, 2010, from http://www.wsu.edu/gened/learn-modules/top_culture/culture-definitions/arnold-text.html

Bonner, A., & Sando, J. (2008). Examining the knowledge, attitude and use of research by nurses. *Journal of Nursing Management, 16*(3), 334-343.

Bosher, S. & Pharris, M. (2009). *Transforming nursing education: The culturally inclusive environment*. New York: Springer.

Brown, J.S., Collins, A., & Deguid, P. (1989). Situated cognition and the culture of learning. *Educational Researcher, 18*(1), 32-42.

Browning, Meyer, Truog, & Solomon,. (2007). Difficult conversations in health care: Cultivating relational learning to address the hidden curriculum. *Academic Medicine, 82*(9), 905.

Bruner, J. (1997). *The culture of education*. Cambridge, MA: Harvard University Press.

Burns, P., & Poster, Elizabeth C, PhD,MS, BSN. (2008; 2008). Competency development

    in new registered nurse graduates: Closing the gap between education and practice.

    The Journal of Continuing Education in Nursing, 39(2), 67-67-73.

Cadogan, M. P., Franzi, C., Osterweil, D., & Hill, T. (1999). Barriers to effective

    communication in skilled nursing facilities: Differences in perception between

    nurses and physicians. *Journal of the American Geriatrics Society, 47*(1), 71-75.

Caldwell, S. D., Roby-Williams, C., Rush, K., & Ricke-Kiely, T. (2009). Influences of

    context, process and individual differences on nurses' readiness for change to

    Magnet status. *Journal of Advanced Nursing, 65*(7), 1412-1422.

Campinha-Bacote, J. (2010). *Transculturalcare.net.* Retrieved February 21, 2010, from

    http://www.transculturalcare.net/

Cashin, A., Newman, C., Eason, M., Thorpe, A., & O'Discoll, C. (2010). An

    ethnographic study of forensic nursing culture in an Australian prison hospital.

    Journal of Psychiatric & Mental Health Nursing, 17(1), 39-45.

Chan, R., Gardner, G., Webster, J., & Geary, A. (2010). Building research capacity in the

    nursing workforce: The design and evaluation of the nurse researcher role.

    Australian Journal of Advanced Nursing, 27(4), 62-69.

Clare, J. (1993). A challenge to the rhetoric of emancipation: Recreating a professional

    culture. *Journal of Advanced Nursing, 18*(7), 1033-1038.

Clare, J., & Hawes, C. (2001). Engendering change: Empowering nurse academics to

    take part in a university research culture. *Australian Journal of Advanced Nursing,*

    18(4), 32-36.

Clark, B. R., & Yale University, New Haven, CT Institute for Social and, Policy Studies. (1980). *Academic culture*

Clark, P. G. (1997). Values in health care professional socialization: Implications for geriatric education in interdisciplinary teamwork. *Gerontologist, 37*(4), 441-451.

Clarke, P. N., McFarland, M. R., Andrews, M. M., & Leininger, M. (2009). Caring: Some reflections on the impact of the culture care theory by McFarland & Andrews and a conversation with Leininger. *Nursing Science Quarterly, 22*(3), 233-239.

Cohen, H. (1981). *The nurse's quest for professional identity*. Menlo Park, CA: Addison-Wesley.

Cohen, J. A. (1991). Two portraits of caring: A comparison of the artists, Leininger and Watson. *Journal of Advanced Nursing, 16*(8), 899-909.

Cooke, A., & Green, B. (2000). Developing the research capacity of departments of nursing and midwifery based in higher education: A review of the literature. *Journal of Advanced Nursing, 32*(1), 57-65.

Corchon, S., Watson, R., Arantzamendi, M., & Saracíbar, M. (2010). Design and validation of an instrument to measure nursing research culture: The nursing research questionnaire (NRQ). *Journal of Clinical Nursing, 19*(1-2), 217-226.

Crow, K. (1993). Multiculturalism and pluralistic thought in nursing education: Native American world view and the nursing academic world view. *Journal of Nursing Education, 32*(5), 198-204.

Csokasy, J. (2009). Philosophical foundations of the curriculum. In Billings, DM &. Halstead, JA (Eds.), Teaching in nursing: A guide for faculty (3 rd ed., pp. 105-118). St. Louis, MO: Saunders

De Bellis, A., Longson, D., Glover, P., & Hutton, A. (2001). The enculturation of our nursing graduates. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 11*(1), 84-94.

Deem, R., & Lucas, L. (2007). Research and teaching cultures in two contrasting UK policy contexts: Academic life in education departments in five English and Scottish universities. *Higher Education: The International Journal of Higher Education and Educational Planning, 54*(1), 115-133.

Deitrick, L., Bokovoy, J., Stern, G., & Panik, A. (2006). Dance of the call bells: Using ethnography to evaluate patient satisfaction with quality of care. *Journal of Nursing Care Quality, 21*(4), 316-324.

Donaldson, S., & Fralic, M. (2000). Forging today's practice-academic link: A new era for nursing leadership. *Nursing Administration Quarterly, 25*(1), 95.

Dracup, K., & Morris, P. (2008). How will they learn? *American Journal of Critical Care, 17*, 306--308.

Duchscher, J., & Cowin, L. S. (2004). The experience of marginalization in new nursing graduates. *Nursing Outlook, 52*(6), 289-296.

Duphily, N. (2011). From clinician to academic: The impact of culture on faculty retention in nursing education. *Online Journal of Cultural Competence in Nursing & Healthcare, 1*(3), 1-21.

Emerson, R., Fretz, R. & Shaw, L. (1995). *Writing ethnographic fieldnotes*. Chicago IL: University of Chicago Press.

Eraut, M. (n.d.). *Transfer of knowledge between education and workplace settings.*

    Retrieved from http://www.mofet.macam.ac.il/iun-

    archive/mechkar/pdf/TransferofKnowledge.pdf

Estabrooks, C. A., Midodzi, W. K., Cummings, G. G., Ricker, K. L., & Giovannetti, P.

    (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing*

    Research, 54(2), 74-84.

Fawcett, J. (2007). Nursing qua nursing: The connection between nursing knowledge and

    nursing shortages. *Journal of Advanced Nursing, 59*(1), 97-99.

Fink, R., Thompson, C. J., & Bonnes, D. (2005). Overcoming barriers and promoting the

    use of research in practice. *Journal of Nursing Administration, 35*(3), 121-129.

Flaming, D. (2003). Orality to literacy: Effects on nursing knowledge. *Nursing Outlook,*

    51(5), 233-38.

Foster, R. L. (2006). A perspective on Watson's theory of human caring. *Nursing Science*

    Quarterly, 19(4), 332-333

Freed, S., & Freed, R. (1992). *Clark Wissler 1870 - 1947: A biographical memoir.*

    Washington DC: National Academy of Sciences.

Gazza, E. A., & Shellenbarger, T. (2005). Successful enculturation: Strategies for

    retaining newly hired nursing faculty. *Nurse Educator, 30*(6), 251-254.

Gething, L., & Leelarthaepin, B. (2000). Strategies for promoting research participation

    among nurses employed as academics in the university sector. *Nurse Education*

    Today, 20(2), 147-154.

Giddings, L. S. (2005). Health disparities, social injustice, and the culture of nursing. *Nursing Research, 54*(5), 304-312. Gillespie, M. (2005). Student-teacher connection: A place of possibility. *Journal of Advanced Nursing, 52*(2), 211-219.

Gillespie, M. (2005). Student-teacher connection: A place of possibility. *Journal of Advanced Nursing, 52*(2), 211-219.

Giroux, H. A. (1998). Education incorporated? *Educational Leadership, 56*(2), 12-17.

Godfrey, E. (2003). *Knowing ourselves: A theoretical model of culture* University of Auckland.

Gordon, S. (2006). What do nurses really do? *Topics in Advanced Practice Nursing, 6*(1), 9p.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care, 19*, 188-196.

Halstead, J. (Ed.). (2007). *Nurse educator competencies: Creating an evidenced based practice for nurse educators*. New York: National League for Nursing.

Hildén, H., Honkasalo, M. L., & Louhiala, P. (2006). Finnish doctors and the realisation [sic]of patient autonomy in the context of end of life decision making. *Journal of Medical Ethics, 32*(6), 316-320.

Hodges, H. F. (1997). Seeking balance to dialectic tensions in teaching through philosophic inquiry. *Image: Journal of Nursing Scholarship, 29*(4), 349-354.

Holkup, P. A., Rodehorst, T. K., Wilhelm, S. L., Kuntz, S. W., Weinert, C., Stepans, M., . . . Hill, W. G. (2009). Negotiating three worlds: Academia, nursing science, and tribal communities. *Journal of Transcultural Nursing, 20*(2), 164-175.

Holland, C. K. (1993). An ethnographic study of nursing culture as an exploration for determining the existence of a system of ritual. *Journal of Advanced Nursing, 18*(9), 1461-1470.

Holland, K. (1999). A journey to becoming: The student nurse in transition. *Journal of Advanced Nursing, 29*(1), 229-236.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). West Sussex, UK: Wiley-Blackwell.

Hong, G. (2001). Front-line care providers' professional worlds: The need for qualitative approaches to cultural interfaces. *Forum, Qualitative Social Research, 2*(3)

Horsburgh, M., Perkins, R., Coyle, B., & Degeling, P. (2006). The professional subcultures of students entering medicine, nursing and pharmacy programmes [sic]. *Journal of Interprofessional Care, 20*(4), 425-431. Retrieved from

Horton, B. (1998). *Nurse anesthesia as a sub culture of nursing in the United States.* (Unpublished D.N.Sc). Rush University, Rush University.

Howkins, E. J., & Ewens, A. (1999). How students experience professional socialization [sic]. *International Journal of Nursing Studies, 36*(1), 41-49.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington DC: National Academy Press.

Institute of Medicine. (2003). In Greiner, A., & Knebel, E. (Ed.), *Health professions education: A bridge to quality*. Washington, DC: National Academy of Science.

Institute of Medicine (2010). *The future of nursing: Leading change, advancing health.* Washington, DC: National Academic Press. Retrieved from

http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

Interprofessional Education Collaboration Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington DC: Interprofessional Education Collaborative.

Ironside, P. M. (2003). Trying something new: Implementing and evaluating narrative pedagogy using a multimethod approach. *Nursing Education Perspectives, 24*(3), 122-128.

Iwasiw, C. L., Andrusyszyn, M., & Goldenberg, D. (2007). Fostering future nursing professionals: It's a matter of values. *International Journal of Nursing Education Scholarship, 4*(1), 4p.

Jacelon, C. S., & O'Dell, K. (2005). Demystifying nursing research. analyzing qualitative data. *Urologic Nursing, 25*(3), 217-220.

Johns, C. (1999). Framing learning through reflection within carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing, 22*(2), June 7, 2008.

Kalisch, B., & Kalisch, PA. (1975). Slaves, servants, or saints? an analysis of the system of nurse training in the united states, 1873-1948. *Nursing Forum, 43*(3), 222--263.

Kalisch, B., & Kalisch, PA. (1983). *Anatomy of the image of the nurse: Dissonant and ideal models* ANA Publications.

Kalisch, B. J., & Begeny, S. (2010). Preparation of nursing students for change and innovation. *Western Journal of Nursing Research, 32*(2), 157-167.

Kaminski, J. (2006). *Nursing through the lens of culture: A multiple gaze.* Unpublished PhD, University of British Columbia,

Kelly, J., & Ahern, K. (2009). Preparing nurses for practice: A phenomenological study

of the new graduate in Australia. *Journal of Clinical Nursing, 18*(6), 910-918.

Kelly, L., A., McHugh, M., D., & Aiken, L., H. (2011). Nurse outcomes in MagnetÂ®

and non-Magnet hospitals. *Journal of Nursing Administration, 41*(10), 428-433.

Kinsella, E. A. (2007). Technical rationality in Schön's reflective practice: Dichotomous

or non-dualistic epistemological position. *Nursing Philosophy, 8*(2), 102-113.

Knoblauch, H. (2005). Focused ethnography. *Forum, Qualitative Social Research, 6*(3)

Kramer, M., & & Schmalenberg, C. (1977). *Reality shock: Why nurses leave nursing*.

Wakefield, MA: Contemporary Publishing.

Lee, Dapremont, & Sasser (2011). Nursing students' perception of class size and

its impact on test performance: A pilot study. *Journal of Nursing Education, 50*(12),

715-718.

Leininger, M. (1970). *Nursing and anthropology: Two worlds to blend*. New York: John

Wiley & Sons.

Leininger, M. (1991). *Culture of care diversity and universality: A theory of nursing*.

New York: National League for Nursing.

Leininger, M. (1994). The tribes of nursing in the USA culture of nursing. *Journal of

Transcultural Nursing, 6*(1), 18-22.

Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research & practice*

(2nd ed. ed.). New York: McGraw-Hill.

Leininger, M. (2007). Theoretical questions and concerns: Response from the theory of

culture care diversity and universality perspective. *Nursing Science Quarterly, 20*(1),

9-13

Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage
Publications.

Lindeman, C. A. (2000). The future of nursing education. *Journal of Nursing Education,
39*(1), 5-12.

Little, M. A., & Milliken, P. J. (2007). Practicing what we preach: Balancing teaching
and clinical practice competencies. *International Journal of Nursing Education
Scholarship, 4*(1), 1-14.

Locke, D. C. (1998). *Increasing multicultural understanding: A comprehensive model*
(2nd ed.). Thousand Oaks, CA: Sage Publications.

Locsin, R. C. (2002). Culture corner. culture of nursing, preoccupation with prediction,
and nursing intention. *Holistic Nursing Practice, 16*(4), 1-3.

Lordly, D., & Taper, J. (2008). Assumptions lead to the devaluation of dietitian roles in
long-term care practice environments. *Journal of Allied Health, 37*(2), 78-81.

Loughran, J. J. (2002). Effective reflective practice: In search of meaning in learning
about teaching. . *Journal of Teacher Education, 53*(1), 33.

Ludwick, R., Silva, M.C. (2000). Ethics: Nursing around the world: Cultural values and
ethical conflicts. *Online Journal of Issues in Nursing, 5*(3) Retrieved from
http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJ
IN/Columns/Ethics/CulturalValuesandEthicalConflicts.html

Lysaught, J. (1970). *An abstract for action*. New York: McGraw-Hill.

Mangold, K. (2007). Educating a new generation: Teaching baby boomer faculty about
millennial students. *Nurse Educator, 32*(1), 21-23.

Marquis, B., & Huston, C. (2009). *Leadership roles and management functions in nursing: Theory and application* (6th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

McNicholl, M. P., Coates, V., & Dunne, K. (2008). Driving towards an improved research and development culture. *Journal of Nursing Management, 16*(3), 344-351.

Mendoza, P., & Berger, J. B. (2008). Academic capitalism and academic culture: A case study. *Education Policy Analysis Archives, 16*(23)

Merton, RK., Reader, GG., & Kendall, PL. (Ed.). (1957). *The student physician: Introductory studies in the sociology of medical education. A report on the bureau of applied social research of Columbia university*. Cambridge, MA: Harvard University Press.

Mexibov. D. (2000). The American Association of Colleges of Nursing. *Policy, Politics and Nursing Practice, 1*(2), 139--143.

Michigan Center for Nursing. *Survey of nurses 2009.*, 2011, from http://www.michigancenterfornursing.org/mimages/nursesurvey09.pdf

Moody, R. C., Horton-Deutsch, S., & Pesut, D. J. (2007). Educational innovations. appreciative inquiry for leading in complex systems: Supporting the transformation of academic nursing culture. *Journal of Nursing Education, 46*(7), 319-324.

Mooney, M. (2007). Professional socialization: The key to survival as a newly qualified nurse. *International Journal of Nursing Practice, 13*(2), 75-80.

Munhall, P. L. (1993). 'Unknowing': Toward another pattern of knowing in nursing. *Nursing Outlook, 41*(3), 125.

Munhall, P. L. (Ed.). (2007). *Nursing research: A qualitative approach* (4th ed.). Sadbury, MA: Jones and Bartlett.

National League for Nursing. (2007). *About the NLN.*. Retrieved, 2010, from http://www.nln.org/aboutnln/info-history.htm

Parse, R. R. (2007). Building a research culture. *Nursing Science Quarterly, 20*(3), 197-197.

Pascarella, E., & Terenzini, P. (Ed.). (2005). *How colleges affects students, volume 2*. San Francisco: Jossey-Bass.

Pecukonis, E., Doyle, O., & Bliss, D. L. (2008). Reducing barriers to interprofessional training: Promoting interprofessional cultural competence. *Journal of Interprofessional Care, 22*(4), 417-428.

Pierson, P., Miller, J., & Moore, K. (2007). Professional issues. engaging staff in the MAGNET journey: The key is communication. *MEDSURG Nursing, 16*(1), 23-28.

Poduska, D. D. (2005). Magnet designation in a community hospital. *Nursing Administration Quarterly, 29*(3), 223-227.

Polit, D. & Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th. ed.). Philadelphia, PA: Wolters Kluwer Lippincott Williams & Wilkins.

Popkewitz, T. S. (1985). Review: Intellectuals, sciences, and pedagogies: Critical traditions and instrumental cultures; ideology, culture and the process of schooling; theory and resistance in education: A pedagogy for the opposition. *American Journal of Education, 93*(3), 429-436.

Porter-Grady, T..(2003). Nurses as knowledge workers. *Creative Nursing, 9*(2), 6-9.

Pratt, D. D., Boll, S. L., & Collins, J. B. (2007). Towards a plurality of perspectives for nurse educators. *Nursing Philosophy, 8*(1), 49-59.

Raines, D. A. (2006). CAN-care: An innovative model of practice-based learning. *International Journal of Nursing Education Scholarship, 3*(1), 1-17.

Rassin, M. (2008). Nurses' professional and personal values. *Nursing Ethics, 15*(5), 614-630.

Rhoads, R. A., Tierney, W. G., & National Center on, P. T. (1992). *Cultural leadership in higher education.*

Rossetti, J., & Fox, P. G. (2009). Factors related to successful teaching by outstanding professors: An interpretive study. *Journal of Nursing Education, 48*(1), 11-16.

Rush, K. L., McCracken, B., & Talley, C. (2009). Nursing students' self-perceptions as insiders in the practice culture. *Nurse Education in Practice, 9*(5), 314-321.

Scheckel, M. M., & Ironside, P. M. (2006). Cultivating interpretive thinking through enacting narrative pedagogy. *Nursing Outlook, 54*(3), 159-165.

Schein, E. H. (2004). *Organizational culture and leadership* (3rd ed. ed.). San Francisco CA: Jossey-Bass.

Schlag, M. K. (2005). Administrative angles. Education: Key to the Magnet culture. *Journal of Continuing Education in Nursing, 36*(1), 12-13.

Schön, D. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

Schriner, C. L. (2007). The influence of culture on clinical nurses transitioning into the faculty role. *Nursing Education Perspectives, 28*(3), 145-149.

Spangler, Z. (1991). *Nursing care values and caregiving practices of Anglo-American and Phillipine-American [sic] nurses conceptualized within Leininger's theory*. (Unpublished PhD). Wayne State University, Detroit, MI.

Speagle, A. (2009). Building a magnet culture. *Colorado Nurse, 109*(1), 3-4.

Spector, R. (2009). *Cultural diversity in health and illness* (7th. ed.). Upper Saddle River NJ: Pearson Prentice Hall.

Stajduhar, K. I., Balneaves, L., & Thorne, S. E. (2001). A case for the 'middle ground': Exploring the tensions of postmodern thought in nursing. *Nursing Philosophy, 2*(1), 72-82.

Stiller, C. (2000). Exploring the ethos of the physical therapy profession in the united states: Social, cultural, and historical influences and their relationship to education. *Journal of Physical Therapy Education, 14*(3), 7-15.

Street, A. F. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Albany, NY: State University of New York Press.

Suominen, T., Kovasin, M., & Ketola, O. (1997). Nursing culture -- some viewpoints. *Journal of Advanced Nursing, 25*(1), 186-190.

Tabak, N., Adi, L., & Eherenfeld, M. (2003). A philosophy underlying excellence in teaching. *Nursing Philosophy, 4*(3), 249-254.

Tourangeau, A. E., Cummings, G., Cranley, L. A., Ferron, E. M., & Harvey, S. (2010). Determinants of hospital nurse intention to remain employed: Broadening our understanding. *Journal of Advanced Nursing, 66*(1), 22-32.

Tresolini, CP., and the Pew Fetzer Task Force. (1994). *Health professions education and relationship centered care.* San Francisco, CA: Pew Health Professions Commission. Retrieved from http://jerrykaiser.com/html/Pew-FetzerReport.pdf

Tutton, E., Seers, K., & Langstaff, D. (2008). Professional nursing culture on a trauma unit: Experiences of patients and staff. *Journal of Advanced Nursing, 61*(2), 145-153.

U.S. Department of Health and Human Services Office of Minority Health. (2007). *National standards on culturally and linguistically appropriate services (CLAS).* Retrieved, 2010, from

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

United States Census Bureau. (2010). *State and county quick facts.* Retrieved from http://quickfacts.census.gov/qfd/states/26000.html

Upenieks, V. V., & Abelew, S. (2006). The Magnet designation process: A qualitative approach using Donabedian's conceptual framework. *Health Care Manager, 25*(3), 243-253.

Wagner, D., J., & Whaite, B. (2010). An exploration of the nature of caring relationships in the writings of Florence nightingale. *Journal of Holistic Nursing, 28*(4), 225-234.

Walker, J. A., Urden, L. D., & Moody, R. (2009). The role of the CNS in achieving and maintaining magnet® status. *Journal of Nursing Administration, 39*(12), 515-523.

Watson, J. (1998). Reflections: Florence nightingale and the enduring legacy of transpersonal human caring. *Journal of Holistic Nursing, 16*(2), 292-294.

Watson, J. (2007). Theoretical questions and concerns: Response from a caring science framework. *Nursing Science Quarterly, 20*(1), 13-15.

Watson, J. (2008). *Theory of human caring: Transpersonal caring and the caring moment defined.* Retrieved, 2011, from http://www.ucdenver.edu/academics/colleges/nursing/caring/humancaring/Pages/TranspersonalCaringandtheCaringMomentDefined.aspx

Weis, D., & Schank, M. J. (2002). Professional values: Key to professional development. *Journal of Professional Nursing, 18*(5), 271-275.

Wolf, J. (1988). *Nurses' work: The sacred and profane*. Philadelphia: University of Pennsylvania Press.

Zerwekh, J., & & Claborn, J. (2006). *Nursing today: Transitions and trends* (5th ed. ed.). St. Louis, MO: Saunders Elsevier.

Appendix A

Semi-Structured Interview Guide

Demographic questions:
How long have you been a nurse?
How long have you been teaching in a BSN program? How long have you taught in this program?
What do you teach?
What is your educational preparation (include credentials, specializations, etc.)?
Note participant's gender M F
Can you tell me which age group you belong to?

          ___Under 30 years of age
          ___30 – 39 years of age
          ___40 – 49 years of age
          ___50 – 59 years of age
          ___60 years of age and older

Questions related to research questions

Can you tell me in your own words what culture means to you?
Can you tell me more about that?

With what you said in mind can you tell me if you think nursing is a culture/professional culture?

How would you describe this culture of nursing? Can you think of an example that describes this culture?

What might influence this professional culture of nursing? Is there anything that might influence or help shape this culture of nursing (influences can be either within or outside of nursing)?

Based on how you described the culture of nursing, do you consider nursing students to be part of this culture of nursing?

If yes, tell me how you think nursing students learn this culture of nursing.   Can you give me an example?

How do you view your role with students in this culture of nursing? What assists you with this role/hinders you in this role?

Any other thoughts on these questions or things we have discussed.

Follow up probes include statements such as:
Can you tell me more about that?
Can you think of another incident similar/dissimilar to that?

Notes/comments/memos during interview including non-verbal behavior

DUQUESNE UNIVERSITY
600 FORBES AVENUE   ♦   PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE:	Nurse Educators Perceptions on the Culture of Nursing: A focused ethnography.
INVESTIGATOR:	Susan M. Strouse, RN MSN
ADVISOR:	Carolyn J. Nickerson, EdD, RN, CNE Duquesne University School of Nursing 116 Fisher Hall 600 Forbes Avenue Pittsburgh, PA 15282 412.396.6552
SOURCE OF SUPPORT:	This study is being performed as partial fulfillment of the requirements for the doctoral degree in Nursing at Duquesne University.
PURPOSE:	You are being asked to participate in a research project that seeks to investigate nursing faculty perceptions about the culture of nursing, and the role of nursing faculty in transmitting that culture to students. You will be observed in your day-to-day interaction as faculty with students, such as during class, formal college or school events such as graduation or orientation sessions, or as advisor or mentor during student activities, such as club or student government meetings. In addition, you will be asked to allow me to interview you one to three times. Interviews will last between 30 and 90 minutes. The interviews will be audio recorded and transcribed.

	These are the only requests that will be made of you.
RISKS AND BENEFITS:	There are no risks greater than those which occur in the daily life of a nursing faculty. One benefit of participating in this study is the opportunity for personal reflection on the study topic. In addition, you will have the satisfaction that the information you provide to the researcher may eventually help advance the science of nursing education, and the profession of nursing.
COMPENSATION:	Participants will not be compensated for their time**.** However, participation in the project will require no monetary cost to you.
CONFIDENTIALITY:	Your name will never appear on any transcripts or excerpts from transcripts of interviews, narratives, or descriptions of activities. All interviews will be de-identified. No identity of participants or those observed will be made in the data analysis. Findings from the study may be used in presentations or publications, but names of participants will never be used. Confidentiality of participants will be maintained throughout the study. All written materials, audio tapes, and consent forms will be stored in a locked file in the researcher's office. The consent forms will be kept secured and separate from the transcriptions. Audio-recordings will be destroyed upon completion of the study, with transcripts preserved in a secure location until completion of the study and dissemination of the findings, after which time they will be destroyed.
RIGHT TO WITHDRAW:	You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time. If you withdraw from the study, information gathered before the withdrawal date will not be used in the study and will be destroyed. You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. Your decision to participate in this study will not affect your employment status.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request after completion of the study.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Susan M. Strouse RN MSN at   , or her advisor, Dr. Carolyn J. Nickerson at 412-396-6552, or Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board at 412-396-6326.

_____   _____
Participant's Signature   Date

_____   _____
Researcher's Signature   Date

Appendix C
Invitation to Participate

Greetings. My name is Susan Strouse, and I am a PhD Candidate at Duquesne University School of Nursing. For my dissertation, I am conducting research on nurse educators' perceptions on the culture of nursing. I have been given permission by your dean/director to use your school of nursing as a research site.

I am inquiring into your desire to participate in the interview aspect of this study at a date, time, and location that is mutually agreeable. Participation in this study would entail being interviewed for approximately 30 – 90 minutes on this topic, with one or two possible follow up interviews in the future.

If you agree to participate in this aspect of the study, further information including informed consent will be provided.

Please contact me at   within the next week to let me know if you are interested in participating. Thank you for considering participation in this interview, and assisting me with completion of this study and my degree.

Susan M. Strouse, RN MSN

Appendix D
Thank you for Participation in Research Study

Thank you for recently participating in my research study on nurse educators' perceptions regarding the culture of nursing. Please feel free to forward my contact information listed below to any other faculty that you believe might be interested in participating in this study. As a reminder, the participation would entail being interviewed for approximately 30 to 90 minutes on this topic, with one or two possible follow up interviews in the future. I will gladly respond to their inquiry and provide them with more information regarding the study.

Thank you once again for your participation and for sharing my contact information with other prospective participants.

Sincerely,

Susan M. Strouse, RN MSN

Appendix E
Statement of Confidentiality

I_____ understand that I will have access to information
provided by individuals in the research study: **Nursing educators' perceptions on the**
culture of nursing: A focused ethnography

While I assist with this study, I understand that I may hear names mentioned in the
interviews. I recognize that I have an obligation to protect the confidentiality of this
information and that I may disclose information only to the principal investigator of this
study, Susan M. Strouse, RN MSN.

My signature below indicates my acceptance of the obligation and restriction on
disclosure set forth above and that I realize that failure on my part to fulfill this obligation
can lead to appropriate disciplinary action.

Name:

Title:

Date:

Appendix F

CITI Training Certificates
Susan Strouse

CITI Collaborative Institutional Training Initiative (CITI)

Biomedical Responsible Conduct of Research Curriculum Completion Report
Printed on 12/16/2010

Learner: Susan Strouse
Institution: Duquesne University
Contact Information

        Department: School of Nursing
        Phone:

Biomedical Responsible Conduct of Research: This course is for investigators, staff and students with an interest or focus in **Biomedical Research**. This course contains text, embedded case studies AND quizzes.

Stage 1. RCR Passed on 11/28/10 (Ref # 5213208)

Elective Modules	Date Completed	Score
Introduction to the Responsible Conduct of Research	11/07/10	no quiz
Research Misconduct 1-1215	11/07/10	5/5 (100%)
Data Acquisition, Management, Sharing and Ownership 1-1308	11/08/10	5/5 (100%)
Publication Practices and Responsible Authorship 1-1380	11/08/10	4/5 (80%)
Peer Review 1-1368	11/09/10	4/5 (80%)
Animal Welfare 13301	11/09/10	7/8 (88%)
Conflicts of Interest and Commitment 1-1622	11/27/10	5/6 (83%)
Collaborative Research 1-1450	11/27/10	6/6 (100%)
RCR for Administrators - Collaborative Research	11/27/10	4/4 (100%)
Human Subjects 13566	11/27/10	11/11 (100%)

Introduction to the Responsible Conduct of Research for Administrators	11/27/10	no quiz
RCR for Administrators - Conflicts of Interest	11/28/10	7/7 (100%)
RCR for Administrators - Responsible Financial Management	11/28/10	6/6 (100%)
RCR for Administrators - Mentor/Trainee Responsibilities	11/28/10	4/5 (80%)
RCR for Administrators - Data Management	11/28/10	5/5 (100%)
RCR for Administrators - Completing the Course	11/28/10	no quiz
The CITI RCR Course Completion Page.	11/28/10	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

Return