THE LIVED EXPERIENCE OF ASSOCIATE DEGREE NURSING EDUCATION: CONDITIONS AND BARRIERS IN THE LEARNING ENVIRONMENT THAT SHAPED STUDENTS' LEARNING, IDENTITY DEVELOPMENT, AND SUCCESS

by

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ABSTRACT

This qualitative study examined how 13 students, from 3 ADN programs, experienced nursing education. Students' constructed the formal curriculum in three central ways: knowledge acquisition as privileged, disconnect between teaching, learning, and assessment, and clinical learning as evaluation. Participants' perspectives about the informal curriculum revealed two themes: supportive relationships with faculty as a critical condition of learning and development, and faculty incivility as a barrier to learning, development, and professional identity. In addition, students' felt a need to identify and enact unspoken norms of an ideal nurse. Faculty were key in promoting or hindering students' learning, development, and successful navigation of the nursing curriculum.

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away the dirty dishes. You never once asked me to leave my "cave." Instead, you encouraged me and made me laugh. You are my rock and I love you more than ever!

Chapter One: INTRODUCTION

For over two decades, a dominant discourse in the higher education literature has called for a paradigm shift to enact student-centered learning environments which promote student learning and development (Barr & Tagg, 1995; Baxter Magolda, 2001; Kegan, 1994). A parallel discourse in nursing education has also advocated for major curriculum revision, one that enacts a humanistic, caring, educational paradigm and which centers the teacher-student relationship and the learning environment (Bevis & Watson, 1989; Diekelmann, 1992; National League for Nursing, 2003; Tanner, 1990).

This dissertation research examined how 13 nursing students experienced and navigated their learning environment. Participants represented three different associate degree nursing (ADN) programs in the northeast region of the United States. The purpose of this research was to contribute to a better understanding of ADN students' experience of the classroom and clinical learning environment.

My interest in the lived experience of nursing students was personal, professional, and scholarly. I have been a registered nurse (RN) for thirty years and a nurse-educator for the last nineteen years. Although my memories of nursing school have faded with time, I recall the challenge of giving my first injection, caring for critically ill and dying patients, and the fear of failure that permeated the atmosphere in the school of nursing. While the numbers are beyond my recollection, I also remember the dismay and tears of classmates who were evaluated as clinically "unsatisfactory," many of whom ultimately failed out of the nursing program.

When I first became a teacher I taught largely the way I remember being taught - I lectured. I spent hours preparing my lectures so that I could "give" students the best

presentation possible. Good teaching at that time meant covering content efficiently and well. Of course it also meant "giving" students the most current medical and nursing knowledge and engaging their interest. My focus, like that of many educators, was on course content, students' learning, and their thinking. I did not appreciate the complex ways that my relationships with students shaped their learning and how they saw themselves as thinkers and as nurses.

These experiences have shaped who I am as a nurse, a teacher, and a researcher. My professional desire to further develop as a teacher and researcher led me to enroll in a doctoral program in higher education. One of the first courses I took, *College Student Development,* influenced my thinking in countless ways. The class introduced cognitive-developmental theories of adult development including Sanford's (1966) theory of challenge and support. Baxter Magolda's (2001) constructive-developmental theory later extended this context by providing a theoretical framework that came to inform my teaching practice and my concurrent efforts to provide the conditions that facilitate students' learning and development.

When I conducted the pilot study that led to this dissertation I had been a faculty member in a hospital based associate degree (AD) nursing program for 15 years. I was also a course coordinator and had counseled many students who shared how stressed they felt. I became increasingly aware that many students were feeling distressed about their schooling experiences which led me to wonder – Why? What was going on? and, "What can I do as their teacher to better support them?" Baxter Magolda argued that colleges must work harder to provide "good company" for students. However, providing students with good company requires that we first understand their journey by "listening carefully

to hear students' perspectives on their experiences and progress" (Baxter Magolda, 2001, p. xxii). Baxter Magolda's work resonated with me from the beginning. I often dialogued with students about the importance of a client-centered approach to nursing practice which requires actively listening to the client. Understanding the client's lived experience for example, of losing a child to cancer, is prerequisite to providing holistic nursing care to the child and family. In the same way, I recognized a phenomenological understanding of students' lived experience as a critical first step to improving my own educational practice. My desire to understand the students' journey, how *they* perceived and appraised their learning environment, including their perception of challenges and supports, led to this dissertation research.

Relevant Literature

Socialization into nursing is a challenging process by which students develop the knowledge, skills, and identity characteristics of a nurse (Cohen, 1981). The construction of a professional identity as nurse is grounded in social interactions and feedback from others, especially teachers (du Toit, 1995; Lewis, 1998; Olesen & Whittaker, 1968; Reutter, Field, Campbell, & Day, 1997; Secrest, Norwood, & Keatley, 2003; Wilson, 1994). A sense of belonging was essential to professional identity development, as was feeling affirmed and knowing (Secrest et al., 2003). Previous research has suggested that the early development of a nursing identity may contribute to student success (Cook, Gilmer, & Bess, 2003).

Professional socialization of students in baccalaureate nursing education has been widely studied (Bradby, 1990; Cohen, 1981; Colucciello, 1990; du Toit, 1995; Olesen & Whittaker, 1968; Reutter et al., 997; Simpson, 1979; Ware, 2008; Wilson, 1994).

However, none of the published studies reviewed centered the experiences of students in associate degree nursing programs. Reutter et al. (1997) examined the process of socialization into nursing through the four years of a baccalaureate nursing program. The challenge of clinical learning – caring for acutely ill patients and becoming a safe practitioner – was especially evident. Students' feelings of inadequacy and stress, lack of confidence with decision making, dependence on clinical instructors for validation, and the influence of feedback from others in shaping students' identity as nurse underscored the critical role of the clinical instructor to students' learning and development. Complicating this process, Reutter et al. (1997) found that every time a student rotated to a new clinical unit they had to adapt to a new clinical instructor. However, faculty expectations often varied and students had to adjust their behavioral responses accordingly based on the anticipated responses of others including faculty.

Students make decisions about whether to persist or withdraw from nursing based on the meaning constructed around their experiences "during and at the conclusion of each nursing course" (Jeffreys, 2004, p. 10). Unfortunately, no published studies were located that examined the professional socialization experience during associate degree nursing education. Reutter et al.'s (1997) findings specifically, raise several obvious and important questions about how students' socialization experience differs in an associate degree nursing program. For example, students in baccalaureate programs are not typically confronted with the challenges of clinical practice until the sophomore or even junior year of college. However, associate degree students are generally engaged in clinical learning within weeks of beginning the first semester, an obvious but often overlooked difference in students' socialization experience that warrants further study.

Research Study and Design

The purpose of this research was to contribute to a better understanding of associate degree nursing students' lived experience. Understanding students' perspectives will contribute to a better understanding of how faculty, student affairs, and administrators can support students and facilitate their success.

This qualitative study examined the reality of associate degree nursing education as a particular group of participants experienced it. Qualitative inquiry acknowledges students as experts on their lived experience in college. As a qualitative researcher committed to my participants' perspectives (Streubert & Carpenter, 1999), I was not interested in the facts of their stories or whether their perceptions of their experiences were accurate or "true." Rather, my approach to understanding students' narratives was a recognition that the truth "depends on where you are sitting, how things look to you" (Bogdan & Biklen, 2003, p. 23).

This study used a phenomenological mode of inquiry to examine students' lived experience in nursing school as a particular group of 13 participants experienced it. A phenomenological methodology (Husserl, 1931, 1962, 1964; Spiegelberg, 1975) was chosen because of its humanistic perspective which is congruent with nursing's humanistic philosophy. Phenomenological research is an inductive method which focuses on understanding the essence of a phenomenon as experienced by a particular group of people, as well as the meaning of that experience as they perceive it (Husserl, 1931). Streubert and Carpenter recommended phenomenological inquiry as the most appropriate method when two conditions are met. First, there is a need for additional clarity on the phenomenon of interest. In this case, several gaps in the literature were

identified and a better understanding of aspects of the phenomenon was needed. Specifically, few studies have examined the lived experience of students in associate degree nursing education. In addition, a limited number of nursing education studies included the perspectives of non-traditional, male, and minority students. Second, the participants' lived experience is a rich descriptive source of data (Streubert & Carpenter, 1995).

Understanding the essence of a phenomenon, as well as the meaning of that experience as the individual perceives it, is central to phenomenological inquiry (Husserl, 1931). However, "objects, people, situations, and events do not possess their own meaning; rather, meaning is conferred on them" (Bogden & Biklen, p. 25). Therefore, symbolic interactionism (Blumer, 1969) which purports that "human experience is mediated by interpretation" (as cited by Bogden & Biklen, 2003, p. 25) was considered in analyzing the data. Applying the tenets of symbolic interactionism, that the meaning of experiences are socially constructed by students as they interact with peers, faculty, patients, and others (Bogdan & Biklen, 2003) was instrumental to my understanding of students' decisions and behaviors in nursing school.

This research study was conducted at three different associate degree nursing programs in the northeast region of the United States. Two of the nursing programs are located in an urban setting and one is in a rural setting. All three nursing programs (described in Chapter Three) were accredited by the National League for Nursing Accrediting Commission.

Research Questions

The primary research question which framed this study was, How do nursing students enrolled in an associate degree nursing program experience their learning environment, including classroom and clinical settings? Three additional questions extended the primary question: 1) What experiences do associate degree nursing students' perceive as contributing to their learning and success? 2) What experiences do associate degree nursing students' perceive as barriers to their learning and success? and 3) How do students' experiences shape their emerging identity as nurses? This dissertation study addressed these questions on three dimensions – how students experienced learning in the academic and clinical classrooms, how students experienced relationships with faculty, and critical negotiations students needed to navigate and reconcile to be successful.

In-depth, semi-structured interviews were conducted with 13 first and second year nursing students at different phases of their program of study (see Appendix C). The interviews were guided by a set of questions (see Appendix D) which typically began with a broad question such as "Tell me about your experience in nursing school?" However, I allowed students the space to tell *their* story and shape the direction of the interview and used probes to elicit a deeper discussion of concerns and issues my respondents initiated. Interviews followed this loosely structured format and lasted 50 to 120 minutes each. Semi-structured interviews allow the researcher to develop an in-depth understanding of how participants think (Bogdan & Biklen, 2003). Interviews with informants continued until repetition of salient themes was apparent and no new information emerged from data collection (Polit & Beck, 2006).

Second interviews were completed with five participants to capture additional

perspectives, acquire clarification, and ensure accuracy of participants' perspectives. During the follow-up interviews I conducted informal member checks to establish credibility of the data by asking for participants' responses to preliminary findings (Polit & Beck, 2006). Altogether, 18 individual in-depth interviews were completed (13 primary interviews and 5 follow up interviews). I attempted to contact seven of my 13 participants for follow up interviews but as explained in Chapter Three, some students did not return my phone calls. At the time, I did not have further questions for the remaining six informants and did not attempt to contact them. I now recognize this as a mistake on my part and a limitation of the study.

I transcribed all but one of the interviews myself which was time-consuming but facilitated an intense engagement with the students' lived experiences early on. Once transcribed I added observer's comments and wrote theoretical and/or methodological memos. Then I reviewed each transcript, looked for recurring words and phrases, and clustered similar data into themes as they emerged from my data. These codes and emerging themes were documented in a Microsoft Word file. Acquiring a deep understanding of what my data conveyed required months of "dwelling with the data" (Streubert Speziale & Carpenter, 2003, p. 36). This process was further facilitated by the writing of multiple drafts as well as regular dialogue with my dissertation advisor, an experienced qualitative scholar who continually pushed my thinking and analysis.

The Participants

This dissertation is grounded in the voices of the students who gave their time and energy to this project and candidly shared their stories. Over a period of three academic semesters during the fall of 2005, the fall of 2007, and the spring of 2008, I conducted in-

depth interviews with first and second year nursing students at different phases of their "two year" program of study. Participants' narratives revealed how they experienced learning in the academic and clinical classrooms, how relationships with teachers shaped their experience, and negotiations they needed to navigate and reconcile to be successful in the nursing program.

The 13 students who volunteered to participate were diverse in terms of gender and age and to a minimal extent, race, and sexual orientation (see Appendix C). While most of the students who participated in this study entered nursing school as adult learners, three entered directly or within one year of high school graduation. In the following section, brief profiles of each of the student participants are provided. (Note: As is customary with qualitative research, all student names, college names, and other identifying information, have been replaced with pseudonyms).

Jack. Jack was a 41 year old, single, Caucasian, gay man. Jack was in his first semester at Private Hospital College when he participated in a focus group and an interview. Two and a half years later, after he had graduated and had been working as a RN for several months, Jack shared his perspectives a third time. Jack grew up in an upper middle class home, completed a bachelor's degree in business, and had worked in a variety of settings. After the death of several friends, Jack decided to volunteer at a local AIDS clinic in his community. He found that caring for people who were dying was meaningful for him and he decided to pursue a career change by returning to school for a degree in nursing. Jack felt fortunate that he was "financially independent" which enabled him to pursue further schooling without the additional burden of having to work part-time.

Teresa. Teresa was a 30 year old married Caucasian woman in her fourth semester at Private Hospital College. Teresa was a self-described "A" student who worked as a peer tutor in her school. After high school, Teresa attended Community College and had been working towards a math-science degree when marriage, an unplanned "honeymoon baby," and subsequent family responsibilities put her schooling on hold. Several years and three children later, Teresa decided to return to school for a nursing degree. To lighten her course load she enrolled in Community College part-time and spent two years taking all but one of her non-nursing classes before enrolling in nursing school.

Jason. Jason was a 29 year old Caucasian student in his first semester at Private Hospital College. After high school Jason attended college and completed a bachelor's degree. He worked in the computer field for several years but said he "never liked it… I always wanted to be dealing with people and make people better." Jason was married and had a three year old son. Losing his job due to company downsizing prompted Jason to pursue a nursing degree because he needed to support his young family and nursing offered job security as well as the opportunity to engage in meaningful work.

Marie. Marie was a twenty year old single Caucasian woman who lived in the residence hall at Private Hospital College. Marie decided she wanted to become a nurse when she was 13 years old and entered nursing school directly from high school. As a second year student, Marie failed her advanced medical-surgical nursing course and was repeating the course at the time of our first interview. At our second interview two and one-half years later, she had graduated, was working as a RN, and was close to completing her bachelor's degree in nursing.

Kyle. Kyle was a twenty year old single Caucasian male student who lived in the residence hall at Private Hospital College and was in his third semester. Kyle shared his perspectives twice; he participated in the initial focus group and also volunteered for an individual interview. Kyle shared that he "didn't have great grades in high school" so took a year of classes at Community College. This helped him to strengthen his academic transcript and gain admittance to nursing school. Like many of his classmates, Kyle said he completed many of his non-nursing courses the year before he began nursing school. He was successful his first semester but failed his second semester medical-surgical nursing course and had to repeat it which put him a year behind the rest of his class. He was successful the second time, had begun his third semester, and anticipated completing his nursing program successfully when he participated in this study. Unfortunately, Kyle later failed his advanced medical-surgical nursing course and consequently his nursing program.

Maggie. Maggie was a 43 year old second semester Caucasian student at State College. Maggie said she entered nursing school because she wanted to be someone who "makes a difference." Married with two children, Maggie had thought about a nursing career after she helped provide care to a hospitalized family member but kept "putting it off." Years later when her children were both in school Maggie decided it was the "perfect time." Like many of the other non-traditional students in this study Maggie saw her pursuit of nursing education as an opportunity to advance herself.

Jacqueline. Jacqueline was a 19 year old single Caribbean-American woman who lived in the residence hall at State College. Jacqueline said she had wanted to become a nurse "since eighth grade." During high school she completed vocational course work

and became certified as a nurse's aide. A self-described first generation college student, Jacqueline was excited to be in nursing school but described her first semester at State College as a "huge transition." Jacqueline's family lived several hours away but Jacqueline said she felt supported by two relatives from home who were attending State College with her. Jacqueline had failed Nursing II and at the time of our interview was repeating the course.

Lalia. Lalia was a 32 year old Caucasian student in her first semester at State College. Married with a young daughter, Lalia described her life as a wife, mother, and student as a "juggling act" and expressed regret about not finishing school when she was younger. However, she felt that the timing was good for her family as her daughter was in school during the day. Lalia was a paramedic and had completed an associate's degree before deciding to pursue nursing. She reported completing all of her prerequisite and most of her non-nursing courses at Community College with an overall grade point average of 3.8. Lalia viewed her pursuit of nursing education as an opportunity to advance herself and better provide for her young family.

Annette. Annette was a 32 year old African American woman who shared her perspectives twice, during her second semester and again during her third semester at State College. Annette described herself as a "smart, naturally intelligent" person who learned quickly. Annette had a four year old daughter and said she had little family nearby for support. She was separated from her husband who lived over a hundred miles away and her parents, while supportive, also lived in a distant city. Annette reported that her sister was her primary source of support in the area. Annette said she planned to move back home after graduation. Annette had several years of college experience and

many of her previous college courses had been transferred towards her nursing degree. She was also a Licensed Practical Nurse (LPN) and was admitted advanced placement directly to the second semester nursing course (typically, the first semester ADN curriculum overlaps that of the LPN curriculum).

Marcy. Marcy was a 32 year old married Caucasian woman with a three year old daughter. She participated in two interviews, one during her second semester and another during her third semester at State College. In high school Marcy said she took "all the hard classes" and graduated near the top of her class. She enrolled in college immediately after high school and completed a two year business degree. After years of working in her family's business Marcy decided to pursue a career as a Registered Nurse. A self-described "A" student, she planned on pursuing her bachelor's degree immediately after graduation from State College.

Charles. Charles was a 26 year old Caucasian student in his third semester at State College. Charles was single but had a girlfriend who was also a nursing student. He reported his high school grade point average as 97% and said he was ranked in the top 5% of his class of 189. After high school, Charles completed two years of college but "didn't like it very much." After working for a few years he returned to college and completed a bachelor's degree in psychology. Charles said he decided to pursue a nursing degree because of the many diverse opportunities for career advancement.

Jessica. Jessica was a 36 year old Caucasian divorced mother of two who was in her fourth semester at Private Hospital School of Nursing but withdrew two days before our scheduled interview. She had already completed an associate's degree in business when she decided to return to college for a degree in nursing. Jessica said she entered nursing

school determined to have "a better life." Like many of her peers, she spent one full year taking liberal arts and science courses before entering Private Hospital School. Jessica reported her current GPA as a 3.5 and said she had been awarded a scholarship. Despite her academic success, Jessica withdrew from Private Hospital School during her fourth and final semester.

Chloe. Chloe was a 34 year old married Caucasian woman with two school-aged children. Chloe had completed all of her non-nursing courses before entering nursing school. She was in her final semester at Private Hospital School of Nursing when she failed the clinical component of the advanced medical-surgical course. She had been in the process of repeating the course but failed a second time. Chloe had been dismissed from the nursing program just prior to our interview.

Limitations of Study

This study is limited to the experiences of the 13 student participants who were enrolled in one of three associate degree nursing programs in the northeastern U.S. The themes examined in the three data chapters are presented in the context of these 13 students' lived experiences in an ADN program. The experiences of students enrolled in other types of degree programs and from other geographic locations are not represented in this work. Given the limited body of research which has examined the perspectives of ADN students, this study contributes to an enhanced understanding of nursing students' experiences in their classroom and clinical learning environments and also highlights the need for further research with ADN college students.

My social location as a white middle-class nurse educator was also a limitation. This became evident when I encountered difficulty recruiting students of color for this study.

I recognize that minority students might have made assumptions about me that may have interfered with their ability to trust me as a researcher and volunteer for my study (explained further in Chapter Three).

This dissertation study represents insider research. That is, I shared a nursing identity with student informants who were in the process of developing their nursing identity. While my insider status offered advantages it also presented limitations. For example, my role as a nurse educator posed a potential limitation related to my status as an authority figure. I worked to minimize this limitation by establishing a rapport at the beginning of each interview and also emphasized participants' knowledge and authority (Bogdan & Biklen, 2003).

Being a novice researcher represented an additional limitation. However, as I describe later in Chapter Three, I was fortunate to receive expert instruction and guidance from experienced qualitative researchers throughout the research process which helped me to develop my interviewing skills and minimize this limitation.

Significance of Study

The current nationwide nursing shortage is expected to deteriorate even further in the next decade. Experts estimate that by 2020 the nation will have 20% fewer RNs in the workforce than will be needed (Goodin, 2003). Given the projected critical shortage, it is important that higher education professionals focus attention on the retention and success of nursing students. Retention of nontraditional, minority, and male students is especially important if the nursing profession aspires to reflect the ethnic, racial, and gender characteristics of the population it serves.

Given what is known about how students' experiences in the learning environment shape their learning and development, studying the lived experience of nontraditional students in ADN programs is warranted. Tinto (1993) described student adaptation to college as a complex process of achieving academic and social membership and noted that almost one-half of the students who enroll in two-year colleges leave at the end of their first year. Adaptation is largely affected by the students' perception and appraisal of the college environment, including favorable interactions with other students and faculty both in the classroom and outside it. Student departure reflects the individual's experience in the institution and the meaning constructed around those experiences (Tinto). Supportive faculty-student relationships contribute to student satisfaction and retention (Astin, 1984; Beal & Noel, 1980; Shelton, 2003; Tinto, 1993). In fact, among the nontraditional population of students nonacademic variables may be more important to student retention than academic variables (Jeffreys, 2004).

Wells (2003) noted that much of what is known about nursing student retention emerged from studies carried out in the 1970s and 1980s when the typical student was White, middle class, and entered the nursing program directly from high school. Furthermore, previous research has primarily explored professional socialization in baccalaureate nursing education (Cohen, 1981; du Toit, 1995; Lewis, 1998; Olesen & Whittaker, 1968; Reutter, Field, Campbell, & Day, 1997; Secrest, Norwood, & Keatley, 2003; Simpson, 1979; Wilson, 1994).

Since its inception, associate degree nursing (ADN) education has advanced educational access for a more diverse student population including more nontraditional, minority, and male students (Mahaffey, 2002; Speakman, 2006). Since traditional three

year hospital-based nursing education programs required students to reside on campus they eliminated many from pursuing nursing. The ADN pilot programs attracted a different population of students, including older, working, and married students who were not previously accepted into traditional nursing programs (Mahaffey, 2002; Speakman, 2006). A higher percentage of male students entered these pilot programs as well (Haase, 1990). Today there are over 800 ADN programs nationwide and these programs supply nearly 60% of new graduate nurses each year (Mahaffey, 2002).

ADN programs not only attract a diverse student population, they are inherently different than baccalaureate nursing programs. Associate degree nursing education was conceptualized as a two-year educational program for a *technical* nurse, including prerequisites and co-requisites (Haase, 1990; Hood & Leddy, 2006; Huston, 2006; Orsolini-Hain & Waters, 2009). However, the curriculum has proliferated over the last several decades to keep up with *professional* workplace expectations.

The accelerated socialization experience of ADN students means they must negotiate the multiple challenges of preparing to become a registered nurse in two years rather than four. Previous research revealed that the journey of professional education is frequently experienced as challenging and stressful (Beck & Srivastava, 1991; Kleehammer, Hart, & Keck, 1990; Mahat, 1998; Oermann, 1998; Pagana, 1988; Wells, 2007). However, the majority of this literature also focused on students' enrolled in baccalaureate programs.

Engstrom and Tinto (2008) pointed out that access to higher education without concurrent support does not represent opportunity. Yet few studies have examined the perspectives of ADN students regarding how they construct support. Educational practices that promote the learning and success of nontraditional undergraduate nursing

students remains incompletely understood (Jeffreys, 2004). This gap in our understanding about ADN students' educational experience is especially problematic given the fact that ADN programs currently prepare the majority of Registered Nurse (RN) graduates in the United States (National League for Nursing News Release, 2006).

Creswell (1998) argued that the strongest rationale for a study follows from a documented need in the literature for increased understanding and dialogue. The need for a better understanding regarding how nursing programs might support nontraditional students' success has been documented in the literature. Astin (2005) and DesJardins et al. (1999, 2003) recommended more research centered on discipline-specific programs, nontraditional students, program completion time, student stopouts, and outcomes of education (as cited by Jeffreys, 2007). Jeffreys (2004, p. 3) argued that, "The untapped potential of the nontraditional student population demands focused attention on promoting nontraditional nursing student success."

Given the current national nursing shortage and the need for a diverse nursing workforce a better understanding of the associate degree nursing (ADN) students' journey, how they appraise supports and challenges in the learning environment, and how they navigate through nursing education is warranted. This study will contribute to the limited knowledge base regarding how ADN students' construct the meaning of experiences in the learning environment and how these experiences shape their learning, identity development, and success.

Organization of the Chapters

Chapter Two of this dissertation provides a review of the published higher education and nursing education literature that provides the context for this research. This chapter

reviews the literature in four key areas: 1) the history of nursing and nursing education, 2) professional socialization and identity, 3) contemporary associate degree nursing education, and 4) the students' experience of nursing education.

Chapter Three describes my methodological position and mode of inquiry. How I conducted the research, the decisions made along the way, and how data analysis was accomplished are explained in detail. Limitations of the study are also further addressed.

Chapters Four, Five, and Six address the central research question: What is the students' *lived* experience of associate degree nursing education? What is it *really* like for the students? The overarching theme, present in every interview, was that nursing education is challenging, stressful, and often overwhelming. How different aspects of students' experiences in nursing education contributed to their perception of feeling overwhelmed comprise the three data chapters.

Chapter Four examines how students experienced the pedagogy of the formal academic and clinical classrooms. The chapter argues that traditional teacher-centered learning environments in nursing education predominated at the three nursing schools represented in this study. Chapter Four revealed that, for many students, the demands of the nursing curriculum were experienced as overly challenging and stressful. Chapter Five focuses on conditions and barriers in the informal curriculum that shaped students' learning, identity development, desire and willingness to persist in nursing, and eventual success in the nursing program. Chapter Six examines how participants' navigated the curriculum. The chapter extends the arguments of Chapters Four and Five regarding the critical role of faculty in promoting or hindering students' ability to successfully navigate the academic and clinical curriculum of the nursing program and develop a positive self

concept as nurse.

Finally, Chapter Seven summarizes the dissertation findings described in each of the chapters which explicate aspects of students' experiences of feeling overly challenged and inadequately supported. The implications of these findings for undergraduate nursing education and retention, graduate education of future nurse educators, and recommendations for further research are addressed in Chapter Seven.

Chapter Two: REVIEW OF THE LITERATURE

This dissertation study of students' lived experience in nursing education is in the end a study of how participants experienced their professional socialization into nursing. Therefore, this chapter opens with a brief historical overview of nursing as a profession, the ideology embedded in nursing's history, and nursing education. Collectively, the data chapters examine students' socialization experience – how they developed the knowledge, skills, and sense of identity that are considered characteristic of a member of the nursing profession (Cohen, 1981). Therefore, the socialization literature is also reviewed. Teachers play an important role in nursing students' socialization and influence the students' developing self-concept as nurse (du Toit, 1995; Lewis, 1998; Olesen & Whittaker, 1968; Reutter, Field, Campbell, & Day, 1997; Secrest, Norwood, & Keatley, 2003; Wilson, 1994). While this literature has contributed to an understanding of baccalaureate students' socialization into nursing, few published studies have centered the experiences of associate degree nursing students. A review of the literature which examined students' lived experiences in nursing education extends this context and informs the discussion in the data chapters. Since this study focused on students enrolled in associate degree nursing (ADN) programs I provide a brief historical overview of ADN education, a description of current ADN student demographics, and an overview of the literature regarding the time required to complete an associate degree program. This literature provides the reader with a context for understanding the dissertation findings.

The History of Nursing and Nursing Education

The history of nursing and the history of women in the United States intersect in numerous ways. In the following section, the historical view of nursing as women's

work, caring as a core professional value in nursing, and the influence of Nightingale's training philosophy on nursing education and professional socialization are briefly summarized.

Nursing as Women's Work

Historically, nursing was considered women's work. In colonial days, American daughters were typically instructed in the art of caring for family members or friends in their community by their mothers as part of a female apprenticeship (Reverby, 1987a). So embedded was this concept of selfless caring for others as inherent to the woman's natural character, it became a central expression of women's expression of love for others and thus "integral to the female sense of self" (Reverby, 1987b, p. 199). However, like other women's work which was critically important to society, nursing was often rendered diminished and invisible (Reverby, 1987a). Reverby (1987a) argued that the central dilemma for nurses has always been the order to care in a society that devalues caring.

Nursing has always been a nurturing, caring activity but it was Florence Nightingale who established nursing as a profession, separate from medicine, which required specific personality characteristics for entry and concrete educational requirements (Chinn & Kramer, 2008). In Nightingale's era, Victorian women had no opportunities to exercise their intellect or passion. Nightingale saw nursing as a profession which allowed women to use both while contributing to society (Chinn & Kramer). Nightingale established training programs which disciplined and molded women with the appropriate character into practitioners skilled at "gaining acceptance from hospital authorities and physicians, as well as compliance from her patients" (Reverby, 1987b, p. 49). Nurses managed and

staffed the early nursing schools and directed the practice of nursing in homes and hospitals (Chinn & Kramer) within a hierarchical model which required "strict adherence" to orders "passed down from the nursing superintendent to the lowly probationer" (Reverby, 1987a, p. 7).

Numerous changes in nursing from the early 1900s to the 1950s continue to influence the profession today (Chinn & Kramer, 2008). American nurse training programs, first established in the 1870s, were heavily influenced by the philosophy of Nightingale who believed that disciplined training was necessary to perfect a woman's natural virtues to nurse (Reverby, 1987).

Higher Education and the Molding of Character

Reverby (1987b) noted that a focus on the molding of students' character permeated the philosophies of most educators in the nineteenth century who saw character development as a critical *rite de passage* into adulthood. Likewise, nurse educators felt a moral obligation and "pedagogical concern for the character of those they trained" (Reverby, 1987b, p. 50). Nurses were trained, disciplined, and molded into women of character: mature, altruistic, refined, submissive, quiet, and obedient (Melosh, 1982; Reverby, 1987b). In turn, the nursing student was expected to enact these norms for behavior or risk dismissal from the nursing program (Reverby, 1987b).

Historically, for many women, nursing provided an opportunity for an education and a career. Then as now, nursing could "empower a young woman (sic) by giving her meaningful work, a sense of accomplishment, and a group identity" (Reverby, 1987b, p. 57). However, Reverby (1987b) argued that the training school philosophy hindered the development of independent thinking and autonomy in its students.

Bevis and Watson (1989) raised similar concerns and proposed a new curriculum-development paradigm for nursing education. Indeed, they and others have argued for a humanistic, caring, student-centered paradigm that trains nurses but also educates them as caring, scholar-clinicians prepared to practice in an increasingly complex and unpredictable health care environment (Bevis & Watson, 1989; Diekelmann, 2001; National League for Nursing, 2003; Tanner, 1990).

Caring as a Core Professional Value

Nursing's historical roots as an altruistic, caring activity have shaped the profession's current philosophy and values. Watson (1990) noted that caring underpinned nursing's epistemology and Leininger (1988) viewed caring as "the central and unifying domain for the body of knowledge and practices in nursing" (as cited by Cohen, 1993, p. 621). Indeed, caring has become so central to nursing's ideology that even lay people entering nursing school as beginning students were found to have expectations about nursing as a caring profession (Cook, Gilmer, & Bess, 2003).

Nursing's core values are delineated by two of the profession's premier professional organizations, the American Nurse's Association (ANA) and the National League for Nursing (NLN). The principal goals, values, and obligations of the nursing profession are articulated in *The American Nurses Association (ANA) Code of Ethics* which includes nine provisions. While a review of all nine provisions is beyond the scope of this chapter, the first provision described compassion and respect for human dignity as an important professional value:

> The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by

> considerations of social or economic status, personal attributes, or the nature of health problems.

In summary, attributes identified as central to the profession of nursing include caring, respect for human dignity, autonomy, beneficence (doing good for another), non-malfeasance (doing no harm), and justice (American Nurses' Association, 2005). According to the ANA (2005) Code of Ethics, "Individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession but also to embrace them as a part of what it means to be a nurse…" (http://nursingworld.org/ethics/code/protected_nwcoe813.htm#preface).

Likewise, the core values of the National League for Nursing (NLN), the professional association for nursing education, include caring, integrity, diversity, and excellence. The NLN (2007) website described caring as a core professional value:

> A culture of caring, as a fundamental part of the nursing profession, characterizes our concern and consideration for the whole person, our commitment to the common good, and our outreach to those who are vulnerable. All organizational activities are managed in a participative and person-centered way, demonstrating an ability to understand the needs of others and a commitment to act always in the best interests of all stakeholders (http://www.nln.org/aboutnln/corevalues.htm).

Students learn professional values and norms during their professional socialization into nursing. In the following section, the process of professional socialization is reviewed.

Professional Nursing Socialization

Professional socialization has been widely studied by both sociologists and nurse researchers (Becker, Jeer, Hughes, & Strauss, 1961; Bradby, 1990; Cohen, 1981; Colucciello, 1990; du Toit, 1995; Merton, Reader, & Kendall, 1957; Olesen & Whittaker, 1968; Reutter, Field, Campbell, & Day, 1997; Simpson, 1979; Wilson, 1994). Cohen (1981) described professional socialization as the process by which an individual attains the knowledge, skills, and sense of identity that are characteristic of a member of that profession. It includes the internalization of values and norms held by members of the profession into the individual's own behavior and self concept. An important outcome of professional socialization into nursing is that the individual's concept of self changes and an identity as a nurse evolves (Colucciello, 1990; du Toit, 1995).

Theoretical Frameworks

The process of professional socialization can be understood in the context of two different theoretical frameworks, the functionalist approach and the interactionist approach. Each of these theoretical approaches, as well as a combined approach which integrates aspects of both perspectives, are discussed in this section.

Functionalist approach. In the functionalist approach, the purpose of society is to transmit norms and values to its members. Likewise, the professional school educates and socializes students to the values and norms of the professional culture. First described by Merton, Reader, and Kendall (1957) in their research with medical students, the functionalist perspective views the student as a passive recipient who is socialized to conform to professional values and norms. Faculty, professional practitioners, and peers are viewed as the socializing agents of students (Simpson, 1979). The assumption is that

a consensual value system exists among practitioners, faculty, and students as well as the profession as a whole. The professional school and its faculty control the educational process and induct students into this value system (Simpson).

Interactionist approach. A growing interest in the meanings students make of their schooling experiences led to a second approach to understanding professional socialization, the interactionist or reaction perspective (Simpson, 1979). Based on symbolic interactionism (Blumer, 1969), the interactionist approach assumes that an individual constructs meaning through interaction with others in the environment. According to Blumer (1969), the self is a process which develops during social interaction with other individuals and other's perception of the self. In contrast to the functionalist view, the interactionist approach views students as determining their own behavior (Reutter, et al, 1997; Simpson, 1979). Individuals respond to one another on the basis of their interpretation of the meanings of behavior rather than on the actual behavior itself. The student acts toward others and makes decisions based on the meaning of educational experiences.

The interactionist perspective that an individual constructs meaning through interaction with others in the environment is evident in several studies of professional socialization. For example, students in Becker, Jeer, Hughes, and Strauss's (1961) study were focused on survival in medical school. Students' demonstrated agency by assessing the meaning of faculty demands, learning the ropes, and then fronting the expectations of the faculty. Likewise, in a now classic phenomenological study of professional nursing socialization, Olesen and Whittaker (1968) used participant observation to examine the experiences of baccalaureate students in the class of 1963 (N=39) from their entry in

1960 to their graduation three years later. Researchers also conducted semiannual interviews with 15 students from the core class, a sample which decreased to 12 after several students dropped out. Olesen and Whittaker noted that most of the students entered the nursing program directly from high school and had high expectations for success. However, student participants had not anticipated the difficulty of nursing education and responded to their "reality shock" (p. 292) by becoming active agents in their own socialization. To reach their goal, students practiced the art of "studentmanship" – a type of "underground student behavior" (p. 149) whereby they made decisions and adopted strategies to get through and succeed in the nursing program (Olesen & Whittaker).

A combined framework. Both the functionalist and the interactionist approaches have contributed to the current understanding of professional socialization (Reutter et al., 1997; Simpson, 1979). In a qualitative longitudinal study in Canada aimed at exploring the process of socialization into nursing, Reutter et al. reported that both functionalist and interactionist approaches were evident in the learning experiences of the 131 baccalaureate student participants in their study. The key informants comprised 50 nursing students who were interviewed. An additional 81 students completed open-ended questionnaires. During the first year, students focused on learning theoretical concepts, observing role models (primarily faculty), rehearsing basic clinical skills, and following the rules given to them. First year students' socialization reflected the functionalist approach in that students were relatively passive learners of the ideal professional culture conveyed in both the classroom and clinical laboratory (Reutter et al., 1997).

In contrast, as second year students became more involved in clinical learning they were confronted with the "real" versus "ideal" dichotomy. Caring for patients prompted students to become conscious of the potentially negative outcomes of inadequate knowledge, their professional responsibilities, and how much more they needed to learn to become safe practitioners. Some students experienced feelings of inadequacy and stress (Reutter et al., 1997). Students demonstrated "situation (or reality) negotiating" as they learned to adopt what they learned in the first year to the unpredictable hospital environment and the needs of patients (Reutter et al., p. 152). However, students continued to lack confidence with clinical decision-making and depended on clinical instructors for validation of their decisions. They also felt vulnerable to others' appraisal of how they were doing professionally. Reutter et al. concluded that, "The student's reliance on the feedback of others demonstrates that the development of a self-concept or identity as nurse occurs through ongoing interaction with others in which the responses of others help shape the self" (p. 153).

Third year students in Reutter et al.'s (1997) study continued to demonstrate an interactionist approach to learning as they were confronted with the more complex needs of acutely ill, less stable patients. Providing optimal patient care given these circumstances represented a challenge as students worked to adapt by improving their organizational skills. However, third year students were more confident about the nursing care they provided and felt less dependent on others' appraisal. During their fourth year students began to prepare for graduation. For example, they actively looked for learning opportunities that would further enhance their competence as a new graduate nurse.

Reutter et al.'s (1997) study provided an important contribution to an understanding of the process of socialization into nursing through the four years of a baccalaureate education. The challenge of clinical learning - caring for patients and becoming a safe practitioner – is especially evident. Students' feelings of inadequacy and stress, lack of confidence with decision making, dependence on clinical instructors for validation, and the influence of feedback from others in shaping students' identity as nurse underscores the critical role of the clinical instructor to students' learning and development. Unfortunately, no similar published studies were located that examined the professional socialization experience during associate degree nursing education.

Professional Identity as Nurse

An important outcome of professional socialization into nursing is that the individual's concept of self changes and an identity as nurse gradually evolves (Colucciello, 1990; du Toit, 1995; Reutter et al, 1997). In several studies, having a professional identity as nurse was portrayed as the subjective *feeling* of being a nurse (Ohlen & Segesten, 1998; Secrest, Norwood, & Keatley, 2003). Some research suggested that the early development of a nursing identity may contribute to student success (Cook, Gilmer, & Bess, 2003). The literature which examined this process of feeling like a nurse is examined in this section.

Aspects of nursing identity. In a descriptive, cross-sectional study with Australian nursing students (N=173), du Toit (1995) found that autonomy, leadership, critical thinking ability, and professional commitment were essential aspects of professional nursing identity. In addition, the "ideal" nurse was described as one who demonstrated caring towards clients and a strong service orientation (du Toit, p. 171).

Caring. Several other studies identified caring as a significant aspect of nursing identity. In a descriptive study in Ireland, Ryan and McKenna (1994) examined the attitudes of nursing and medical students to aspects of patient care and the nurse's role in organizing that care. A sample comprised of 19 fourth year nursing students and 11 medical students completed a 31- item questionnaire which examined their attitudes toward their profession. Ryan and McKenna found that nursing students displayed more care oriented attitudes while the medical students were more cure oriented. Cook et al (2003) used a qualitative design to examine 109 beginning nursing students' written definitions of nursing. On their first day of the nursing program students were asked the open-ended question, "What is your definition of nursing?" (p. 313). Researchers concluded that nursing students entered their educational programs with complex conceptions of professional identity. Three major themes – nursing as a verb, noun, and transaction were identified. Nursing as a verb was comprised of caring, nurturing, teaching, implementing, assessing/analyzing, advocating and managing. Nursing as a noun was comprised of five categories of profession, holistic system, connecting system, delivery system, and discipline. Nursing as a transaction was comprised of promotion of health, treatment of illness, prevention of illness, and promotion of self care.

Belonging, knowing, and affirmation. Secrest, Norwood, and Keatley (2003) used a phenomenological approach to examine the perspectives of 64 junior and senior baccalaureate nursing students about what it meant to be a professional. Participants were asked to write about, and describe in detail, a specific experience of feeling professional. The researchers concluded that students' experience of feeling professional "was grounded in a world of self and others" (p. 77). Three interrelated themes -

belonging, knowing, and affirmation – emerged from, and were experienced within, this ground of self and others. Students' experienced a sense of belonging when they were a valued member of the health care team. The experience of belonging facilitated confidence and professionalism. Knowing, the ability to provide patients and their families with information, also fostered students' sense of competence and was professionally affirming. Affirmation, experienced during encounters with others, enhanced feelings of knowing and professionalism.

Confidence with clinical judgment. The capacity to make clinical decisions has also been identified as an important aspect of nursing identity (Benner, Sutphen, Leonard, & Day, 2007; Etheridge, 2007). In a qualitative, longitudinal study which investigated the perceptions of recent nursing graduates, learning to think like a nurse was described as the appearance of confidence, the acceptance of responsibility, changing relationships with others, and the ability to think critically (Etheridge, 2007). Participants were females 22 to 26 years of age, baccalaureate graduates, had passed the national RN licensure exam on their first attempt, and had also completed an internship with a RN preceptor. Etheridge found that new RNs lacked confidence in making clinical judgments and relied on "other" authorities such as preceptors and experienced nurses to help them make clinical decisions (Etheridge, p. 26). By nine months after graduation, new RNs had developed the capacity to make complex clinical decisions and act on those decisions autonomously.

Subjective and objective components. Ohlen and Segesten (1998) studied the concept of professional identity of the nurse with the purpose of accomplishing theoretical clarity and investigating implications for clinical nursing practice. The concept was examined

through theoretical analysis (an extensive review of descriptions in the literature) combined with fieldwork (descriptions from interviews with eight Scandinavian nurses). From the literature analysis and the interviews, an inclusive description of the concept emerged: the nurse's professional identity is incorporated into the personal identity of the nurse. Professional identity included a personal component comprised of "the person's feeling and experience of her/himself as a nurse" as well as an interpersonal aspect which included "other people's image of the person as a nurse**"** (Ohlen & Segesten, p. 725). The nurse's professional identify is "developed in socio-historical context through intersubjective processes of growth, maturity, and socialization where interpersonal relations are important, and attained maturity of the nurse influences further growth" (Ohlen & Segesten, p. 725). Personal attributes, consistent with personal identity, included assertiveness, compassion, competence, confidence, conscience, commitment, and courage. Interpersonal attributes were personal growth and professional maturity as well as congruence between feelings and behavior towards others.

Clearly, relationships with others, especially teachers, are an important aspect of professional socialization (Ohlen & Segesten; Reutter et al., 1997; Secrest et al, 2003). A sense of belonging was essential to feeling professional, as was feeling affirmed and knowing. However, no published literature was found that examined the socialization experience of students enrolled in a two-year ADN program.

Professional identity development and students' sense of self. The values and norms of the nursing profession outlined earlier in this chapter are taught and communicated to students during their formal and informal education and gradually students incorporate these into their own behavior and self concept. Nursing faculty play an important role in

students' socialization and influence the students' developing self-concept as nurse (Reutter et al., 1997; Secrest et al., 2003; Ware, 2008; Wilson, 1994).

Bevis and Watson (1989) contended that "curriculum is the interactions and transactions that occur between and among students and teachers with the intent that learning occur" (p. 5). Much of this socialization is overt and intentional but some of it is a product of those day-to-day interactions in the classroom and clinical setting that are outside the teacher's conscious awareness and which subtly socialize students to the values and attitudes of the profession. According to Bevis and Watson, this hidden (informal) curriculum is communicated in how faculty teach, their priorities, teaching strategies used, and relationships established with students. Most important, the hidden curriculum shapes students' thinking and identity development in significant ways and, when perceived as negative and unsupportive, may contribute to diminished confidence, academic withdrawal and attrition.

Reutter et al. (1997) noted that every time a student rotated to a new clinical unit they had to adapt to a new clinical instructor. However, faculty expectations often varied and students had to adjust their behavioral responses accordingly based on the anticipated responses of others including faculty. Students also had to learn the hospital unit's formal and informal norms and locate supportive nursing staff each time they begin a new clinical rotation, a process often experienced as stressful. Reutter noted that these behaviors were consistent with situation "negotiating" behavior, a characteristic of the interactionist conceptualization of socialization (described earlier).

Consistent with Mead's (1934) assertion that the knowledge individuals acquire about themselves occurs through social interactions, Reutter et al. (1997) concluded that

students developed a nursing identity based on the responses and feedback of others, especially teachers. Students were dependent on and vulnerable to these responses and feedback and felt they had to constantly prove themselves to faculty. Negative feedback decreased students' professional self-esteem (Reutter et al.). Keatley (1998) also reported that nursing students' experiences of critical incident stress (stressful encounters with nursing staff and clinical professors) left them feeling alienated, demeaned, and ignorant thus contributing to negative socialization (as cited by Secrest et al., 2003).

Likewise, Wilson (1994) found that senior baccalaureate nursing students in the clinical practice environment developed "a shared understanding of what the world of clinical nursing education was like" (p. 82). Participant observation was carried out as students provided care to patients and interacted with teachers, staff nurses, and family members. The process of becoming a nurse involved the accomplishment of six major goals identified by the 30 students interviewed as: To cause no patient harm, to help patients, to integrate theoretical knowledge into clinical practice, to learn clinical skills, to look good as a student, and to look good as a nurse. Participants in Wilson's study identified looking good as a prerequisite to achieving good grades and staying in the nursing program. Evaluation and self-concept, the focus of the last two goals, were interrelated. Students felt they needed to look good to teachers, nursing staff, peers, and patients. Students who successfully accomplished this goal received positive feedback which contributed to their developing sense of competence and confidence. Furthermore, Wilson reported that students perceived the clinical learning environment as one involving constant evaluation of their performance against a standard of perfection which included answering all of the instructor's questions correctly and making no mistakes in

clinical performance.

In summary, socialization into nursing is a challenging process by which students develop the knowledge, skills, and identity of a nurse (Cohen, 1981). The construction of a professional identity as nurse is grounded in social interactions and feedback from others, including teachers du Toit, 1995; Lewis, 1998; Olesen & Whittaker, 1968; Reutter et al., 1997; Secrest et al., 2003; Wilson, 1994). Students make decisions about whether to persist or withdraw from nursing based on the meaning constructed around their experiences "during and at the conclusion of each nursing course" (Jeffreys, 2004, p. 10). However, few published studies reviewed centered the perspectives of associate degree nursing students. Reutter et al.'s (1997) findings specifically, raise several obvious and important questions about how students' socialization experience differs in an associate degree nursing program. Reutter et al's first year baccalaureate students' learning was primarily reflective of a functionalist (induction) approach but students in baccalaureate education are not typically confronted with the challenges of clinical practice until the sophomore or even junior year of college. However, associate degree students are generally engaged in clinical learning within weeks of beginning the first semester, an obvious but often overlooked difference in students' socialization experience that warrants further study.

Associate Degree Nursing Education

There are currently three different educational pathways which qualify students to take the registered nursing (RN) licensure exam: two-year associate degree programs, traditional three-year hospital based diploma programs, and four-year college/university degree programs (Stone & Kelly, 2002). However, all graduates are required to pass the

same licensing examination, the National Council of State Boards of Nursing (NCLEX-RN) (Hood & Leddy, 2006). The following section provides a brief synopsis of associate degree nursing (ADN) education including a historical overview, current student demographics, the typical curriculum, and a brief examination of current challenges including the time required to complete an ADN program.

Historical Overview

Associate degree nursing (ADN) education evolved in the early 1950's in response to a national nursing shortage and a growing concern that the nation was educating an inadequate supply of nurses (Haase, 1990). Prior to this time students studied nursing in either a three year hospital-based diploma program or a four year baccalaureate program. The community college movement was already underway and the prospect of offering nursing in the curricula had been discussed as early as 1945 by the U.S. Office of Education and the American Association of Junior Colleges (AAJC), now known as the American Association of Community Colleges (Haase, 1990). A few years later Mildred Montag's (1951) doctoral dissertation, *Education for Nursing Technicians,* proposed a two year education for the technical nurse (Haase, 1990; Hood & Leddy, 2006). Montag's proposal described a technical nursing position whose scope of practice was broader than that of the practical nurse yet more limited than that of the professional nurse (Haase, 1990).

Nursing leaders formed The National Nursing Council to investigate the creation of nursing programs in community colleges and in 1946 released a position paper that recommended nursing education be relocated from traditional hospital-based programs to higher education institutions (Speakman, 2006). Between 1952 and 1958, the

Cooperative Research Project in Junior and Community College Education for Nursing, based at Teachers College, Columbia University launched seven pilot associate degree nursing programs (Mahaffey, 2002; National Organization for Associate Degree Nursing, 2005).

Student Demographics

Since its inception, associate degree nursing education has advanced educational access for a more diverse population of students (Mahaffey, 2002; Speakman, 2006). Since traditional three year hospital-based nursing education programs required students to reside on campus they eliminated many from pursuing nursing. The associate degree pilot programs attracted a different population of students, including older, working, and married students who were not previously accepted into traditional nursing programs (Mahaffey, 2002; Speakman, 2006). A higher percentage of male students entered these pilot programs as well (Haase, 1990).

ADN programs attract students with lower tuition costs, geographic location, faster completion time, and reputation (Mahaffey, 2002). Today there are over 800 ADN programs nationwide and these programs supply nearly 60% of new graduate nurses each year (Mahaffey, 2002). ADN programs continue to attract a greater percentage of minority and male students (Mahaffey, 2002). According to the U.S. Department of Health and Human Services (2004), 21.5% of ADN graduates represented minority groups. Furthermore, the average associate degree graduate was 33.2 years of age, nearly six years older than the average 27.5 year old baccalaureate graduate (U.S. Department of Health and Human Services Administration).

The Curriculum

Boland and Finke (2005) described the typical ADN curriculum as comprised of approximately 30 credit hours of general education coursework in the biological and social sciences and approximately 38 credit hours of nursing courses. Nursing courses generally concentrate on providing students with knowledge related to medical-surgical, pediatric, maternal-child, and psychiatric mental health nursing practice.

The National League for Nursing Accreditation Commission (1999) suggested that ADN programs should be comprised of a maximum amount of 72 credits (108 quarter units), but many ADN programs "struggle to meet these criteria" (Huston, 2006, p. 12). Indeed, many ADN programs require 75 or more semester units (Nelson, 2002).

A National League for Nursing [NLN] position statement (1993) argued that all nurses, regardless of educational background or area of practice, should be prepared to intervene at the macro level, to exert greater authority, accountability, and responsibility, and to depend less on institutional authority and policy. As a result, content in the ADN curriculum has proliferated and the corresponding number of credits exceeds that required for associate degrees in other disciplines (Nelson, 2002).

Time Required to Complete

While many students are attracted to the concept of completing their nursing education in two years, Huston (2006) contended that the two-year ADN program is largely a myth. Although ADN programs required two years of coursework at their inauguration in the 1950s (including prerequisites and co-requisites) the current nursing curriculum includes 12 to 24 months of prerequisites followed by a full two years of nursing education (Huston, 2006; Orsolini-Hain & Waters, 2009). In fact, nearly all

ADN programs currently require at least three years of education rather than two (Bednash, 2001; Benner et al., 2007; Huston, 2006; Orsolini-Hain & Waters, 2009).

Orsolini-Hain & Waters (2009) pointed out that contemporary ADN programs continue to evolve in length in order to meet healthcare expectations for a more educated nursing workforce:

As in the 1960s, when AD programs began adding leadership courses in response to work world expectations, contemporary programs have intensified and lengthened nursing courses, pushing more and more of the general education and science components into a prerequisite category, making most programs at least 3 years in length… Today, earning an ADN degree takes almost as long as a BSN (p. 269- 270).

The National Organization for Associate Degree Nursing (N-OADN) has maintained that associate degree nursing programs prepare students to safely enter clinical practice in two years:

> Associate degree programs provide a sound foundation for the delivery of safe client care in the current complex health care delivery system. The programs are a reasonable investment of time and money for the student, allowing for licensure and employment in two years from the time of admission to the nursing program (N-OADN, 2001).

In contrast, many nursing leaders have argued that it becoming increasingly difficult, if not impossible, to adequately prepare an entry-level professional nurse in *four years* (American Association of Colleges of Nursing, 1998; Benner et al., 2007; Nelson, 2002; Tanner, 1998). The amount of content in contemporary nursing curricula has been acknowledged as problematic (Diekelmann, 2002; Institute of Medicine, 2003; NLN,

2003) and nursing leaders agree that curriculum reform is needed (Bevis & Watson, 1989; Diekelmann, 1993; Ironside, 2004; NLN, 2003; Tanner, 1990). However, how best to implement curriculum reform remains a contentious issue.

Recently, Benner et al. (2007) reported the concern of nursing leaders regarding the current "practice and education gap," that is, it has become more and more challenging for nursing education to keep up with biotechnology, information, and research driven changes in contemporary health care systems. Similarly, Nelson (2002) challenged nursing leaders to consider whether "nursing education has evolved beyond the community college setting" (p. 4).

The Students' Experience in Nursing Education

In this section studies which examined the student's experience in generic undergraduate nursing education are reviewed. Two studies which investigated the overall lived experience of students are reviewed first. This is followed by a review of research which explored specific dimensions of students' experience, including the experience of stress.

The Lived Experience

Three published studies were located which examined the lived experience of students in U.S. nursing programs. The lived experience of the 17 baccalaureate nursing students in Nelms' (1990) study was that of a life - pervasive intensive commitment. Students, all of whom attended Georgia State University, described the volume of content to be learned and mastered as overwhelming and felt constant pressure to keep up. They worried about mastering knowledge and skills according to strict criteria and knew that any deviation would result in dismissal from the program. Students described clinical

experiences as the most meaningful aspect of their lived experience. In fact, "…it was within the context of their clinical experiences that (students) developed and began to feel good about their ability to perform competently as nurses" (Nelms, p. 290). According to Nelms, students expected teachers to recognize and value them as human beings. They wanted to be treated like "adults who have prior knowledge of many things" (p. 295), but are now learning nursing knowledge. Finally, students' expected nursing faculty to be competent, caring, and supportive of their learning.

Diekelmann (1988, 1992) studied the lived experience of nursing students but was one of the few researchers to include associate degree students as well as students enrolled in diploma, baccalaureate, and graduate nursing programs. Hermeneutic analysis of students' narratives reflected the following themes: "Feeling Overwhelmed," "Getting the Right Answer," and "Testing as Teacher-Centered Learning" (Diekelmann). Learning as testing emerged in every student narrative and conveyed the relationships among themes. Like the students in Nelms' (1990) study, Diekelmann's participants felt overwhelmed by the amount of content and pressured to learn it. Students described their experience as frequently adversarial and many reported feelings of frustration with teaching and evaluation practices (Diekelmann).

More recently, Magnussen and Amundson (2003) conducted a qualitative study which sought to describe and explain the experience of being a nursing student. A diverse sample of 12 students enrolled in a six semester nursing program from a single public university in Hawaii were interviewed. According to researchers, the students' socialization experience was exciting but "filled with obstacles and stress" (p. 265). Four

major themes were identified: a) meeting conflicting demands, b) feeling overworked, c) feeling unprepared, and d) seeking respect and support from faculty.

One of the themes identified in each of these three studies was the overwhelming nature of nursing school. Students' perception of teaching practices in nursing education as stressful and even adversarial suggests the need for further research aimed at better understanding the students' lived experience.

The Experience of Stress

A plethora of research literature has explored nursing students' experience of stress (Beck & Srivastava, 1991; Kleehammer, Hart, & Keck, 1990; Kushnir, 1986, Magnussen & Amundson, 2003; Mahat, 1998; Oermann, 1998; Pagana, 1988, Wells, 2007). A variety of terms including anxiety, frustration, emotional arousal, and pressure have been employed in these studies (Kushnir, 1986). It is important to recognize that the stress experienced in a particular situation is largely influenced by the individual's perception (Lazarus & Folkman, 1984). Thus, one's cognitive appraisal of stress determines whether stress is interpreted as a threat, challenge, or harm/loss (Lazarus & Folkman). Lazarus and Folkman defined threat as the possibility of harm, challenge as the aptitude for mastery or growth, and harm/loss as injury or loss which has already occurred.

Several studies used Lazarus and Folkman's (1984) cognitive appraisal of stress theory as a theoretical framework to examine nursing students' perspectives about clinical practice experiences. Pagana (1988) developed the Clinical Stress Questionnaire to assess the challenging and threatening features of the clinical experience in a sample of 262 sophomore and junior baccalaureate students in their first medical-surgical clinical experience. Open ended questions asked students "to describe the clinical experience

from the perspective of being a new experience and to describe the stresses, challenges, and threats" they were experiencing (Pagana, p. 419). Six main threats were identified: personal inadequacy, fear of making errors, uncertainty, the clinical instructor, being scared or frightened, and fear of failure. The clinical teacher was described by 68 students (26%) as "intimidating, threatening, demeaning, impatient, strict, and demanding" (Pagana, p. 422).

Likewise, in a study of 107 racially diverse junior baccalaureate students, negative instructor-student relationships were identified as a significant stressor (Mahat, 1988). Mahat used Flanagan's (1954) Critical Incident Technique Tool, a technique whereby students were asked to "recall and write down the most stressful event they experienced during their clinical rotation" (p. 13). Mahat categorized students' perceived stressors into five areas: initial experiences, interpersonal relationships, ability to perform, heavy workload, and feelings of helplessness. Initial clinical experiences (giving injections, providing care, communicating with clients, and performing physical exams) were reported the most frequently. A disturbing finding was that 45% of the students in Mahat's study described negative interpersonal relationships with faculty. Students "perceived that instructors were unsupportive, lacked understanding, were demeaning, and made them feel incompetent" (p. 7).

Beck and Srivastava (1991) used a descriptive correlational design to study the perceived level and sources of stress in 94 baccalaureate students. Sources of stress included the amount of material, exam grades, lack of timely feedback, patient responsibilities, and relationships with faculty. Students ranked relationships with faculty as the fourth greatest stressor.

Similarly, Kleehammer, Hart, and Keck (1990) used questionnaires to identify possible anxiety-producing clinical experiences for 92 junior and senior baccalaureate nursing students. An open-ended question, included in the questionnaires given to the last 59 subjects, asked them to identify the main cause of anxiety during their clinical experience. Researchers found that "negative interaction with the instructor was mentioned most often…" (p. 186).

In one of the few studies to include ADN students, Oermann (1998) compared the clinical experiences of 211 ADN and 204 BSN students and described these experiences from the students' perspectives. A descriptive exploratory design was used to collect both quantitative and qualitative data. Teachers who facilitated learning were depicted as clinical experts who helped students apply theory to clinical practice and supervised them without hindering their independence. Other teacher behaviors students identified as facilitators of learning included caring behaviors and empathy, offering feedback, and being available to answer questions or provide support. Students reported that the main inhibitor of clinical learning was the teacher. The qualities of teachers who inhibited learning included being uncaring, not providing immediate feedback, and not being available to answer questions or help them. Furthermore, students reported that nonsupportive clinical staff, insufficient time to accomplish patient care, and anxiety inhibited their learning.

The predominant stressor identified by the ADN students in Oermann's (1998) study was the clinical instructor followed by fear of making a mistake while for BSN students it was patient care first and then the clinical instructor. Significantly higher amounts of clinical stress were reported by the ADN students. For both ADN and BSN students, the

experience of stress increased as they progressed through the nursing program. The most stressful period for both groups was the semester just before graduation. Oermann concluded that:

> At the end of the curriculum, as clinical experiences become more complex and require independent decision making by students, learners may experience a higher degree of stress in comparison to beginning courses in which the faculty guides learning and decisions to a greater extent (p. 201).

Oermann further speculated that the higher amounts of clinical stress experienced by the ADN students, "who were significantly older and had more work experience than the BSN group, may reflect the need to combine the demands of clinical practice with family and work commitments" (p. 201).

However, the complex clinical decision-making expected of students approaching graduation may also explain the higher stress level experienced by the ADN students. Indeed, the accelerated socialization of students enrolled in associate degree programs means that students must negotiate the challenges of clinical practice in two years rather than four.

Many of the experiences students reported as stressful are inherent to the nurse's role in the clinical practice setting. Unfortunately, while teachers are in a position to modify students' stress by creating supportive learning environments the literature revealed that clinical teachers often exacerbated students' stress. As mentioned previously in Chapter One, the student's ability to cope with multiple stressors is recognized as an important determinant of retention (Glogowska, Young, & Lockyer, 2007; Prichard & Wilson, 2003; Wells, 2007). The literature suggested that for some students high levels of stress

may lead to withdrawal from the nursing program (Dreary, Watson & Hogston, 2003; Policinski & Davidhizar, 1985). In fact, in a qualitative investigation by Wells (2007) the accumulation of academic, social and/or external stressors was associated with academic failure or voluntary departure from nursing school.

Summary

This chapter reviewed the literature which provides a context for nursing education and key aspects impacting students' socialization, professional identity, and success. Nursing education requires students to master an extensive body of knowledge and clinical skills while learning to become a nurse. The literature has examined baccalaureate students' socialization into nursing. However, none of the published studies reviewed centered the experiences of associate degree nursing students. Reutter et al.'s (1997) findings specifically, raise several obvious and important questions about how students' socialization experience differs in an associate degree nursing program. Reutter et al's first year baccalaureate students' learning was primarily reflective of a functionalist (induction) approach but students in baccalaureate education are not typically confronted with the realities of clinical practice until the sophomore or even junior year of college. However, associate degree students are generally engaged in clinical learning within weeks of beginning the first semester, an obvious but often overlooked difference in students' socialization experience that warrants further study.

Previous research revealed that the journey of professional education is frequently experienced as challenging and stressful (Beck & Srivastava, 1991; Kleehammer, Hart, & Keck, 1990; Mahat, 1998; Oermann, 1998; Pagana, 1988; Wells, 2007). However, the majority of this literature focused on students' enrolled in baccalaureate programs. Few

published studies examined students' stressful experiences in generic nursing education and included the perspectives of ADN students (Diekelmann, 1989; Oermann, 1998).

Caring is central to nursing's ideology and the importance of a caring learning environment for students is widely recognized in both the higher education and nursing education literature. However, few studies reviewed included the perspectives of students about their lived experience in associate degree nursing (ADN) education. This underscores a gap in the literature regarding how ADN students' construct the meaning of supportive and unsupportive experiences in the learning environment including relationships with faculty and pedagogical practices, and how these experiences shape students' learning, identity development, and academic success.

Chapter Three: Methods and Procedures

"Knowledge screens the sound the third ear hears, so we hear only what we know"

(Kurtz, 1989; as cited by Munhall, 1993a, p. 44).

How do we come to know? Munhall (1993a) proposed an epistemological perspective of "unknowing." She cautioned that "knowing" can give rise to confidence and a subsequent position of closure. The risk is that "we can become limited by our own belief systems" (p. 41). When we believe we "know" something we stop asking questions or searching for answers. Munhall contrasted this with "unknowing," a state of openness to new understandings and perspectives.

As a nurse educator with many years of experience first as a clinician, then as a faculty member and course chairperson, I thought I "knew" a great deal about nursing education, nursing students, and what it means to be a good teacher. Learning qualitative research and becoming a qualitative researcher has taken me on a challenging but professionally rewarding journey. By assuming an epistemological position of "unknowing" I have come to know so much more about students' day-to-day experience of nursing education and what it means to be "good company" to them on their journey (Baxter Magolda, 2001).

This chapter explains how this qualitative study of associate degree college students' lived experience in nursing education was designed and implemented. First, a description of methods which grounded this dissertation research are described. Next, I portray my role as a researcher. Finally, I examine the limitations, procedures, and specific techniques, employed in this research study.

Methods

There are several types of qualitative research but all share certain important characteristics. Boyd (1993) described qualitative research as:

> involving broadly stated questions about human experiences and realities, studied through sustained contact with persons in their natural environments, and producing rich, descriptive data that helps us understand those persons' experiences. The emphasis is on achieving understanding that will, in turn, open up new opportunities for action and new perspectives that can change people's worlds (p. 69-70).

The purpose of a qualitative inquiry then is to fully understand reality as the participants' view it rather than how the researcher might view it. This understanding is accomplished through an analysis of participants' subjective experience. Grounded as it is in the experiences of participants, qualitative inquiry recognizes that students are experts on their lived experience in college. This qualitative study allowed me to study the reality of associate degree nursing education as a particular group of diverse participants experienced it. Since qualitative researchers are committed to participants' perspectives (Streubert & Carpenter, 1999) I was not concerned with the facts of my participant's stories or whether their perceptions of their experiences were accurate or "true." Rather, my approach to understanding students' narratives was a recognition that the truth "depends on where you are sitting, how things look to you" (Bogdan & Biklen, 2003, p. 23). Indeed, a nursing student sits in a very different location than a faculty member.

Phenomenology

A phenomenological methodology (Husserl, 1931, 1962, 1964; Spiegelberg, 1975) was chosen for this study because of its humanistic perspective which is in philosophical agreement with nursing and nursing education. Phenomenology evolved out of Husserl's (1962) philosophical critique of positivism which had been borrowed from the pure sciences and was being employed to address questions in the human sciences (as cited by Sadala & Adorno, 2002). Husserl argued for a phenomenological methodology, "a return to the lived world, the world of experience, which as he (saw) it is the starting point of all science" (Sadala & Adorno, p. 283). Indeed, for Husserl, scientific rigor required going to the roots or foundations of all knowledge, "the "things," the Sachen, the phenomenon …" (Spiegelberg, p. 82). Later Husserl argued that that "these roots lay deeper, namely in the consciousness of the knowing subject to whom these phenomenon appeared"(Spiegelberg, p. 82).

A central philosophical precept of phenomenology is the concept of intentionality, the idea that people are connected to and inseparable from their worlds (Husserl, 1964). According to Merleau-Ponty (1964) the researcher cannot describe the objective world but only the world *as experienced by the subject* (as cited by Sadala & Adorno, 2002). Phenomenological inquiry focuses on understanding the eidos, the essence of a particular phenomenon as experienced by a group of people, as well as the meaning of that experience as they perceive it (Husserl, 1931). Subjective phenomena are examined "in the belief that critical truths about reality are grounded in people's lived experiences" (Polit & Beck, 2006, p. 219).

The phenomenological method is an inductive, descriptive research method which has been used in studies which investigated nursing students' experiences of caring (Beck, 1991; Hanson & Smith, 1996; Hughes, 1992). Streubert and Carpenter suggested phenomenological inquiry as the most appropriate method when two conditions are met. First, there is a need for additional clarity on the phenomenon of interest. In this case, several gaps in the literature were identified and a better understanding of aspects of the phenomenon was needed. Specifically, few studies have examined the lived experience of students in associate degree nursing education. In addition, a limited number of nursing education studies included the perspectives of non-traditional, male, and minority students. Second, the participants' lived experience is a rich descriptive source of data (Streubert & Carpenter, 1995). Polit and Beck (2006) suggested that phenomenological inquiry is especially suited to issues basic to human experience such as the experience and meaning of stress.

Symbolic Interactionism

The theory of symbolic interactionism was considered in analyzing the data. The primary assumption of symbolic interactionism that "human experience is mediated by interpretation" (Blumer, 1969) is "compatible with the phenomenological perspective and basic to the approach…" (as cited by Bogden & Biklen, 2003, p. 25). "Objects, people, situations, and events do not possess their own meaning; rather, meaning is conferred on them" (Bogden & Biklen, p. 25). Blumer (1969, p. 2) described three premises of symbolic interactionism:

1) individuals act toward things on the basis of the meanings that the things have for them;

2) the meaning of such things is derived from or arises out of social interaction;
3) these meanings are handled in, and modified through, an interpretive process as the person responds and deals with the things that are encountered.

Applying the tenets of symbolic interactionism was instrumental to an understanding of students' decisions and behaviors in nursing school. Since the meaning of things – classes, clinical experiences, and teachers - are socially constructed by students as they interact with peers, faculty, patients, and others, students often share perspectives about their experiences (Bogdan & Biklen, 2003). Bogdan and Biklen pointed out that "it is not the rules, regulations, norms, or whatever that are crucial to understanding behavior, but how these are defined and used in specific situations" (p. 26). Indeed, students in my study identified particular rules and norms they interpreted as essential to successful navigation through nursing school.

Symbolic interactionism is a particularly useful lens for understanding how nursing students come to construct a sense of self as nurse. The possession of a "self" means that the individual recognizes himself or herself as a student attempting to become a nurse but also for example as a father or single mother with a family to support, the first in her family to attend college, or a 40 something gay man who has found fresh meaning in his life by caring for people who are dying. The individual "guides himself (sic) in his (or her) actions towards others on the basis of the kind of object he (or she) is to himself (or herself)" (Blumer, 1969, p. 12).

Research Questions

The following research questions emerged from preliminary interviews and helped to frame the focus of the expanded study. The primary research question was, How do

nursing students enrolled in a two-year curriculum experience their learning environment, including classroom and clinical settings? Three additional questions were inherent in the primary question: 1) What experiences do associate degree nursing students' perceive as contributing to learning and success? 2) What experiences do associate degree nursing students' perceive as barriers to learning and success? and 3) How do students' experiences shape their emerging identity as nurses?

Procedures

The Pilot Study

The pilot study which led to this dissertation began with a desire to more fully understand students' experience of stress in an associate degree nursing program and the meaning of that experience for students. The pilot study was conducted to fulfill an advanced qualitative research course assignment. I began the assignment by conducting participant observation of a support group for traditional first year associate degree nursing students. Traditional students at my institution, defined as those within a year or two of high school graduation, often struggled with the challenges of nursing school and the college was actively working to provide additional support to retain them. I thought the support group would be an opportune place to discover traditional students' perspectives of their experience. Unfortunately, the "support" group did not yield the rich data I was looking for. A few students brought up issues or concerns and then the two faculty facilitators explained why things were the way they were. Students did not talk nearly as much as I had hoped. None of the support group data was relevant or used in this study.

Next I conducted a focus group with four students from the college. The focus group helped me to establish a rapport with these students who provided rich data. However, very little of the focus group data is represented in this dissertation because most of the data obtained did not address my research questions. My professor provided feedback that helped me to see that what I was most interested in was students' individual stories. I realized that interviews, rather than focus groups, would be more appropriate to my research questions.

Convenience sampling was used to recruit participants for the pilot study. I left notes for each of the focus group participants that asked them to contact me if they were willing to engage in an individual interview; three of the four students volunteered. In order to recruit additional participants I visited the second level advanced medical-surgical class at the completion of class and introduced myself as a nursing instructor interested in understanding students' experiences in associate degree nursing education for a doctoral class I was taking. I emphasized that the project was not affiliated with the school of nursing and that their participation was voluntary. I offered to stay after class to talk further with anyone who was interested in participating and answer any questions; two female students volunteered that day.

The first interview I did was with Teresa, a 30 year old adult learner. Towards the end of the interview, and after a considerable amount of probing, Teresa shared a story that would ultimately shape my thinking about students' experiences. Teresa, an "A" student, described an interaction with a faculty member which she described as "very stressful." She said the incident prompted a "panic attack" and had such a negative impact on her that she thought about quitting the nursing program. At the time of our interview which

took place over a year *after* this incident, and just a few weeks before graduation, Teresa reported that she continued to experience feelings of anxiety due to her fear of "subjective" clinical evaluation and subsequent failure.

I continued to conduct open ended, in-depth interviews and began each with the question, "Tell me about your experience in nursing school." I let student participants shape the direction of each interview and used probes when necessary. I received encouraging feedback from my qualitative research professor that pilot study participants had provided "rich" narrative data and that further study was warranted.

The Expanded Study

In the fall of 2007 I resumed the research for this study at two additional schools of nursing. After contacting and speaking with each school's director (see Appendix A) I visited several classes on campus to speak to students about my study. All study participants were matriculated in a traditional day program at one of these three nursing programs accredited by the National League for Nursing Accrediting Commission. In addition, all three school websites reported National Council Licensing Exam (NCLEX-RN) pass rates which exceeded both state and national levels.

The first college of nursing, "Private Hospital College," was established in 1898 as a three-year diploma school of nursing and is affiliated with a not for profit teaching hospital. The school is located in an urban setting and has a traditional day program as well as a weekend program. The majority of students' clinical experiences take place at the affiliated hospital including its many off site services and clinics. In 2007, approximately 200 students were enrolled; nearly 90% of these were female. The faculty to student ratio at Private Hospital College averages 1:8.

The second school of nursing, "Private Hospital School," was established in 1913 and is also located in an urban setting. In 2007, the school had over 280 students enrolled. Founded as a three-year diploma program, this associate degree school of nursing has continued its affiliation with a not-for-profit teaching hospital where most of the students' clinical experiences occur. This school offers a traditional day program as well as an evening program and students may attend full or part-time. Most of the students' clinical experiences take place at the affiliated hospital including several of its offsite clinics. The faculty to student ratio at Private Hospital School is 1:8.

The third associate-degree college of nursing, "State College," is located in a rural setting and is part of the state system of colleges. State College offers both bachelor degrees and associate degrees in a large number of concentrations, including nursing. In recent years the State College typically enrolled over 200 students in its ADN program. Nursing students rotate through a variety of health care agencies including area hospitals**,** clinics, and nursing homes in order to gain clinical experience. State College's website reported their faculty to student ratio as 1:7-8.

At each school I introduced myself as a nurse educator and doctoral student interested in understanding students' experiences in associate degree nursing education. I used a written script to describe the study, the voluntary nature of participation, as well as risks and benefits of participation (see Appendix B).

The director of nursing at State College graciously welcomed me, showed me around the department of nursing, and took me to each faculty member's office to introduce me so that we could coordinate my classroom visits and introduce my project to as many students as possible. In a field note I wrote, "Many have tests today so I was warned (by

faculty) that anxiety levels were high and that "You can feel it in the air." Altogether, I visited six classes at State College over a two day period in October. Several students approached me right away to volunteer and several more called a few days later.

However, my first visit to Hospital School the week before Thanksgiving was less successful. While several students took my study and contact information I did not receive a single phone call. I couldn't help but wonder what I had done wrong. Had my timing been bad? Perhaps my visit caught students too close to final exams? I decided to call the director of the nursing school and seek her advice. She encouraged me to visit again and was gracious in arranging a second visit with faculty and staff. In the end, two students volunteered from Hospital School, both of whom were in their final semester and planning to graduate.

Participants

The 13 students who volunteered to participate in this study varied in gender, age, race, and sexual orientation (see Appendix C). Over a three semester period, I conducted one focus group and 18 individual interviews. The pilot study, conducted in the fall of 2005, included one focus group with four participants and five individual interviews. Thirteen additional interviews extended data collection in the fall of 2007 and spring of 2008. Eight of these 13 interviews represented first interviews and five were follow up interviews.

I used convenience sampling early in this study and later incorporated snowball sampling to seek participants (see Appendix C). A purpose of phenomenological research is to capture how different individuals construct the meaning of an experience in their own particular way (Munhall, 1993b). Student volunteers were solicited from three

different associate degree nursing programs with the goal of maximizing diverse sampling. The majority of previous research has focused on white females in baccalaureate nursing education. Therefore, it was important that my research include a diverse group of student' perspectives. Three men and two women had participated in the pilot study and they represented both traditional (18 to 23 years old) and non-traditional (24 years old or older) perspectives. Also, one of my male participants self-identified as "queer" which contributed additional diversity. However, finding students of color who were willing to participate proved to be more challenging.

When I resumed research in the fall of 2007 at State College I described the lack of minority student representation in nursing education research and encouraged students to consider participating as an opportunity to "have a voice." I was thrilled when Valerie, who introduced herself as Native American, approached me to volunteer for my study and gave me her phone number. I followed up with Valerie the next day and left a message when she did not answer her phone. An additional phone call a few days later and a personal note left in her mailbox at State College the following week were also unsuccessful.

Determined to find minority students who would be interested in sharing their experience, I used snowball sampling and asked early participants to refer others who met eligibility criteria (Polit & Beck, 2006). At the end of my interview with Marcy, after thanking her for her time, I explained the lack of minority representation in nursing education research and asked her if she had classmates who might be interested in talking to me. I have Marcy to thank for recruiting two students of color, Jacqueline and Annette, both of whom proved to be key informants.

When I visited classes at Private Hospital School of Nursing I also made a point to mention the lack of minority student representation in nursing education research and again, welcomed students who wished to "have a voice" in my work. One first year Black student took information from me but never called. In the rush of trying to meet the teacher's need to begin class I made the mistake of not getting contact information from the student. However, when I visited the classroom of second year students, a class of approximately 35 to 40 students, I did not notice a single student of color.

Meanwhile, I continued to interview participants. In a memo after the ninth interview, an interview with a first semester nursing student, I wrote:

> I am disappointed because (Lalia) had little to offer that I haven't already heard. Am I reaching saturation? It seems that I am beginning to. I think part of the issue is that I need to talk to third and fourth semester students – those closer to graduation who have navigated the system. Perhaps I also need to talk to students who have been unsuccessful (Methodological Memo, 11/14/07).

The qualitative researcher's sampling decisions should be shaped by the data (Polit & Beck, 2006). Although the ninth interview with Lalia contributed no new data, it did prompt me to ask better sampling questions as reflected in my methodological memo. Following this interview I began to consider which participants might provide rich data that would augment my understanding of nursing students' lived experience (Polit & Beck, 2006). I suspected that because they had navigated more of the nursing program, talking to third and fourth semester students as well as students who had failed out of the nursing program might provide additional rich data.

The next four participants I talked to met the criteria I had identified as important, one was a student of color and three were in their third or fourth semester of nursing school. All four provided dense descriptions of their experiences. The decision to use snowball sampling had been an important one because it led me to Jacqueline. Jacqueline was repeating her second semester and provided rich data about academic failure. Charles offered the perspective of a third semester male student. Finally, Jessica provided the perspective of a woman in her final semester who decided to withdraw because of what she described as "faculty abuse."

Interviews with informants continued until repetition of salient themes was apparent and no new information emerged from data collection (Polit & Beck, 2006). Data saturation became evident with the last two interviews. However, the process of reviewing transcribed interviews with my dissertation advisor led me to formulate several additional questions for seven informants. I attempted to contact six of these seven informants for second interviews – Jacqueline, Marcy, Annette, Marie, Teresa, and Jack. Four of the six returned my phone call and were interviewed. Unfortunately, as mentioned earlier, Jacqueline did not return my phone calls. Teresa returned my phone call two weeks later but we were not able to schedule a mutually convenient appointment for several additional weeks by which time IRB approval for the study was scheduled to end. I did not have further questions for the remaining six informants and did not attempt to contact them. I now recognize this as a mistake on my part and a limitation of the study. Second interviews with all of the participants would have allowed me to establish a deeper rapport with participants who may have provided a richer understanding of their lived experience (Munhall, 1993b).

Protection of Participants' Identity

Institutional Review Board (IRB) approval was obtained from Syracuse University as well as each of the three institutions represented. Prior to applying for IRB approval the dean or director of each program was contacted for college approval to recruit first and second year student participants that represent diversity in gender, age, sexual orientation, and ethnic background. Participants, as well as their college, self-assigned or were assigned pseudonyms. To protect participant's identity, each participant in the pilot study was assigned a pseudonym. In the extended study each participant was given the opportunity to choose his or her own pseudonym. The pseudonym was chosen before the interview and transcribed. In addition, the name of each participant's college was changed. Finally, participants were given the opportunity to choose the interview location. Participants were assured that the perspectives they shared with the researcher would be kept confidential. Participants were informed they could choose not to answer any question(s) and were free to end the interview at any time. Participants were also informed of their right to withdraw from the study at any time and for any reason.

Data Collection: The Interviews

Open-ended, in-depth interviews were conducted in order to accurately capture descriptive data in the participants' own words. I tried to meet participants' needs by letting them choose the interview location. When Marcy suggested we meet in the hospital cafeteria after she finished clinical for the day, we scheduled a 2:00 appointment thinking it would likely be quiet at that time of day. We sat in a quiet corner of the cafeteria and our interview went well. As nurses, we were used to the regular overhead pages for doctors and so on and were able to ignore them; however, transcribing with

these interruptions was a different story. Each overhead page overpowered our conversation and I missed an occasional word or two of Marcy's narrative. I found this a little frustrating and became deliberate in suggesting my informants choose a quiet location for subsequent interviews.

The interviews were guided by a set of questions (see Appendix D) which typically began with a broad question such as "Tell me about your experience in nursing school?" However, I allowed students the space to tell *their* story and shape the direction of the interview and used probes to elicit a deeper discussion of concerns and issues my respondents initiated. Interviews followed this loosely structured format and lasted 50 to 120 minutes each. Semi-structured interviews allow the researcher to develop an in-depth understanding of how participants think (Bogdan & Biklen, 2003). In order to capture students' perspectives accurately I audio taped all interviews and transcribed them verbatim. I personally transcribed every interview but one. While home from college on Christmas break my daughter transcribed one interview for me. After she completed the transcription I listened to the interview several times to check for accuracy, made a few minor corrections, and added memos and observer comments. While labor intensive, repeatedly listening to the interviews during the process of transcription helped me to become fully immersed in students' narratives early on and facilitated initial data analysis.

According to Husserl (1964) getting at the "pure datum" requires a systematic approach that begins with phenomenological reduction, a process of "suspending all beliefs characteristic of the natural attitude" (p. xvii). Bracketing is the "process of identifying and holding in abeyance preconceived beliefs and opinions about the

phenomenon under study" (Polit & Beck, 2006, p. 220). Bracketing allows the researcher to get at the pure datum (pure data). Maykut and Morehouse (1994, p. 123) noted that:

> The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others – to indwell- and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand.

As a nurse educator and a doctoral student, I had many thoughts, feelings, and assumptions about nursing education which I worked to bracket before beginning research and throughout the duration of the study. For example, this project was prompted by an interest in stress among college students. Students often complained to me about feeling stressed and I thought it was important to know more in the belief that a better understanding of ADN students' perspectives would help faculty, including myself, support students more effectively. However, when I began data collection in the fall of 2005 I bracketed the assumption that nursing school was stressful. This led me to begin each interview with an open-ended questions such as, "Tell me what your experience in nursing school has been like?"

Bracketing my experience as a nurse and nurse educator was ongoing. In reviewing the field notes from the first few pilot study interviews I noted that I occasionally made assumptions about what I was hearing from participants and failed to ask a probing question which would get at the *meaning* the experience had for them. I include here an excerpt from the focus group I conducted in the fall of 2005 as an example:

> Jack: This is *challenging* (emphasis his). This is the most challenging thing I've

ever done.

Darlene: Really?

Jack: Uh ha, I've been to school and have a degree already but this is much harder.

Darlene: You have what degree?

Jack: I have a bachelor's degree in (Business).

In an Observer's Comment I noted that I had "missed an obvious opportunity here." When Jack said that nursing school was the "most challenging thing" he had done I should have said something like, "Tell me more" or "Challenging how?" Although he had addressed this earlier he might have explained in more detail and I would have obtained richer data. Instead I focused on his prior degree partly because I was still trying to get to know him and the other participants as individuals but also because I made an assumption that nursing school *was* challenging.

However, my interviewing skills improved over the course of the study as I learned firsthand the importance of bracketing my assumptions, maintaining a perspective of open unknowing (Munhall, 1993a), and asking better probing questions which resulted in richer data. For example, during a later interview, Jacqueline responded to my question about experiences she had where she felt supported, by describing a teacher who "helped a lot." My ability to bracket and suspend my natural attitude (Husserl, 1931) is evident in the following interaction:

Darlene…What's been the most helpful?

Jacqueline: (laughs) Being able to actually laugh in nursing class. She makes all of us laugh.

Darlene: Why is that helpful?

Jacqueline: Because when you laugh it just relieves stress. It makes you think, "Oh, I can get through this, you know?"

Darlene: Is it stressful?

Jacqueline: Yes, very stressful.

Darlene: What makes it stressful?

Jacqueline: The amount of reading which isn't all of it but, frustrating because you're reading something, you read it over and over again and you don't, like, I study. I study so much and you don't get it. I mean, I think I get it but when I get to the test completely different story.

Phenomenological reduction, the process of temporarily suspending my prior knowledge and assumption that nursing school *was* stressful (and that laughter *was* therapeutic) allowed me to get at Jacqueline's lived experience of nursing school as stressful and the meaning of that experience for her. If instead I had agreed with Jacqueline that it was helpful to laugh I would have missed uncovering aspects of the essence of *her* experience (Husserl, 1931).

I used open-ended questions which allowed students to share their stories about what was important to them, in *their* own words. I did not want to lead students to respond in a particular way based on what they thought was important to me as the researcher. Based on their initial responses I used probing questions to elicit more descriptive data.

One of my research questions centered on barriers students encounter in their learning environment so I asked students, "What experiences, if any, did you experience as unsupportive?" Several students commented that nursing school was "more difficult" or

"different" than their previous college experience. When students did this I asked, "Tell me how it is different?" or "What is different?"

Near the conclusion of later interviews I began asking students a valuable question, "Is there anything else that stands out that you want to share with me?" For example, Charles responded, "I hope I got across what I hoped to in general about how I feel about things. It's hard; it's hard for me to watch other people fail… when I see them working so hard." Charles' comment led to further discussion about his role as a tutor and his desire to help his peers be successful.

Altogether, 13 students participated in this study. The pilot study included a single focus group and five individual interviews. Eight additional participants were recruited and interviewed during the extended study. In addition, second, follow up interviews were conducted with five of the 13 participants. The follow-up interviews were conducted in the spring of 2008 with Annette, Marcy, Marie, Jack, and Jessica.

Altogether, 13 students participated in 18 in-depth interviews for this study. The five follow-up interviews were the longest ranging from one hour and 40 minutes to just over two hours. The follow-up interviews proved to be quite helpful to a more complete understanding of these five students' lived experience. Munhall (1993b) noted that while qualitative researchers frequently rely on single interviews, more than one interview with each participant may be especially helpful as further "reflected upon" material is typically offered (p. 158). In this study this was especially true of the two follow-up interviews with Marie and Jack for whom well over a year had passed since the first interview. Munhall's suggestion was good advice that I regret not putting into practice and now consider a valuable lesson learned for my next study.

I began each of the follow-up interviews by asking students to tell me about their experience since our last interview. For two of my informants this meant reflecting on a period of two and one-half years! Jack had been a first semester student when he participated in the focus group and initial interview. The follow up interview was valuable because it allowed him to reflect on his experiences as a second year student. Jack also spoke about graduation, taking the NCLEX-RN, and the challenges he experienced working as a new RN.

During the follow-up interviews I conducted informal member checks to establish credibility of the data by asking for participants' responses to preliminary findings (Polit & Beck, 2006). For example, Jack was a first semester student the first two times he talked to me in the fall of 2005 (focus group and interview). In our follow-up interview in the spring of 2008 I shared data provided by several students that faculty-student relationships had a "power over" quality to them and asked Jack what he thought. Jack agreed with this preliminary finding and said, "Yes, there's definitely a rankism" and then explained his perspectives on the issue.

Since I already had a rapport with my informants I found it easier to ask more sensitive questions about aspects of students' experience. For example, Jack had been open about being gay during our first interview but hadn't shared in what ways, if any, his sexual orientation had shaped his experience in nursing school. In my doctoral coursework I had become familiar with the literature which suggested that gay students often experience feelings of being marginalized in college (Farrell, Gupta, & Queen, 2006). However, bracketing this preconception was essential to understanding Jack's lived experience. By our follow-up interview, which represented our third meeting, I felt

a strong enough rapport to ask Jack about *his experience.* I reminded Jack that at our first interview (two and a half years earlier) he had said to me, "You do know that I'm queer right?" and then asked him:

D: How did (being queer) shape or affect your experience, if at all, in your two-year program?

J: Well I can say this, I've always been more comfortable with females on a social basis. And going into a field like nursing I'm going to be able to work with women and it's going to be a lot easier for me.

D: Uh huh, what makes it easier?

J: I get along with them. I have more, you know this is it - when I was younger and I was born and I didn't know; and I was kind of a sissy… I wasn't in the boy's club. They didn't allow me in the boy's club.

Jack shared that for him, being "a gay man" did not represent a barrier to success in nursing school. Rather, Jack felt a sense of belonging with women which made things "easier" for him. He added, "I was picked at the school of nursing … I was accepted by everybody…" Jack's perspective also underscores the value of qualitative research in uncovering the differences in how people construct the meaning of experiences in individual ways (Munhall, 1993b).

Data Analysis

This dissertation research began with a pilot study I conducted while enrolled in an advanced qualitative research class. The literature review was postponed until after data analysis when participants' viewpoints were elucidated. According to Streubert and Carpenter (1999), the rationale for delaying the literature review is to achieve a pure

description of the phenomenon being examined. “The fewer ideas or preconceived notions researchers have about the phenomenon under investigation, the less likely their biases will influence the research” (Streubert & Carpenter, p. 61).

Data analysis began with data collection. Transcribing each of the interviews myself had an unanticipated benefit in that listening and re-listening led to an intense engagement with students’ stories. Accurate transcription of a typical one hour interview generally took twelve hours or more (I was compulsive about transcribing every “uh huh” and every pause accurately) but in the end I believe this helped me to get a better sense early on of how each participant experienced nursing school.

Once transcribed I reviewed the final transcript again, made final corrections, added observer’s comments, and wrote theoretical and/or methodological memos. The next step in data analysis involved reviewing participants’ narratives line by line and assigning preliminary codes. Coding, a process of sorting through and organizing descriptive data into patterns and topics, is an essential precursor to data analysis (Bogdan & Biklen, 2003).

Next, I scheduled an appointment with a graduate research assistant from the Higher Education department at Syracuse University who taught me how to use Nudist, a computer software program designed to organize and analyze qualitative data. After learning the basics I invested many hours over several days struggling to learn to use the software to analyze my data. Although I successfully created coding categories and an initial coding tree of my pilot study data I was becoming frustrated and soon realized that my lack of skill with the software was slowing down the process of data analysis.

Being a visual learner, I decided to try a more basic hands-on approach to data

analysis. I used colored pencils, a ruler, and multi-colored post-it notes and again went through my data line by line. I looked for recurring words and phrases and clustered similar data into themes as they emerged from my data. DeSantis and Ugarriza (2000) defined a theme as "an abstract entity that brings meaning identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (as cited by Streubert Speziale & Carpenter, 2003, p. 36). I underlined sections of narrative with an assigned color based on established categories which I had also color coded. I also created a list of codes and emerging themes in a Microsoft Word file as well as a coding schema. As I continued working with my data the list of codes and coding schema was revised several times as some categories overlapped or were unsupported and eliminated while others repeatedly appeared, thus gaining support. For example, the first time Maggie described her efforts to behave in ways that she perceived as expected I created a category called "Good girl behavior." However, I later renamed the category "Flying under the radar" because the behavior was referred to by both female and male informants and also because it was gender neutral.

I found Bogdan and Biklen's advice to "look for words and phrases subjects use that are unfamiliar to you" (p. 173) as these may indicate important aspects to explore further especially helpful to data analysis. I initially noted that two of my participants (Maggie and Marcy) had repeatedly used the phrase "flying under the radar" as a strategy they adopted to avoid negative attention and get through nursing school. I was unfamiliar with this phrase but once I understood the students' meaning, re-examining earlier transcripts proved to be critically important as students from all three nursing programs

had used similar phrases.

An audit trail was established by creating Microsoft Word files for each category and subcategory (Koch, 2006). I reviewed all 19 transcripts (18 individual interviews; one focus group), copied sections of narrative, and then pasted them into these Word files. Student narratives were organized in these Microsoft Word files which proved instrumental during the writing of the data chapters of the dissertation. I also developed a conceptual diagram for the relationships I was observing (Bogdan & Biklen, p. 173).

Data analysis began was data collection but once the last interview was transcribed the real work began. Although I was already immersed in my data and felt that I knew my participants' stories well, acquiring a deep understanding of what my data conveyed required months of "dwelling with the data" (Streubert Speziale & Carpenter, 2003, p. 36) a process I found frustrating because it required a much longer period of thinking time than I had anticipated. Engaging in the writing of a first draft facilitated the process of dwelling with my data. Furthermore, regular feedback from my dissertation advisor, an experienced qualitative researcher, was instrumental in pushing my thinking and analysis further.

During the fall of 2005, how to address the theme of unsupportive educational practices became an ethical snag. It was both surprising and disturbing to me that participants' perceived their learning environment as uncaring. After all, I believed nursing to be a caring profession. I recognized early on that bracketing this assumption by putting it aside and remaining open to data as revealed by study participants was critical (Munhall, 1993a; Streubert-Speziale & Carpenter, 2003). However, I was initially uncomfortable with the prospect of sharing participants' perspectives that nursing

education was sometimes uncaring.

Initial concern about how to proceed led me to search for answers from qualitative research experts. Bogdan and Biklen (2003, p. 33) noted that qualitative researchers work to "objectively study the subjective states of their subjects." In their discussion of ethical approaches to fieldwork Bogdan and Biklen further recommend qualitative researchers "Tell the truth when you write up and report your findings" (p. 45) While I struggled to understand some of my findings I was reassured that "the most important trademark of a researcher should be his or her devotion to reporting what the data reveal" (Bogdan & Biklen, p. 45).

My Role as Researcher

This dissertation study represents *insider research*. As described by Asselin (2003), the researcher conducting insider research "shares an identity, language, and experiential base with the study participants" (as cited by Dwyer & Buckle, 2009, p. 58). As a nurse-researcher, I share a nursing identity with student informants who were in the process of developing a nursing identity. I also experienced nursing education, albeit many years ago, and recall all too well how challenging it was. While my insider status afforded certain advantages, it also presented limitations. My role as a teacher posed a potential limitation related to my status as an authority figure. Furthermore, being a novice researcher also represented a limitation. In this section I discuss the advantages and limitations related to my roles as nurse, teacher, and researcher.

Adler and Adler (1987) noted that participants often accept the insider researcher more quickly and completely (as cited by Dwyer & Buckle). This represents an advantage in that participants are generally more open allowing the researcher to collect

richer data (Dwyer & Buckle). Another advantage I had as an insider was that I understood the medical and nursing language student participants were learning to speak. When Marie described her experience of caring for two acutely ill patients, one with "q2 vitals" (q2 is the abbreviation for every two hours and "vitals" is short for vital signs, one's pulse, respiratory rate and blood pressure) and one with a hematoma (active internal bleeding) she did not have to explain the language or her clients' diagnoses to me. Instead, she was able to explain what she was thinking and her struggle to prioritize the nursing care for two different patients. She knew that I understood the clinical significance of "q2 h vitals" as well as the clinical implications of a hematoma. This allowed me to focus more on the *meaning* of the experience for her as a novice clinician – her struggle to make the right clinical decision and her concurrent perception of being left alone, misunderstood, and unsupported by her clinical instructor.

While my insider status afforded these advantages, it also presented several important limitations. First, because influence and authority are inherent to the role of teacher, my role as a faculty member represented a potential limitation. To minimize this limitation I made the decision early in the pilot study not to interview any of my own students. Because I was a faculty member at the pilot school, a few participants knew who I was. In fact, the two second year students who volunteered to participate had been in my class the year prior to the pilot study. However the other three participants were first year students who did not initially know that I was a second level teacher at the school. I was deliberate in informing all participants of my teaching role but also clarified that my research interest in their lived experience was for a research class I was taking towards

my doctorate in education and as such was not in any way connected to the school of nursing.

S*taying in Researcher Role*

The process of doing qualitative research was not always a smooth one. Especially in the early stages my status as a novice researcher led to several "mistakes" which complicated the process of data collection. In the earliest interviews I would sometimes ask "yes or no" questions, provide reassurance, or agree with informants, saying something like, "Yes, I see that too." These first five interviews were conducted while I was taking an advanced qualitative research course and consequently, were reviewed by my professor, a nationally recognized expert in qualitative research who pointed out my behavior with the comment, "Watch your role!" Learning to do qualitative research in this way, with an experienced qualitative researcher providing feedback helped me to identify my strengths as well as weaknesses and to work to change ineffective behaviors.

Once these behaviors were pointed out to me I found myself watching my professor during class each week. In leading our class discussions I noticed she rarely expressed an opinion. Instead she often nodded her head and said things like "Uh huh" or "Tell us more about that." As I continued conducting interviews I worked to incorporate these techniques into my own repertoire of responses to informants. I learned that one of the best ways for me to stay in the researcher role was to keep my mouth shut which was sometimes hard to do! I learned to reflect more carefully on the words of my informants so that probing questions were open-ended. I learned that getting rich data meant learning how to push informants for a specific example by asking them to "Walk me through what that was like for you." I also learned to become more comfortable with

silence in my new role. In my later interviews I noted several instances where I was so intent on listening and understanding my participant that I kept silent while they kept talking and talking.

Social Location as White Middle-class Nurse Educator

My social location as a white middle-class nurse educator presented several challenges. Being white and middle-class seems to have been a limitation in several ways. As previously discussed I encountered difficulty recruiting students of color for the study. I now recognize that minority students might have made assumptions about me that may have interfered with their ability to trust me as a researcher and volunteer for my study.

Establishing trust was also critical to the quality of the stories students decided to share with me. For example, I began my interview with Jacqueline, a 19 year old Caribbean-American woman of color with the open-ended question I typically started with; I asked her what her nursing school experience had been like. Jacqueline said,

> I came straight from high school into college, straight into the nursing program and it was this huge transition, a huge transition… I should be in Nursing III right now, I had to repeat it. It was just difficult for me. And being up here and the atmosphere is not as diverse as I'm used to. It's just different. Like, I'm used to all types of people and here you hardly ever see Asians (laughs).

Establishing trust with Jacqueline was important so I worked to listen to *her* story, establish a rapport, and acquire an emic view; I did not want to "put words in her mouth." In my field notes I recorded an Observer's Comment part of which I include here:

> (Jacqueline's) concern about the lack of diversity "up here" is important to me. I

> was curious about her reference to "not seeing Asians." I waited for her to say it was difficult because there weren't many Black students on campus but she did not say it…

Upon further reflection I realize that Jacqueline may not have trusted me enough to be completely open with me about her discomfort with the lack of diversity on her campus. Bogdan and Biklen (2003) emphasized that skin color and race can complicate and present a barrier during fieldwork. While I knew this on an intellectual level I did not understand or fully appreciate how my position as a white woman interviewing a young woman of color could complicate data collection. However, I was deeply interested in Jacqueline's story and must have communicated this as she shared further:

> Jacqueline: It's hard because…I never had to deal with racism (laughs), never… And here, it's like, some people on this campus are very open and stereotypical about it. It's not even funny.
>
> Darlene**:** Ok, so you're actually dealing with racism?
>
> Jacqueline: Yeah, like, not personally but you hear on campus what someone has said and you're walking by this person and you're like, "Are you serious?" (laughs). What year are we? It doesn't, it hasn't affected me personally but it's just like - you get vibes. And it's like people write it on the computer or facebook or stuff like that, "These niggers and that and the third." Or girls in the bathroom talk (laughs) about African Americans and they don't realize you're in the shower so when they see you come out they kind of leave kind of thing. But you're going to have to deal with stuff like that in life.

In an Observers Comment I wrote:

> It is difficult for me to hear this. How can I, a white woman, possibly understand racism? I want her to trust me enough to tell me about her experience. We need to understand her experience, and students like her, if nursing education is going to improve our retention of students of color. As I transcribed this I had difficulty with some of the language she used. I was surprised that in 2007 she was hearing such language.

I was able to establish rapport with Jacqueline and she was a key informant who helped me to understand many aspects of her lived experience in nursing school. However, one of my biggest regrets, and a limitation of this work, is that I did not have the opportunity to speak with Jacqueline again after this interview.

Limitations of Study

This study is limited to the educational experiences and meaning making processes of the 13 student participants who participated from three associate degree nursing schools in the northeastern region of the United States. The qualitative design used in this study is not expected to obtain generalizable data. Therefore, study findings may not be generalizable to other students from other nursing programs. According to Lincoln and Guba (1985), transferability is the extent to which qualitative research findings can be transferred to other settings and groups. The qualitative researcher's responsibility is to provide a description of the phenomenon of inquiry that is sufficiently rich and thick enough that the reader can evaluate the transferability of the study's findings (Polit & Beck, 2006).

Influence and authority are inherent to the role of teacher. My dissertation committee and I had discussed the possibility that some participants might perceive me as an

authority figure. This could have interfered with participants' willingness to be completely open with me as the researcher and therefore represents another possible limitation. To minimize this limitation I was open with potential participants about who I was as a nurse, a nurse educator, and a student researcher working on a doctoral degree in higher education. At the beginning of each interview I worked to establish a rapport with participants, explained the purpose of my research, and assured them that they would be helping me, and other educators, to better understand nursing education because they were *the experts* on what contemporary nursing school was *really* like. This approach emphasized informants' knowledge and authority. Bogdan and Biklen (2003) suggested this approach because it "establishes the subject as the one who knows and the researcher as the one who has come to learn" (p. 99). I also assured participants that confidentiality would be maintained and that I would use pseudonyms for them as well as their college and family.

A major limitation is that the perspectives of only two students of color are represented in this study. Given the need for more minority RNs in the nursing profession, nursing programs must focus attention on the retention of racial and ethnic minority students. My dissertation proposal committee and I had discussed how important it was that students of color be represented in this work and my hope had been to recruit more students of color as participants. Unfortunately, as described earlier, this proved to be much more difficult than I thought it would be.

Another limitation, related to the researcher's role as an active participant in the qualitative research paradigm, is risk of researcher bias, the chance that the researcher may have interpreted the data according to her own perceptions rather than the

perceptions of participants (Polit & Beck, 2006). While this is always a risk with qualitative research, I worked to minimize this limitation in two ways. First, I used many of the active listening and communication skills I first learned in my generic nursing program and later honed in graduate education as a Clinical Nurse Specialist. While my role as a researcher required me to build on these skills and develop many new ones, I was able to use certain therapeutic skills, such as active listening and reflection to clarify that I had accurately heard my informants' words. Second, follow-up interviews were conducted with five informants to clarify their perceptions further, capture additional reflections, and acquire their perspectives regarding emerging themes.

This chapter described how this dissertation study was designed and implemented. The following three chapters examine the students' perspectives about their lived experience in one of the three AD nursing programs represented. In Chapter Four, the first of the three data chapters, the students' lived experience in the academic and clinical classroom is examined.

Chapter Four:

LEARNING IN NURSING EDUCATION: HOW STUDENTS EXPERIENCED THE ACADEMIC AND CLINICAL CURRICULUM

> Nursing is hard. You're dealing with people's lives so I understand why it's hard. I just think that maybe there could be different ways it could be taught. Jacqueline

This chapter examines how students experienced learning in the academic and clinical classrooms. The experiences of students examined in this chapter revealed that traditional teacher-centered learning environments in nursing education persist (Benner, Sutphen, Leonard, & Day, 2007; Candela, Dalley, & Benzel-Lindley, 2006; McEwen & Brown, 2002; National League for Nursing, 2003, 2005). The pedagogies of the classroom suggested a privileging of course content and a concurrent lack of sufficient opportunities for students to engage in thinking to develop an understanding of how information presented in the classroom applied in the context of clinical nursing practice. Students' experience of the classroom underscored their perception of being taught nursing knowledge but not how to apply or synthesize that knowledge. Students were frustrated and stressed because they did not feel prepared for exams that assessed comprehension and application of nursing knowledge in context. Students viewed this disconnect between what was being taught and what they were being evaluated on in the nursing program as a problem.

This chapter further examines students' construction of the clinical classroom as a site for evaluation rather than learning. Students were anxious about learning clinical skills, passing competencies, completing lengthy nursing plans of care, and caring for actual patients competently. However, the focus on clinical evaluation was perceived as a

barrier to learning and an added stressor. For many students, the demands of the nursing curriculum – the epistemological demands of the traditional classroom curricula, coupled with the demands of learning to become a safe clinical practitioner – were experienced as challenging and stressful.

Pedagogies in the Formal Classroom: Course Content as Privileged

A major theme to emerge from this study was students' experience of the formal classroom and assignments as primarily focused on the dissemination and acquisition of knowledge through traditional teaching methods. This privileging of knowledge acquisition was comprised of two related issues that students' identified as barriers to learning: a) the volume and difficulty of content, b) traditional lectures which felt rushed, and c) insufficient time for questions or dialogue.

Volume and Difficulty of Content

A traditional student in her second semester described her struggle to learn complex nursing material as "very stressful." Jacqueline explained, "It's not easy reading. Like, you can easily look it up because I have my (medical) dictionary next to me and stuff like that. It's just time consuming; and you have other classes to worry about." Getting through all of the assigned reading was challenging for Jacqueline because she did not always comprehend the meaning of complex material. She needed to research the meaning of medical vocabulary she encountered as she read, a process she found time consuming and stressful:

> You try to get everything done, all the reading done. But me, I'm a slow reader and I have to absorb and I have to know what I'm reading and sometimes I don't get all the reading in. Sometimes I'll miss like, maybe a chapter you know what I mean?

Unlike most of the other students in this study, Jacqueline was taking three other classes in addition to her nine credit nursing course. The demands of her other classes contributed to the stress Jacqueline perceived.

Students' described the sheer volume of content as a hindrance to their learning. Even students with a previous college degree felt challenged. Jack, an adult learner with a bachelor's degree in another field, described nursing school as "the hardest thing I've ever done." He explained:

> It's time consuming. I do it until I drop you know. I wake up at seven. You know, I do my work. It's 8:30 at night, and then I've had, 8:30, 9:00, and my brain's just frozen, fried. I can't go any further you know? And then I have to stop it because I'm at the age I know my limits too.

Charles, who had also previously earned a bachelor's degree, said it was "impossible" to complete the required reading and offered as an example the most recent assignment for a two week time period.

> Because the amount of reading in nursing school in general is *vast* (emphasis his). A huge amount of reading to do and giving equal amounts of energy to each portion of the reading is impossible because there's not enough room in my brain for it. I just can't process 485 pages of reading like there was for our introductory maternity section that I did a few weeks ago. I could not process 485 pages of reading.

Charles' frustration was centered on his perceived inability to learn the large volume of new material. The challenge of sustaining one's concentration long enough to process a large volume of reading has been previously described in the constructive-developmental

literature. Charles concluded that he did not have "room" in his brain for the hundreds of pages of material he was supposed to read. This notion was recognized by Perry (1967) who noted the "impossibility of passively receiving material for any length of time with no place to put it" (as cited by Kegan, 1994, p. 279-80). What Perry referred to of course, the place where human beings put knowledge, is the brain. Perry noted that teachers could support students' efforts to learn and process what they read by engaging their interest in reading for a specific purpose (Kegan, 1994). Putting knowledge in a particular context creates a place for that knowledge.

Marcy also reported feeling challenged by the volume of required reading which she too said was "impossible" to complete.

> I like to make *sure*, and I'm a perfectionist - that I've read everything I'm supposed to read, that I do everything that I'm supposed to do, that I thoroughly understand everything...And the pace I am running at its impossible to do all the reading, it just is, it's physically impossible. I just don't feel like I can adequately do everything the way that I want to do it. So I guess the inability to slow down, to take things slower, stresses me out. Like I think I would do this, if they split it up somehow, so that I could take part of it now and part of it next semester, it would take me longer to finish but I felt like I was doing it at a more reasonable pace so that I felt I would have a good grasp on everything I would like that better.
>
> Darlene: So right now you don't feel like you have as good a grasp of it as you'd like?
>
> M: No, not when they (teachers) give you post-op pulmonary disease, vascular disease and God there was something else. There were like four major topics you

> had to learn them all in two weeks. I know it's a two year program, we have to learn everything in two years, I understand that but oh, my God! No, you can't physically read everything that they assign. And you can't know everything as well as you would like to.

Marcy's perspective, that teachers "give" information about diseases and then students have two weeks to *learn* that information, highlighted the disconnect students in this study often perceived between teaching and learning (discussed further later in this chapter). Marcy recognized the importance of knowing material presented in the classroom and in the textbook but felt overly challenged by the task of *learning* that material in such a short period of time. She worked to learn information by studying, often with a friend, but did not feel confident that she understood the information.

Maggie also felt overly challenged. She described feeling overwhelmed by faculty expectations to integrate information across multiple reading assignments.

> The amount of knowledge that they (teachers) throw at you and expect you to understand at one particular time is too much. The fact that you have got seven different textbooks to learn from is too much. It's very overwhelming when you've got information from seven different sources. They don't all agree. Which one do you, you know, pick a textbook and teach from that textbook. If that's not adequate maybe you can add another one but they should have the same, you know, ideal as far as what you should learn. Not everyone has the same opinion on things. You know, if you can get two textbooks that are different, which one do you go by? Which is the one that you want?

Maggie's narrative suggested an epistemological disconnection between the knowledge that teachers "throw" at her and teachers' expectations that she would subsequently understand that knowledge. Her assessment, that it was "too much" suggested her sense of being overly challenged by the epistemological demands being placed upon her. Maggie's assumption that there was one right answer or one right textbook is consistent with that of a received knower (Belenky et al., 1986). Sorting through the multiple perspectives presented in seven textbooks was overwhelming for Maggie. Her frustration was centered on determining which book had the "correct" knowledge her instructor wanted (Baxter Magolda, 2001) because she knew that this was what she would be tested on.

Maggie's perspective captures the essence of absolute knowing - that right and wrong answers (in textbooks) exist and also, that authorities know the correct answers (Baxter Magolda, 2001). At 42, Maggie, a first time college student, felt frustrated when the teacher did not identify the "ideal" textbook she should use, the textbook with the right information (Baxter Magolda, 2001).

Maggie also experienced dissonance because the task of synthesizing knowledge from several sources was too cognitively complex. "It's just confusing when you have like four pages from this book, a chapter and a half from this one, two from this one, and let's put them all together… overwhelming". She did not appear to have the skills to identify evaluative criteria to adequately assess the accuracy of various sources, particularly if they conflicted. According to Kegan (1994) educators often demand of their students a way of thinking and making meaning that is beyond their current developmental location, an experience Kegan described as painful. Study participants used words like

"frustrated," "confused," and "overwhelmed" to describe their cognitive pain. Challenging students at this level is acceptable provided they are also given adequate support (Kegan, 1994). Maggie hinted at her desire for additional support in learning how to synthesize information from multiple books.

The participants in this study felt overwhelmed by the volume and difficulty of material as well and the time consuming nature of keeping up with this material. This finding is consistent with Nelms' (1990) study in which baccalaureate students' perceived that there were "insurmountable amounts of knowledge to be learned and mastered" in nursing (p. 288). Indeed, the 21st century has witnessed enormous gains in biomedical and nursing knowledge. Nursing is increasingly burdened with adding essential content to an already packed curriculum yet as noted by Ironside (2004), much less content, if any, is eliminated to make room. The Institute of Medicine (2003) has alluded to "overly crowded curricula" (p. 38) in the health professions and has called for educational reform as has the National League for Nursing (2003; 2005).

Traditional Lectures

Study participants described traditional teacher-centered classrooms where the primary teaching method was lecture and the role of faculty was to provide the student with essential knowledge (Barr & Tagg, 1995). Students did not perceive all lectures as problematic. In fact, certain teachers were described as "excellent" or "wonderful" lecturers. Lectures identified as not supportive of student learning included "rushed" lectures, "boring" lectures, and lectures given by teacher who did not demonstrate mastery of course content.

Reflecting back on her five semesters at Private Hospital College, Marie, a student who had since graduated, explained,

> It was always lecture. And if you asked questions they would get off track and they hated that. They had to stick by what their handout said, and a lot of times especially if you asked a question (the teacher would) be like, "People, people, questions later, questions later." It was one of those things, you could tell it would throw them.

The teachers' exclusive use of lecture and intent on covering all of the content in her handout reflected the instruction paradigm (Barr & Tagg, 1995). In the instructional or teacher-centered paradigm, the teacher lectures to students who passively listen and (perhaps) take notes. Charles also reflected on his classroom experience of being lectured to:

> My first semester I had seven different lecturers. Some (teachers) were a lot better than others. Some I didn't get anything from their lectures. Others I got a whole lot from their lectures. So there was this variation in the delivery of the material to me. And the same thing with this year - some of my lecturers are excellent at delivering the material to me. Other professors are very poor at delivering the material. So it's hard, you have to vary what you're doing studying based on who's lecturing to you rather than having some consistency.

Charles' argued that his teachers used lectures exclusively but varied in their delivery styles. Reflecting further on his classroom experience Charles added that the pace of lectures was also problematic. He explained: "I think that the faculty members are so rushed in what they're trying to bring to us sometimes that they don't give a chance for

questions to be asked."

Although he attended a different nursing program than Charles, Jack concurred regarding the hurried speed of classroom instruction:

> I had (Ms. Brown) for class. I think she has a very hard topic to convey. And she has to rush – and I feel bad. It's a catch 22 situation. A lot of this information is just, it's rushed. The pace is really fast for some of the topics that are more difficult.

Jack pointed out the challenge of learning complex material presented in a rushed manner but also empathized with the teacher who had to deliver the material in a short period of time.

Rushed lectures were reported as a barrier to learning in the Carnegie National Nursing Education Study (Benner et al., 2007). They found that nursing students were anxious about the volume of subject matter to be covered in lectures as well as "the speed and style of delivery…" (Benner et al., p. 8). In another study, student participants reported that the teacher's ownership of the classroom, including rushed lectures, hindered their ability to be successful (Poorman, Webb, & Mastorovich, 2002). The majority of participants believed that power in the classroom should be shared and complained about teachers who "gave lectures at the speed of light" and "had no interest in interacting with students" (Poorman et al., p. 7).

Marie described one teacher who "was very nice" but she said often induced lethargy because she taught by reading to students word for word "directly from her handouts." Marie confessed that she often "zoned out" during this particular teacher's class and would later supplement her notes with those of her friend. She explained, "You didn't

really have to pay attention. She (the teacher) tends to drone on." Marcy, who attended a different college than Marie, shared this perspective regarding monotonous lectures by drawing a contrast between two of her teachers.

> I have two instructors for class. One is my clinical instructor - love her, oh my God. I feel like she knows everything, she can explain it, she will sit down with you. She's great, I love her. She's awesome. The other one very nice person, really nice person - boring, puts you to sleep in lecture. She just goes right from the PowerPoint.

Bevis (1989, p. 240) criticized the traditional lecture because it often "lulls the brain to sleep," a notion shared by several students in this study. However, Barr and Tagg (1995) pointed out that lecturing is not prohibited in the learning paradigm. Rather, they suggest lecturing as a teaching method be assessed based on whether it facilitates students' learning. Marcy respected and felt she effectively learned from the lectures given by one of her teachers who she described as an expert in her content area and a skilled teacher. However, Marcy did not feel engaged in learning when the second teacher read to students from PowerPoint slides.

Freire (1970) critiqued the traditional model of education reflected in some of these students' stories about their classroom experiences. Freire stated "The contents, whether values or empirical dimensions of reality, tend in the process of being narrated to become lifeless and petrified" (Freire, 2000, p. 71). Students' comments about "zoning out" or "being put to sleep" during teachers' lectures reflects the core problem highlighted by Freire. Instead, Freire argued, authentic teaching requires dialoguing with students in a mode of reciprocity. Indeed, students in this study argued that talking to faculty and

asking questions would facilitate their learning, a topic examined further in the next section.

Insufficient Time for Dialogue and Questions

While a few students in this study reported that certain teachers allowed questions, many teachers were described as so focused on covering essential content that minimal, if any, time was afforded for student questions or dialogue. In his first year of nursing school Jack reported that:

> They (faculty) were giving the information. We only have an hour to do this, save the questions for later. You can come to our office anytime and stuff. But the thing is it's the now. I mean when you're doing something you have the question now and you're not getting it. You have other things to do after class or it's not a priority so. It was just that first semester.

Jack said that as a first year student he could not ask questions during lecture even when he did not understand the information being presented. Dialogue that might have facilitated Jack's understanding of content (Baxter Magolda, 1999, 2001; Freire, 1970) was discouraged until after class. Yet Jack pointed out that questions emerged in the moment and lost their relevance to learning when postponed.

Similarly, Jacqueline shared her need to ask questions and her frustration with certain teachers:

> It's just when I have questions sometimes it's just like you get the vibe that they (faculty) don't want to help you. They don't want to, they answer it briefly and its like, because they don't have time for this kinda thing.

Marcy reported a similar experience of asking questions during class:

> Last year my experience at (college) was, I felt like I was in nursing boot camp. The instructors were black and white. Yes or no answer, you do it or you don't do it. You could not ask them a question without getting your head ripped off and feel like you were bothering them. I mean more in the classroom. Well, did you do your reading? Yes, but I still have a question. Or you have a question about an exam. You did not ask questions about exams. They did not want to discuss it. This is what the answer is and that's the end of it. They were very unapproachable.

Marcy's narrative spoke to her sense of the traditional teacher-student relationship where the teacher assumed the role of authority and distributor of knowledge (Barr & Tagg, 1995). Marcy had questions which she wanted to discuss with the teacher. However, her needs as a learner were disregarded when she was told, "This is what the answer is." Furthermore, dispensing the right answers and discouraging questions reinforces continued reliance on external authorities, such as teachers and hinders the student's critical thinking and development towards self-authorship (Baxter Magolda, 1998).

Charles shared the perspective of his peers that certain teachers discouraged both questions and dialogue.

> I've had a lot of questions shot down in class throughout every semester… I felt a lot of the time like I shouldn't be asking questions or I shouldn't be adding things because for some reason it felt like I was challenging the (teacher). And that's my personality. I have a tendency to be pretty defiant in my learning. I'm like, "Well you know, "Why? You know, why should I do this? Why does that work like that?" And in my first year it was a lot of you know, "This is how it is, take it like that." There's no room for any discussion on any of this type of stuff.

Charles' classroom experience reflected the traditional view of teaching where the delivery of content is centered, even sacrosanct. In contrast to the traditional notion of teaching, Bevis and Watson (1989) suggested that content be viewed as a vehicle to learning. They pointed out that teachers promote student learning, scholarship, and critical thinking when content is "looked at from every angle, questions about it are posed, assumptions are examined, and thinking becomes the road to learning – not memorizing – information" (Bevis & Watson 1989, p. 172). Charles' questions indicated his need to engage in thinking about the material his teacher had presented. Yet the teachers' unwillingness to make room for Charles' questions and dialogue suggested that his teacher did not appreciate how students' questions engages their attention and enhances their learning of course material.

The students in this study expected to be able to talk to faculty and ask questions. When discouraged from asking questions students' perceived that faculty were unapproachable and that the faculty did not respect them. Marcy's voice was laced with a trace of anger as she described how she sometimes felt after asking her teacher a question.

> It's just they (teachers) are unapproachable. I just feel like, you know I'm an adult, I'm 33. I've been a decent student my entire life. Yes, you have your master's degree and I'm not a RN (registered nurse) yet and I'm just a little peon student but I should be able to, as an adult, talk to another adult with a question and be able to get an answer without being made to feel like I'm an inconvenience or stupid.

Learning is facilitated when students are given the opportunity to question (Baxter Magolda, 2001). An adult learner, Marcy had questions and wanted to engage in the

process of thinking and learning with her teacher but did not feel welcomed by her teacher. Instead, she felt resentful when certain teachers did not recognize students' questions as an important part of the learning process (Baxter Magolda, 2001).

A few students reported that particular teachers asked occasional questions of students during their lectures. Marie described how a teacher responded to her attempt to answer a question posed during class.

> We were doing this question... "The patient is in CHF (Congestive Heart Failure), suddenly short of breath, very anxious, lung sounds are crappy (sic). You call the doctor who prescribes 40 of Lasix IV (intravenous). All you have on the unit is 20 mg. What do you do?" I turned to Kyle, the student next to me and I said, "Call the doctor and see if you can split the dose. Can I give 20 now and the other 20 when it comes from pharmacy?" Because I don't know how long it's going to take to get it from the pharmacy. It's an emergency, we need it *now*! (The teacher) asked, "Who wants to split the dose? So I raised my hand but I was going to explain. And she (the teacher) says, (sarcastically) "Well everyone, guess what Marie wants to do? Marie wants to split the dose! That's wrong!" Everybody just looked at me. She didn't ask, "What do you mean you want to split the dose? How do you want to split the dose? Or that's not what the doctor's order is. In front of the whole class it was just, "Marie's wrong!"

Marie's narrative can be analyzed on several levels. First, Marie described the experience of being belittled by this particular teacher in front of the class as humiliating and added that she "had a hard time going to (this teacher's) classes" afterwards. Unfortunately, Marie was not alone in her experience. In this study, students from all

three nursing schools shared stories of being belittled and humiliated by a teacher, often in public (discussed further in Chapter Five).

Marie's narrative warrants analysis from a pedagogical perspective as well. According to Marie, the teacher had presented a brief patient scenario and then posed a simple clinical question to the class which Marie wanted to answer *in context.* Marie also described questions she had formulated as she reflected on the patient's situation and considered how to answer the teacher's question. However, as Marie depicted the incident she was not given an opportunity to explain and no class dialogue occurred. Though communicated subtly and covertly, what students' learned in a class context like the one Marie described is that they need not question because there was one right answer (Baxter Magolda, 2001) which the teacher provided as the authority.

The findings of this study are consistent with Benner et al's (2007) findings that students were being taught nursing as a body of knowledge separate from the clinical context. In a practice discipline like nursing having knowledge is inadequate. If students are to effectively use knowledge in clinical practice they must also understand and be able to interpret and apply knowledge. Consistent with the traditional teaching paradigm, students in this study frequently described classroom experiences where faculty lectured and they listened. Rushed lectures and insufficient time for questions and dialogue were perceived by students as hindering their learning and understanding of course content. Minimally, students were not encouraged to ask questions or dialogue. At other times, the consequences were harsh resulting in faculty expressing frustration, anger, and even belittlement of students.

Disconnect between Teaching, Learning, and Assessment

Study participants' perceived a disconnect between the teaching, learning, and assessment of nursing knowledge. This disconnect was evident in several aspects of students' lived experience in the classroom. In this section I extend the examination of classroom pedagogies to the learning of nursing content and the nursing program's assessment of that knowledge. As described earlier in this chapter, students' felt overwhelmed with the volume and rushed delivery of course material by teachers. In this section I share how students' struggled to learn nursing knowledge and experienced stress over not being prepared adequately to succeed on exams. Exams typically focused on three components besides knowledge acquisition: comprehension, synthesis and application of course material in a clinical context. Yet students' argued that classroom pedagogies focused on knowledge acquisition, not comprehension, synthesis, or application. The pressure to pass nursing exams shaped students' perspectives about the meaning of learning in nursing school. Students often focused more on how to pass the test than learning the course material.

Inadequate Preparation for Exams

Annette shared her sense of frustration that the knowledge presented during nursing classes was rushed through and inadequate compared with what she felt she needed to know to pass nursing exams.

> …And just the amount of reading and it seems like you talk about something only once and you're expected to know *so* much about it for you know, an exam. It just seems sometimes …like we'll run through things in two hours, we'll learn *all* about cancer in two hours and it just seems like that just really isn't enough to know all

> about cancer (laughs). I don't know if I want my nurse only having had a two hour lecture and then coming to work on me. So it's being able to pick up the book and getting most of, I guess the most in-depth knowledge from the book and then I think the lecture is just kind of there to piece it together. But that's tough. I know we don't have a lot of time but it seems like we should get a little more than that. We have seven exams; you don't have much wiggle room for failure within that either. You fail maybe two or three and then you're starting to get to the point where you may not make it. So, it's tough.

Annette felt that what she had received from lectures and textbooks was lacking; she wanted more time to learn and understand complex material and worried about passing exams. Indeed, she believed that students should get more time during classes to learn course material. Annette's narrative makes visible the disconnect students perceived between what was being taught and what they were being evaluated on. Annette was stressed because she did not feel that the rushed classroom presentation about cancer prepared her for the exam. She felt she needed more time to learn such complex material. There is no mention in Annette's narrative of classroom opportunities to engage in thinking and learning about cancer in the context of patient care, reflect on experiences with cancer, or examine connections between her clinical (or personal) experience with cancer and knowledge (Baxter Magolda, 2001). However, students later discovered that the course exams required this ability to apply theoretical knowledge to practice.

Even the self-described "A" students felt challenged by nursing exams and worried about failure. Jack remarked, "I would like to do better as far as the tests go…I'm an "A" student in general and so it's just hard because it's a different kind of test, it's a different

kind of thinking."

While Jack never described in any depth what he meant by the "different kind of thinking" he reported as challenging (and I missed the opportunity to probe further), other students did describe the level of thinking required to be successful in nursing school. Marcy, a student from a different nursing program than Jack, contrasted her previous college experience where she said tests were knowledge based with nursing tests that required a deeper understanding of course material.

> Well the nursing tests - you know, all through high school and my whole college career I've ever taken up until now - you do your reading – it's knowledge based. You know it or you don't know it. You get to nursing, it's completely different and intellectually I understand that but that doesn't mean I'm going to test well at it right away. And they don't have any class, it should almost be like an introductory thing where they sit down and say, "The testing is going to be different. It's in this format and this is the reason why." They never told us why we were tested this way.

During Marcy's previous schooling experiences, including two years of college, she had learned that knowledge acquisition ensured academic success. Now the rules had apparently changed and she felt unprepared. She felt that she could have adjusted sooner had teachers explained the testing expectations and rationales during orientation.

Teresa, a fourth semester adult learner who tutored both first and second year students in her nursing program, reflected on her experience of trying to help several classmates whose studying strategies had proven inadequate for success on nursing exams.

> I think they (students) memorized things which is what a friend of mine did in

> Nursing I. She used to think of all these little mnemonics, these crazy little rhymes. And I used to tell her, that's great and wonderful but you need to know how to *apply* those. So just because you've made up this silly little rhyme, is it going to help you over there (in the hospital)? You know sit there and play out this rhyme when you get over there and then start plugging in what you need to do for this patient …. And a lot of these level two students …are in tears. They're memorizing the information. They know the information but they don't know how to correlate the information to answer the questions on the exam.

Teresa's narrative also highlighted the disconnect between teaching and learning that many study participants' experienced. Some of the students Teresa tutored worked to learn the body of knowledge that was presented in class by memorizing information but struggled when they had to apply that knowledge in a clinical context (to pass exams).

Overwhelmed with the volume of information there was to learn and disappointed with the lack of time and assistance provided to help them acquire an understanding of information presented in class, students focused on learning what they believed they would be tested on.

Jacqueline shared her struggle to complete the volume of assigned readings but also, worried about what would be on the next test.

> Just going over it and over it and thinking to yourself, "Is this going to be on the test?" Sometimes the amount of reading that they assign, and …like a chapter with 50 pages on it right and maybe two questions will be on the test. It's happened to me a couple of times... It's just frustrating.

There is no evidence in Jacqueline's narrative of thinking about how she might apply

what she was learning to a clinical practice context. Rather, her focus was on completing the assignment and determining what aspects of the reading would be on the next test. Charles also focused on studying and learning "important" content, the knowledge he would be tested on.

> I was trying to do all the reading and pull everything there but then you can get in a trap where you are not looking at the things that are important. You are not looking at the information that is necessarily going to be tested on.

Like Jacqueline, Charles' had learned that completing all of the assigned reading did not ensure success on exams. Instead, Charles shifted his focus to learning essential content. Students in the current study echoed the sentiments of students in Diekelmann's (1992) study who also felt "overwhelmed" and "pressured to learn" the content delivered by teachers.

Success in nursing school depended on passing nursing exams. These exams were a frequent source of anxiety among study participants. Jacqueline shared her frustration with questions that were modeled after the National Council Licensing Exam for Registered Nurses (NCLEX-RN).

> The amount of reading which isn't all of it but - frustrating because you're reading something, you read it over and over again and you don't. Like, I study so much and you don't get it. I mean, I think I get it but when I get to the test completely different story.
>
> Darlene: Why do you think that is? What is it about the tests?
>
> Jacqueline: The way they word the questions. But I have to, they (faculty) say I have to get used to it because that's the way they word it on the Boards (NCLEX-

RN) . So I just have to adapt I guess.

NCLEX questions are generally written to assess comprehension, application, and synthesis of information (Twig, Rasmussen, & Speck, 2005). Jacqueline studied and thought she understood the material she was trying to learn until she took the exam. However, the exam questions required her to know more than the facts she had learned. The way the exam questions were worded often required her to apply the facts she has learned, in a clinical context. Jacqueline struggled to pass the exams and became increasingly frustrated. Her statement, "I study so much and I don't get it" underscores the disconnect between teaching, learning, and assessment students in this study often experienced.

Students knew that they needed to pass the NCLEX-RN exam after graduation in order to practice as a registered nurse and recognized that course exams strived to prepare them for the NCLEX exam format. Like her peers Annette worried about failing NCLEX style exams but described the current exams as good preparation. She clarified, "Do I like the tests? (laughs) No! But the mature adult part of me understands why they're testing that way." She explained:

> I actually think the questions are really good here because they aren't straightforward questions. They're questions that you get on the Boards the way they phrase them. "A patient comes in and what's your first priority?" But that's good because that's what you're going to get on the Boards [NCLEX-RN] exam. A patient comes in and what's your first priority? So we always have more than one right answer and you're always like, "Oh no!" (laughs). But that's good because that's what you're going to see on the Boards. It's best to get it now and make all

> your mistakes and get the rationales behind it so when you're faced with that on the Boards you understand how to prioritize so that you know, Ook, what are they (faculty/exam writers) looking for?

Annette's narrative makes explicit the idea that although nursing exams were difficult, the school was preparing her to take and succeed on the NCLEX-RN. In fact, although she was frustrated when she did not do well on an exam, she viewed the mistakes she made as good practice.

Maggie had a different perspective. She said that testing at State College was like being "thrown to the wolves" and "set (students) up" for academic failure. She claimed the difficulty level of NCLEX (National Council Licensing Exam) style test questions were not appropriate for first year students who had not yet developed these intellectual skills.

> Well, I'm not even struggling with the theory, and I'm not struggling with the knowledge base. It's, you know, it's the way in which they test. You're automatically set up to fail, and not pass. They give you half a semester to learn the process of NCLEX exam questions and then throw you into the three hardest levels of questioning… And when it comes time to take the NCLEX exam, we've heard from people who have taken the course here at State College that the NCLEX is way easier than any test they've taken here which I appreciate but that's a year from now. You know, that's not now. Don't set me up to fail on Nursing II so I never get to IV. I think that's the difficult… I mean I can understand the concept but there's no reason why you can't make the questions progressively more difficult instead of throwing you out there to the wolves immediately.

Bloom's taxonomy (1956), often referenced as a guide for the construction of nursing exams, is comprised of six cognitive levels: Knowledge, comprehension, application, analysis, synthesis, and evaluation (as cited by Twig, Rasmussen, & Speck, 2005). Similar to Maggie's claims, Twig et al. (2005) recommended that testing evaluate a mixture of cognitive levels and that the focus on higher level skills increase as instruction progresses. This approach is viewed as a way to prepare students for the national licensing exam which tests primarily at the application and analysis level (Wendt & Brown, 2000; as cited by Twig, Rasmussen, & Speck, 2005).

Maggie reported feeling overly challenged by exams which tested her at "the three hardest levels" and worried about failing them. Maggie's concern, shared by many of her peers, pointed to one of the problematic assumptions of the traditional teaching paradigm - that students must learn the knowledge of their discipline before they can participate in constructing knowledge (Barr & Tagg, 1995; Baxter Magolda, 2001). However, like Jacqueline, Maggie reported that exam questions required her to know much more than nursing facts; many of the NCLEX-style questions required her to apply facts in a clinical context, something the formal curriculum had not introduced her to in class or in assigned work.

Students struggled to pass nursing course exams and many blamed the difficulty of NCLEX (National Council Licensing Exam) style test questions on academic failure and student attrition. Several students expressed a desire for additional forms of academic assessment which they felt would better capture what they knew as well as their potential to become successful nurses.

Charles' explained:

> I always want an A and I'm just not hitting it. I'm like well, I'll study a little bit more, I'll study a little bit differently, this type of thing. And I'm looking at a question saying, "You know I can explain this to them (faculty) why don't they give us an essay? Why don't they give me some short answer options?" And I've brought it up a million times. "Oh, well, the NCLEX isn't like that." Well the NCLEX also isn't as hard as these tests you're giving us right here, because I do those NCLEX questions all the time when I'm practicing for tests. If we're able to do these tests we certainly should be able to do the NCLEX thank you. Are you really teaching what you think you're teaching here? Obviously not because 50% of the class is failing.

The focus on preparing nursing students to pass the NCLEX by assessing them with exams modeled after the NCLEX has interfered with the promotion of student learning. Charles cited a 50% attrition rate in his nursing program and shared Maggie's perspective that students were "set up to fail" nursing school by overly difficult NCLEX-style exams. Maggie and Charles were not alone in their point of view. Indeed, a key finding of the Carnegie National Nurses' Education Study stated:

> …Assessment of students on formal written tests is often structured along the strategies used by the NCLEX exams. We found too few other means of assessing student knowledge and skill acquisition which are necessary for practice and worry that there is too much teaching to the test (Benner et al., 2007, p. 19).

Maggie shared this perspective and hinted at her desire for additional forms of academic assessment:

> There's so much riding on the tests. Are you going to get through nursing school based on your tests? I don't believe testing is a fair and accurate representation of who I am as a nurse. That's how I test. It's not how I perform in a clinical. And it definitely doesn't represent my knowledge base, I really don't believe it does.

Maggie believed that her test performance was an inaccurate reflection of her nursing knowledge and ability. Indeed, the Carnegie National Nurses' Education Study addressed Maggie's concern with the recommendation that "assessment of students should be more varied and should test the level of integration of the three apprenticeships (theoretical and factual knowledge; skill based practice and clinical judgment; moral and ethical practice).

This section examined students' experience of a disconnect between nursing content taught in the classroom and the learning of that content. Students' narratives revealed that the focus on learning as knowledge acquisition was experienced as problematic and incomplete. Success on nursing exams required the contextual application of nursing knowledge, a challenge many students felt they had not been taught to accomplish in their coursework or assignments. Participants' narratives revealed a focus on preparing students to take and pass the NCLEX-RN rather than the promotion of student learning. Several students expressed a desire for additional forms of academic assessment which they felt would better capture their knowledge base as well as their potential to become successful nurses.

Pedagogies of the Clinical Classroom: Learning Nurses' Work

A central component of generic nursing education, the place where students learn clinical practice skills, integrate and apply knowledge learned in the classroom, and learn

to manage the healthcare needs of clients is the clinical practice setting. The question was recently raised, "How well do clinical faculty know the day-to-day experiences of students in contemporary practice education?" (Ironside, Diekelmann, & Hirschmann, 2005, p. 49). This section aims to describe students' day-to-day lived experiences of learning in the clinical practice environment. While some aspects of the clinical curriculum facilitated student learning many other aspects actually hindered learning. The following narratives highlight students' perception of clinical learning as a stressful high stakes endeavor which was so centered on evaluation of clinical performance and presentation of self it often induced anxiety and fear and inhibited students' ability to focus on learning.

Anxiety of Learning Clinical Skills and Passing Competencies

For study participants, a major aspect of nursing education and professional socialization began in the clinical learning laboratory (also called the competency or "comping" lab). Students learned fundamental clinical skills or "competencies" (giving injections, managing intravenous therapy, changing dressings, and so on) and practiced these skills on mannequins in the clinical learning lab. Students' ability to perform each skill correctly and safely (their competency level) was then formally evaluated by nursing faculty. Students had to pass each skill or "competency" in the simulated setting before they were permitted to begin applying skills with patients in the clinical practice setting. Students' reported that once they passed clinical competencies in the simulated lab setting their performance was further evaluated in the clinical practice setting (clinic, nursing home, or hospital).

When asked what her experience was like in nursing school Annette described it as

"intense" and added, "I just get real anxious when I'm doing the one-on-one when someone's watching me. That's probably one of the things I hate about this program (laughs) is the lab, or the comping lab I guess." The "comping lab" she explained, was where students performed new clinical competencies in front of one of the instructors. Consistent with Kushnir's (1986) work, students in this study, including Annette, described the presence of faculty during performance of clinical competencies as stressful.

I asked Annette to "walk me through what it's like" for her in the clinical learning lab during one of these competency evaluations.

> Oh, well you walk in. You have the kardex [patient's clinical paperwork] and the MAR [Medication Administration Record]. They give you a little card with the patient's name and room number and depending on what the skill is you either, you look at their MAR, look at their kardex. Then you go over to the patient and introduce yourself. Then you set the room up according to what's most convenient. If you're doing something sterile then obviously you need to use asepsis and, all the while, while they're [the teacher] boring down at you (laughs). And you have to have 100% accuracy, you get two chances. If you don't do well the second time then you have to do … some kind of contract I forgot what the actual name is for it. And after that if you don't do it then, bye-bye (laughs).

Study participants described feeling "nervous" during competencies and were keenly aware that they were being closely watched. Annette explained (emphasis hers),

> It's just the fact that someone's *watching* me, and they're standing *over me.* And it is *quiet* in there – there's no music, no distractions, and it's just really, for me,

> nerve wracking. I *can't stand it*.

Initially, Annette used humor to describe potential failure – "If you don't do it then, bye bye." However, a few minutes into our interview she reported feeling anxious during clinical competencies because she knew she had a limited number of opportunities to perform the skill correctly; otherwise Annette knew she would fail.

> There's just *way* too much anxiety when you go in knowing you only have one chance left. Some people just take longer to get things and it doesn't mean that you won't be a great nurse if you need it five times as opposed to someone who got it in two. So I don't like the fact that you only get two chances to do it, especially if you mess up the first time. Then you're going in like really psyched out for the second time.

Annette's narrative underscores the relationship between anxiety and mistakes:

> I shake a little bit, I mean, I'm not like having tremors or anything, but my hands might shake. My voice gets shaky. And I just get uncoordinated and I also get like a speech impediment when I get nervous, like I can't pronounce certain syllables (laughs). I don't know why I do that but, and then I'll make mistakes when I'm nervous which is usually what I'll do.

Annette's experience has been described extensively in the literature. Lazarus and Folkman (1984) suggested an inverse correlation between stress and learning; that is, as stress increases, learning decreases. Furthermore, Yerkes and Dodson (1908) argued that when an individual was too anxious or aroused performance became less efficient (as cited by Kushnir, 1986). This was true for students in this study who reported, as Annette did, that they made mistakes when they felt anxious.

Other students shared similar stories of stress and high anxiety. Marcy shared how feeling anxious with a new clinical instructor in the hospital affected her clinical performance of a basic skill she felt she had already mastered.

> My instructor claims that she won't make you nervous when she stands over you but you do. I mean simple things like I was changing tubing on an [intravenous/ IV] bag and dropped it on the floor, and had to get another one, got air in the line. I was like a bumbling idiot. I know how to run an [IV] pump. I just get so nervous. She makes me nervous.

Marcy's anxiety affected her ability to perform a simple task she felt confident about. Her experience makes explicit the paradox noted by Kushnir (1986) in the way nurses are educated. Kushnir argued that the presence of an instructor, though meant to minimize mistakes during learning and performance of clinical skills, may be experienced as stressful which he hypothesized, would lead to increased errors. Marcy expressed disappointment in herself for making several mistakes which shook her confidence and left her feeling incompetent, "like a bumbling idiot." Jacqueline also described her acute awareness of being watched and evaluated by faculty during competencies and pointed out that some faculty had earned a reputation for failing students.

> For me I'm always nervous when someone's watching me, always. But when someone's not watching me its natural, you know what I mean? It comes naturally to me. But when someone is there watching me it's difficult. And there are a couple of faculty who are known for failing students (laughs). Like they're *known* for failing students (her emphasis).

Several students explained that the amount of stress they perceived and their concurrent ability to perform varied to some extent with the behavior of the faculty member conducting the evaluation. Students perceived some faculty behaviors as supportive and others as hindering their learning and performance. Lalia shared what faculty support during a dressing change competency meant to her:

> I was nervous. And, she (faculty) was like you know, "Don't worry, relax, it's no big deal, just show me what you need to do." She was just very supportive and she was like, "Take a deep breath. Don't worry about it." I had my folder out, and I had my daughter on there, and she talked about my daughter for a minute with me. I did everything perfect up to a point - I did the hand washing fine, I identified the patient, pulled the curtain, you know, took the dressing off fine. Then when I put the gloves on I had contaminated the one glove. She (the instructor) was really good about it. She was like, "Well, you have to stop now because you contaminated yourself and you'll have to redo this." But she was good about it. But you would think that, you know? It just put me over the edge that day; I just cried. And I was like, "Oh my gosh. I am thirty-two years old, I don't need to cry over a failed dressing." But I did. One of my other classmates, who's a friend, she was like, "Well, it's no big deal, you can do it over." And I did, and the second time was better. I passed it, although I did go home and practice.

Lalia reported feeling supported by the instructor, who recognized Lalia's anxiety and took a moment to establish a relational connection with her, despite the fact that the instructor subsequently failed her. Although Lalia was disappointed in herself, the perceived support of the teacher, coupled with the encouragement of a peer, enabled

Lalia to move forward, practice, and re-test successfully.

Managing Coursework and Clinical Preparation

Students' reported that managing their academic schoolwork and concurrent demands of preparing for clinical as very challenging. Jason, a first semester student offered an explanation which captured the escalation in academic work and stress commonly experienced when students began their clinical practicum in the hospital.

> No, seriously the pace has picked up. Right before we got into our clinicals we were told that things would even out, so I was kind of looking forward to that. Here we've been hit with a sledge hammer of paperwork. And now all of a sudden it's like great, we're going to get over to the hospital and we'll be doing [clinical paperwork] that I haven't seen before. Coursework will be more evened out and be lighter and we're going to be working with people. It'll be a better learning experience. We'll be doing it instead of being in a classroom and having people talk at me. And then I realized that the course work hasn't lightened at all. Despite the fact that I certainly remember it being told to us that things would get easier. *No*, after I got on clinical things skyrocketed in terms of difficulty and stress level. It was much, much worse. And I'm not alone in that. It's not that I find clinical, the clinical experience to be stressful. I really enjoy working with people. I really, really enjoy my time on the [hospital] floor. But it hasn't gotten easier at all.

While Jason had been looking forward to beginning his clinical learning and viewed it as superior to classroom learning, the required clinical paperwork intensified his stress level.

Annette described how difficult it was for her in the beginning when she had to complete all of the clinical paperwork. Later in the term her teacher lightened the

paperwork requirement for "satisfactory" students. Until then however, she reported getting little sleep.

> But that's another thing is the clinical paperwork. It's overwhelming and they hand it out as though you have no life. It's ridiculous (laughs). I mean, I used to stay up and do clinical paperwork when I had to hand everything in until 3:00 in the morning and then I would get back up at 5:00 and finish it and go to clinical for 7:00. Two hours of sleep and there was a girl in our class who has a small baby, she'd get no hours of sleep. She'd come in, her eyes would be bloodshot because she was up the entire night either with the baby and trying to do her clinical paperwork. That clinical paperwork is just unnecessary. It's just, it's overwhelming. I mean if you don't work or do anything else I guess its do able but it's hard.

Despite the amount of work and concurrent stress, most students acknowledged that the clinical paperwork was valuable because it facilitated their learning. Marcy explained:

> (The) paperwork takes *forever* but I do feel like I get knowledge from the paperwork. It used to take me like eight hours to do the paperwork for clinical… we had to do patho. (pathophysiology) sheets for the primary diagnosis, like a four page assessment sheet, nurse's note of your assessment, umm concept map, what else did we have to do? -- Oh, evaluation form. But it would take me like forever. We had to drug cards for all the drugs they (patients) were on. It would take me like eight hours. But … you *really* had a good understanding of what was going on and why. Why is this patient having heart failure? You know, they have pneumonia or they're having heart failure why? It started to make sense. You

> know, because the heart is overworked because of the pressure from the pneumonia and all the fluid in the lungs pressing. You go home, do your reading and it makes sense, and you come back

For Marcy, clinical paperwork was worth the hours of work because it helped her to "get knowledge" and "really understand." Marcy's perspective underscored the connection between situating knowledge in a clinical context and student learning. Jack argued:

> Clinical is great. It's really wonderful to have the hands on experience. It's a lot of work. The (clinical paperwork) is a lot of work but I'm finding them (papers) worthwhile. Well you know, you hear these words – diabetes, colitis - you just hear them and you take them for granted basically, but we have to actually research them and figure out what they are. So you get into these med-surg books and you're reading it and you're like, "*Oh,* that's what it is." And then all of a sudden you know, four hours go by and you're like "Oh my God I've got to go to bed."

Like Marcy, Jack described the process of completing clinical paperwork as all-consuming but valuable to his learning. However not all students shared this point of view. When I asked Annette if the clinical paperwork helped her to learn she argued:

> I think it can. I don't think for me it does just because I'm doing it so late. Nothing is even sinking in because I'm just trying to get it done so I can hand it in. If I go back and look it over then I'm sure it has its benefits but I feel like the only time I get to look this stuff over is when the semester is over because you're going on to the next thing and the next patient. And there's a test you know, every other Monday.

Annette completed the required paperwork but acknowledged her lack of engagement with the activity. Annette was also taking a microbiology class and shared her frustration that she was not able to begin her clinical paperwork until she arrived home from that class at 10:00 PM. Her perception was that working on the assignment "so late" inhibited her ability to learn from it.

In summary, students in this study explained that the amount of stress they perceived and their concurrent ability to perform varied to some extent with the behavior of the faculty member conducting their clinical evaluation. Students perceived some faculty behaviors as supportive and others as hindering their learning and performance. Furthermore, although completing clinical paperwork was described as time consuming and an additional stressor, most students' reported that the process facilitated their learning of complex material.

Clinical Learning as Evaluation

A major theme identified by study participants was clinical learning as evaluation. Students repeatedly described an adversarial clinical learning environment which was often so centered on evaluation it induced anxiety and fear and inhibited learning. Jessica's account of how she and her classmates were introduced to the clinical expectations of their culminating medical-surgical course sums up the theme of clinical learning as evaluation:

> Darlene: What is the atmosphere like at the school of nursing?
>
> Jessica: It's scary. It's scary to the point that I was going home and throwing up. I was so upset and tense and nervous. They (faculty) really scare you. Like, here's an example, One of the videos at the beginning of the semester that they played for

us was, *Every Breath you Take*. Have you ever heard that song?

Darlene: I've heard the song, yes.

Jessica: (softly sings) *Every breath you take. Every move you make. Every breath you take I'll be watching you*. They played it over and over in the beginning. *Every breath you take. Every move you make, I'll be watching you.* And they played it again.

Jessica's perception of her new learning climate was shaped by the lyrics of this song. Jessica added that scare tactics like hearing this video played over and over in class made her and a classmate feel "like they (faculty) are going to show up on your door step."

In the clinical practice setting, the overall atmosphere for learning is largely determined by the clinical instructor and the type of learning climate created (Kleehammer, Hart, & Keck, 1990; Oermann, 1998). At our third meeting Jack, who had since graduated and was working as a RN, reported that as a fourth semester student two weeks into his final advanced medical-surgical rotation his clinical instructor began to hover over him (and his peers) during clinical procedures.

Jack: She trusted me, I did all this stuff (procedures) and everything was hunky dory. And then all of a sudden she just horded over us and made us nervous and made it impossible to do anything.

Darlene: Tell me what you mean by hording over you?

Jack: Like she would just comment on everything you did. I changed an IV (intravenous) bag once and she was like, in this tone (sarcastic voice) "Do it this way like you were taught in learning lab." It was just mea…Like she would just be mean. It wasn't a teacher, it wasn't helpful. Like it wasn't helping. Like (mimics

> teacher by rolling his eyes and sighing deeply as if in disgust), "Don't you know by now? You're graduating." I mean it was just like, you're making me nervous as all hell.

Jack went on to share that the experience had a significant emotional effect on him - shaking his confidence and leaving "a toxin" in him that persisted long after graduation.

> I was scared as hell of her. In that this person who doesn't listen has this control thing. I felt petrified, petrified. I didn't know what to do. It inhibited my education. I have to say, it was really only three days but it was enough to scar me for the next month or so. I mean I had that toxin in me until well after I graduated. And I think that's why I still expect that letter saying "We made a mistake you have to come back."

Jack and Jessica attended different nursing programs yet each described an experience in the clinical classroom that centered evaluation of performance, induced fear of failure, and inhibited learning.

The literature acknowledged that faculty observation and evaluation were significant sources of student anxiety and psychological stress (Kleehammer et al.,1990; Kushnir, 1986; Oermann, 1998; Wilson, 1994). Consistent with this literature, students in the current study often felt anxious and stressed about being evaluated. However, the narratives of students in the current study extend our understanding of specific dimensions of being evaluated as stressful. Specifically, students in this study interpreted faculty "hovering" behavior as a threat; it meant they would be/were being watched closely. In the clinical practice setting faculty "hovering" was often interpreted by students to mean they had been "targeted" for closer observation and consequently were

at risk for clinical failure (a theme further examined in Chapter Five).

Charles's description of hovering behavior, what he termed "hazing," further highlighted the evaluative component of clinical learning. Charles contrasted an experience he had in his first semester with his current experience to illustrate his point.

> In the clinical setting I felt like I was being hazed. Like, "I had to do this so now you have to do this and I can sit here and yell at you if you're not," you know? I saw some people cry because they were being…basically berated… You know, "You're not doing that right. You need to know how to do this right. I'm going to stand here right over your shoulder and I'm going to watch you and I'm going to judge the way you're doing this." Whereas my clinical instructor this year was not going to do that kind of stuff. She was like, "I know whether you're doing that right or not and I'll stop you if you're going to do something that's unsafe, is going to harm somebody or whatever. But when you're comping on how to do an IM (intramuscular) injection or whatever I am not going to sit there and you know, be over your shoulder." And the thing is, when you're in your first semester of clinical, they're berating you on how to do a bed bath.

Charles' narrative makes explicit the adversarial nature of clinical evaluation and also highlighted that clinical evaluation was privileged rather than student learning. After Charles stated that he felt like he had been hazed, I asked him if he had a personal example he could offer from *his* experience.

> The first time I gave a subcutaneous injection it was this little old lady and she was about 90 pounds and she was less than five feet tall; she was tiny. I was giving her a subcutaneous injection… When I walked into the room to give this shot the

> professor was so close to me that I was getting uncomfortable. This woman had very tough skin and when I gathered her skin to give the injection the skin, rather than having some spring to it, it actually folded under the needle and I pushed it in and the skin just folded underneath. And immediately the professor was yelling at me. "You need to do that again, you need to put it in there harder." I was trying to tell her (the instructor) that it's just collapsing under the needle so, "Can I hold it taut? Should I go in at a different angle?" … This kind of stuff are the questions that are coming to my mind. But she is there going, "You need to do that again, you didn't do it right." You know, making the woman nervous. She made it unable for me to ask any questions about what I had just tried to do… Rather than saying something like, "Well you need to go in at a different angle or you need to do this." It was "You did that *wrong*, you need to go back and practice more. You need to do this, you need to do that." That made me feel pretty crappy at the time.

Charles' *first* injection should have been a learning experience. Instead, the focus was on evaluation of his performance and what he did incorrectly. For Charles, being reprimanded in front of his patient made him feel "like I was being hazed." The incident hindered Charles' learning; he had "many questions" but the teachers' "yelling" prevented him from asking those questions. According to Charles, he "had practiced a lot." However, when the elderly woman's skin folded up under the needle [due to lack of skin turgor and aging] he did not know what to do. Benner (2001) noted that the problem solving of a novice (like Charles) differs from that of a proficient or expert nurse. The expert nurse, with an extensive amount of experience to draw from, develops an "intuitive grasp of each situation" and "operates from a deep understanding of the total

situation" (p. 32). The problem, Benner (2001) noted is that experts (such as teachers) often struggle to teach what they know. Applying Benner's model as a theoretical lens to Charles' injection story, it seems likely that Charles' teacher grasped the problem and expected Charles to also "know" what to do. However, Charles lacked experience and the embedded knowledge that comes with it; He did not know what to do.

Chloe, a student who clinically failed her nursing program two weeks into her fourth and final semester, also reported that nursing faculty at her school emphasized the evaluative component of nursing education:

> You're scared of all of them (faculty). I think it's just because it is grilled into you. "I don't care if you have a 99.9% average in theory if I (faculty) do not feel you should pass you will not pass." They tell you that when you first come in your first semester and remind you dearly of that every semester after that. "It is up to me if you pass."

The perception among students that nursing faculty constantly evaluated their performance and presentation of self is a prevalent theme in the literature (Diekelmann, 1989; Kushnir, 1986; Olesen & Whittaker, 1968; Wilson, 1994). Researchers have reported that faculty observation and evaluation processes are significant sources of nursing student anxiety and psychological stress (Kleehammer, Hart, & Keck, 1990; Kushnir, 1986; Oermann, 1998) and as noted earlier in this chapter, the process may inhibit learning and performance and promote errors (Kushnir, 1986; Lazarus & Folkman, 1984).

Furthermore, as reported earlier, students expected nursing faculty to exemplify the espoused values of the nursing profession and nurture their learning. Jessica's

disappointment with the learning environment during her fourth semester underscored this sentiment:

> It's not an atmosphere like we (faculty) are here to help you, nurture you, go out in the world and help other people. It's a totally different take. Its like, "We (teachers) are here to hurt you. That's what it seems like. We're here to crush you. And if you make it through you have to be a really good person because you made it."

The lived experiences of participants in this study parallel those of the nursing student participants in Diekelmann's (1989) study completed 20 years ago. Students felt angry and frustrated by the evaluation process described as adversarial. Similarly, the perspectives of this study's ADN participants also reflect those of the baccalaureate students in Wilson's (1994) study who described clinical learning as an adversarial contest where the student tried to look good as a nurse and the teacher tried to make the student look bad (p. 85). The evaluation process was rarely perceived as a formative process that would assist the students to improve and develop as a practitioner (Wilson, 1994).

Conclusions

The lived experiences related and interpreted in this chapter bring to light that the traditional teaching paradigm dominated classroom teaching practices in three associate degree programs. The teaching or instructional paradigm's privileging of course content was evident throughout students' narratives regarding the volume and difficulty of content and lectures as the predominant teaching method; dialogue and questions about course content were often discouraged or not allowed.

As novice nurses, students need a large body of knowledge in order to begin to provide safe patient care. However, the focus on learning as knowledge acquisition is problematic for students of nursing because it emphasizes the "acontextual application of content" (Benner et al., 2007). The findings of this study suggested that students are primarily being taught nursing as a body of knowledge separate from the clinical context. Students' narratives revealed that structured classroom opportunities to think about knowledge in the context of clinical practice "like a nurse" (Benner et al., 2007) were minimal or lacking altogether. Students' accounts of their classroom experiences revealed that the teacher was most often positioned as the authority – the giver of knowledge – while the student was socialized to remain passive and dependent on the teacher for knowledge.

Study participants often felt overly challenged by the demands of the nursing curriculum. Exams tested students' ability to synthesize and apply nursing knowledge, however, students' claimed these skills were not addressed in their coursework. Consistent with the Carnegie study preliminary findings (Benner et al, 2007), students' argued that the focus on NCLEX format testing encouraged a climate of learning for tests.

This chapter also examined students' day-to-day lived experiences of learning in the clinical practice environment. Students anticipated clinical learning opportunities with excitement but experienced the demands of clinical preparation as challenging. However, for many students, the work of preparing to provide individualized nursing care to their assigned patient facilitated learning and understanding by providing a structured opportunity to engage in thinking about selected aspects of nursing knowledge in a

particular clinical context.

The theme of clinical learning as evaluation was another major finding in this study. Clinical evaluation was rarely perceived as a formative process that assisted the nursing student to improve and develop as a practitioner (Wilson, 1994). Instead, many students shared that their performance in the clinical practice setting was constantly being evaluated by faculty and often, the feedback they received was not constructive. For some, the clinical learning climate was deemed as adversarial and the feedback debilitating, a theme further examined in Chapter Five.

Chapter Five

THE INFORMAL CURRICULUM: CONDITIONS AND BARRIERS FOR LEARNING AND PROMOTING STUDENTS' IDENTITY DEVELOPMENT AND SUCCESS IN THE NURSING PROGRAM

"Why put adversity into it? It's not a nurse. It's not caring. It's not generous. It's not kindness." (Jack)

Jack shared his sense of frustration and disillusionment that adversarial educational practices he experienced in nursing school were inconsistent with nursing's core values, values that had attracted him to nursing in the first place. Unfortunately, Jack was not alone; his sentiment echoed the feelings of participants from each of the three nursing schools represented in this study.

This chapter examines conditions and barriers in the learning environment that shaped study participants' learning, identity development, and success in nursing. The chapter contends that a supportive learning climate was created by faculty who were approachable, available, caring, and respectful. Supportive faculty provided constructive feedback and validation and conveyed their belief in students' ability to learn and become successful nurses. Barriers to learning, development, and success in nursing reflected a range of unsupportive educational practices that often included faculty incivility or bullying. Students who experienced faculty bullying reported feelings of humiliation, being traumatized, decreased self-esteem, and diminished confidence. They felt discouraged, questioned whether they were good enough or smart enough to be a nurse, and considered withdrawing from the nursing program. Finally, perceptions of discrepancies between their learning experiences and the espoused caring values of the nursing profession contributed to some students' feeling of disillusionment. profession

Positive Faculty-Student Relationships Promoted Learning and Development

According to study participants, conditions which contributed to a positive learning environment and facilitated their learning included faculty approachability and accessibility, mutual respect, positive feedback and validation, and modeling the espoused values of the nursing profession (caring, kindness, and compassion). Unfortunately, while participants were able to articulate what they needed from teachers, their narratives indicated that the supportive, caring relationships they desired were often lacking. In the following section each of these facets of students' lived experience of relationships with teachers as well as the meaning of those experiences for students, are described.

Approachability and Availability

When study participants were asked what experiences they felt supported their learning, the importance of faculty being approachable and available came up again and again. In this study, participants' appraisal of their teachers' approachability and availability shaped their perceptions

about whether teachers cared about them. Unfortunately, study participants described numerous encounters with faculty who were both unapproachable and unavailable to them. There were notable exceptions. For example, while Jacqueline perceived that most teachers did not seem to care she was appreciative that one of her current teachers did care about her.

> Jacqueline: So, she actually cares. She cares and it's rare to find that. I mean she *cares* (emphasis hers) about you.
>
> Darlene: Why do you say it's rare to find that?

> Jacqueline: Because you ask all these teachers for help (laughing) and they blow you off. And she goes, "You know what, I have a conflict here and here, this time and this time." And if she's not free, "Walk with me and we'll talk while we're walking" you know what I mean? She tries to find that time. Meanwhile she has like four kids, she's a supervisor of the hospital, and she's working a full-time job. But she just finds that time.

For Jacqueline, the teachers' effort to "find that time" and make herself available to meet with Jacqueline meant that the teacher cared about her. Her appreciation for her teacher's willingness to find time for her is consistent with the literature. Halldorsdottir (1990) reported that the teachers "sharing and giving of self" was reported by nine graduate nursing students as an essential aspect of the caring teachers' approach. Similarly, in a qualitative study which examined the concept of caring, participants reported that teachers who were accessible to them facilitated a feeling of faculty-student connectedness and caring (MacNeil & Evans, 2005).

Charles reported that "the relationship with the faculty member" was an essential component of whether he felt supported in the learning environment. He explained by providing an example from his previous college experience where he said teachers wanted to help students:

> The approachability of the professors is huge. I could go to any of those professors (at former university) and say, "Listen, I have some stuff going on. Sorry I missed class can I get the notes?" You're going to get variations in how people are in general but they were all, you know they wanted to help you.

Charles further explained by drawing a contrast with his current experience in the school

of nursing where he said he often felt unsupported:

> Approachable faculty members are a lot easier for me to deal with than the ones who are more aloof. I mean I don't think you have to be friends with all your faculty members but you have to relate to your audience. You know what I mean? If you don't, if you're a faculty member who you know, just thinks, "I'm here to teach you this," you know kind of this hard nosed approach, "You have to do this yourself." It just doesn't seem conducive to learning to me.

Charles believed that connected relationships with faculty supported his learning. In one study, connected teachers were described as emotionally and physically available to students (Gillespie, 2002). In contrast to the cold, rigid demeanor which Charles experienced as a barrier to learning, students felt comfortable to approach connected teachers because they were "genuine and present as a person as well as a teacher" (Gillespie, p. 6).

In Jacqueline's narrative both the physical and relational (emotional) components of being approachable and available are made especially visible.

> …They [faculty] are hard to find… They'll say, "Oh, I'm in my office." And in the lab, like this really bothers me, you try to get them to watch you and help you [with clinical skills]. They're talking about their kids and what they had for dinner last night. And it's like, "Come on!" And I don't have any kids (laughs) so I can't relate to nothing you know what I mean? It's like, I'm sorry but I have classes, I have to go. It's like the other students are older so they can relate like, "Oh my kids are this, that and the third." And it's like, I'm sitting here waiting for you to watch me.

Jacqueline's perception was that the older students had more in common with the teachers. She felt left out but also resented it when teachers engaged in personal conversation rather than giving her the time and help she needed to accomplish her work in the lab.

Likewise, Chloe described a time when she attempted to meet with her instructor after clinical hours because she recognized she might be in clinical jeopardy but her instructor did not make time for her. She explained:

> I repeatedly tried to meet with her outside of clinical. That wasn't happening. She would say, "Well, I don't have the time." She always walked real fast, "I don't have the time, I'm busy." And then she'd go walking down and there were two times in particular that I remember I looked down [the hall] and saw her with the two who were her favorites, "Hee, hee, hee" outside of her office. Wait a minute, I only need five minutes.

Chloe's perception was that this particular teacher had favorite students (further discussed later in this chapter). Chloe wanted her teacher's help and feedback and resented that her teacher had a few minutes to talk with these favored students but not with her.

Marcy shared that some of her current instructors were approachable and "seem to want to help you." She contrasted this with her first year experience when she "couldn't approach (faculty) about anything" and offered an example:

> The one instructor was so intimidating that you'd get butterflies in your stomach if you had to approach her about anything. I had a friend that …had her for clinical who threw up everyday before she went to clinical because [the instructor] made

her so nervous. Marcy said that after approaching this particular teacher with a question she felt "stupid for asking … a major inconvenience." She explained:

> This woman is my advisor and I can't approach her about anything. Like, for instance tomorrow at 7:30 AM is when you can sign up for classes. She didn't post any office hours to sign up until next Tuesday. I want to sign up at 7:30 tomorrow morning so that I can get the clinical time and the site that I want... but I can't do it. I need a PIN number and you get your PIN number from your advisor… but I can't get it because she doesn't have any office hours until *next* Tuesday... I tried to talk to her about it yesterday and she came out very irritated and in a huff and acted like I was a major inconvenience and was like, "Well, you're just going to have to come back." She's making me drive to (offsite) to see her tomorrow. Because if I didn't want to go in next Tuesday then I had to drive to (offsite) tomorrow to meet with her. Even though she was on campus yesterday and I was willing to wait for her. She was on campus yesterday.

Although Marcy felt intimidated, she needed her advisor, approached her, and offered to wait. However, instead of feeling a welcoming connection Marcy perceived being a bother to the teacher who had no time for her. Jason described a similar experience during his first semester when he needed to discuss a course-related problem with the designated faculty in charge.

> I'm feeling frustrated because I'm not sure who to turn to about this. I understand there are certain people who are supposed to be my go to people. I don't find them to be particularly approachable. I don't find conversations with them to be particularly helpful. I personally don't find Ms. Smith to be particularly helpful. I

> find conversations with her to be condescending and, "Well, this is just the way it is." So in other words I don't feel that she's a person I can refer to or bring issues to. I feel like I'm running against a brick wall at that point.

Jason's narrative underscored the intersection of respect and approachability as important dimensions of feeling supported. Instead, Jason experienced his teachers' attitude towards him as a barrier to any dialogue or relationship with her. Like the students in Hughes (1992) study, the negative institutional climate Jason experienced discouraged him from approaching important "go to" teachers.

A negative encounter can also influence the students' perception about whether they belong in a particular college. Annette explained how an uncaring encounter with a faculty advisor in another RN program influenced her decision to withdraw from that program.

> It took me weeks to find out (who my advisor was) …that's just outrageous. Then when I finally got to meet her she seemed pretty indifferent to me. She didn't really care one way or the other about what I was doing, how I was doing. She never even asked how I was doing in my classes, ever. She never asked if I was having trouble with anything. I really felt on my own there and I didn't want to go into their nursing program like that because I had a good suspicion that I probably wouldn't have done well… It's just too difficult. I mean, it's hard enough, and then to add to that feeling like no one really cares one way or the other. It probably wouldn't have worked for me.

For Annette, part of the meaning of this encounter with her advisor was the perception of incongruence (Tinto, 1993), the feeling that her needs as a learner would likely not be

met in this particular nursing program and therefore, that it was not a good fit for her. For Annette, the advisor's disinterest and lack of caring meant that if Annette went to school there she would likely be on her own. Belenky et al. (1986) noted that, "For women, confirmation and community are prerequisites rather than consequences of development" (p. 194). Indeed, Annette's narrative made explicit her recognition that for her, supportive connected relationships were critical to her ability to learn and succeed in the nursing program. Many participants shared the perspective that faculty just did not care about them. Marcy stated, "I mean if you have any kind of family problem they don't care; they don't want to hear it. Too bad, figure something out. They don't care." Charles concurred; reflecting on his previous experience as a psychology major, he shared his current experience at State College:

> I have never met professors who could care less…about what we are learning or care less about us as students... I'm coming from my experience. Maybe psychology professors are a little more touchy feely than others, you know they're worried about your feelings and what's going on with you… Particularly in my first year, you know, going to those professors with concerns they said, "Deal with it, you know, you're just going to have to learn how to do this because this is how this goes."

Chickering and Reisser (1993) described faculty accessibility as a key component of the supportive faculty-student relationship. They stated that accessibility "requires an institutional climate where talking with faculty members is legitimized, where students feel free to "take up the professors' valuable time, and where such contacts are viewed as an important and necessary part of teaching" (Chickering & Reisser, p. 335).

Unfortunately, participants in this study identified faculty inaccessibility as a major aspect of feeling unsupported in an uncaring learning environment. Study participants often perceived that they did not matter to teachers. This finding is consistent with the higher education and nursing education literature. According to Schlossberg, Lynch, and Chickering (1989) mattering "refers to the belief people have, whether right or wrong, that they matter to someone else, that they are the object of someone else's attention and that others care about them and appreciate them" (as cited by Rendon, 1995, p. 7).

Likewise, Beck (1991) reported that the teacher's time was perceived by the student as A cherished gift; it communicated to the student that they were important, valued, and cared about as a person. Teachers in this study were perceived as uncaring when they were: unapproachable, too busy to make time for a student, aloof and/or unwilling to listen, or expressed indifference to their needs. Study participants who experienced uncaring teacher-student interactions did not perceive that they or their learning mattered to teachers. These students' narratives point to the importance of a caring learning environment for students and the multidimensional nature of learning. Indeed, Charles' comment that his teachers did not care about him or his learning underscores how the affective and cognitive dimensions of learning are interconnected. Baxter Magolda (2001) noted that "If instructors are uncaring, teaching (and thus learning) is ineffective" (p. 31). An uncaring learning environment inhibits the students' ability to engage in thinking and learning and develop the sense of self needed to participate in knowledge construction (Baxter Magolda). Instead of feeling empowered to find their voice students who experience uncaring feel unwelcomed in the community of learners and disempowered.

Mutual Respect

Another major expectation students voiced, which often intersected other expectations, concerned their desire for warm relationships with faculty based on mutual respect. When Charles stated that one of his current teachers "commanded a lot of respect from the students," I asked him why he thought this was so. Charles explained:

> Charles: She commands respect because of the way she treats the students.
>
> Darlene: How does she treat the students?
>
> Charles: She treats the students with respect as well.

Unfortunately, many participants described the meaning of being talked down to by particular teachers. Jack described a classroom teacher's response to his first year class after one student "removed the answer key" to an assignment before everyone in the class had reviewed it. Students were upset because they no longer had access to the correct answers. According to Jack, the teacher "reprimanded" the entire class by not replacing the answer key and also "threatened" not to supply future answer keys unless whoever removed the answer key replaced it. When Jack proposed an alternate course of action, to place the answer key on reserve in the library, the teacher's response according to Jack was a firm "No!" Jack viewed this undeserved "punishment" as indicative of a lack of respect.

> I don't need to be re-taught or reprimanded. I just, I want the respect. I want to give you the respect too as my teacher, as my *guide* (emphasis his). And I want the respect too. Because I'm going to do my part of my work and you do your part of your work. Why put the obstacles?

At 42, Jack expected to relate to his teacher with mutual respect and to be treated like an

adult. He viewed the teacher's punitive attitude as an "obstacle" to learning.

The research literature identified respect as a critical component of the supportive teacher-student relationship (Baxter Magolda, 1999, 2001; Belenky et al, 1986; Halldórsdóttir, 1990; Miller, Haber & Byrne, 1990; Rendon, 1993; Theis, 1988). Respect has been described as a key condition for learning; a prerequisite to facilitating students' development of the sense of self needed to participate in knowledge construction and self authorship (Baxter Magolda, 2001). Halldórsdóttir (1990) identified authentic respect and concern for students' learning as essential components of the caring teacher's approach and a prerequisite to mutual trust, the foundation of a developing teacher-student relationship. In fact, many of the students in Halldórsdóttir's study identified the connection or establishment of a relationship with teachers as the core difference between caring and uncaring encounters.

Feedback and Validation

A prevalent theme among participants was centered on the meaning of feedback and validation to learning and persisting in nursing school. At our second meeting Jack spoke about the meaning of validation and motivation for persisting in school. Referring to one of his clinical teachers Jack said, "He (faculty) has helped me a lot. And he's been very good at validating my skills, validation of my (nursing plan of care)…. And I think that's also the fuel to keep you going."

Many participants described experiences where faculty gave them feedback about aspects of their clinical performance that needed improvement. For students, the way such feedback was delivered by teachers emerged as a major aspect of feeling supported. Marie described how one instructor's feedback about her clinical performance facilitated

her learning and also, her willingness to persist in the nursing program:

> At the end of each week he (faculty) would tell me what I did right. At the beginning of each week, he took the time before clinical to sit down with me and show me what I could do better. He took the time. Didn't just tell me what I was doing wrong. Told me what I did right and told me how to fix what I did wrong. You know there were times I'm like, "Oh my God, why am I in this rotation?" But every week I was willing to come back. Let's do this again; you know, I'm going to learn something. I had a lot of great experiences with him. I learned so much from him.

Marie's narrative highlighted two aspects of feeling supported and cared about that emerged in this study. For Marie, the teacher's willingness to take time to meet with her every week meant that he cared about her and her learning. The teacher gave Marie formative feedback about what she was doing well as well as what she needed to work on to be clinically successful. In a qualitative study with baccalaureate nursing students Reutter, Field, Campbell, and Day (1997) found that students felt vulnerable to negative feedback; it decreased their self-esteem. However, like Marie, students in the current study reported that their vulnerability to negative feedback was minimized when they were also provided with some positive feedback. Jack further explained this perspective:

> Jack: When she (the teacher) has criticism she starts off the right way of saying, "You know, you got everything together fine and stuff like that but you need to do this."
>
> Darlene: So that helps? How is that different from what the other instructor did?
>
> Jack: Yeah; well you get the validation. You get some validation and it's easier to

> take the criticism that's why. Of course you have to hear criticism but criticism is hard to take so you have to, I don't want to say sugarcoat it but I do want to say sugarcoat it.
>
> Darlene: Hmm, makes it easier to go down, I see.
>
> Jack, an adult learner in his forties, always projected a calm confidence about who he was when we spoke. Yet at our third interview, he shared his vulnerability to criticism and his need for positive feedback as a balance to the negative.

In contrast, Jason, also an adult learner in his first semester, shared his sense of frustration because he had not received any written or oral feedback during a five week clinical rotation.

> I walked out of my first clinical experience not knowing if I was going to pass because I had not received a single positive comment on any of my (clinical papers), not a one. I walked out of there not knowing what a good (clinical paper) was. I worked my *ass* (sic) off on these (clinical papers) and there was nothing but criticism. Because we (peers in clinical group) were constantly in fear of, "Oh my God is this gonna make it? Is this (nursing plan of care) good enough?" It was very stressful. I have to be honest with you I didn't know if I was going to get a satisfactory from my first rotation, I didn't.

Rendon (1993) argued that impersonal evaluation which instills fear in students, like the situation Jason reported, is experienced as academically invalidating. Not receiving feedback about where he stood academically was stressful for Jason and induced fear that he might not pass. Researchers have identified early validation as important to students' successful transition and faculty are critical validating agents especially early on, during

the first month of the college experience (Rendon, 1995; Terenzini et al., 1994). Students like Jason who have an invalidating experience early in their college experience must then rely on out-of class validation from family, spouses or peers (Rendon, 1993). Jason was fortunate to have a supportive wife and family. However, students deprived of both in and out-of-class validation who also lack a supportive personal network to encourage them, what Rendon termed "fragile students," are at risk of leaving college (Rendon, 1993). In light of these findings, it is especially important that faculty recognize their students' learning needs and provide appropriate feedback and validation.

The findings reported in this chapter are consistent with previous research with baccalaureate nursing students. The 32 baccalaureate students in Hanson and Smith's (1996) study identified recognition, connection, and confirmation/affirmation as core components of the caring faculty-student interactions. In contrast, the not-so-caring teacher "has no time, is unavailable, hurried, insensitive, condescending, dismissive, and disrespectful of students" (p. 109). Students who experienced not-so-caring interactions felt "rejected, discouraged, decreased motivation (to learn), doubts about nursing as a career, and wanted to drop out" (Hanson & Smith, p. 110).

Faculty Incivility

In this study, students' descriptions of faculty incivility emerged as a major barrier to learning, development of confidence, self esteem, and persistence. Students' narratives of their lived experience are consistent with the phenomenon of horizontal violence, incivility, bullying, and verbal abuse, terms that are often used interchangeably in the literature. Clark (2008) defined academic incivility as "everything from insulting remarks and verbal abuse to explosive, violent behavior" (p. 4). This section describes

the phenomenon of faculty incivility by examining student participants' interrelated experiences of: a) verbally abusive and demeaning experiences, b) favoritism and subjective evaluation, c) rigid expectations for perfection (discussed further in Chapter Six) and time management, and d) being targeted and weeding out. Some faculty incivility reported by students occurred during their first year. However, the majority of negative experiences were reported by second year students in their culminating medical-surgical nursing course.

Verbally Abusive and Demeaning Experiences

Several students described faculty who were verbally abusive with students. Charles' reported an experience he had as a first semester student where he observed an instructor being "verbally abusive" to a classmate who was performing her first sterile dressing change on a patient. It was kind of a hard dressing to do especially if it's your first one. And I had gone in with this other student. I was just helping …I was holding a mirror and I was making sure things remained sterile, handing her swabs and this kind of stuff. I was in there trying to do this and I'm being quiet and she (the teacher) was basically verbally abusive to the other student while she was trying to do this. You know, I'm getting embarrassed and red because the student wasn't doing a very good job of it and I realized that so I'm embarrassed for her. And I'm embarrassed that I have to be there witnessing this…

> I just remember the faculty member getting angry and you know spouting off things that weren't conducive to that environment; it's just making this person more nervous and making her do things more incorrectly.

Witnessing this incident left Charles feeling embarrassed for his classmate because she

was not performing the sterile dressing change correctly. Charles' empathized with this classmate and pointed out that the dressing change was not only the student's first, it was also a technically difficult one to do. Charles also noted that the instructor's anger and verbal abuse did not establish a supportive learning environment and his classmate had increased difficulty performing.

Chloe reported that on the very first day of her advanced medical-surgical rotation she was belittled by her clinical instructor in a public area of the nurse's station. Chloe said she had been criticized and "yelled at" by her clinical instructor "all morning" prior to the following incident where her patient needed 12.5 mg. of medication.

> The instructor would go in, pull out our meds [medications] and then we would go in and double check them for the patient… The instructor pulled a 25 mg. pill out. And because I was already upset at that point I just looked at it. I said to myself, "I think she gave me the wrong dose." I just stood there with it and I was looking at it, I wasn't like, "Oh does anybody know?" I was trying to process it and she comes over and yells at me in the medication room, which of course is in front of other student nurses and other nurses. "I can't believe how stupid you are! How did you ever pass math? What are you doing here that you can't figure this out? A four year old could do this." That's the kind of thing that went on and on and on.

One might argue that a second year nursing student should have recognized such a simple dilemma rather quickly. She had a 25 mg. pill but her patient needed 12.5 mg. of medication; she needed to obtain the correct dose (if available) or cut the 25 mg. pill in half. For whatever reason, the student reported being handed a 25 mg. pill and shared her thinking at the time – "I *think* she gave me the wrong dose." What is essential to

consider here is the student's report of what she heard her instructor say to her. The words the student heard were demeaning words. bell hooks (1994) maintained that the teacher should teach in a manner which "respects and cares for the souls of our students" (as cited by Baxter Magolda, 1999). Likewise, Bonnel et al. (2005) emphasized that evaluation of student performance should respect students' dignity and self esteem. Therefore, angry, belittling, or demeaning words are never justified even if the student is deemed to be an unsafe practitioner.

Favoritism and Subjective Evaluation

Clinical evaluation was described as biased and subjective by several students in this study. Students reported that their anxiety about clinical evaluation (described in Chapter Four) was also due in part to their perception of the clinical evaluation process as biased and subjective and their fear of being targeted for failure. Marie, who had experienced clinical failure of her advanced medical-surgical nursing course summarized this perception of subjectivity: "It's all in the instructor; all the way the instructor does it." Teresa concurred, "Part of clinical is instructor interpretation and it's subjective on a certain level and I just don't like that subjectivity." When asked to explain what she meant Teresa offered the following example:

> Well I had (Ms. Jones) for two semesters and I almost dropped out of nursing school. She gave me a really good evaluation the first semester and then the second time I apparently was rude and disrespectful or something and I ended up having to switch clinical instructors … But it was all subjective and everything else was fine; my paperwork was fine. I really couldn't be given any examples.

Teresa reported feeling devastated by this incident. In fact, she described being so upset

by the experience that she had what she described as a "panic attack" and thought about withdrawing from school. That the experience caused Teresa to consider withdrawing from nursing school points to the meaning the incident had for her, shaking her confidence in herself but also in her decision to pursue a nursing career. Although Teresa ultimately decided not to withdraw from school the experience continued to affect her. At our interview, a year and a half after this incident, Teresa shared that although graduation was only a few weeks away she continued to worry about subjective clinical evaluation.

> I have five more weeks and it's still… they can still fail you on the clinical rotation and it's like everything that I've done up until this point can be null and void based on someone's subjective, what I feel is subjective, and you have really no leg to stand on.

Marie and Teresa were not alone in their perception of clinical evaluation as biased and subjective. Charles' attributed the subjectivity of teachers to favoritism: "They say the grading system and everything is completely objective but I don't think it is. I think there's a lot of favorites and stuff right here." Charles' clarified by describing an experience he had as a first semester student when he was helping a classmate with her first sterile dressing change on a patient (described earlier). According to Charles, while the instructor was "verbally abusive" to his classmate (described earlier) she did not mistreat Charles. He explained how he avoided similar treatment:

> And it just so happens that that faculty member likes me a lot, I get along with her well. I did very well in her courses. I worked very hard, but she also knows my father from the medical field ... so I got a little bit of a break when it came to

that kind of stuff from her. But I saw her being *really* nasty to some people.

A few students described incidents of favoritism in classroom interactions**.** Jacqueline shared the following story:

> There was a teacher… I'm not saying she's racist. I'm just saying maybe she plays favorites and I happen to be... I don't know what she is. But there was a couple of people who came in, there was a situation where a couple of people came in late for a test and quiz and she let them take the quiz. And there was one point where I came in three minutes, three minutes late, and she didn't let me take it. And (the teacher) told me, "It will not affect your grade because your grades are good."

Although Jacqueline perceived the teacher's rules as rigid and unfair she felt that she had little recourse. However, later in the semester Jacqueline realized that not being allowed to take the quiz *had* affected her grade significantly so she went to administration and complained, was allowed to take the quiz, and said she passed with a 98%. With probing Jacqueline reflected further on the incident:

> D: Is there anything else that stands out that you want to tell me about?
>
> J: I don't know…I think she just had favorites. There were two teachers in that class. One of them was very nice and the other one she has favorites, she just has favorites…
>
> D: What makes you think that she has favorites? What did you see that?
>
> J: Because… when other girls came late to class right, there wasn't a problem, go ahead and do it…But when I come, I step one foot in and she points (points to the door), you know what I mean? Come on? And this one girl was *always* late for class, like 50 minutes late. … And it's just, I notice stuff (pause).

D: Why do you think some people were her favorites? Is there anything you can point to?

J: I don't know, I have no idea. I try not to use the race card, me personally because I see people use it and they use it too much. Sometimes that's not the case…but I just saw [the teacher] has favorites – [the student] was pretty, skinny, with long blonde hair kind of thing, you know what I mean?

Jacqueline did not classify this incident as racism. Instead, she described favoritism and felt she had been treated unfairly by this teacher who often allowed other students (such as the pretty one with blonde hair) into the class late. Her narrative suggested that she was struggling about whether this incident represented racism.

Likewise, Jack reported that during his fourth and final semester he "saw the proof" regarding favoritism and biased evaluation practices during one clinical rotation. He explained:

I heard stories of previous people who had this clinical instructor. And it was always the male students or the older students, or the odd students let's say who were just, had a little bit more challenging times… They were the ones that had the problems… Where the, you know - kind of the pony-tailed blonde haired girls, the pretty faces just kind of smoothed by.

Jack shared his observation that certain types of students were targeted for closer evaluation by this particular clinical instructor. According to Jack, a "heavyweight girl" had been targeted yet "there were some pretty girls that were ignored" (not targeted). It is also noteworthy that while Jack and Jacqueline attended different schools that were located hundreds of miles apart they each perceived a favored status for pretty, blonde-

haired students. Educational practices, especially the clinical evaluation process, were perceived as biased and subjective by several students in this study from each of the three schools represented. This subjectivity contributed to students' anxiety and fear of failure. This finding has been previously reported. Students in Poorman et al.'s (2002) study identified favoritism as a hindrance to academic success and reported that "it was obvious to them that the teacher favored one or several students more than others" (p. 133). While the purpose of clinical evaluation is a fair, objective appraisal of the student's clinical performance the potential for subjective clinical evaluation is acknowledged in the nursing literature (Bonnel et al., 2005; Brozenac, Marshall, Thomas, & Walsh, 1987; Orchard, 1992). Orchard (1992) noted that faculty evaluation, influenced by unconscious factors which shaped perception, could result in misrepresentation of students' clinical performance. In fact, for the student whose clinical performance is borderline "progression or dismissal may actually depend upon their assignment to a particular nursing instructor" (Brozenac, Marshall, Thomas, & Walsh, 1987, p. 42). The narrative data presented in this section extends this understanding by describing students' experiences of subjectivity in both the clinical and the classroom setting as well as the meaning these experiences had for them.

Rigid Expectations for Perfection – "*Making it Impossible*"

Several students described clinical incidents where the clinical instructors' expectations were perceived as rigid, unrealistic, or too high. Unrealistic expectations included students being held to a higher standard than the staff nurses, rigid expectations regarding time management, and expectations regarding what students should know. The students' perspective was that being held to such expectations for perfection placed

them at a clinical disadvantage which made success "impossible."

Jessica, a fourth semester student in her culminating medical-surgical course shared the following example which she said occurred in the patient's room:

> My patient had surgery… and he was getting IMs (Intramuscular injections) in his Vastus Lateralis [anterior leg muscle] and that's what the doctor ordered. And when I went in, you know I wasn't just following what everybody else (the unit nurses) did but he had a hard time turning because of his surgery. She [instructor] *chewed me out*. She's like (in an angry tone of voice), "*Why are we giving him injections in his Vastus Lateralis?*
>
> What's the preferred site?" I'm like, "The Ventral Gluteal" [lateral] leg muscle]. And she *chewed me out* because I was doing what everybody else was doing, what the doctor had ordered, by giving him his injections there.

Jessica stated that she knew the Ventral Gluteal was the preferred site for an IM injection (Potter & Perry, 2008) but explained that the unit nurses had been administering medication in the patient's anterior leg muscle so that he would not have to turn to his side and incur additional pain. Whether the clinical teacher agreed with the staff nurses or not, Jessica's narrative suggested she was being held to a different standard than the unit RNs who had altered the patient's written plan of care. Given the student's lack of power in the hospital hierarchy it would be an exceptional student who could navigate such a situation independently without the support of the clinical instructor or experienced nurse.

Jessica offered a second example from the same clinical rotation. In this narrative, Jessica described how she tried to answer her instructor's question about how a particular

medication worked:

> (The instructor) asked me about Proton Pump Inhibitors. I was telling her about Plavix, that it works on the G-pump and inhibits acid secretions... (The instructor) looked and me and goes, (in a demeaning tone of voice) "*What is that*?" (emphasis hers) I'm like, "Well I looked it up and I know it inhibits acid secretions." She cut me down! I was trying to explain to her what I had just read - that it inhibits acid secretions. She wanted me to say it right (Pause). I just feel ripped apart (started crying). There was *nothing* that I did that was acceptable, *nothing* (struggling to talk while crying)… I know I could've done this. Every one of my efforts was squashed. It wasn't good enough.

Jessica assumed that her explanation did not meet her instructor's expectations. Consistent with the literature, Jessica's narrative is a powerful example of being demeaned and invalidated by a teacher and the subsequent effect on a student's confidence and self-esteem. Jessica reported that the teacher's sarcasm, "nit picking" and "constant criticism" of her performance in front of patients, doctors, and other nurses became so unbearable that she decided to withdraw from the nursing program just a few days before our scheduled interview. Several minutes later when she had regained her composure Jessica shared her sense of confusion and "depression" over the incident because she pointed out, she had never had clinical difficulty before. I went through seven clinical instructors and never got a deficiency, a mid-term deficiency, any problems at all. And then I got to (final advanced medical-surgical course) and it was like hitting a brick wall. I mean you have to be *way* (her emphasis) up here or you know you might as well forget it… they will not let you through. It's like, you either have to be

the best of the best or you're not going to make it. Jessica described herself as a "good student" with a 3.49 grade point average. Her perception was that her clinical instructor's expectations were unreasonably high.

> I know that I could've worked even better had she (instructor) not kept interfering with my patient care and criticizing me and cutting me down. It was almost like she was trying to make it impossible for me. I think her expectations were way too high. Because I was on time with things and it still wasn't good enough. Like, I should've been earlier and better.

Jessica's description of this incident is consistent with previous nursing literature. Graduate nurse participants in Deppoliti's (2003) study also reported that clinical instructors, whose confidence bordered on arrogance, belittled students and diminished their confidence.

Jessica felt that certain faculty had excessively high expectations and abused their power; she explained:

> I think that they (faculty) are misusing their power. They're expecting too much from (advanced medical-surgical) students especially. Which…the ex-director said she is aware and something needs to be done. She said, **"**When this many students are dropping like flies, it's not the students, something's got to be going on in the program."

Jessica's appraisal of her teacher's behavior as a misuse of power is consistent with Fuller's (2003) concept of rankism, the abuse of power "to demean or disadvantage" others one outranks (as cited by Clark, 2008a, p. 6). Fuller compared rankism to racism, sexism, and ageism "where one group uses power and control to disadvantage another

group or render individual members of that group as less worthy" (Clark, p. 6). Clark pointed out that while reasonable exercise of power and rank are essential to the functioning of social institutions like colleges, the *abuse* of power and rank destroys students' confidence and inhibits learning.

Targeting and Weeding Out

Perceptions of subjective clinical evaluation and unrealistic expectations were also evident in students' narratives about being targeted by faculty. Participants' reported becoming a target if they did not meet the expectations of the clinical instructor (described further in Chapter Six). Students from all three nursing programs shared the perspective that being targeted by a teacher was never a good thing since it often resulted in a negative clinical evaluation or worse, clinical failure or withdrawal. Marcy described some of the nursing faculty at State College as "Barracuda who want to chew you up and spit you out." She explained:

> I feel, or have observed that if they (faculty) earmark somebody that they don't want they will ride them until they can't take it and get rid of them. There was one girl who was a little alternative. She had like her eyebrow pierced and black nail polish. She had been in lab with us a few times and she seemed like she really knew what she was doing but my God, the instructor was on her like a Hawk.

Marcy's narrative makes explicit students' perception of hovering and targeting as a faculty strategy for getting particular students to withdraw from nursing, in this case a student who had not adopted professional norms for appearance (described further in Chapter Six).

Chloe, who clinically failed what would have been her final semester in advanced

medical-surgical nursing at Private Hospital School, shared this view:

> I think it's just the bottom line that if you're not on the right terms with the right instructors you may as well leave. They (faculty) will ride you, they will harass you… If you piss (sic) somebody off you're screwed, you might as well leave.

Students' perception that some faculty would "ride students" until they could no longer take it was evident in the narratives of several other students, from different schools of nursing. For example, although Jack attended a different program than Marcy, he used the same metaphor to describe how a peer in his fourth semester advanced medical surgical clinical group was targeted and weeded out:

> There was an African American boy, well African boy in my class too. It's not that he didn't have a clue, he was very intelligent. But clinical was very hard for him. He didn't have a chance. From day one he was chewed up and spit out. He ended up quitting the group after two weeks. And after he left I felt we were all you know, open for targets.

Jack's classmate was in his fourth and final semester of his ADN program yet withdrew after only two weeks of a five week rotation. I missed an opportunity to probe further about this incident. However, Jack's narrative points to an additional feature of the targeting phenomenon as perceived by study participants. Students who had observed the targeting and weeding out phenomena in their own clinical group often felt vulnerable; they worried about becoming the clinical instructor's next target.

Chloe reported that during the first two weeks of her culminating medical-surgical course at Private Hospital School she knew that she had become a target. Her narrative illustrates the phenomenon of being targeted and then bullied with negative feedback.

> It happened sometime between the first and second week of our first clinical rotation that semester. And from then on she (clinical instructor) was constantly accusing me of things I didn't do, yelling at me in the hallway, belittling me in the hallway. And I can almost take it if you do it in private but you do this in front of people that are walking by and some maybe are peers, and the doctors who already look down on you. I mean it was just so demeaning. It was very clear where it was going. And my paperwork, which I brought with me. Have you ever read something and felt like you were being yelled at in pen? I felt like she was like, just screaming at the top of her lungs – in pen.

Chloe's description of being yelled at and belittled in public is consistent with previous literature. Adams (1997) described bullying as the relentless, demeaning and downgrading through vicious words and cruel acts that undermine the victim's confidence and self-esteem (as cited by Randle, 2003). Indeed after sharing several stories of being "accused" of things she "didn't do" Chloe stated that, "I don't know how to explain how crushing it is to your self-esteem to have someone knowingly falsely accuse you day in and day out."

When asked if the nursing program had a formal process where she could have asked to be transferred to a new clinical group with a different instructor Chloe responded, "Any time I've ever seen somebody switch to another clinical instructor I've never seen that person pass. Because then you're kind of like a red flag. The instructors are really tight together." Chloe explained what happened after she made the decision to request a transfer to a new clinical group/instructor.

> They (instructors) act like, "Oh, you can switch (clinical) groups. No problem,

> some people just do it." But anybody who switched groups failed. So I should've known better. The week after I left two of the gals from my group – one of them came up to me and said, "Thanks a lot for leaving because as soon as you left me and Sue ended up on the shit (sic) list and now she (instructor) bounces between us everyday."

Chloe's account that two of her clinical classmates were targeted after Chloe left the group, reflects the perspective shared by several students, including Jack (described earlier), that certain faculty had a reputation for repeatedly targeting students; that is, when a targeted student withdrew or failed another student was often targeted.

Students in this study said that switching clinical groups could cause one to become a target for closer clinical scrutiny or even eventual failure. However, there were other red flags" students identified. According to Marie, asking the wrong kinds of questions could also mark you as a target.

> If you asked questions and Ms. Nell (clinical instructor) had decided that you were supposed to already have this knowledge base you kind of put yourself out there. Because the first week I had her I made a mistake and I never had any real repercussions from it. I got really worried, like, "Oh oh, she's going to pick me out." And the next week instead of making a mistake I asked a question first and that's when I noticed that the trouble really started. And that's what frustrated me. Was that we were told to ask questions if we didn't know the answer but I felt like I had to know which questions to ask in my hell rotation.

Students like Marie felt that asking questions could be risky if the teacher thought you should already know the answer. As a result, students perceived a learning climate

centered on evaluation (previously discussed in Chapter Four) of what they knew or did not know. Similarly, students in Wilson's (1994) study were intent on convincing their clinical instructor that they were becoming good nurses; they did not feel free to ask questions for fear that they would be evaluated poorly. According to Wilson, "Looking good as a student was a type of self-presentation where it was not so much what you knew that counted, but rather what the teacher thought you knew" (p. 85).

Students also explained, as Jack did earlier in this chapter, that some teachers had a reputation for targeting and failing students or getting them to withdraw. Marie, who interviewed twice and had since graduated, shared her experience during her final semester at Private Hospital College. Marie explained that six or seven students (including Marie) comprised her clinical group in advanced medical-surgical nursing but as their five week rotation concluded, only two students remained.

> We had five weeks with (Ms. Hall). She had gone from six to seven students to…. two! What the heck happened there? How *did that* (her emphasis) happen? …How do you take a group of students who have successfully made it that far? And it wasn't the first rotation of the semester, it was the second. Our other rotation was on a cardiac floor with a higher level of acuity… Hers was a less acute floor. How do you take these students and obliterate them like that, literally?

According to Marie, the clinical instructor had weeded out all but two students. Aspects of these findings have been previously reported. Wells (2007) reported baccalaureate student's perception of a "weeding out" process which contributed to stress and disillusionment with nursing. However, Wells did not describe the phenomenon of weeding out in any depth nor was targeting described. In fact, only one other reference to

the targeting phenomenon was located in the published nursing literature reviewed:

> The student initially accumulated a series of tiny mistakes, errors in fronting, transgression of faculty expectations, perhaps threatened faculty's commonsense world. There then ensued a phase in which faculty or fellow students, perhaps partially aware of these small errors, themselves became more cognizant of them and to label this student as someone to be watched, or, in the rhetoric of the school, "to be helped" (Olesen & Whittaker, 1968, p. 296).

Study participants' perceptions that making a mistake or not meeting the instructor's expectations prompted faculty hovering mirrors Olesen and Whittaker's portrayal of students that needed to be watched. While recent literature briefly identified students' perception of weeding out in a baccalaureate nursing program (Wells, 2007), no other published literature was located that described the phenomenon. Understanding students' perception that certain faculty weed out students contributes to our understanding of students' lived experience in important ways. Numerous studies have documented the clinical stress of nursing education. As reported in Chapter Four, the lived experience of students in Diekelmann's (1989, 1992) study was frustration with a learning climate that focused on clinical evaluation. My findings contribute to the nursing literature by further explicating aspects of clinical evaluation not previously considered.

As articulated in Chapter Two, caring for others is a core professional value in nursing. The literature has centered caring as a critical aspect of professional nursing whether practiced at the patient's bedside, in administration, or in nursing education. In light of the profession's emphasis on caring as a core value it is especially ironic, and difficult for some to acknowledge that faculty incivility occurs.

Yet experiences like those described by study participants have been previously reported. Incivility (horizontal violence) has been recognized as a significant problem in nursing but to date, researchers have focused almost exclusively on its occurrence among health care professionals in the clinical practice environment (Curtis, Bowen, & Reid, 2006; McKenna, Smith, Poole, & Coverdale, 2003; Randle, 2003). Few studies have examined nursing *students*' experiences of faculty incivility and those which did examined students' experiences of being bullied by staff nurses in the workplace (Curtis, Bowen, & Reid, 2006; Ferns & Meerabeau, 2007; Hoel, Giga, & Davidson, 2007; Randle, 2003).

Braxton and Bayer (1999) purported that academic incivility among both faculty and students is increasing on colleges campuses nationwide (as cited by Clark & Springer, 2007). However, few published studies investigated students' experience of incivility in nursing education (Clark, 2008a; Clark & Springer, 2007). Clark (2008a) employed a phenomenological design to examine current and former nursing students' perceptions of faculty incivility in nursing education and students' responses to perceived incivility. The seven participants, all Caucasian, represented both women and men from four nursing schools in two states. Informants reported their experiences of incivility while enrolled in a variety of nursing programs (one LPN, one AD, two BS, two MS, and one BS and PhD). In this study, students' perceived faculty to be demeaning and belittling, to treat students unfairly or subjectively, and to pressure students to conform to unrealistic demands. Students reported a sense of powerlessness to confront or report the situation due to their lack of power and fear of failure or expulsion (Clark).

Consistent with Clark's (2008a) findings, students in the current study reported that they felt powerless to confront or report faculty incivility/bullying. Instead, participants like Teresa and Chloe shared that being students meant they "had no leg to stand on." Furthermore, students in the current study who experienced bullying reported subsequent humiliation, feeling traumatized, disillusionment with nursing, and powerlessness because passing clinical and progressing in the program depended on a satisfactory clinical evaluation. Rather than risk clinical failure some students in this study decided to front the perceived expectations of the faculty (Olesen & Whittaker, 1968) and "fly under the radar" (described in Chapter Six).

The findings of this study parallels those previously reported by Olesen and Whittaker and extend our understanding of factors which may shape the clinical evaluation process. Several students reported that making a mistake or asking a question – "errors in fronting" (Olesen & Whittaker, 1968, p. 296) had preceded faculty hovering and/or targeting behavior and was sometimes accompanied by negative, demeaning feedback.

Consistent with this literature, students in the current study felt anxious and stressed about clinical evaluation. However, the narratives of students in the current study add to our understanding of specific dimensions of being evaluated as stressful. Specifically, students in this study interpreted faculty "hovering" behavior as a threat; it meant they were being watched closely or "targeted," and were at risk for clinical failure. Students often perceived little allowance for their clinical learning. Instead, as introduced in Chapter Four, experiences in the clinical practice setting were often centered on the subjective evaluation of their performance as a nurse. Jessica, who withdrew during her

fourth and final semester at Private Hospital School, shared a conversation she had with the former director of her nursing program:

> The ex-director said, **"**Something's going on here. It's not the students when someone like you who comes into the program with straight A's and was awarded a scholarship (withdraws)." I have a 3.59 average… I even heard about them asking people to leave because, "You're not at an (advanced med-surg) level, you may as well leave the program." … I know they told one of my friends that.

Disillusionment with Nursing

For study participants, the decision to persist in the nursing program was continually under review. Like Jack whose perspective was shared in the introduction to this chapter, students who experienced unsupportive, uncaring or bullying encounters with faculty often felt disillusioned that their experience was contradictory to what nursing education should be.

Jason articulated a sense of disappointment when certain nursing instructors failed to enact the values they had lectured students about:

> There are some instructors that preach about compassion and caring and communication that is therapeutic with our patients and then use communication styles with the students that is less than therapeutic. I'm not entirely sure what the background preparation is for instructors. I don't know if teaching classes are required. But there does certainly seem to be some work that is required by some. Give and take is good. Positive feedback, as opposed to just constantly negative feedback is good; not just criticism.

Jason's expectation was that faculty should model the same therapeutic relationship with

students that they expected students to enact with patients. Like many of his peers (described earlier), Jason pointed to his need as a learner for positive feedback along with the negative and also suggested that the delivery of balanced feedback was one way faculty could communicate more therapeutically with students.

Similarly, Jessica's description of her experience in her advanced medical-surgical course revealed her sense of disappointment, and also anger, that nursing faculty did not model the caring, nurturing behaviors she had expected them to:

> It's not an atmosphere like we (faculty) are here to help you, nurture you, go out in the world and help other people. It's a totally different take. Its like, "We (teachers) are here to hurt you. That's what it seems like. We're here to crush you. And if you make it through you have to be a really good person because you made it.

This finding is consistent with Wells (2007) grounded theory study. The students in Wells' study also perceived contradictions between their expectations and actual interactions with faculty.

Jessica withdrew during her final semester at Private Hospital School and was not eligible to sit for the NCLEX-RN exam. However, she said she had successfully completed enough credits and clinical experience to sit for the Licensed Practical Nurse (LPN) exam. While she was happy that she would be able to fulfill her dream of helping others she also felt conflicted about continuing her nursing career and worried about whether she would be able to adapt.

> I am honestly questioning what I got myself into. I have an application in at (State Hospital). Do I want to do this? Because I don't want to be hurt like this

> constantly. It's almost like, it's a very caddy atmosphere. And I know that I could make a positive difference in other people's lives. But I just don't know. Am I thick skinned enough? I wasn't thick skinned enough to stick it out in this semester and go through what she (clinical instructor) was doing to me. And I'm frustrated because I have a good heart, I have good intentions. I came into this because I want to help people.

Conclusions

This chapter revealed how conditions for learning in the informal curriculum shaped students' learning and development of confidence and self-image as nurse, as well as their continued commitment and willingness to persist in nursing school. The nature of student-faculty relationships emerged as a major aspect of feeling supported or unsupported**.** Within the teacher-student relationship important conditions for learning included faculty accessibility, mutual respect, caring, positive feedback and validation, and modeling the espoused values of the nursing profession.

Some students' narratives revealed how supportive faculty connected with students by being approachable, making time for them, and communicating an attitude of caring. Supportive faculty provided constructive feedback and validation, and conveyed their belief in students' ability to learn and become successful nurses, thus facilitating the development of the sense of self needed to participate in knowledge construction and self authorship (Baxter Magolda, 2001) and also, persist in the nursing program.

Unfortunately, many students' described particular teacher-student relationships as a multiple barrier to learning, development, and success in nursing school. Barriers within the teacher-student relationship reflected a wide range of behaviors which included being

unapproachable and/or unavailable, disrespectful, giving insufficient or exclusively negative feedback, favoritism, rigid expectations, verbal abuse (often delivered in public), targeting and weeding out practices. Students reported unsupportive encounters with teachers as a frustrating "obstacle" to learning and a hindrance to success; they felt like they did not matter to teachers and were not cared about as learners. Students at all three schools of nursing shared the perspective that aspects of the clinical evaluation process were subjective, biased, and sometimes adversarial. Students described experiences of favoritism and shared the perspective of students in Wells (2007) study that students were targeted for weeding out if they did not "fit" some ideal characteristic of a nurse.

My findings contribute to the acknowledged gap in the nursing literature regarding nursing students' experiences of faculty incivility. Students from each of the three associate degree programs represented reported experiences with teachers which left them feeling "belittled," "demeaned," "beneath dirt," "powerless," and "ripped apart." Students' responses to faculty bullying included fear, humiliation, feeling traumatized, anger, diminished confidence, and powerlessness. Some students questioned whether they were good enough or smart enough to be a nurse and reported thoughts of giving up or withdrawing. Although students were angry, they felt powerlessness to report experiences where they felt they had been treated unfairly or bullied because of the fear of academic and/or clinical retaliation. These findings are consistent with previous research literature in both higher education and nursing education and provide additional qualitative evidence regarding the conditions which promote student learning and development in college.

Uncaring practices in nursing education have received little scholarly attention and few

studies have explicitly examined nursing students' experiences of faculty bullying. Halldorsdottir (1990) examined the structure of caring and uncaring encounters with teachers as perceived by baccalaureate nursing students. Her description of uncaring as "ridiculed or treated with contempt" parallels the experiences described by study participants and is consistent with what more recent literature has labeled as bullying or incivility. Similarly, 45% of baccalaureate nursing student participants in Mahat's (1988) study reported negative teacher-student relationships. Like the students in the current study, students reported that teachers who were unsupportive and "demeaning" left them feeling "incompetent" (Mahat, 1988, p. 7).

Despite a learning environment that was often unsupportive, study participants were generally determined to achieve their goal to become a nurse. Chapter Six examines how students demonstrated agency and navigated the challenges described in Chapters Four and Five to get through the nursing program. Furthermore, Chapter Six explicates the critical role of faculty in promoting or hindering students' ability to successfully navigate the academic and clinical curriculum of the nursing program and develop a positive self concept as nurse.

Chapter Six: BECOMING A NURSE: NAVIGATING THE POLITICS OF THE CURRICULUM TO BE SUCCESSFUL

> It's what I want to do but they don't tell you how much work its going to be, how much of your life you have to give up. I've had to give up my whole life for this. All I do is schoolwork all the time. It's a *lot* to sacrifice. And it's more than a lot of people can handle (Marcy).

Marcy's comment echoed the sentiment of many of her peers. Students at all three nursing programs represented in this study talked about the personal compromises they had made, and were making, to get through and remain successful in school. In the nursing program, students were confronted with key sets of negotiations within the formal explicit curriculum as well as the informal, hidden curriculum (Bevis & Watson, 1989). This chapter reveals that in order to navigate the curriculum successfully participants became active agents in negotiating challenges in their environment. Specifically participants: a) adopted strategies to navigate the two year curriculum and pass exams, b) implemented approaches to present oneself as a competent nurse (and pass clinical), and c) enacted perceived professional norms for appearance and behavior.

The perspective of many students was that failure to enact nursing school norms was risky behavior which could cause one to become a target (see Chapter Five), and increased the possibility of clinical failure or withdrawal from the nursing program. In order to achieve their goal and get through the program, some students demonstrated agency by fronting what they perceived as faculty expectations by flying under the radar.

Several students' shared the perspective of Maggie that they were "set up to fail" the nursing program in the academic and clinical curriculum. Despite these challenges

students adopted key strategies which they believed were essential to successful navigation through the nursing program. The chapter extends the themes of Chapters Four and Five by further explicating the critical role of faculty in promoting or hindering students' ability to successfully navigate the academic and clinical curriculum of the nursing program and develop a positive self concept as nurse.

Key Negotiations in the Academic Curriculum

As introduced in Chapter Four, the academic curriculum represented numerous challenges students had to navigate to be successful in the nursing program. In this section, critical negotiations in the academic curriculum discussed include the two-year curriculum and nursing exams. How students negotiated each of these challenges is examined in this section.

Time to Completion of an ADN Program

A number of study participants shared the belief that successful negotiation of the ADN program actually required three (or more) years of academic coursework. Maggie was adamant that nursing programs should tell prospective students that an associate degree nursing education is a three year experience and not a two year program as claimed:

> There's no way you can do it in two years. Stop telling people you can do it because you can't. With the prerequisites that are required, that you need to take at the same time as nursing, it is not physically possible to do. You will not be successful in everything. So make your two year program a minimum of three years... and set it up so that you can take your pre-requisites first and that your nursing is full time to keep you going for those three years.

Marcy concurred with Maggie and added that some teachers shared this belief:

> Nobody makes it through nursing in two years. One of my instructors told me she only knew one person who did it in two years. It takes everybody three years. Three years and you're going to have to sacrifice everything.

Students identified various alternative ways to complete the ADN requirements including: a) taking some required courses before beginning the nursing program, b) transferring course credits and requirements from prior degrees, and c) extending the time of completion.

Lalia, a first semester adult learner who had an associate's degree before she decided to apply to nursing school, said that she had taken a year to complete almost all of her non-nursing courses before matriculating into nursing. She added,

> I guess it's a two year program if you're fresh out of high school. Although, I don't know how some of these girls are doing it with the English besides…It really is a three year program.

Lalia speculated on the level of challenge for traditional students who were taking non-nursing courses like English in addition to nursing. Like Lalia, many students had invested a year or more to the completion of required science and liberal arts courses *before* beginning their first nursing course. In fact, Marcy reported that her school recommended that students complete particular courses prior to enrolling in their first nursing course:

> You've taken English and math, and psychology, and nutrition, and microbiology, and two A & Ps (anatomy and physiology), and child development. And you've taken all these classes before they even want you to take a nursing class… That's

what they recommend.

Many of the students in this study shared the perspective that completing some non-nursing courses before beginning the nursing courses was critical to negotiating and getting through the two-year curriculum successfully. Jack for example, shared how "lost" he would have been if he had not completed anatomy and physiology *before* enrolling in his then current first semester nursing course. Jack explained:

> We're doing IV (Intravenous) therapy and enteral tubes. With the IV therapy we're doing diffusion and I had that with A and P (anatomy and physiology) and active transport and if I didn't have that I'd be *really lost* right now. It's just so intense and rushed for that time. But I don't know what the solution is unless you want to just make nursing a four year program.

Jack had completed a bachelor's degree years before he decided to study nursing. His course load in nursing school was lighter than many of his classmates because several previous courses, such as English, had transferred into nursing. Furthermore, although A and P and nursing were identified as co-requisites in the two-year curriculum, Jack saw his completion of A and P ahead of time as critical to his ability to learn and understand "rushed" and "intense" nursing content (also described in Chapter Four). Given these challenges, he suggested almost as an afterthought that a four year curriculum might be the answer.

Another major concession for some study participants was extending the length of their program of study, a compromise viewed as necessary to eventual success in nursing. Marcy, a self-described "good" student with an associate's degree in another field described her first semester in the nursing program as "impossible" and felt she had been

poorly advised. She explained:

> They (advisors) could do a better job of really giving you a better idea of what you're getting into… I mean they signed us up for an impossible class load. One of my professors was like, "Do you know this is virtually impossible? Didn't they tell you that?" No, they didn't tell me that. They said, "You're a strong student you'll be fine…" Yeah, I almost killed myself getting through the fall semester last year. I took Nursing IA, IB, anatomy and physiology, and child development and it almost killed me. And I've been a good student all my life.

Marcy explained what made the nursing course especially difficult for her:

> This semester for nursing I have a nine credit class. So I have four hours of lecture, two hours of lab and you're supposed to have 10 hours of clinical but it's always more than that. And that's one class and one grade, you pass everything or you pass nothing. You can't split it up and do part of it at a time, you can't slow down if you want to, there's no option.

For Marcy, the demands of the nursing curricula were overly challenging and stressful. She decided to withdraw from nursing for one term so that she could better manage the workload. To lighten her academic course load, she took anatomy and physiology by itself in the spring, microbiology during the summer term, and resumed nursing the following fall semester.

As a first semester student, Maggie also felt overwhelmed. She perceived the demands of the nine credit nursing course (which included 10 hours of clinical each week) coupled with the demands of her other courses as "too much" and like Marcy, decided to extend her program of study. She took a semester off from nursing to complete two required

science courses so that the following fall she would be able to concentrate her efforts on nursing.

> I'm not the typical student that that's happy with getting by …I push myself and I expect a lot from myself so I really wouldn't settle for less than A s which I have gotten over that. But uh, a very committed student and it was just… so much that it was too much… So last semester I took just (anatomy and physiology II) and Nutrition at the same time.

Unfortunately, not all students were able to navigate the demands of ADN curriculum by taking non-nursing courses ahead of time or by spreading out requirements into a third year. Jacqueline described her transition from high school to State College as a "huge transition." She said she felt "frustrated and completely lost" and ended up failing the second half of her nursing course. Jacqueline explained:

> Coming here and getting that work load was just crazy for me. Like I passed everything but Nursing I had to repeat. That's why, I should be in Nursing III right now, I had to repeat it. It was just difficult for me.

Because she entered State College immediately following high school Jacqueline was not able to complete any of the required non-nursing courses before beginning the nursing curriculum. She said she took "everything together" – anatomy and physiology, general psychology, English, and nine credits of nursing that included a demanding clinical practice component. She passed all of her non-nursing courses but according to her school's policy, failed the nursing course with a C . When I asked Jacqueline if there was anything that she could identify that would have supported her better during her first semester of college she replied:

> Not giving me so many credits…. My first semester I think it was 15 or 18 credits and that's probably average but it's nursing so I don't think it's as easy as somebody who is taking 18 credits but isn't taking nursing. Nursing is hard. It's just generally hard. You're dealing with people's lives so I understand why it's hard but I just think that maybe there could be different ways it could be taught.

While Jacqueline did not explain what made nursing "hard" other students in this study (see Chapter Four) pointed out that nursing classes were difficult because in addition to classroom lecture, nursing classes included a clinical lab as well as ten to twelve hours of clinical practice experience in the hospital each week. In her frustration Jacqueline also suggested, as several other participants did, that perhaps the nursing curriculum itself needed revision.

Nursing literature supports the assertion of students in this study that the ADN curriculum is difficult to complete in two years. Huston (2006) contended that the two-year ADN program is largely a myth and pointed out that the nursing curriculum often includes 12 to 24 months of required prerequisites followed by a full two years of nursing education. Consequently, nearly all ADN programs require at least three years of education rather than two (Bednash, 2001; Huston, 2006).

Strategies for Mastering Exams

Study participants knew that staying in the nursing program meant they needed to pass the frequent, often difficult multiple choice exams (described in Chapter Four). The stress of passing exams was prevalent. In an effort to pass exams students adopted particular strategies, often times assisted by faculty who provided guidance and functional support. Key strategies included: a) attending to faculty strategies and/or cues

regarding priority content, b) learning to study knowledge in a clinical context, and c) studying with a study group

Prioritizing content. As reported in Chapter Four, students in this study felt overwhelmed with the amount of content they needed to learn, were unable to discern which knowledge was most important to learn, and wanted faculty to help them prioritize content. Charles shared his sense of frustration with one of his teachers' lectures:

> Why aren't you telling me what's important versus what is not important? Why you are just surveying a whole bunch of stuff and saying go read it? If you really want me to learn something thoroughly you have to tell me what to learn.

For Charles, navigating through the curriculum successfully meant determining what was important to learn versus what he could skim over or even ignore. In the following passage Charles drew a contrast between two teachers to describe how the second teacher helped him to sort through the volume of lecture material and prioritize content.

> Now the first part of that maternity material was given to us in a way that I didn't pull out the important things that I needed. I wasn't getting my attention called to this or that or these things or this page in the book. It was like, "Here's some stuff go do it." Now the second section of the maternity was done by a different faculty member who I think is an excellent, excellent lecturer and really finds it important to give us clues as to what we really need to learn. She made us a study guide, handed out a study guide, and I did that study guide and it was you know, 20 written pages. But since I had that study guide to do that gave me the ability to say, "Ok, I need to figure these things out." It didn't, it wasn't every single thing that was in the reading but in order to fill out the study guide I needed to go into

> the reading and I needed to read sections. I needed to correlate it with what I had been given in lecture… and I did wonderfully on that test.

Charles found it helpful that one of his teachers provided a study guide which helped him to prioritize the nursing content he had been given in class. The guide provided a written structure for studying that directed Charles' attention to particular content areas that the teacher had identified as important for students to learn.

Likewise, Marcy also reported that some teachers supported her learning by helping her to prioritize important content. Marcy explained how one teacher provided subtle clues during the lecture.

> If you listen really carefully…if you listen really closely, it's like you don't even have to look at her. If you kind of really listen, you can kind of tell what little things to put a star next to. Now she's not telling you the answer, she's saying, "I really think you need to understand this concept and be able to apply it." So you make sure you spend time with that.

Like Charles' teacher, Marcy's teacher did not make assumptions about students' ability to prioritize the large volume of course material (described in Chapter Four). Students appreciated these teachers' efforts to help them to prioritize essential content they needed to study and learn for exams. Specifically, students identified teachers as helpful when they gave hints during lecture about content that was important to know and provided a written study guide.

Studying strategies and demystifying exams. Students' described how certain faculty provided critical support by offering assistance with studying strategies. Jacqueline explained how a faculty member supported her by helping her with studying techniques:

> She sat me down and tried to understand how I learn and how things fit with me. She says, "Ok, does colors work with you? Does this work with you? How do you think? You know, how do you put this and this together? Does clinical help you out?" You know, because she's my clinical teacher too. She's like, "If you see it in clinical will it help you?" You know, all this helps me. If I see it in clinical, like if see a chest tube on clinical it's going to help me on the test where a question on the test is what I saw. So she helps me a lot.

Students' learning is facilitated when they are given opportunities to make cognitive connections between knowledge presented in the classroom and the integration of that knowledge with clinical practice experiences (Baxter Magolda, 2001; Benner et al., 2007). Jacqueline's teacher provided support by trying to help Jacqueline see the connections between what she was learning in the classroom and her clinical experiences. Unfortunately, nursing students get hands-on clinical experience with only a fraction of the things they learn about in the classroom.

Maggie reported that she and her friend had gotten help with how to study for tests from one of their teachers, "Which has been really good for us because I think she doesn't want us to fail." She explained:

> She (the teacher) has sort of taken us under her wing and said, "Maybe if you try it this way. You know this is what I look for and this is how I test." So I think that has helped a great deal.

Marcy, a second semester student, also reported that one of her teachers had reached out to her and offered assistance. She explained:

> This year I have a different set of instructors. I don't know if it's because the

> instructors are different or the atmosphere has changed but the instructors seem to ask, "How are you doing? Do you need help with something?" I didn't do well on my last test and our instructor sat down with the two of us (her and her friend) in a meeting and went over what are you doing with your studying? They made suggestions.

With probing Marcy described the suggestions of her teacher - to study course material by integrating knowledge and applying it *in a clinical context:*

> (The teacher) sat down with us and said, "Do your reading. When you're done go through each of these sections and ask yourself." She gave a list: "What are the early signs and symptoms? What are the late signs and symptoms? What test is the doctor probably going to send them for? What do I (the nurse) do to get them ready for the test? What does the test entail so I can teach the patient about it? What am I going to do for them when they come back?" She (the teacher) said, "You need to understand all these things and this is what you're going to be tested on." Well, that clicked for me. It made sense to me. Now I know you have to think it through more than *just knowing* what I read by being able to apply it.

Marcy's teacher did more than help her learn to study better for the test. Marcy's teacher helped her to think it through, like a nurse, in a clinical practice context. Some students figured out how to effectively study for nursing exams on their own. Charles explained his strategy for studying, a strategy he shared when tutoring other students:

> …I'm a tutor so I've tutored a lot of people on study skills… I said, You know, there's gonna be some stuff in our medical-surgical textbook that you're gonna ignore because you know it. It's stuff from A & P…basic stuff. Then they're going

> to get into a meat and potatoes kind of thing that's going to describe a condition …whether it's Congestive Heart Failure or STDs [Sexually Transmitted Diseases] or whatever. They're going to look at how you diagnose it and how you assess it, the etiology, everything. So you're gonna have to know that. From there you have to know that you take this stuff and you have to look at the interventions and what you're going to do with interventions and when….You gotta know what you're talking about first and then you got to know how to apply that knowledge based on these things that you're supposed to do.

Charles showed students how to prioritize information when they studied - he explained what information in the textbook was important to learn. Like Marcy, he had determined that understanding how he would need to use knowledge and when – like a nurse in a specific clinical context - was essential to success on exams.

Teresa had also figured out how to study for exams and like Charles, often tutored other students. She shared that in order to answer questions correctly on the nursing exams one needed to focus on the correlation of information; she explained:

> …You need to see patho [pathophysiology], kind of correlate the patho, and then what you're going to do for that patient because of whatever it is you're seeing. And a lot of these level two students that are coming over here now are in tears. They're memorizing the information. They know the information but they don't know how to correlate the information to answer the questions on the exam.

Like Marcy and Charles, Teresa focused on studying how knowledge would be applied in a patient context. Several students in this study were able to make this connection between facts and knowledge presented in the classroom to clinical practice and were

able to figure out how to pass NCLEX style exams. Some students had teachers who helped them learn to study this way while others seem to have learned it on their own. Unfortunately, not all students figured this out. For example, as reported in Chapter Four, Jacqueline reported that she was still trying to figure out how to study for nursing exams as were some of the students Teresa reported tutoring.

Creating study groups. Participating in a *s*tudy group was another helpful strategy identified by some study participants. Several students reported that studying with a friend or formal study group facilitated their learning. Lalia, a first semester student, stated that early in the nursing program:

> [Faculty were] really harping on us to form study groups. They don't form them for you. You just kind of form them on your own, you know? And it does help when you study as a group. It definitely helps when you study as a group.

Jack reported that studying with peers was instrumental to his success on "brutal" second year exams.

> The one thing that helped me, because the first semester, the first year when I was studying, I studied by myself. And then the second year, because the way nursing school is tested, it's just, it's so foreign. So, the second year was difficult; those test questions were brutal. I couldn't do it on my own. I had to get a study group. I had a study group to get me through. I had a study group because if I didn't have that I wouldn't have passed the class. Well the test questions are hard but the answer was the teamwork to get the information through and not relying on yourself ... Let's get through this together. You can't do it alone, it's crazy.

Jack pointed out that he could not successfully learn on his own and relied on classmates to help him learn and understand the information. Study groups have been shown to be effective because they provide students with a structured opportunity to discuss the material they are learning, relate it to their own experiences, and apply it (Chickering & Reisser, 1993) in a supportive atmosphere.

Maggie explained that she studied with her close friend because "She's much more academically advanced than I am and she actually has a great way of teaching me. Because she can explain something to me which reinforces her knowledge but also I understand it." Maggie's explanation underscores an additional benefit of studying in a peer group. Students like Maggie and her friend engaged in a team effort to learn nursing knowledge. Such collaboration to teach each other and share insights tends to increase engagement in learning and facilitates a deeper level of comprehension (Chickering & Reisser, 1993).

Key Negotiations in the Clinical Curriculum

Olesen and Whittaker (1968) pointed out that being successful in the school of nursing required the correct "handling of the patient" (p. 152). In this study students were confronted with key negotiations as they learned how to manage the care of patients in the clinical practice setting. Navigating these challenges successfully required students to overcome numerous anxieties inherent to their new role, address the needs of their patient(s), and simultaneously meet the objectives of the institution, nursing school, and clinical instructor. As will become evident, students often struggled to navigate competing negotiations and while many were ultimately successful, many others were not.

Orienting to a New Learning Environment

Like the students in Olesen and Whittaker's (1968) study, students in this study often felt "burdened by a sense of (their) own lack of knowledge and competence" (p. 248). These sources of anxiety were especially apparent at the beginning of a clinical rotation when students entered a new, unfamiliar clinical learning environment. Jason, a first semester student, described his thinking and the meaning of adjusting to a new clinical learning environment.

> I'm on (the cardiac telemetry unit) right now. And when I was going from orthopedics to (cardiac) I was like, "Oh, this is really serious" because while on orthopedics you're dealing with an exceptional level of pain, you're usually not dealing with something as essential as the heart. There's most definitely a possibility that somebody could die on the orthopedic floor, that's a very real possibility on any of the floors. It's more of a mainstream concern when you're on the cardiac telemetry floor. And moving over like that, I felt like I did when I first started clinical. I don't know what I'm doing. Well I do know what I'm doing you know what I mean? A bed bath is still a bed bath, a linen change is still a linen change. Ambulating a patient; there's a couple different things to keep in mind but it's still ambulating a patient. But before I hit the floor I was really concerned. I don't know where anything is in the supply cabinet over there.

Jason's anxiety as he began his cardiac rotation was rooted in his perception that the stakes were higher there. The more critical nature of the cardiac unit where patients were susceptible to death left Jason feeling inadequate and he worried that he lacked essential knowledge he needed to safely care for such vulnerable patients. Jason's narrative also

made evident the additional stress of navigating an unfamiliar environment and his need to learn the location of patient supplies and equipment. However, realizing that the basics of patient care were the same, and that he knew these basics, was reassuring for Jason as he transitioned to the new unit.

Many students felt anxious on a new clinical unit until they became oriented to the unit. Charles shared how difficult it was to transition to a new learning environment:

> I have a hard time when I'm in new surroundings. I'm pretty uncomfortable for a few weeks. Some people are right the first day, they know their way around a hospital better than I do I guess in the first place and they're very comfortable. Go find this, go find that, that type of stuff. I have a little bit more of lag time when I'm learning a new system. I got a new kind of chart I have to learn, I have a whole new clean utility room, I have to find out where stuff is. I have a lot of lag, well not a lot of lag, it doesn't take me forever but I need a little bit of breathing room to get that stuff.

Charles was unfamiliar with the hospital environment and felt this put him at a disadvantage. He appreciated that his new clinical instructor was supportive while he became oriented and comfortable in the new learning environment.

Like his peers Jack perceived adjusting to a new physical learning environment as a challenge. However, Jack shared an additional strategy - to establish effective working relationships with the nursing staff, a process he described as essential to working together and communication.

> Week after next, we'll be on a different floor. I'll have to go to a different storage room to find out where different things are. When I was starting to get familiar

> with where things were on this rotation, and familiarity with people. I'm on this unit, I want to work with these nurses, so tell me your name. Please tell me your name so I can say, "Can I trouble you for a second, Kim?" Let's make this easy. Let's make this, you know, it impedes the action. You need the communication and the familiarity.

Clinical experiences, while anticipated with excitement, were anxiety provoking for students as they confronted the reality of the nursing role, concurrent responsibilities, and their lack of knowledge and confidence in their ability to provide safe, competent nursing care. Learning to navigate their physical environment and establishing working relationships with nursing staff assisted students to successfully transition to each new clinical learning environment. These findings are consistent with the literature. Reutter, Field, Campbell, and Day (1997) reported that continually adjusting to a new nursing unit was stressful for students until they became oriented to the unit, learned the formal and informal norms, and located those staff nurses who were supportive of students.

Negotiating Competing, at Times Conflicting, Expectations

Assuming the role of nurse regarding the management of patient care was a complicated undertaking in that it often required students to negotiate competing demands. Jason, a first semester student described his transition to the role of nurse as "a growing pain." As Jason described it, the challenge was learning to manage his patient's care in a way that felt comfortable for him while also meeting the expectations of the nursing program.

> I came personally to a point where I could feel good about being assertive in the commanding way that nurses are in a room without feeling like I was being bossy.

> Because at first it just felt that way and it was what I was seeing, "You're going to do it this way." I had to figure out, mull it over in my brain, come to the point where I could command a situation the way a nurse needs to be, and still be comfortable with it. But I did reach that, I found that. That was a source of some confusion for me, a little bit of stress.

Jason felt uncomfortable as he struggled to answer to competing expectations. Assuming the nursing role and accomplishing the work of patient care within the constraints of a particular timeframe felt domineering to Jason initially. He explained:

> They (the patient) don't want a bed bath or they don't want to ambulate. You know, basic things that are part of their care. That is stressed to us that it's very important that these things need to happen. And yes they can refuse any care. Here's the duality – a patient can refuse any care at any time and yet we are supposed at the same time to be reinforcing that this (care) needs to happen and this is why. A lot of times it is presented in class that we just need to make it happen. And I understand the rationales behind it. Obviously, if a person has been refusing baths for two days (they) have to have one or else they might develop a complication.

In class, Jason had learned the scientific principles for managing his patient's care in a particular way to prevent potentially life-threatening complications. However, his belief that the patient had the right to refuse nursing care and "shouldn't be coerced" caused a dilemma for Jason and while he knew he needed to "make it happen" he struggled with how to do so in a way which felt authentic to him.

> It reflects negatively on me. Then people come back to me, "Why wasn't that

> done?" I'm in this weird duality position where I'm trying to be a compassionate person, I'm trying to be a nurse, but I'm also a student, and I'm being held to a certain set of standards. So not only do I have to take care of my patient in a therapeutic way but I also have to show the school I've done this, this**,** and this as per my assignment. I've got both happening at the same time. So they (the patients) can refuse stuff but I'm supposed to get this done. There's definitely a command authority to take a policing term. The word assertive is used here at the school and it's, I suppose it's a good word for it.

Jason's narrative makes explicit the conflicting set of negotiations nursing students struggle to reconcile as they confront the realities of clinical practice. The dilemma Jason struggled with has been addressed by Benner (2001) who argued that, "To empower, nurses sometimes border on coercion as they coach and prompt the patient to engage in painful tasks that patients would not readily undertake on their own" (p. 209). Nurses use their power in the context of a caring relationship with the patient to accomplish the patient's recovery and well-being (Benner). However, as a first semester student Jason struggled to enact the professional perspective described by Benner. For Jason, learning to be assertive with patients so as to accomplish nurse's work and prevent complications (such as, in this case, a urinary tract infection) initially conflicted with his views about being a compassionate nurse. At the same time, Jason recognized that his ability to manage his patient's care in a particular way and demonstrate that he was a competent nurse was critical to his clinical success.

Jason's story highlights one of the critical challenges of nursing education. However, the challenge is not a new one. In their now classic study of nursing students' socialization Olesen and Whittaker noted that:

> In the School of Nursing, the matter of being successful transcended mere grading and entered the arena where problems of implementation of knowledge, handling of the patient, and presentation of self in the appropriate terms were salient (Olesen & Whittaker, 1968, p. 152).

Learning to handle the patient and present oneself as a competent nurse represents one of the critical negotiations students in this study had to navigate in order to succeed clinically. Observing the assertive behavior of staff nurses on the clinical unit who "commanded authority" as they cared for patients helped Jason to identify the professional behaviors expected of him and he began to work through this challenge.

Teresa also described the challenge of accomplishing nurse's work and pointed out that as a student nurse, she was required to manage her patient's care within a particular timeframe and without the assistance RNs normally receive from the "bedside" nurses; that is nurse's aides and/or licensed practical nurses (LPNs).

> They [faculty] say this is what you're going to have to do when you get out but that's why there's bedside [nurses] doing some things. So from a clinical perspective, we're not doing that plus doing meds [medications] and trying to get the patient up and ambulating and sitting in a chair. It's a little different trying to get them [patients] to conform to our schedule, which they [faculty] say we're not, but you are. All this stuff has to be done because you have to be off that clinical floor by 12:30 with all your stuff documented and done by 12:30, including all

your medications.

Like Jason, Teresa said that handling the patient meant getting their cooperation so as to accomplish particular tasks within the hospital and school of nursing schedule. Whereas the unit nurses shift ended at 3:30, the student nurses' school schedule ended three hours earlier. Teresa described this as challenging because students were expected to accomplish all of the patient's care independently and within the timeframe of the school.

Students also reported how the expectations of the clinical instructor to watch them perform procedures or verify medications added to their stress. Teresa said that "chasing the instructor down" was frustrating and added "there's one instructor and five or six of us and we need her to get (medications) out, to check meds and give out meds. It's crazy; the added stress of all that." Being dependent on the clinical instructor, who was responsible for numerous other students, meant that students had to manage their patient's care while also negotiating the constraint of the instructor's availability.

Several students described how faculty helped them to navigate their anxiety and promoted their clinical learning by "giving" them confidence, especially when performing a procedure for the first time. Marie described an experience she had during her labor and delivery (L and D) rotation where she felt nervous about giving an injection to a newborn. Marie shared that she felt conflicted because "You don't (give a shot) to a baby, that's mean!" Marie's anxiety was rooted in her desire not to inflict pain which would make the infant cry. At the same time, Marie knew she needed to enact the role of L and D nurse which includes the administration of Vitamin K to every newborn. Marie's struggle, like Jason's presented earlier, represents one of the many clinical challenges students must navigate in order to be successful in nursing. Marie's shared

the meaning of her teacher's encouragement:

> I knew (the teacher) was right there with me. I wasn't afraid to say to (her), "What do I do?" because she'd say, "Do this, you *can* do it." That gave me confidence - I can do this. It really is about giving the student confidence.

Like Marie, other students reported that encouragement and validation from faculty enabled them to overcome their anxiety and successfully navigate challenges within the nursing role, and in turn, enhanced their developing sense of confidence in themselves as nurses. This finding is consistent with the higher education literature. Baxter Magolda (2001) identified validation of the learners' capacity to know as a critical precondition to student learning and development. Like the students in Rendon's study who "yearned for acceptance" (p. 20) and wanted to hear from teachers that they were capable of learning, students in the current study reported how teachers who expressed belief in them promoted their development by helping them to believe in themselves as learners and nurses. At the same time, students who felt invalidated by a teacher responded with subsequent discouragement and decreased confidence; they questioned whether they were good enough, smart enough, or had what it took to be a nurse.

While Teresa, Jason, and Marie were able to negotiate competing expectations in the clinical practice setting other students were less successful. Jessica, a fourth semester student who ultimately withdrew from her nursing program, offered an example where she struggled to meet the professional expectation to administer her patient's medications on time within the constraint of her instructor not being available to sign off on those medications. Jessica shared how her attempt to negotiate conflicting expectations by being professionally assertive with the instructor led to an unsatisfactory clinical

evaluation.

> I came to her [instructor] with my meds… I said, "Nancy, can you sign off on my meds?" She nodded like she saw me and went on to talk with the Nurse Practitioner (NP)… Talked for about 15 minutes… After the 15 minutes I said, "Ok, can you sign off on my meds now?" She looks at the clock and says, "Why are you running so late?" I must have looked visibly upset because she took me in the back room. She's like, "Come on we'll talk." I spent another five minutes talking to her. I told her, "I'm sorry but I was waiting for you to sign off on my meds." I said "I respect you as my instructor but I want you to know it was a full 15 minutes." She wrote in my anecdotal that I pointed to my watch in anger and that I should've been… What did she say? (read from her paperwork), "Also unprofessional in the manner in which you spoke about the 15 minutes pointing to your watch in anger." It was not in anger. I was trying to tell her that it was 15 minutes that's why I'm 15 minutes behind and that's why I was running late. She ignored me about giving my patient's meds and then tells me I have a problem with time management when I just waited for her for 20 minutes.

Learning to manage their patient's care represents a complex challenge for students because they must negotiate the competing and at times unfair demands of managing their patient's care within the structural constraints of the hospital and nursing program in order to receive a positive evaluation and advance clinically. However, students are dependent on teachers and hold little power in the clinical learning environment. As described earlier in this chapter, speaking up for oneself as Jessica did sometimes had negative repercussions. Indeed, Jessica felt that she was set up for clinical failure by her

instructor and later withdrew from the nursing program.

This relationship between feedback from instructors, the students' sense of self as a nurse, and their subsequent decision to persist or withdraw from nursing is further evidenced in Marie's narrative. Marie described an experience during her "hell rotation" which caused her to consider withdrawing from nursing. Marie said, "I think it was once I hit week two and I realized that no matter what I did, if I did it right or wrong, it was *gonna* be wrong. I kind of threw in the towel and gave up." Marie went on to explain by describing an incident when she questioned whether her patient's intravenous heart medication was infusing correctly.

> I came at Ms. Nell [instructor] with the math done for a Dobutamine drip. I did the math and I looked at the way it was running and I looked at what they [emergency room (E.R.) nurses] had done and I said, "Oh, it's calculated wrong." I came up to her and showed it to her. I said, "I think the drip's running wrong." She didn't look at the math, she didn't look at anything. She said, "No, you're wrong" and just walked away.

Marie's narrative suggests that the teacher maintained power over her by withholding information; in this case, how the dosage of Dobutamine was calculated in the E.R. Undoubtedly, many students upon being told "you're wrong" would have taken the instructor's word for it; the teacher is after all the authority (Belenky, et al., 1986). However, Marie reported that instead of giving up she sought out the charge nurse who willingly shared her knowledge with Marie and showed her how to do the math in a particular context.

> So I went up to my charge nurse and asked "How do they calculate this drip?" She

> said "That's how they come up from the ER [Emergency Room]." Ok, how do they do it in the ER, do we know? She says, "They take a chart, they find the closest weight and they program it to that and the chart in the computer." Well he didn't weigh exactly, let's say 75 kg. He must've weighed like 76.2. I came up to her (the instructor) and said, "Well, I wasn't wrong," I said it right to her. I go, "But neither were they. This is how the ER does it. This is the correct math. I wasn't wrong."

While Marie's narrative suggested she was determined to learn the correct math she shared that, "This instructor made me feel beneath dirt, like I was incapable of doing this." Her response to what she perceived as constant criticism was a sense of discouragement, thoughts of giving up, and a diminished self-image as a nurse. At the same time, the support of the charge nurse coupled with the knowledge that she was not wrong after all seemed to empower Marie to succeed despite an unsupportive clinical instructor.

Some teachers might argue that a tough approach is necessary, even beneficial, to help students become better nurses. At our second interview two and a half years later, I asked Marie, "Do you think there is any possibility that the teacher being so tough on you helped you become a better nurse?" Marie responded:

> I will say that when I'm getting frustrated because someone doesn't understand what I'm telling them and it's a simple thing, I remember what it was like to be treated like that and I strive not to do that. So in that aspect yes, I will say it helped me to be a better nurse.

Shuval (1980) noted that students evaluate practitioners they work with and become

selective regarding role models. Like Marie, students also select antimodels whose professional behavior is judged to be undesirable (as cited by du Tiot, 1995).

Negotiating Professional Expectations: Presentation of Self as a Safe, Competent Nurse

Study participants knew that presenting themselves as competent, safe practitioners was an nonnegotiable prerequisite to passing clinical. Successful students demonstrated agency by adopting key strategies which assisted them to successfully navigate this challenge. These strategies included preparing and practicing, scheduling clinical competencies with "nice" faculty, and verifying decisions and assessments with faculty.

Preparing and practicing. Marcy shared how her growing sense of professional responsibility influenced her decision about how much to prepare and practice new skills before caring for patients in the clinical practice setting:

> I work extremely hard; that's all I do. I have no life but I feel like it's important that I learn these things because I'll have someone's life in my hands. So I take it very seriously. And a lot of people I feel don't work as hard and they don't get the results they want and it's their own fault.

Maggie shared a similar perspective:

> Maggie: I'm extremely confident in what I do. I make sure that I am. I don't get on that [hospital] floor not knowing what I'm doing. You gotta figure there's someone in that bed that I'm taking care of that relies on me to know what I'm doing. I'm going to know what I'm doing before I get there. So my skill level - I'm very confident in. But that's because I make myself that way.
>
> Darlene: How do you make yourself that way?
>
> Maggie: You go to (clinical) lab and you practice... you learn your techniques.

> You force yourself to go to that lab and you force yourself to practice, to learn those things.

When asked whether practicing was required by the nursing program Maggie clarified:

> Some of it; you have to go practice once, that's required. Then you have to go for your competency [be evaluated by faculty], that's required. But the other times in between it's not required. You don't have to spend a specific amount of time there.

Consistent with the interactionist approach to professional socialization (described in Chapter Two), nursing students like Maggie demonstrated agency by making decisions about how often and how long to prepare for and practice new skills in the clinical learning lab. Determined to succeed, Maggie reported that she and her friend had been practicing their clinical skills for five to six hours a week, far more time than what was required by the school.

Likewise, Teresa, a fourth semester student, reported feeling confident as she performed a complex skill for the first time with a patient. When asked what helped her to develop that confidence she responded, "Definitely getting to the lab and practicing. Trying to research and read." Teresa shared an additional dimension to this perspective:

> I always tried to be as prepared as I could. I knew it [performing complex procedures] could potentially happen. You don't go in there going, "What am I going to do?" The lady [patient] would be like, "Come back when you have a little more (laughs) confidence." The lady kept going, "You're going to do that [a clinical procedure]?" Yeah! "And you're going to do that [another procedure]?" Yeah! And she was fine with me the entire day.

Teresa's outlook was that patients expected student nurses to project the confidence of a professional nurse. Being prepared and projecting confidence were intentional strategies Teresa employed to gain her patient's trust and willingness to allow Teresa, a student, to provide her nursing care for the day.

Scheduling clinical competencies with "nice" faculty. Several students reported how they actively attempted to be evaluated in the clinical learning lab by particular faculty who had a reputation for being "nice". Jacqueline explained how she learned this strategy:

> Jacqueline: They [classmates] told me my first semester here, they told me, "Do not comp with that lady" [a particular teacher]. Both of the girls I was telling you about told me, "Do not comp with her." And I comped with her and I failed. They said, "Look to see if Kate and Sue are comping and comp with them instead." So now what I do is I look to see who is comping that day. I'm like, if this person [the faculty who failed her and her friends] is comping I'm not doing it.
>
> Darlene: Really? So you plan it?
>
> Jacqueline**:** Yes, I ask her [nice faculty], "When are you comping?" and she tells me. I tell her, "I'm going to come and sign up for your day." If it's somebody else I am not comping.

Olesen and Whittaker (1968) noted that students responded to the difficulty of nursing school by becoming active agents in their own socialization. To reach their goal, students practiced the art of "studentmanship" - they made decisions and adopted strategies to get through the nursing program. Jacqueline regretted that she had not listened to her classmates "cautionary tale of studentmanship" (p. 296) and later failed a competency.

Her subsequent decision to seek out particular faculty for clinical competencies represents one of the strategies students in this study adopted in order to navigate the clinical curriculum successfully.

Jacqueline never described in depth what she meant by "nice" faculty and I missed the opportunity to probe for clarification. However, Annette did describe the behavior of "nice" faculty by drawing a contrast with faculty hovering behavior.

> There were four or five different faculty who did the lab and [students] try to find the ones who are nice. Some people are more laid back. They know they make you nervous so they stand further away or they just kind of glance up while they're reading a magazine and they'll just glance over and watch you. Others, they stand *right over you*. Literally, if the patient is here (demonstrates) and I'm standing here, she's standing there. That's just outrageous. No one learns like that. It makes the person ridiculously uncomfortable. I mean [the teacher] is boring down. The teacher is staring. You can feel their breathe every time they exhale. No one learns like that.

Annette pointed out that the hovering behaviors of certain teachers inhibited her ability to learn. In contrast, she appreciated teachers who seemed to be aware that their presence made students anxious and worked to put students at ease during competencies by de-emphasizing their evaluative role.

The desire to look good to instructors and pass clinical competencies and the concurrent fear of failing competencies prompted students to exercise agency by making decisions about preparing for and practicing skills, verifying skills, and working to test competencies with particular faculty. Sometimes it was a positive experience with nice

faculty which informed the students' decision. Other times, it was the experience of failing a competency with a particular teacher and/or observing or hearing about the experiences of one's peers.

Verifying decisions and assessments with faculty. Students' sense of professional responsibility and their concurrent fear of making a mistake, often led them to ask questions or verify clinical assessments or decisions with an instructor to prevent making an error. Teresa explained:

> I would rather ask [the instructor] and check than make a mistake. If I have the opportunity to say, "Wait a second I don't know what's going on here." I'm going to verify something. I would rather verify and check than make an error.

Even when they felt well prepared students like Teresa often worried about making a mistake which could cause harm to the patient. This finding is consistent with the literature. Reutter et al. (1997) described how students, lacking both knowledge and experience, sought validation from instructors in order to verify their clinical judgments.

Furthermore, like the students in Wilson's (1994) study, Teresa moved out of the role of student where errors and learning by trial and error were expected and acceptable to he role of nurse where she assumed responsibility for another person's well-being. Teresa described how she took the initiative to review a procedure with the instructor outside her patient's room.

> I was doing an IV push (Intravenous Push) medication on a peripheral line and I was like "Ok, I'm just going to run the procedure (by the instructor). This is what I'm going to do. Because I would rather run it by (the teacher) really quick out here (outside patient's room) than have (the teacher) say, "You're doing what?" in

> front of the patient. It's only going to make the patient nervous. And (faculty) are like, "Do you have that, you know whatever?" Yeah I have that (piece of equipment) or whatever because I just told you verbally that I was going to do… the steps I was going to do. I like to do that with the instructors especially if it's something that I've never done before.

Wilson (1994) found that senior baccalaureate nursing students developed a perspective which guided their actions in the clinical practice environment. The process of becoming a nurse involved the accomplishment of six major goals: To learn clinical skills, to cause no patient harm, to help patients, to integrate theoretical knowledge into clinical practice, to look good as a student, and to look good as a nurse. Teresa's narrative revealed that several of these themes drove her decision. Like the participants in Wilson's study, one of Teresa's goals was to cause no patient harm. Since IVP medications enter the patient's bloodstream quickly Teresa knew that accuracy was important. Teresa also wanted to look good as a student in front of the instructor. The students in Wilson's study identified looking good as a prerequisite to achieving good grades and staying in the program. Verbally rehearsing step-by-step with her instructor allowed Teresa to demonstrate her level of knowledge and preparation for the IVP procedure and also circumvented potential mistakes or errors of omission. Teresa felt that it was better to be corrected in private since being corrected in front of the patient would make her look incompetent. Finally, Teresa wanted to look good as a nurse (Wilson, 1995) so that her patient would feel confident in the care she provided.

Annette described how she actively sought her clinical instructors' feedback about her assessment of a patient's lung sounds.

> She [faculty] just kind of puts you at ease. I have a terrible time and I think it might be my hearing (laughs). So I always ask her to recheck. If it were a different instructor I probably wouldn't ask, I would probably ask a student. But I'm comfortable enough to ask her, "Well, what do you think? Do you hear the same thing I hear?" And she'll say no in a way where you don't feel like an idiot. She won't say, "Ok, what's wrong with you?" She'll be like, "I didn't really hear that, maybe you want to just take another listen."

Annette lacked experience - she did not yet feel competent to assess lung sounds or trust her clinical judgment. The teacher was responsible for providing feedback which would help Annette learn from her experience by validating whether Annette's assessment was accurate. Annette's narrative makes explicit one of the ways that teachers promoted students' clinical learning and professional development. Reutter et al. (1997) noted that students' developing sense of competence and professional self-esteem were shaped by the teachers' delivery of feedback. Annette trusted that her teacher's feedback would be given in a manner that would not diminish her sense of professional competence. However, Annette pointed out that if she were with a different instructor she "probably wouldn't ask" the teacher for feedback. Many of the students in this study reported that they had learned not to ask particular teachers for feedback.

Becoming the Ideal Nurse

Emerging from students' perspectives was the overriding notion that they were socialized, often in subtle ways, to become the ideal nurse - a nurse who maintains a obedient, and submissive to authority.

Fitting the Professional Mold: Norms for Appearance and Behavior

Marcy explained that some faculty expected student nurses to fit a particular professional mold:

> Some college students will go to school in sweat pants and look like they just got out of bed. You don't do that in nursing. (Faculty) have a certain mold they want you to fit. You look presentable, you act presentable; they want you to be very professional at all times. And some [faculty] view your appearance as being a part of that… The whole piercings and tattoos and stuff - they make you cover them.

One of Marcy's strategies for getting through the nursing program was to adhere to what she perceived as professional norms, a strategy that so far, had served her well. In contrast, Maggie reported how a classmate who did not fit the professional image was treated:

> There was a girl who came to clinical with a bunch of piercings and black nail polish and instead of the instructor nicely saying, "I would appreciate it if you would remove your piercings and let's get that fingernail polish off," she took her into the clean linen room which was where you got in trouble. She basically lit into her about her appearance and how unacceptable it was. Which I can understand but there's a nice way of doing it.

Students like Maggie learned professional norms by observing how peers who failed to enact those expectations were reprimanded. This perspective that students had to fit a particular mold to be successful in nursing has been previously reported. Olesen and Whittaker (1968) described the typical nursing student: "(T)he nurse does not think of fashion or self-decoration. She (sic) wears no jewelry, and her (sic) fingernails are short

and unpainted; the nurse is not frivolous" (p. 63). Olesen and Whittaker acknowledged reporting these characteristics with "tongue-in-cheek" (p. 64) and pointed out their function in a hospital environment where cleanliness and quietness were essential. While the schools represented in this study have replaced the traditional white nursing uniform with scrubs, students described norms regarding professional appearance which are consistent with the traditional norms described by Olesen and Whittaker.

According to several participants, navigating the curriculum also required the student to behave in particular ways. Maggie's narrative highlights the norms she learned regarding both appearance and behavior:

> There were a few girls (in the class) who would disappear on their break and go smoke. You could see the difference in the way that the instructor treated those girls as opposed to those who didn't say anything, who were on time, who were clean and neat and had a professional appearance. There was a definite difference in the way that she treated those students from the way she treated us (her and her friend). You learned quickly what not to do, what they wanted to hear. We didn't complain. You didn't cause trouble.

Maggie did not elaborate on how the instructor treated "those girls" differently and I failed to probe enough. However, a few minutes later she added:

> Picked up on that probably on probably the first night of class. And you can tell also the people who sit in the back of the room. Our particular instructors had no use for anyone who sat in the back. She directed most of her conversation to the front two rows. Those were the students that were serious; you know, those were the ones who wanted to learn. And the ones in the back were just wasting her

> time…Yeah, there was a definite difference in the way specific people were treated. And you just learned very quickly not to make waves.

The reaction model of professional socialization (described in Chapter Two) purported that students make conscious choices which facilitate their survival in the system by "adaptive responses to their subordinate position in professional schools" (Simpson, 1979, p. 10). Maggie's perception was that certain behaviors were expected and desirable. Her decision to conform to those expectations – to maintain a professional appearance, be on time, sit in one of the front rows, and "not say anything" - was an intentional strategy to please her teacher, be perceived favorably, and avoid negative attention.

Surviving Nursing "Boot Camp"

Several students, from different schools of nursing, shared the perspective that behavioral norms for future nurses were taught in nursing boot camp. Marcy shared how er experience affected her:

> Well, it definitely knocks your confidence down. Definitely; I mean, I've always been a very strong student all through high school and college, all the classes leading up to nursing. The [faculty] here don't treat you like you're an adult; like you're in boot camp. You know, you speak when you're spoken to, you don't ask questions. You don't feel like you're being treated as a fellow adult.

Marcy was not the only student to invoke the metaphor of boot camp to describe her experience of being treated like a subordinate in nursing school. At our third meeting, Jack, who had since graduated from a different nursing program than Marcy, offered his explanation for the behavior of "controlling" instructors:

> Jack: It was a boot camp mentality. It was (the teacher's) way or the highway. It was strict. It was no talking in class. It was controlling. But her control thing was to break us down. I have to believe it was that military thing - break 'em down to build 'em up.
>
> Darlene: Why would she want to break them (students) down?
>
> Jack: So you can mold them. You can mold them the way that they're supposed to be.
>
> Darlene: Oh, how are you supposed to be?
>
> Jack: Well, you're supposed to be the perfect, the ideal nurse you know? Clean cut, quiet, speaking only when spoken to, studying, keeping all your ducks in a ow. Keep your bed made so you can flip a quarter on it (laughs).

Reflecting on testing practices, Marcy also shared Jack's viewpoint that educational practices were intended to press students into submission.

> At first I thought they were trying to kill us. I remember Danielle [a classmate] saying, "Why are [faculty] doing this?" I don't know, so they can beat us down and make us humble. That's how I felt at the time.

Charles compared his previous college experience where he felt that the teachers cared about his learning and academic success to his experience in the nursing program:

> They [psychology professors] wanted you to make it through. But here we are in this nursing program where 60% are going to drop out anyway so I could care less about you. If you make it through this war you're going to, *good for you*, here's a pat on the back.

While Charles used the word "war" students from different schools of nursing used other

military metaphors to summarize their experience in nursing school such as "boot camp" (Marcy and Jack), "hell" (Marie, Jessica, and Jack), and nurses as the "troops on the front line" (Jason). Jack, who interviewed several times and had since graduated, described nursing school as "all consuming" and added, "I see the fellow students that have families and they're having problems because their husband doesn't understand that they're going through this hell." With probing, Jack shared a negative experience in his advanced medical-surgical nursing course with one instructor (previously reported in Chapter Five) who he described as "…A Nazi kind of, well I hate to use that word Nazi but more of a dictator nurse."

It is relevant to note that early American nursing was shaped by the hierarchy, duty, and ideology of discipline represented by both the military and the Victorian family (Reverby, 1987b). Historically, nurses were trained, disciplined, and molded to be altruistic, submissive, quiet, obedient, and refined women of character (Melosh, 1982; Reverby, 1987b). The training of nurses to deal with the emergencies of disease and death was often compared to the drilling of soldiers battling a war (Reverby, 1987b). In fact Dock, a prominent nursing leader, reportedly spoke to an international group of nurses in 1893 and stated, "The organization of a training school is and must be military. It is not and cannot be democratic … to this end complete subordination of the individual to the work as a whole is as necessary for her (sic) as for a soldier" (Reverby, 1987b, p. 52).

"Flying Under the Radar"

In order to achieve their goal and navigate through the nursing program, several students in this study made the decision to **"**fly under the radar." Marcy shared how she

learned this:

> We had a test question and one of the answers was, "Blood tinged urine is a common outcome after inserting a Foley." Our lab instructor taught us about Foley care and that was one of the things she said is that sometimes you will have that. So we all answered that on the test and we got it wrong because they [faculty] said it's not normal. Well, Joyce [the lab instructor] said it was. We had a petition, we had like 35 people in the class; we all signed it. They wouldn't review the test question or consider omitting it or anything. They just refused to bend at all…. So then you stop trying because you realize it's not going to do any good. You keep your head down. You fly low. You fly under the radar. You just fly under the radar.

Students like Marcy learned through experience the futility of speaking up. Rather than challenging the status quo students' tacit decision was to become silent. Metaphors students used to describe this strategy of remaining silent, not complaining, and/or not asking questions included "flying under the radar" (Marcy; Maggie), "don't make waves" (Maggie), keeping your head down" (Marcy; Marie), not "stirring the pot" (Chloe), "playing by (following) the rules" (Maggie; Jack), and "not ruffling" (Charles). Maggie shared this perspective:

> You really don't want to go to them (faculty). You sort of learn early on, hopefully you learn early on, the smart ones (laughs) learn early on that you don't make waves. That you fly below the radar and you let the other ones who complain be the ones with the targets you know, painted on their backs; because they draw the negative attention, let them fail themselves. You draw that attention away from

> yourself, you play by the rules and you just fly below the radar.

As Maggie described it, complaining was risky behavior because it could result in becoming a target for clinical failure (discussed in Chapter Five). Rather than risk this type of negative attention students learned to keep silent. Maggie said, "I don't break the rules. I'm not a fighter I'm not, going to argue with you. I learned quickly that you just don't do that. So I've never had any trouble."

Marie explained how she shared her strategy for getting through clinical with a particular instructor who had targeted her with junior classmates:

> I'm working on my bachelor's and I'm taking classes with students from my A.D. program. They're all getting ready to enter second year and they ask, "Well what's my biggest recommendation?" And I said, "Keep your head down and out of the way on *that* rotation. Do not put your head up. If you put your head up and ask a question you're in trouble."

Marie's advice to her peers represents a "cautionary tale of studentmanship" (Olesen & Whittaker, 1968). Although Marie had learned the benefits of "flying under the radar" too late she was happy to share her hard-earned lessons with junior classmates so that they could avoid negative attention.

Despite the passage of over a century, students in this study described experiences which reflect aspects of the training philosophy and ideology of discipline and submission that was characteristic of early American nursing. This finding has been reported in previous literature. Historically, as explained in Chapter Two, nurse educators typically felt a moral obligation and "pedagogical concern for the character of those they trained" (Reverby, 1987b, p. 50). Nursing students were socialized to become women of

character: mature, altruistic, refined, submissive, quiet, and obedient (Melosh, 1982; Reverby, 1987b).

Negotiating Faculty Favor

Several students reported that it was easier for them to navigate the curriculum and fly below the radar when relationships with faculty were positive and friendly. Maggie explained that part of navigating the politics of the curriculum was to work to be perceived favorably by faculty.

> All the instructors – they know who we (my friend and I) are, they know our names. So, it's made it a lot easier I think that there is some politics that go on, that it makes a difference. And fortunately, in an unfortunate situation as far as politics, I'm on the good side. Do I think its right? Absolutely not. But am I thankful I'm on the side I am? Definitely!

Jack laughed as he shared his strategy of using his "charm" and sense of humor to establish favorable relationships with instructors:

> I was kind of manipulative with my personality. Well, I was manipulative in a good way. I know how to use my personality to create. I know people and I have insight into things pretty quickly when I talk to them. I know how to get past them when I have to. I know how to compliment. I know how to support you know? I just know how to do that so, and I know how to stand up for myself too.

Jack was intentional in his efforts to be perceived favorably by teachers sharing that he would "walk down to the cars and stuff, per chance if we were leaving at the same time. I would walk down to the cars with (certain) teachers and they would talk to me like they would talk to a peer."

Charles shared this viewpoint and elaborated further that maintaining faculty favor was important because it affected how one might be treated and evaluated by clinical faculty.

> I'm not going to ruffle. I'll be argumentative and I like getting into discussions and that sort of stuff but I put myself in a position where I'm friends with all the faculty because even though I might disagree with some things they have to say or the way they do it I'm not going to vocalize it you know? Because I think that'll have a detrimental effect possibly on my grade and certainly on how I am treated, in places such as clinical. Like I said I have an inside track on that clinical professor who I said was hazing. So I try to keep myself there because I'm afraid that if I really vocalize what I want to say that's its going to be detrimental. I don't think I'm free to speak my mind here. Certain professors yeah, I can say what I want to say but other ones I'm just making nice because they're going to make my life *horrible* if I don't.

Charles had observed one of his clinical instructors "hazing" a peer (reported in Chapter Five) and felt that he escaped being treated in a similar way by this particular instructor because she was a professional colleague of Charles' father. Charles' was worried that speaking up and saying what he wanted to could lead to negative clinical repercussions. Rather than challenge the status quo and risk clinical failure, Charles' strategy was not to "ruffle" particular teachers.

These findings are consistent with Becker et al's (1961) classic study of medical student culture which found that students assessed faculty demands and enacted specific behaviors which they believed would please faculty. Students in the current study

perceived the faculty as expecting certain professional behaviors and decided to enact those behaviors to please faculty. However, for students in this study, pleasing faculty was also a matter of self-protection. Students believed that failure to enact these behaviors could elicit negative consequences including a poor clinical evaluation and/or clinical failure.

Challenging Behavioral Norms: The Repercussions of Speaking Up

As already reported, several students in this study shared the belief that "flying under the radar" – that is, keeping quiet and not complaining - was beneficial to their success and survival in the nursing program. Indeed, there were implications for those students who did not "fly under the radar" but instead chose to speak up or question.

As reported in Chapter Five, Teresa shared a negative experience with a clinical instructor who evaluated Teresa as "rude and disrespectful." With probing to determine whether she knew what her teacher was referring to Teresa described a clinical incident where she spoke up for herself. Teresa explained:

> She [teacher] asked me if I had signed my [patient's] bedside sheet. She told me I didn't sign my bedside sheet and I informed her that *I did* sign my bedside sheet. Because she had told us she was giving out occurrence reports [clinical deficiency] if we didn't sign our bedside sheet.

Teresa, an adult learner, said that she was accustomed to speaking up for herself and reported that while she felt she had done so in a respectful way, challenging the authority of the clinical instructor was not well received. As reported in Chapter Five, Teresa said she was "written up" for being rude and disrespectful.

Other students, from all three colleges, also shared that speaking up for oneself was

risky behavior. Chloe described an incident where her clinical instructor "accused" her of leaving her patient naked and uncovered in his bed. Looking back on her experience, she felt that speaking up for herself was a huge "mistake." She explained:

> And I think the worst mistake that I did was I stood up for myself and said, "No I didn't do that." Yes you did. Because she (faculty) started in with, (yelling tone of voice) "I don't know what kind of school you've been to but we have respect here." And I'm standing there like a deer in headlights and I still had no idea what she was talking about. She's like, "You left Mr. So and So completely, you know open to everybody. I said, "No, I didn't." And you could see the change like as soon as I said, "No, I didn't." It was Grrr… she says, "Yeah, you did." No, I didn't… I'm like, I'm not going to be accused of something I didn't do.

Chloe said she was upset that her instructor had "little enough respect to even accuse me of that in the first place." Chloe was further perplexed when a classmate, sent by the clinical instructor to cover Chloe's patient for her, returned and informed Chloe that the patient was indeed, already covered.

> Well I (instructor) sent so and so, which was a student going to school with me, down to fix it for you, fix your mistakes. And the girl (classmate) came out of the room and ...she's like, "It's ok"... and I'm like, "What happened?" She's like, "He's fine. He was totally covered.

Chloe, Marie, Jessica, and Teresa all reported incidents as fourth semester students where they said they respectfully asserted themselves by speaking up or asking a question and were subsequently cited or reprimanded for doing so. While Teresa and Jessica reported being cited for their behavior in a written evaluation, Marie, Jessica, and Chloe reported

being singled out for closer clinical evaluation**.**

Similar to the perspectives of her peers (described earlier in this chapter) Chloe shared her perspective that students could avoid such repercussions by not "stirring the pot" a lesson she regretted not learning sooner:

> Chloe: I think that if you are on the (teacher's) good side, you haven't done anything to stir the pot, you should be ok.
>
> Darlene: What do you mean by stir the pot?
>
> Chloe: Anything where you're questioning what they [faculty] said.

Chloe's perspective that "stirring the pot" was risky is consistent with other student's perspectives about "rocking the boat" and "making waves". As discussed earlier, students reported how they learned the behavioral norms of the hidden curriculum, to be submissive, remain silent, and not question authority through their interactions with particular nursing faculty.

Students' narratives point to the subtle socialization of students to become the ideal nurse – a nurse who is well-groomed, quiet, humble, and speaks when spoken to. This finding is consistent with the previous research literature. Deppoliti (2003) reported that graduate nurse participants in her grounded theory study also experienced rigid instructors who were intent on turning out a certain type of nurse who fit a particular mold. Furthermore, students' portrayal of some instructors as rigid and controlling supports Roberts' (1983) contention that leaders (such as faculty) in oppressed groups exhibit controlling, coercive, and rigid behaviors in order to maintain the status quo.

Conclusions

This chapter described how students responded to the challenges of nursing school by

becoming active agents in their own socialization journey. This finding is consistent with previous research. Olesen and Whittaker (1968) noted that nursing students adopted strategies for success and survival by creating:

> …guidelines for their own socialization, for sustaining themselves against the onslaught of what they deemed to be the unworthiness of the faculty and for protecting themselves against what seemed to them the perils of an incomprehensible and unfriendly institution (p. 292).

Likewise, to reach their goal, students in this study made decisions and adopted academic, clinical, and behavioral strategies to get through the nursing program.

Several study participants shared the perspective that successful negotiation of the ADN program actually required three (or more) years of academic coursework. This finding is consistent with previous nursing literature which contended that nearly all ADN programs require at least three years of education rather than two (Bednash, 2001; Huston, 2006). However, students in the current study identified several alternatives for successfully completing ADN program requirements including: a) taking required non-nursing courses before beginning the nursing program, b) transferring course credits and requirements from prior degrees, and c) extending the time of completion of their program of study.

This chapter extended the arguments of Chapters Four and Five by further explicating the critical role that faculty played in helping students' to successfully navigate the nursing curriculum. While students' demonstrated agency and figured out how to navigate many of their challenges independently, supportive faculty facilitated students' ability to successfully navigate the academic curriculum by providing hints and/or

concrete guidelines for prioritizing content that was most important to learn, demystifying exams, and encouraging study groups.

This chapter also revealed that students felt they were set up for failure by the academic and clinical demands of the two year curriculum which included insufficient academic advising, an over emphasis on academic assessment via NCLEX style exams, and a lack of other methods of academic assessment Marie, Kyle, Jacqueline, and Chloe reported academic and/or clinical failure of a nursing course. Marie, Kyle, and Jacqueline navigated their experience of failure by repeating the nursing course and extending their program of study. Marcy and Maggie negotiated the curriculum by compromising - they withdrew from nursing for one term in order to complete science courses and lighten their course load. Jessica reached a point where she was unwilling to make additional concessions; she decided to withdraw from her nursing program.

Study participants were also confronted with key negotiations as they learned how to manage the care of patients in the clinical practice setting. Being successful in the clinical curriculum required students to demonstrate competent "handling of the patient" Olesen and Whittaker, 1968, p. 152). Participants knew that presenting themselves as capable practitioners was a nonnegotiable prerequisite to passing clinical. Successful students demonstrated agency by adopting key strategies which included preparing and practicing nursing skills, scheduling clinical competencies with particular faculty, and verifying decisions and assessments with faculty.

My findings regarding students' experience of changing clinical units as stressful also warrants further consideration. Consistent with the current study, Reutter et al. (1997) reported that students actively adjusted to frequent rotations in clinical units by becoming

oriented, learning the formal and informal norms of the unit, and locating those staff nurses who were supportive of students. These "negotiating" behaviors reflect an interactionist perspective yet Reutter et al (1997) found that first year baccalaureate students' learning was primarily reflective of a functionalist (induction) approach. However, given the structure of the two year curriculum this finding is not surprising. While the baccalaureate student is not confronted with the realities of clinical practice until the sophomore or even junior year, the associate degree students in this study were engaged in clinical learning within weeks of beginning the first semester.

In this chapter, several students shared Jack's perspective regarding the characteristics of the "ideal nurse" as well-groomed, submissive, and obedient to authority. This finding provides additional evidence that traces of nursing's traditional ideology continue to shape students' experience in contemporary nursing education. Students learned to navigate the hidden curriculum of nursing education by adopting perceived professional norms for behavior and "flying under the radar." Flying under the radar included keeping silent, maintaining friendly relationships with faculty, and not challenging particular faculty by questioning them, speaking up, or asking questions. These findings are consistent with previous research. Beagan (2001) found that physicians used the medical hierarchy to encourage conformity by dissuading medical students from asking questions or criticizing the status quo. The current study found evidence of similar strategies employed in nursing education. Indeed, nursing scholars have criticized traditional nursing education for socializing students to be obedient and submissive to others' control and authority and not to challenge the status quo (Bevis & Watson, 1989). This finding calls for further study.

In the next chapter, the findings reported in each of the data chapters are briefly summarized. In Chapter Seven I draw conclusions and examine the implications of these dissertation study findings for undergraduate nursing education, student retention, graduate education and faculty development. Recommendations for further research are also addressed in the next chapter.

Chapter Seven: CONCLUSIONS

> Here in this nursing program, it's like we expect 40% of you to fail. Why? Why do you expect 40% to fail? I mean yeah, it's harder. It's very hard … But you need to make some adjustments and do some extra measures to try and retain some people because I've seen some really good students get booted (Charles).

The students who participated in this study described the journey of professional socialization into nursing as a challenging, often stressful endeavor. Charles was one of several students who expressed concern because some of his classmates, "good students" with the potential to be successful, were unable to navigate the challenges and failed out of the nursing program. Like many of his peers, Charles thought the attrition rate was higher than it needed to be and felt that nursing education ought to be doing more to support and retain students.

The United States is currently experiencing a nationwide nursing shortage that is expected to deteriorate even further in the next decade. Experts estimate that by 2020 the nation will have 20% fewer RNs in the workforce than will be needed (Goodin, 2003). Given the projected critical shortage of RNs, it is imperative that higher education professionals focus attention on the success of nursing students.

The purpose of this qualitative study was to contribute to a better understanding of ADN students' lived experience of their classroom and clinical learning environment. Thirteen students, from three different associate degree nursing programs, participated in the study. As fully described in Chapter Three, students were interviewed at various points in their nursing education and in several cases, after graduation, withdrawal, or failure from their respective program. Altogether, one focus group with four students and

18 individual interviews were conducted. The perspectives of these 13 students represent a snapshot of one facet of the larger social context that is nursing education.

Research Questions and Summary of Findings

The primary question this study attempted to answer was, How do students enrolled in an AD nursing program experience their learning environment, including classroom and clinical settings? Inherent in the primary question were three additional questions: 1) What experiences do ADN students' perceive as contributing to learning and success? 2)What experiences do ADN students' perceive as barriers to learning and success? and 3) How do students' experiences shape their emerging identity as nurses?

Study participants' constructed multiple meanings of their lived experience in nursing education. The overarching theme which emerged in students' narratives and that answered the primary question was students' perception of being overly challenged and inadequately supported in the nursing program. Study participants wanted, and *expected,* teachers to care about them, their learning, and their success. Unfortunately, while participants were able to articulate what they needed from teachers, their narratives indicated that the supportive, caring relationships they desired were often lacking. Many students perceived the learning climate as uncaring and/or hostile. Students' demonstrated agency as they tried to negotiate challenges to get through and succeed in nursing school. Faculty played a pivotal role in promoting or hindering students' learning, development, and successful navigation of the nursing curriculum.

Contributors to Learning and Success

This study sought to answer the question, *What experiences do ADN students' perceive as contributing to learning and success?* Students' accounts of their

experiences revealed two major categories of contributors to learning and success: a) learning assignments and/or faculty guidance that helped students to prioritize content, engaged students in active learning, situated nursing knowledge in a clinical context, and/or demystified exams, and b) relationships with caring faculty, that is, faculty who were accessible, respectful, provided encouraging feedback and validation, and were non-threatening.

As explained in Chapter Four, students felt overwhelmed by the volume of course material presented in lectures and textbooks. At the same time, students' felt supported by certain teachers who provided assignments and/or gave hints during lecture that helped them to prioritize content they needed to learn. For example, a study guide was described as helpful because it directed the student's attention to essential content but also engaged the student in reading for a specific purpose and active learning.

Students also perceived teachers as contributing to their learning when they offered assistance with studying strategies. Supportive teachers did not make assumptions about students' ability to study for nursing exams. Rather, these teachers helped students make connections between knowledge presented in the classroom with their clinical experiences. They also taught students to study nursing knowledge while reflecting about how they might have to apply that knowledge in clinical practice, like a nurse.

Study participants also identified key conditions within the teacher-student relationship that contributed to learning and success. These conditions included faculty accessibility, mutual respect, balanced feedback and validation, and modeling the espoused values of the nursing profession. Participants wanted, and *expected*, teachers to care about their learning. For students in this study, the teachers' willingness to make

time for them meant that the teacher cared about them, their learning, and their success in the nursing program. Faculty accessibility emerged as an essential quality of the supportive faculty-student relationship in prior studies (Chickering & Reisser, 1993a) and reflects an "institutional climate where talking with faculty members is legitimized, where students feel free to "take up the professors' valuable time, and where such contacts are viewed as an important and necessary part of teaching" (p. 335).

A prevalent theme in this study was the importance of balanced feedback and validation to learning and persisting in nursing school. Students' described supportive faculty who provided constructive feedback but also conveyed their belief in students' ability to learn and become successful nurses. Students who perceived positive feedback and/or encouragement also reported increased learning, confidence, and motivation to persist in the nursing program.

In the clinical setting, participants had to overcome their anxiety and present themselves as competent nurses in order to succeed clinically. Faculty described as supportive helped students to overcome feelings of anxiety by deemphasizing the teacher's evaluative role. That is, supportive instructors observed and evaluated students but did not hover over them. Participants described how these teachers seemed to recognize when students felt anxious about performing clinical skills and put them at ease by establishing rapport, communicating support, offering words of encouragement, and/or instilling confidence. Students often expressed their appreciation for these teachers who "gave" them confidence and helped them to believe in themselves as future nurses.

Barriers to Learning and Success

This study was grounded in a third research question which asked, *What experiences do ADN students' perceive as barriers to learning and success?* Students' experiences revealed the following categories of barriers: a) the instruction paradigm, b) clinical learning as evaluation, c) unsupportive faculty-student relationships, d) faculty incivility/bullying, e) time required to complete the ADN curriculum, and f) perceived professional norms.

Study participants' perceptions of classroom experiences typically reflected the traditional instruction paradigm (Barr & Tagg, 1995) rather than student learning. As explicated in Chapter Four, students' narratives illustrated an emphasis on knowledge acquisition. Students' narratives revealed that structured classroom opportunities to think about knowledge in the context of clinical practice like a nurse were minimal or lacking altogether. The resulting disconnect was described as a source of discouragement and frustration and a barrier to learning and success because passing nursing exams, requisite to progressing in the nursing program, required the contextual application of nursing knowledge, a challenge many students felt inadequately prepared to accomplish.

Participants' revealed that clinical assignments were typically permeated by anxiety over mastering clinical skills, passing competencies, completing lengthy nursing plans of care, and managing the care of acutely ill patients. Participants had to overcome their anxiety, manage their patient's care, and present themselves as competent nurses in order to succeed clinically. Students' construction of the clinical classroom as a site for evaluation was perceived as a major barrier to learning and success. While there were exceptions, students rarely viewed clinical evaluation as a formative process that would

assist them to learn and develop as clinical practitioners. The perceived focus on evaluation exacerbated students' anxiety and fear of failure and inhibited their ability to learn or perform well.

Students' experiences also revealed barriers to learning and success within the teacher-student relationship including unapproachable and/or unavailable faculty, perceived lack of respect from teachers, lack of feedback and/or exclusively critical feedback, and failure to model values of the nursing profession.

For study participants, the teachers' perceived unwillingness to make time for them meant that the teacher did not care about them, their learning, or their success in the nursing program. These teachers were described as unapproachable and "too busy" to help students. Students who reported experiences with these teachers often felt discouraged and several expressed disillusionment with the profession and/or considered withdrawal from nursing. Baxter Magolda (2001) noted that "If instructors are uncaring, teaching (and thus learning) is ineffective" (p. 31). An uncaring learning environment inhibits the students' ability to engage in thinking and learning and develop the sense of self needed to participate in knowledge construction (Baxter Magolda). Instead of feeling empowered to find their voice students who experience uncaring feel unwelcomed in the community of learners and disempowered (Belenky et al., 1986).

Study participants also expected relationships with teachers that were mutually respectful. Unfortunately, many students reported being "reprimanded" or talked down to by particular teachers and several shared the perspective that as *adult* learners they deserved to be treated like adults, with the same respect they were expected to demonstrate towards teachers.

Students felt vulnerable to a lack of timely feedback, constant criticism, and/or verbally demeaning feedback. Students who reported exclusively negative feedback also reported decreased self-esteem, decreased confidence, and thought about leaving the nursing program. The baccalaureate nursing students in Reutter et al.'s (1997) study also felt vulnerable to negative feedback that decreased their self-esteem. However, the lived experiences of students in the current study extends findings previously reported by explicating that students' vulnerability to negative feedback was minimized when they were also given some positive feedback. For study participants, validation regarding what they were doing well made it easier to accept criticism and also influenced their willingness to persist in the nursing program.

Faculty incivility and/or bullying was perceived as a major barrier to learning, self-esteem, identity as nurse, and success. Students' felt invalidated and responded with decreased confidence and discouragement; they questioned whether they were good enough, smart enough, or had what it took to be a nurse. The students' perspective was that being held to expectations for professional perfection placed them at a clinical disadvantage which made success "impossible" and set them up for clinical failure. Although some student's explicated how their sense of self helped them to navigate through a hostile learning environment, others were unsuccessful and eventually failed or voluntarily withdrew from nursing. Furthermore, students reported that these incidents had long lasting negative effects that stayed with them long after the hostile encounters had ended.

These findings are consistent with a limited body of previous research (Clark, 2008; Clark & Springer, 2007). Uncaring practices in nursing education have received little

scholarly attention and until recently few studies explicitly examined nursing students' experiences of faculty bullying. Yet there is evidence in the literature that the problem is not new and may be more prevalent than previously thought. Baccalaureate nursing students in Halldórsdóttir (1990) study also reported "uncaring" encounters with teachers. Their description of uncaring as "ridiculed or treated with contempt" (p. 102) parallels the experiences described by current study participants and is consistent with what recent literature has labeled as bullying or incivility. Similarly, 45% of baccalaureate nursing student participants in Mahat's (1988) study reported negative teacher-student interactions. Like the students in the current study, students reported that unsupportive "demeaning" teachers made them feel incompetent (Mahat, p. 7).

For many participants, the demands of the ADN curricula were perceived as "impossible" (see Chapter Six). Students emphasized the difficulty of taking non-nursing courses at the same time as nursing classes and several expressed frustration because successful negotiation of the ADN curriculum required three (or more) years of coursework. This finding is consistent with the contention of nursing leaders that most contemporary ADN programs require at least three years of education rather than two (Bednash, 2001; Huston, 2006; Nelson, 2002; Nelson & Welch, 2006; Orsolini-Hain & Waters, 2009).

Study participants identified various alternative ways to complete the ADN requirements including taking some required courses before beginning the nursing program, transferring course credits and requirements from prior degrees, and/or extending the time of completion. As revealed in Chapter Six, several participants had spent a year (or more) taking prerequisite and/or non-nursing courses before they

matriculated into nursing. In addition, many participants had transferred in previous college coursework.

Despite these concessions, students' fear of academic and/or clinical failure was pervasive at all three nursing schools. As data collection neared completion, a field note documented that five of the 13 participants (representing all three schools) were required to extend their program of study because of academic and/or clinical failure of a nursing course (Marie, Kyle, Jason, Jacqueline, and Chloe). Two students (Marcy and Maggie) reported that they voluntarily extended their program of study in order be successful. Ultimately, four of the 13 study participants were lost to attrition; three failed out of their nursing program (Kyle, Jacqueline, and Chloe) and the fourth student (Jessica) withdrew from nursing just a few months before graduation because she said, she could no longer cope with the continual "abuse" of her clinical instructor.

Students' Emerging Identity Development as a Nurse

The final research question which grounded this study was, *How do students' experiences shape their emerging identity as nurses?* This section focuses on the findings that addressed this question.

In this study, faculty played an important role in students' socialization into nursing. Feedback from teachers shaped students' sense of self and whether they were "smart enough" to be a nurse but also influenced their thinking about whether to persist or withdraw from the nursing program. Students reported that a teacher's encouragement and validation enabled them to navigate challenges within the nursing role, and in turn, enhanced their developing sense of confidence in themselves as nurses.

For students, the way feedback was delivered by teachers emerged as a major aspect

of feeling supported. Study participants' wanted and expected feedback from teachers but also felt vulnerable. Students' reported that their vulnerability to negative feedback about things they needed to improve to be successful was minimized when they were also given some positive feedback that validated what they were doing well.

In contrast, a lack of timely feedback was described as stressful and also induced fear of failure. Exclusively critical feedback and faculty bullying were described as devastating events that shattered students' self-esteem, confidence, and self-concept as nurse. Students from each of the three ADN programs represented reported experiences with teachers which left them feeling "belittled," "demeaned," "beneath dirt," "powerless," and "ripped apart." Some students questioned whether they were good enough or smart enough to be a nurse and reported thoughts of giving up or withdrawing.

The lived experience of students revealed their construction of what it meant to become a nurse. Participants' narratives pointed to the subtle socialization of students to become the ideal nurse – a nurse who is well-groomed, quiet, humble, and speaks when spoken to. This finding is consistent with a limited body of previous research literature. Deppoliti (2003) reported that graduate nurse participants in her grounded theory study experienced rigid instructors who were intent on turning out a certain type of nurse who fit a particular mold. Furthermore, students' portrayal of some instructors as rigid and controlling supports Roberts' (1983) contention that leaders (such as faculty) in oppressed groups exhibit controlling, coercive, and rigid behaviors in order to maintain the status quo.

Bevis and Watson (1989) argued that the hidden curriculum - the way that teachers interact with students and the covert messages communicated - socialized students about

how to think and feel like nurses. Authoritarian, control-laden educational practices that socialize adult students to remain silent and not question authority hinders their intellectual and professional development (Belenky et.al., 1986; Bevis & Watson, 1989; Stanton, 1996). This is especially problematic in a practice profession such as nursing. The professional responsibilities inherent to the RN role require higher level thinking and reasoning skills. Learning to think critically requires experiences which allow learners to actively apply knowledge and engage in knowledge construction (Barr & Tagg, 1995; Baxter Magolda, 2001; Belenky et al., 1986).

Freshwater (2000, p. 484) asked, "Are nurses socialized into having no voice by the teachers who may themselves feel oppressed?" In this study, the metaphor of voice was present in students' perspectives about learning professional norms to "speak when spoken to," and "don't ask questions." In order to survive and get through nursing school, many students adopted the strategy of "flying under the radar," defined as keeping quiet and not complaining. Indeed, as reported in Chapter Six, several students who did not "fly under the radar" but instead spoke up or questioned authority reported being verbally reprimanded or formally written up for doing so.

These study findings support the argument that educational practices shape student learning and development in multiple ways and extend beyond epistemological development (Baxter Magolda, 2001; Belenky et al., 1986). Rather, adult learning and development reflects three intersecting dimensions: "cognitive (how one makes meaning of knowledge), interpersonal (how one views oneself in relation to others) and intrapersonal (how one perceives one's sense of self and identity)" (Baxter Magolda, 1999, p. 10).

Recommendations for Nursing Education and Retention

Chapter One introduced Sanford's (1966) theory that optimal student growth and development occurs when the learning environment provides a balance of challenge and support. Sanford further contended that too much challenge and/or too little concurrent support could prompt maladaptive coping strategies such as ignoring the challenge or leaving college to escape the challenge (as cited by Hamrick et al., 2002).

In the current study, participants' often appraised their learning environment as overly challenging and stressful and many perceived a lack of sufficient support. The sometimes hostile learning climate described by several informants was perceived as a major barrier to learning that shattered their self-esteem, confidence, and motivation to persist. Although some students were able to navigate these conditions, others were unsuccessful and eventually failed or voluntarily withdrew from nursing.

Learning to care for acutely ill patients in unpredictable practice environments is challenging enough without the added stress of a hostile learning environment. While some study participants expressed anger about the way they were treated, they believed they had little recourse. Students did not typically feel empowered to report faculty they perceived as "misusing their power." Instead, the fear of clinical retaliation led them to remain silent. This finding corroborates a limited body of previous research (Clark, 2008) and suggests several recommendations for supporting student retention and success in nursing education.

First, nursing faculty, student affairs professionals, and nursing program administrators need to believe that every student accepted into the nursing program has the potential to succeed given the right set of conditions, and also that it is the

institution's responsibility to create those conditions (Engstrom & Tinto, 2008). Curriculum transformation that centers student learning and a caring learning climate (Baxter Magolda, 1999, 2001; Belenky et al., 1995; Bevis & Watson, 1989; Diekelmann, 2003; NLN, 2003; Tanner, 1990) provides such conditions and should become a priority. Nursing programs can acquire grant funding to design and implement curricular practices and methods for faculty development.

Faculty play a pivotal role in students' professional socialization into nursing and should be formally prepared as educators to establish affirming, respectful, evidence-based caring relationships with students that facilitates development of self-worth and self-esteem and empowers students as learners and future nurses. As evidenced in students' narratives, reform of the informal curriculum is critical if nursing aspires to walk the talk and educate practitioners in ways that are congruent with the caring human science philosophy espoused by the profession.

It could be that faculty may not be aware of their behavior or recognize it as bullying. Research which examined horizontal violence in the workplace suggested that the phenomenon was so deep-rooted in nursing's organizational culture that it is not recognized by nursing directors or managers (Sellers, Millenbach, Kovach, & Yingling, 2009). Sellers et al. (p. 23) pointed out that, "until a phenomenon is recognized and named little can be done to alter it."

The phenomenon of faculty incivility and bullying has only recently been named (Clark, 2008). This study contributes further understanding to the limited yet growing body of research regarding faculty bullying in nursing education. Nursing education must now work to increase awareness, become conscious of bullying practices, and

recognize the detrimental impact of faculty bullying on students' learning, development, and success in nursing education.

Faculty incivility and abuse of power should be openly discussed as a current professional issue during undergraduate nursing courses. Students need to be educated to recognize incivility and verbal abuse when it occurs, to report it, and also to advocate for one another as future colleagues. Educating and preparing students to manage bullying experiences might help interrupt the cycle of horizontal violence and retain nurses (Randle, 2003). However, breaking the cycle will not occur unless faculty are also educated and held accountable for bullying behaviors. Just as nurses are held accountable for the way patients in their care are treated, faculty must be held professionally accountable for the way students in their care are treated. Institutional and organizational based strategies for dealing with faculty bullying are needed as well as research focused on evaluation of strategies and identification of best practices.

Given the detrimental impact of faculty incivility on students' learning, development, and success in nursing education, this research brings you to the conclusion that nursing programs need to appoint a designated person with the institutional authority to advocate for students who report bullying. A full-time faculty such as a Dean of Students, could be appointed with the responsibility of supporting, empowering, and advocating for nursing students as well as promoting conditions for student retention and success within the academic institution.

Further research is needed to examine how educators can best support students who have already experienced faculty incivility. However, it seems obvious that at the minimum, students should be provided with access to professional counseling resources.

In the current study, students who experienced faculty bullying shared that the incident had "toxic" effects that stayed with them long after the bullying had ended. Educating and counseling for nursing students and/or nurses who have experienced bullying might help interrupt the cycle of horizontal violence and retain nurses (Randle, 2003).

Rethinking Associate Degree Nursing Education

Wells (2003) noted a lack of research regarding factors that influence attrition among contemporary undergraduate nursing students. This research contributes to closing the gap in the nursing literature by providing insight into issues that may influence the success and retention of contemporary ADN students.

Associate degree nursing education began with Mildred Montag's (1951) doctoral dissertation, *Education for Nursing Technicians,* which proposed a two-year education for a *technical* nurse, including prerequisites and co-requisites (Haase, 1990; Hood & Leddy, 2006; Huston, 2006; Orsolini-Hain & Waters, 2009). However, the curriculum has proliferated over the last several decades to keep up with *professional* workplace demands:

> As in the 1960s, when AD programs began adding leadership courses in response to work world expectations, contemporary programs have intensified and lengthened nursing courses, pushing more and more of the general education and science components into a prerequisite category, making most programs at least 3 years in length… Today, earning an ADN degree takes almost as long as a BSN (Orsolini-Hain & Waters, 2009, p. 269- 270).

Leadership courses were not included in Montag's two-year curriculum because as Montag envisioned it, the ADN curriculum would prepare a technical nurse who would

be supervised by the four year professional nurse (Huston, 2006; Orsolini-Hain & Waters, 2009).

Study participants revealed that the journey of professional socialization into nursing was a challenging, often stressful endeavor. As reviewed in Chapter Two, Oermann (1998) reported that significantly higher amounts of clinical stress were reported by the ADN students as compared to the BS students in her study. For both ADN and BSN students, the perception of stress increased as they progressed through the nursing program. Oermann concluded that:

> At the end of the curriculum, as clinical experiences become more complex and require independent decision making by students, learners may experience a higher degree of stress in comparison to beginning courses in which the faculty guides learning and decisions to a greater extent (p. 201).

The lived experience of participants in this study supports Oermann's conclusion. However, what has not been explicitly acknowledged in previous research is that while BSN students are not typically confronted with the challenges of clinical practice until the sophomore or junior year, ADN students are generally engaged in clinical learning within weeks of beginning the first semester. Furthermore, as evident in participants' narratives, ADN students must learn to negotiate the complex challenges of clinical practice at an accelerated pace.

Recently, Benner et al. (2007) reported the concern of nursing leaders regarding the practice and education gap:

> Currently, a major practice-education gap exists with practice knowledge and skill demands exceeding the content taught in the current undergraduate nursing

> programs. Nurses in *all* programs (emphasis added) are currently undereducated for current nursing practice demands (Benner et al., p. 21).

Nelson (2002) challenged educators to consider whether "nursing education has evolved beyond the community college setting" (p. 4). Indeed, nursing leaders have argued that it is becoming increasingly challenging, if not impossible, to adequately prepare an entry-level professional nurse in *four years* (American Association of Colleges of Nursing, 1998; Benner et al., 2007; Nelson, 2002; Tanner, 1998).

The findings of this study support the concerns expressed by these nursing leaders. ADN programs attempt to prepare students for safe practice in two years and while many students are successful, numerous others are lost to attrition. The nursing curricula represented in this study did not adapt to students' learning needs; rather it "targeted and weeded" students out. While there were exceptions, few students in this study perceived clinical evaluation as a formative process that would assist them to learn and develop as clinical practitioners. Rather, many students reported an adversarial learning climate focused on evaluation. Many shared the perspective that clinical expectations during their third or fourth semester were impossibly high which set them, and their classmates, up for clinical failure. Students described "targeting and/or weeding out practices" if a student did not meet the expectations of particular instructors. The focus on evaluation exacerbated students' anxiety and fear and inhibited their ability to focus on clinical learning or perform well.

The question that needs to be asked is, "How many students with the potential to become successful nurses are lost to attrition during their third or fourth semester because they continue to need formative feedback and guidance with aspects of the *professional*

role such as priority setting and clinical decision making?" If nursing education is serious about promoting the retention and success of nursing students it seems clear that more must be done to support students. Rather than focusing on perceived performance inadequacies, attention to creating student centered academic environments with faculty mentors in a collaborative learning
environment must be constructed.

The findings of this study also suggest that nursing education needs to rethink and redesign ADN education to better support students' learning and development. Contemporary ADN programs strive to provide *professional* education yet overall, have not changed their curricular structure to support students' learning and professional development. One program that holds promise and warrants further study is the Dual Degree Program in Nursing (DDPN), a collaborative articulation model between St. Joseph's College of Nursing and the Department of Nursing at Le Moyne College in Syracuse, New York. The DDPN curriculum is a one, plus two, plus one (1+2+1) program of study that requires two years of study at Le Moyne College (years 1 and 4) and two years of study (years two and three) at St. Joseph's College of Nursing (Bastable & Markowitz, 2006). Developed for the traditional high school graduate, the DDPN was designed to minimize first year student attrition and provide an opportunity for RN to BS mobility. The DDPN is also "supportive of [New York] State's initiative to establish the BS degree as a uniform standard for professional practice" (Bastable & Markowitz, p. 178).

Although the DDPN was designed for qualified high school graduates, the program may also support nontraditional students' learning needs. Indeed, in the current study the

demands of the ADN curricula were perceived as "impossible" (see Chapter Six) by many study participants. Both traditional and nontraditional students emphasized the difficulty of taking non-nursing courses (especially science courses) at the same time as nursing classes. In fact, many students shared the perspective that completing some non-nursing courses before beginning the nursing courses was critical to negotiating and getting through the ADN curriculum successfully. Jack for example, had successfully completed a bachelor's degree years earlier, yet shared how "lost" he would have been if he had not completed anatomy and physiology *before* enrolling in his then current first semester nursing course (see Chapter Six). The DDPN curriculum plan acknowledges "the concrete as a route to the abstract" (Kegan, 1984, p. 53). It facilitates the student's mastery of concrete knowledge and facts (anatomy and physiology) in the first year before building on that knowledge in nursing courses during the second year.

Study Limitations and Areas of Future Research

This study is limited to the educational experiences and meaning making processes of the 13 students who participated. The themes identified in each data chapter were presented in the context of these students' lived experience in one of three associate degree nursing programs located in the northeastern United States. The experiences of nursing students enrolled in other types of degree programs and from other geographic locations are not represented in this work.

Nursing students' perspectives are honored in this work. Although faculty perspectives are important to examine, they are not represented in this study and represent a limitation. A better understanding of the faculty's perspective regarding institutional and national barriers to student centered practices in nursing education is

needed. The plethora of content and curriculum mandates in nursing curricula, time constraints, and the pressure to prepare students for success on the NCLEX-RN exam have been acknowledged as constraints to student centered practices (Diekelmann, 1989; NLN, 2003; Schaefer & Zygmont, 2003; Young, 2004). Further study that examines how faculty experience, and overcome barriers to practicing in student centered ways would be especially valuable.

Another limitation of this study is that the perspectives of only two students of color are represented. Racial and ethnic minorities are underrepresented in nursing and nursing education. As the U.S. has become more culturally diverse, the need for practitioners equipped to deliver nursing care to our ethnically and culturally diverse society has increased. The profession has worked to attract students of color and the good news is that the number of students choosing nursing has increased in recent years. Unfortunately, the attrition rate, the number of students who drop out of the nursing program, is high for ethnic and racial minorities (National Advisory Council on Nurse Education and Practice, 2000). Additional research is needed which focuses on the learning needs, development, and success of ethnic and racial minority nursing students. Retention of racial and ethnic minority students in nursing programs is important to the development of a diverse nursing workforce that can deliver ethnically and culturally sensitive health care (Gardner, 2005). Unfortunately, I experienced difficulty recruiting students of color for this study. Although I had hoped to minimize this limitation by conducting second interviews with both minority participants, I was only able to follow up with Annette. As reported in Chapter Three, my attempt to interview Jacqueline a second time was unsuccessful and I later heard she had failed out of her

nursing program.

Another limitation of this study was that I did not follow students over the four (or more) semesters of their nursing school experience. A longitudinal study design would allow a closer examination of the socialization process including the development of a nursing identity as it evolves from the first semester to graduation and would contribute further understanding regarding the socialization of ADN students. Furthermore, I recommend qualitative studies with students who extend their program of study, decide to withdraw, and/or who have already withdrawn from the nursing program. This research will enhance our understanding of how we can best support students' success and retention.

Study participants provided rich descriptions of their lived experiences of being socialized to be obedient and submissive to authorities and to speak when spoken to. These findings have been described in the historical and socialization literature (Cohen, 1981; Melosh, 1982; Reverby, 1987b). Given the implications of this finding for nursing education, I recommend future studies explicitly examine this dimension of students' socialization experience in greater depth. Again, a longitudinal design might enhance a closer examination of the socialization process.

Students' lived experiences revealed that faculty bullying contributed to a hostile learning environment, increased students' perception of stress, and had a detrimental effect on students' learning, confidence, developing sense of self as nurse, and desire to persist in the nursing program. Furthermore, study participants' perspectives of bullying encounters revealed that it often occurred during the students' final advanced medical-surgical course rotation. These findings point to the need for additional research on

faculty incivility and bullying. Descriptive studies are needed that examine the degree to which faculty bullying occurs in nursing programs, why it occurs, and in what contexts. For example, do faculty who bully students do so out of a perceived responsibility to uphold a particular standard of quality patient care? In light of the current national nursing shortage and attrition in nursing education, research focused on the learning climate and bullying practices in colleges of nursing should be recognized as a research priority.

Conclusion

The purpose of this qualitative dissertation research was to contribute to a better understanding of associate degree nursing students' lived experience. The study examined the reality of ADN education as a particular group of 13 participants lived it. Given the limited body of qualitative research focused on students in ADN education, this study provides needed insight into the students' experience. Study participants provided rich, thick descriptions of their lived experience in associate degree nursing education. However, the qualitative design used in this study was not expected to yield generalizable data and the reader is reminded to exercise caution in evaluating the applicability and transferability of this research data to other contexts.

Nurses must be prepared to negotiate the multiple, complex demands of the clinical practice environment. Bevis (1989) argued that the profession needs nurses who "are compassionate, well-educated, creative, capable of independent judgment and action, and morally astute and courageous" (p. 17). Bevis' line of reasoning parallels Baxter Magolda's (1998) argument that a college education ought to facilitate the development

of self-authorship, "the ability to collect, interpret and analyze information and reflect on one's own beliefs in order to form judgments" (p.143).

Based on the perspectives of 13 students' lived experience in nursing education, I argue and recommend educational reform within ADN education that is responsive to students' needs as learners through the implementation of caring, connected models of education (Bevis & Watson, 1989; Belenky et al., 1986) and a learner-centered academic environment (Baxter Magolda, 1999, 2001; Kegan, 1984). The caring, learner-centered curriculum enacts the evidence-based reform called for by numerous nurse leaders and the NLN (2005).

While it was beyond the scope of this study to propose or examine solutions to challenges that currently confront nursing education, my hope is that the students' voices represented in this dissertation may prompt nurse educators, student affairs professionals, academic advisors, and administrators to reflect on current assumptions and practices and dialogue about creating the evidence based learning environments and conditions that supports students' learning, professional development, and success.

APPENDIX A: Letters to Deans and Directors of Nursing Programs

Dean (Smith)
Private Hospital College of Nursing

September 9, 2005

Dear Dean (Smith),
I am a doctoral student in Higher Education at Syracuse University. This semester I plan to begin a qualitative research study for my advanced qualitative research class and also my dissertation. I am writing to ask you, as dean, for authorization to interview nursing students at your institution. I plan to begin this study by observing and audio taping student support groups and/or focus groups. I then plan to interview, and audio tape, select students one or two times during the year.

I plan to begin this study by observing and audio taping student support groups. Upon completion of these focus groups I would like to interview, and audio tape, select students one or two times during the semester.

Your student's participation in this research may benefit the college in several ways. Faculty and administration may benefit from knowledge about student's perspectives on their academic experience. Ultimately this will enhance our understanding of how best to retain students and support them as they transition through the first year. While the risks of participation in this study are minimal, they do exist. Students could fear the repercussions of sharing information with me. Let me assure you, strict confidentiality will be maintained. I will use pseudonyms for each nurse to conceal their identity and only I will have access to the specific information they provide. If a student decides at any time that they no longer wish to participate, they have the right to withdraw from the study, without penalty.

Concurrently, to you receiving this letter, I am submitting the enclosed application to the Institutional Review Board (IRB) for the Protection of Human Research Subjects to the Chair of the IRB at Syracuse University. In order to obtain full approval for Syracuse University's IRB, I need a written statement from the (appropriate official) authorizing access to participants of the study.

I want to assure you that I will uphold the highest ethical principles and care to cause no harm to participants. Furthermore, I promise to contribute important research findings to the discipline of nursing education.

I look forward to hearing from you and beginning this research.

Sincerely,

Darlene Del Prato

APPENDIX A: Letters to Deans and Directors of Nursing Programs

Associate Dean (Jones)
State College

November 13, 2006

Dear Dean (Jones),

I am a doctoral student in Higher Education at Syracuse University (SU). Next semester I plan to begin a qualitative research study for my dissertation. I am writing to ask you, as dean, for authorization to interview nursing students at your institution. I would like to interview, and audio tape, select students one or two times during the semester.

Your student's participation in this research may benefit the college in several ways. Faculty and administration may benefit from gaining knowledge about student's perspectives on their academic experience. Ultimately this will enhance the educator's understanding of how best to support students, and retain them, as they transition through the nursing program. While the risks of participation in this study are minimal, they do exist. Students could fear the repercussions of sharing information with me. Let me assure you, strict confidentiality will be maintained. I will use pseudonyms for each student to conceal their identity and only I will have access to the specific information they provide. If a student decides at any time that they no longer wish to participate, they have the right to withdraw from the study, without penalty.

Concurrently, to you receiving this letter, I am submitting the enclosed application to the Institutional Review Board (IRB) for the Protection of Human Research Subjects to the Chair of the IRB at Syracuse University. In order to obtain full approval for Syracuse University's IRB, I need a written statement from the (appropriate official) authorizing access to participants of the study.

I want to assure you that I will uphold the highest ethical principles and care to cause no harm to participants. Furthermore, I promise to contribute important research findings to your college and to the discipline of nursing education.

You are welcome to contact my academic advisor, Dr. Cathy Engstrom, at SU who can attest to my qualifications to conduct this study.

I look forward to hearing from you and beginning this research.
Sincerely,

Darlene Del Prato

APPENDIX A: Letters to Deans and Directors of Nursing Programs

Dr. Brown
Director, Private Hospital School of Nursing

November 13, 2006

Dear Dr. Brown,

I enjoyed talking with you a few weeks ago when you met with several of us from the College of Nursing. I am also a doctoral student in Higher Education at Syracuse University (SU). Next semester I plan to begin a qualitative research study for my dissertation. I am writing to ask you, as director, for authorization to interview nursing students at your institution. I would like to interview, and audio tape, select students one or two times during the semester.

Your student's participation in this research may benefit your institution in several ways. Faculty and administration may benefit from gaining knowledge about student's perspectives on their academic experience. Ultimately this will enhance the educator's understanding of how best to support students, and retain them, as they transition through the nursing program. While the risks of participation in this study are minimal, they do exist. Students could fear the repercussions of sharing information with me. Let me assure you, strict confidentiality will be maintained. I will use pseudonyms for each student to conceal their identity and only I will have access to the specific information they provide. If a student decides at any time that they no longer wish to participate, they have the right to withdraw from the study, without penalty.

Concurrently, to you receiving this letter, I will be submitting the enclosed application to the Institutional Review Board (IRB) for the Protection of Human Research Subjects to the Chair of the IRB at Syracuse University. In order to obtain full approval for Syracuse University's IRB, I need a written statement from the (appropriate official) authorizing access to participants of the study.

I want to assure you that I will uphold the highest ethical principles and care to cause no harm to participants. Furthermore, I promise to contribute important research findings to your college and to the discipline of nursing education.

You are welcome to contact my academic advisor, Dr. Cathy Engstrom, at SU who can attest to my qualifications to conduct this study.

I look forward to hearing from you and beginning this research.
Sincerely,

Darlene Del Prato

APPENDIX B: Recruitment Script

Good morning (or Good Afternoon). I know how busy nursing students are so I want to thank you for your time today. My name is Darlene Del Prato and I am student at Syracuse University working on my PhD in Higher Education. I am here today to invite you to participate in a research study I am doing about nursing students. Your involvement in the study is *completely* voluntary, so you may choose to participate or not.

Let me tell you what I am doing. I am interested in learning more about how Associate Degree students experience their nursing education. In other words, what has *your* experience been like for *you*? If you take part in this study you will participate in one interview which I will audio tape. The interview will take approximately one hour of your time and you may choose where the interview takes place. All information you share with me will be kept confidential. This means that your name will not appear anywhere and no one will know about your specific responses other than me. In the event that I write or give a presentation about my research findings, I will use a made-up name for you. You will be given the opportunity to choose the name I use for you before we begin the interview. In addition, I will not reveal details that might reveal your identity such as where you work or attend college. Audiotapes and transcriptions will be stored in a locked cabinet and upon transcription, all audiotapes will be erased.

The risks to you of participating in this study are that the hour of time required for the interview could interfere with your studies. This risk will be minimized by limiting the interview to sixty minutes. Also, you may chose not to answer any research question for any reason. If you no longer wish to continue you have the right to withdraw from the study, without penalty, at any time. The benefit of this research is that you will be helping faculty and administrators to better understand the experiences of Associate Degree students and how we might support their success in nursing school. Also, some of you might find it therapeutic to think about and reflect upon your educational experiences with a neutral listener.

Are there any questions?

I invite those of you who wish to take part in this study to take a consent form and read it carefully. Please do not hesitate to ask any additional questions you may have. Thank you for your time.

APPENDIX C: Selected Characteristics of Study Participants (N=13)

Demographic Variable	n
Age	
19-24	3
25-42	10
Race	
Black	2
White	11
Gender	
Female	9
Male	4
Marital Status	
Single	5
Married	6
Separated/Divorced	2
Residence	
College Residence Hall	3
Off campus	10
Semester of enrollment	
At first interview	
1st semester	3
2nd semester	4
3rd semester	2
4th semester	2
4th semester withdrawal/failure	2
At second interview	
3rd semester	2
4th semester/withdrawal	1
Post Licensure; Working as RN	2
Previous college experience	
No previous college coursework	2
Nursing pre-requisites and/or non-nursing courses only	3
College coursework 1-2 years; plus non-nursing courses	2
Associate's degree in another field	3
Bachelor's degree in another field	3

APPENDIX D: Interview Questions

Tell me about your experience in nursing school.

What experiences have been most challenging for you? In what ways?

What has been most helpful to you during the challenging times?

What was not helpful?

Describe a recent experience that was significant for you?

Tell me about an experience you had with a peer, faculty, administrator, or other person that you feel did not help (support) you through a challenging time.

How did your experience affect you as a nursing student?

Tell me about an experience you had with a peer, instructor, administrator, or other person which you feel helped (supported) you through a challenging experience.

How did the experience affect you as a nursing student?

APPENDIX E: A Typical Four-Semester ADN Plan of Study

Semester One Courses	**Credits**
Nur 100 Fundamentals of Nursing w/lab	3
Nur 110 Nursing Care of Adults I	5
Biology 200 Anatomy & Physiology I w/lab	4
English 100 Freshmen English	3
Psychology 101 Introduction to Psychology	3
	18 credits

Semester Two Courses	
Nur 120 Nursing Care of Adults II	10
Biology 201 Anatomy & Physiology II w/lab	4
Psychology 220 Human Growth & Development	3
	17 credits

Semester Three Courses	
Nur 200 Psychiatric and Mental Health Nursing	3.5
Nur 202 Maternal-Child Nursing Care	3.5
Nur 201 Nursing Care of Children	3
Eng 110 Professional Writing	3
Bio 220 Microbiology	4
	17 credits

Semester Four Courses	
Nur 270 Nursing Care of Acutely Ill Adults	9
Soc 101 Introduction to Sociology	3
Bio 210 Nutrition for the Health Care Provider	3
Nur 280 Transition to Professional Practice	1
	17 credits
Total credit hours	**69 credits**

APPENDIX F: Coding Tree

1. Demographics/Academic Background/Transition to College
- (1.1) Demographics (Race, Class, First generation, Sexual Identity, Age, Learning disability)
- (1.2) Family description/experiences/educational views
- (1.3) High school Courses/Grades
- (1.4) College Courses/Degree/Grades
- (1.5) Traditional students' transition to college
  - (1.5.1) Social integration/Relationships (boyfriend/girlfriend)
  - (1.5.2) Academic Integration
- (1.6) Non-traditional students' transition - returning to school
  - (1.6.1) Relationships/ Role conflict/feelings (guilt)
  - (1.6.2) "Juggling it all" - Balancing roles of parent/spouse, & student
- (1.7) Work/Financial Stress

2. Descriptions of Nursing Program/Nursing Curriculum
- (2.1) Reasons for choosing Nursing
- (2.2) Descriptions of nursing courses/grades
- (2.3) Descriptions of non-nursing/other courses
- (2.4) Supportive Services
- (2.5) Perceptions of two-year A.D.N. program
  - (2.5.1) Feelings about
  - (2.5.2) Metaphors
  - (2.5.3) Course load/ "Can't do it in two years"
  - (2.5.4) Stress/Panic attacks
  - (2.5.5) Self-care
  - (2.5.6) Attrition

3. Pedagogies of the Classroom
- (3.1) Knowledge acquisition as privileged
  - (3.1.1) Volume/Complexity of information to learn
  - (3.1.2) Lectures
  - (3.1.3) Insufficient time for discussion/questions
- (3.2) Other Teaching methods
  - (3.2.1) Questions with one right answer
  - (3.2.2) Group work
  - (3.2.3) PowerPoint
- (3.3) Reading Assignments
  - (3.3.1) Volume
  - (3.3.2) Complexity/Multiple perspectives
  - (3.3.3) Preparation for class vs. after class
- (3.4) Types of Teachers
  - (3.4.1) As responsible to deliver information
  - (3.4.2) Expert/Confident/Supportive
  - (3.4.3) Non-expert/Unorganized/Unprepared

4. Nursing Exams

(4.1) Descriptions of tests
(4.2) Inadequate Preparation - "Set up for failure."
    (4.2.1) Need to discuss/ask questions
    (4.2.2) Need for active learning/ in context (See it, hear it, correlate it, do it)
    (4.2.3) Difficulty of NCLEX questions
    (4.2.4) Desire for additional time/support with learning/understanding in clinical context
    (4.2.5) Desire to understand testing format and rationale
(4.3) Anxiety/Fear of failure
(4.4) Feedback/Test review
(4.5) Testing privileged
    (4.5.1) Inaccurate reflection of knowledge/ability
    (4.5.2) As NCLEX-RN preparation
    (4.5.3) Desire for other forms of academic assessment
(4.6) Faculty support for/Strategies
    (4.6.1) Study guide
    (4.6.2) "Hints" during lecture
    (4.6.3) Demystifying "how to" study in clinical context

5**. Pedagogies of the Clinical Classroom**

(5.1) Competencies
    (5.1.1) Descriptions of/ Expectations
    (5.1.2) Anxiety of evaluation/Fear of failure
    (5.1.3) As professional responsibility
(5.2) Clinical Paperwork
    (5.2.1) Descriptions
    (5.2.2) and Learning
(5.3) Clinical rotations
    (5.3.1) Sources of anxiety
    (5.3.2) "Med-Surg"/Specialties
    (5.3.3) Relationships with staff
(5.4) Nursing Role
    (5.4.1) Relationships with patients
    (5.4.2) Medications/Procedures
    (5.4.3) Presentation of self as nurse
        (5.4.3.1) Patient expectations
        (5.5.3.2) Instructor expectations
    (5.4.4) Challenges/Obstacles
        (5.5.4.1) Dependence on instructor
        (5.5.4.2) Accomplishing nurse's work in time, independently/without assistance
        (5.5.4.3) Prioritizing care/multiple patients
        (5.5.4.4) Last minute assignments
        (5.5.4.5) Rigid expectations
(5.5) Feelings about clinical learning

(5.5.1) Anxiety and mistakes
(5.5.2) Meaningful experiences
(5.5.3) Conflict with espoused values (patient's right to refuse care vs. hospital/school expectations; caring)
(5.6) Medication Errors/Mistakes
(5.6.1) Anecdotal/Clinical Deficiency/Occurrence Reports
(5.6.2) Sent to dean's office
(5.7) Clinical Learning Environment
(5.7.1) Instructors
(5.7.1.1) Controlling/Rigid/Intimidating
(5.7.1.2) Supportive/unintimidating/Put you at ease
(5.7.2) Evaluation
(5.7.2.1) As subjective
(5.7.2.2) Adversarial/Fear of failure
(5.7.2.3) Formative vs. Summative

6**. Socialization/ Identity/**
(6.1) Self concept – Smart vs. not smart
(6.2) Sense of Integration/ Belonging
(6.2.1) Metaphors - "Sorority"/ "team"
(6.2.2) Good enough/Not good enough
(6.3) Perceived Norms – "The ideal nurse"
(6.3.1) Appearance (clean, well-groomed)
(6.3.2) Behavior
(6.3.2.1) Speak when spoken to
(6.3.2.2) Submissive/Do not question (of certain teachers)
(6.3.2.3) No smoking
(6.3.2.4) Remorse for errors/Be humble
(6.3.2.5) Organized
(6.4) How Learned - "Boot camp"
(6.5) Challenging the norms
(6.5.1) Speaking up/defending oneself
(6.5.2) Asking a question
(6.5.3) Changing clinical groups
(6.6) Consequences of challenging norms
(6.6.1) Reprimanded
(6.6.2) Targeted/Negative Evaluation
(6.6.3) Denial of learning experiences
(6.7) Confidence vs. Self-doubt
(6.7.1) Experience/Sense of accomplishment
(6.7.2) Faculty Feedback
(6.8) Commitment to the profession vs. Uncommitted/Questioning decision
(6.8.1) The decision to persist /"So much invested"
(6.8.2) Determination/ "Failure isn't an option"

7. Supportive Teacher-Student Relationships

(7.1) Approachable/Available/Care - "There for me,"
(7.2) Mutual Respect/Teamwork
(7.3 Feedback
    (7.3.1) Balanced
    (7.3.2) Give confidence/encouragement - "You can do this"
    (7.3.3) Adjust to student's learning style & ability
    (7.3.4) Tolerate mistakes/Know I'm a student, not a RN
(7.4) Validation - "Fuel to keep you going"
(7.5) Functional support
    (7.5.1) Prioritize content
    (7.5.2) Study guides
    (7.5.3) Tell me what to learn/Give hints
    (7.5.4) Teaching studying strategies

8**. Unsupportive/Uncaring Teacher-Student Relationships**

(8.1) Unapproachable/Unavailable/Uncaring
    (8.1.1) Aloof/Intimidating
    (8.1.2) No time for me/ too busy
(8.2) Lack of respect
    (8.2.1) Reprimanding/Don't treat you "like an adult"
    (8.2.2) Condescending/demeaning
(8.3) Bullying/Incivility
    (8.3.1) Intimidation/Scare tactics
    (8.3.2) Targeting/ Weeding out – "Chew them up and spit them out"
    (8.3.3) "Verbal abuse"/Demeaning/Constant criticism
    (8.3.4) Subjectivity/Racism/Favoritism
    (8.3.5) Rigid expectations for perfection – "Making it Impossible"
        (8.3.5.1) Being held to different standards than others
        (8.3.5.2) Rigid expectations re: time management
        (8.3.5.3) Expectations regarding students' knowledge base
    (8.3.6) Falsifying the anecdotal record
(8.4) Effects of Uncaring/Incivility
    (8.4.1) Lack of trust
    (8.4.2) Anxiety
    (8.4.3) Integration/unaccepted
    (8.4.4) Inhibits learning - Can't ask questions
    (8.4.5) Decreased motivation to learn/persist
    (8.4.6) Decreased confidence and self-esteem
    (8.4.7) Long lasting – "Toxin"
    (8.4.8) Disillusionment with nursing profession

9. "Studentmanship"- Students' strategies

(9.1) Getting through the Two year curriculum
- (9.1.1) Completing non-nursing courses ahead of time
- (9.1.2) Extending the program of study
- (9.1.3) Repeating a course

(9.2) Studying strategies
- (9.2.1) Study group
- (9.2.2) Test bank CD ROMs
- (9.2.3) Tutoring
- (9.2.4) Compromises/Lower expectations

(9.3) Getting through Clinical
- (9.3.1) Preparing/Practicing
- (9.3.2) Rehearsing with instructor
- (9.3.3) Presentation of self as competent

(9.4) "Flying under the radar"
- (9.4.1) Keep silent; do not complain
- (9.4.2) Do not ask questions
- (9.4.3) Keep head down
- (9.4.4) Negotiating faculty favor

(9.5) "Cautionary Tales of Studentmanship

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Curriculum Vitae

Darlene M. Del Prato

Academic Credentials

Ph.D. in Higher Education
Syracuse University, Syracuse, NY
Anticipated Graduation May, 2010

Dissertation: *The lived experience of associate degree nursing education: Conditions and barriers that shaped students' learning, development, and success*
Advisor: Dr. Catherine Engstrom

Master of Science 1994
Summa Cum Laude
Syracuse University, Syracuse, NY
Clinical Focus: Clinical Nurse Specialist, Maternal-Newborn Nursing and Women's Health

Bachelor of Science 1983
Summa Cum Laude
Mercy College, Dobbs Ferry, NY

Nursing Diploma 1979
St Joseph's Hospital Health Center School of Nursing, Syracuse, NY

Professional Experience

Assistant Professor of Nursing, Fall 2007- present
Coordinator, M.S. Nursing Education program
SUNY Institute of Technology, Utica, NY

Provide didactic education to baccalaureate and graduate nursing students.

Undergraduate courses taught include: Nursing Research and Theoretical .

Graduate courses taught include Curriculum, Research Methods, Evaluation Approaches in Nursing Education, and Culminating Seminar in Nursing Education.

Course Chair and Faculty, 2000-2007
St. Joseph's College of Nursing, Syracuse, NY

Coordinated the Maternal-Child Nursing Course. Coordinated didactic education for associate degree nursing students. Coordinated clinical placements for students on labor and delivery, postpartum, and maternal-child health center clinic.

Faculty, 1990- 2007
St. Joseph's College of Nursing, Syracuse, NY

Provided didactic and clinical education to associate degree nursing students. Responsible for teaching Maternal-Newborn Nursing, Pharmacology, and Leadership. Responsible for teaching Labor and Delivery, Newborn, and Women's Health, pharmacology, and leadership. Served as Co-Chaired the Nursing Research Committee. Committee responsibilities included faculty development, admission/promotion, and curriculum.

Staff RN *1987-1989*
Labor and Delivery, Danbury Hospital, Danbury, CT.

Staff RN 1979-1984
Cardio-Thoracic Intensive Care 1981-1984; Medical-Surgical Unit 1979-1981
Westchester County Medical Center, Valhalla, NY

Professional Certification
Inpatient Obstetric Nurse, 1994 to present.

Professional Presentations

- Del Prato, D. *Faculty-student relationships: Conditions and barriers for student learning, development, and success*. April 30, 2010; Iota Delta and SUNYIT School of Nursing and Health Systems.
- Del Prato, D. *Dealing with horizontal violence.* April 16, 2010; The 14th Annual Faculty

Development Conference. Council for Associate Degree Nursing in New York State. Albany, NY

- Del Prato, *D. Teacher-student relationships and faculty incivility.* September 28, 2009; Ellis Hospital School of Nursing.
- Guest lecturer. April 21, 2009; *Qualitative nursing research*. Le Moyne College Department of Nursing, Syracuse, NY.
- Del Prato, D*. The lived experience of nursing education: How educational practices shape students' learning, development, and success*. June 18, 2009; St. Elizabeth's College of Nursing.
- Del Prato, D. (2008). *Preconception counseling and chronic disease in pregnancy*, at 7th Annual Nursing Student Conference, April 1, 2008. Mohawk Valley Perinatal Network and SUNYIT School of Nursing and Health Systems.
- Del Prato, D. (2008). *The lived experience of associate degree nursing students: Educational practices and student development*. Poster presentation at Bassett Healthcare Nursing Research Evening, May 15, 2008.
- Del Prato, D. & Hartel, N. *Inquiring minds want to know: How to integrate critical thinking into your curriculum*. April, 2000; 4th Annual NY State Associate Degree Nursing Council Faculty Development Conference on Critical Thinking, Albany, NY.
- Del Prato, D. & Hartel, N. (2000). Critical Thinking Poster Presentation. At NLN Nursing Education Summit, Nashville, Tennessee.

Contributing Author and/or Reviewer

- Reviewed: McKinney, E. S., James, S. R., Murray, S. S., & Ashwill, J. W. (2009). *Maternal-Child Nursing (3rd ed.).* St. Louis: Saunders Elsevier.
- Contributing Author & Reviewer: Lippincott Williams & Wilkens. (2008). *NCLEX-RN: Questions & answers made incredibly easy (4th ed.).* Author.
- Reviewed: Murray, S.S., & McKinney, E. (2007). *Foundations of Maternal-Newborn Nursing (4th ed.)* Philadelphia: W.B. Saunders.
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Newborn Nursing (3rd ed.) Philadelphia: W.B. Saunders.

- Contributing Author: Dickason, Silverman, and Kaplan (Eds.). (1998). The childbearing family at risk, Chapter 26. In *Maternal-Infant Nursing Care (3rd ed.).* St. Louis: Mosby.

Professional Affiliations & Activities

- Central New York Nurse's Collaborative to Advance Research and Evidence-based Practice (CNY-NCARE); Co-fundraising Chair.
- Central New York Professional Nurse's Association (CCPNA)
- Counselor, Iota Delta Chapter; Sigma Theta Tau International Honor Society of Nursing
- National League for Nursing (NLN)
- Saint Joseph's College of Nursing Alumni Association
- Recipient, Mildred Montag Faculty Development Scholarship, 2005.
- Member, NLN Task Force on Learning Needs and Faculty Development, 2003-2005 biennium.