PROFESSIONAL IDENTITY IN THE LIVED EXPERIENCE OF HOSPITAL NURSES

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the dissertation of TULLAMORA THELMA DIEDE find it satisfactory and recommend that it be accepted.

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PROFESSIONAL IDENTITY IN THE LIVED EXPERIENCE OF HOSPITAL NURSES

Abstract

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The purpose of this study was to explore the phenomenon of the lived experience of nurses working with patients in hospitals and, with that information, identify meaningful themes and patterns of how their workplace environment impacts their sense of professional identity.

The specific aim of this study was to describe, interpret and, therefore better understand the lived experience of nurses working with patients in a hospital environment and the meaning of this phenomenon as it relates to their professional identity.

Over 3 million nurses currently holding active licenses to practice in the U.S.; An estimated 30% of nurses leave their job within the first year and 27% report bullying in the last six months. Nurses experience oppression in their relationships with physicians and other health professionals as well as through lateral violence or bullying from other nurses. Nurses have commonly been viewed as a less important, less intelligent and submissive healthcare team member when compared to other members of the healthcare team. Paradoxically, an annual poll by Gallup consistently identifies nursing as a highly trustworthy profession by the public. This dichotomy of simultaneously being considered incompetent yet holding a high level of trust may leave nurses to question their own professionalism. Historical, political, and sociological factors contribute substantially to this view of nursing within the present health care culture. Because of nursing’s struggle for respect in conjunction with their rates of attrition and bullying, there is a critical need to understand the work of a professional registered nurse.
Philosophical hermeneutic phenomenology was used as the methodology to study this phenomenon. Philosophical hermeneutics believes that there is revealed truth in every human experience, not simply one universal truth to be revealed. Therefore, this methodology uses one-on-one interviews and team analysis of transcripts to reveal a deeper understanding of how nurses create a professional identity for themselves in the work that they do with their patients through the narratives or voices of the nurses themselves.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
</tr>
<tr>
<td>CHAPTER</td>
</tr>
</tbody>
</table>

## CHAPTER ONE: INTRODUCTION

- **Phenomenon**
- **Background and Significance**
- **Statement of the Problem**
- **Purpose of the Study**
- **Research Question**
- **Locating the Researcher in the Research**

## CHAPTER TWO: LITERATURE REVIEW

- **Summary of Nursing History**
- **Current Nursing Workforce**
- **Historical Summary of Nursing Education**
- **Nursing Power within the structure of the Health Care system**
- **Structural empowerment of hospital nurses**
- **Professional Identity among Nursing**
- **Gaps in the Literature**

## CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

- **History of the Philosophy and Methodology**
- **Application of Philosophical Hermeneutic Phenomenology to Research**
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Design</td>
<td>..................................................................................................................</td>
<td>38</td>
</tr>
<tr>
<td>Sample</td>
<td>..................................................................................................................</td>
<td>39</td>
</tr>
<tr>
<td>Data Collection</td>
<td>..................................................................................................................</td>
<td>40</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>..................................................................................................................</td>
<td>41</td>
</tr>
<tr>
<td>Evaluation of Rigor and Trustworthiness</td>
<td>..................................................................................................................</td>
<td>42</td>
</tr>
<tr>
<td>Ethical considerations</td>
<td>..................................................................................................................</td>
<td>44</td>
</tr>
<tr>
<td>Strengths and weakness of method</td>
<td>..................................................................................................................</td>
<td>44</td>
</tr>
<tr>
<td>Human Subjects Review</td>
<td>..................................................................................................................</td>
<td>45</td>
</tr>
<tr>
<td>Pilot Study</td>
<td>..................................................................................................................</td>
<td>46</td>
</tr>
<tr>
<td>CHAPTER FOUR: RESULTS</td>
<td>..................................................................................................................</td>
<td>48</td>
</tr>
<tr>
<td>Background and Demographics</td>
<td>..................................................................................................................</td>
<td>48</td>
</tr>
<tr>
<td>Common Patterns and Themes</td>
<td>..................................................................................................................</td>
<td>49</td>
</tr>
<tr>
<td>A Paradigm Case</td>
<td>..................................................................................................................</td>
<td>52</td>
</tr>
<tr>
<td>Pattern One</td>
<td>..................................................................................................................</td>
<td>53</td>
</tr>
<tr>
<td>Pattern Two</td>
<td>..................................................................................................................</td>
<td>57</td>
</tr>
<tr>
<td>Pattern Three</td>
<td>..................................................................................................................</td>
<td>59</td>
</tr>
<tr>
<td>Pattern Four</td>
<td>..................................................................................................................</td>
<td>62</td>
</tr>
<tr>
<td>Summary of Results</td>
<td>..................................................................................................................</td>
<td>64</td>
</tr>
<tr>
<td>CHAPTER FIVE: IMPLICATIONS</td>
<td>..................................................................................................................</td>
<td>67</td>
</tr>
<tr>
<td>Meaning of Results</td>
<td>..................................................................................................................</td>
<td>67</td>
</tr>
<tr>
<td>Implications for Nursing Practice</td>
<td>..................................................................................................................</td>
<td>72</td>
</tr>
<tr>
<td>Implications for Nursing Education</td>
<td>..................................................................................................................</td>
<td>73</td>
</tr>
<tr>
<td>Implications for Policy</td>
<td>..................................................................................................................</td>
<td>74</td>
</tr>
</tbody>
</table>
Implications for Future Research ........................................................................................................... 75
Conclusions ............................................................................................................................................. 76
REFERENCES ........................................................................................................................................ 78
APPENDIX

A. DEFINITION OF TERMS ..................................................................................................................... 90

B. CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE – I ........................................... 92

C. CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE – II .................................. 94

D. NEGATIVE ACTS QUESTIONNAIRE .......................................................................................... 96

E. NURSES WORKPLACE SCALE ................................................................................................. 97

F. NURSE JOB SATISFACTION INDEX ............................................................................................ 98

G. NURSES PROFESSIONAL VALUES SCALE-R .............................................................................. 100

H. RECRUITMENT ADVERTISEMENT ............................................................................................. 102

I. RESEARCH STUDY CONSENT FORM ......................................................................................... 103

J. INTERVIEW QUESTIONS .................................................................................................................. 107

K. PARTICIPANT DEMOGRAPHICS ................................................................................................. 109

L. TABLE OF PATTERNS AND THEMES ......................................................................................... 111
CHAPTER ONE

INTRODUCTION

Phenomenon

The profession of nursing has evolved dramatically in the last century from nurses being in a subservient role to the physician to independent and respected practitioners. While nurses are an essential component of any health care system in order to provide patient care, nurses continue to struggle with their autonomy and role as professionals. These struggles stem from historical, sociological and political underpinnings of long-held attitudes by healthcare structures such as “male-dominance-female-submission pattern” and “exaltation of the scientific methods” (Pijl-Zieber, 2013, p.141). The Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine formally known as the Institutes of Medicine (2011), a private, non-profit organization dedicated to independent and objective research which makes recommendations regarding public policy in science, engineering and medicine, describe the importance of nurses in their report, “The Future of Nursing,” by concluding that nursing is fundamental to maintaining and improving health care in the United States. “The Future of Nursing” report also states that nurses need more educational support, expansion of their scope of practice and increased autonomous partnership with physicians.

Despite nursing’s advancements as a science, the public perception in the United States of nurses is that they are less intelligent and less competent, when compared to their physician counterparts (Institutes of Medicine, 2010). Despite the public’s perception that nurses are less competent than doctors, an annual Gallup poll (2017) of honesty and trustworthiness among professional groups ranks nurses as having the highest position, above pharmacists, doctors, teachers, police officers, clergy and other professions. These contrasting statistics can be difficult
for nurses to process. Can a professional person feel respected if they are deemed trustworthy but less competent than a member of another profession by the people that they both serve? Because the majority of nurses in the United States (63%) are employed in the hospital setting (Minority Nurse, 2017), it is the aim of this study to better understand the experience of nurses in their hospital workplace and how that lived experience impacts their professional identity, including their self-respect, and the care they provide to patients.

**Background and Significance**

Nurses provide care to patients in a myriad of fast-paced, high-stress environments while interacting with multiple care providers, patients, family members, fellow nurses and multidisciplinary team members. To navigate this challenging environment, registered nurses need to be highly skilled, intelligent, well-organized and effective workers (Johnson, Cowin, Wilson, & Young, 2012). Despite these strong work ethic-related characteristics, many competent nurses continue to report that they are overworked, overwhelmed, disrespected and feel powerless in their workplace (Andrews, Burrs & Bushy, 2011). An estimated 30% of nurses leave their jobs within the first year of employment and 27% of nurse’s report being bullied in the last six months, the majority identifying that the bullying was from managers, directors or charge nurses (Johnson & Rea, 2009). Nurses are taught how to care for and empower their patients but they are often not sufficiently taught how to care for or empower themselves (Kornhaber & Wilson, 2011).

According to the American Association of Colleges of Nursing (2008) there are nine standards explicated in the *Essentials of Baccalaureate Education for Professional Nursing Practice*. The purpose of these “Essentials” are to focus nursing program curriculum onto what needs to be taught to students so that they are safe entry-level registered nurses. To be an
accredited baccalaureate nursing program, a college or university must follow the American Association of Colleges of Nursing (AACN), *Essentials of Baccalaureate Education for Professional Nursing Practice* (2008). The eighth essential is “Professionalism and Professional Value.” This standard states that baccalaureate nurses should display altruism, autonomy, human dignity, and integrity in their nursing practice. It is important to note that not all nurses have bachelor degrees – i.e. 23% of nurses receive diploma training, 39% associate degree, and 38% bachelor’s degree at graduation from their nursing program but all nurses receive education about professionalism and professional values during their programs (Shen, Peltzer, Teel, & Pierce, 2015). It is, therefore, reasonable to assume that all nurses educated in the U.S. are exposed to this content.

Except for diploma program graduates, all nurses who attend a community college (two-year program), or a four-year college receive a degree denoting education with specialized knowledge and theory. Moreover, all nurses who are nationally credentialed for their license can specialize in their particular nursing area and can advance their nursing degree from RN to BSN through the doctoral level. Additionally, due to past and current efforts of nurses in the U.S. to advance the practice role of nursing, nurses who achieve their doctorates in nursing practice now have advanced training and credentialing to assess, diagnose and treat patients. Nurse practitioners also have the authority to perform many interventions previously reserved for physicians such as prescriptive authority and the ability to bill for services rendered (Institutes of Medicine, 2011). However, many nurses continue to struggle to define their specific role with patients, with other providers and within the hospital organizational structure (Atsalos, et al., 2014).
According to Abraham Flexner’s definition of a profession, an occupation becomes a profession when an occupational group has specialized knowledge, theoretical foundations which lead to the creation of new rigorous scientific knowledge, the ability to apply that knowledge and theory to human and social problems and to transmits it to novice professionals, has an established ethical/legal criteria for practice and is altruistic in nature (Buhai, 2012). By this definition, nursing should be considered a profession. Historically, the Oxford English Dictionary defines a profession as a service that requires a specialized education and an independent practice, namely lawyers, physicians, clergymen, and accountants. Nonetheless, nursing defends its professional status by citing its independent practice or autonomy defined as client advocacy (Wade, 1999). Put another way, nursing leaders claim that nursing, as a profession has a mandate and opportunity to use client advocacy to improve patient outcomes (Vaartio, Leino-Kilpi, Salantera, & Suominen, 2006) So the question remains – why do nurses continue to struggle with their professional self-concept or self-identity when nursing leaders claim their unique role is that of client advocacy? Therefore, the phenomenon of interest for this study is to better understand nurses’ lived experience working with patients in a hospital environment where most nurses are employed.

Oppression is defined as a condition arising when a privileged group uses their power to maintain control over, marginalize or silence a non-privileged group (Dong & Temple, 2011). Power can be defined as an individual or group’s influence on another person, group, or situation (Pieranunzi, 1997). Power or influence that causes the less powerful entity to abandon or modify his or her own existing core values about how they act is defined as oppression. Human beings experience feelings of power and powerlessness on a daily basis but for nurses, power means the
ability to influence control over their practice and their workplace (Breau and Rheaume, 2014). This leads to what Risjord (2010) describes as the, “Standpoint Position Theory of Nursing.”

The Standpoint Theory states that those in an oppressed position are aware of their own worldview as well as the dominant or oppressor worldview (Risjord, 2010). This then allows the oppressed person to view the world in a more comprehensive way. To qualify as oppressed by the Standpoint theory, four conditions must be met. First: One role, such as the nursing role, must be oppressed by a more dominant role. Two: The role that is oppressed must be largely controlled by the needs and interest of the dominant role. Three: The oppressed role facilitates making these needs and interests possible, commonly in an unseen way for the dominant group. Four: The oppressed role understands the perspective of the dominant role as well as their own perspective, while the dominant group usually remains oblivious to their empowerment by the oppressed group (Risjord, 2010). It is through this “oppressed group” lens that nurses view the world and also view the world of physicians and organized health care. In other words, nurses are aware of their limited power and are aware of the power that others hold within the medical model work environment. This oppressed lens enables nurses to better understand the health care environment and culture, particularly in hospitals and subsequently nurses are better able to support their patients because patients can also be defined as another oppressed group in the health care system. The purpose of understanding the Standpoint Theory is to motivate the oppressed group to seek political and social justice on behalf of themselves as the oppressed group and also show solidarity with others including patients, who are oppressed.

To further support the Standpoint Theory, it can be demonstrated that nurses fulfill all four conditions. Nurses are commonly oppressed by a more dominant role, physicians. Nurses have traditionally held a submissive role in the hierarchy of a hospital and historically have had
less power than other members of the healthcare team, particularly physicians ((D’Ambria & Andrews, 2014; Olofsson, Bengtsson, & Brink, 2003). Nurses are less likely to be part of a hospital’s executive organizational structure than any other health profession (Falter, 2012). Nurses are largely controlled by the needs and interest of the dominant role. Nurses are not able to bill for their work like other health care providers such as physicians or physical therapists. A nurse’s work is included in a daily room rate for patients and considered a fixed cost (Welton, Fischer, DeGrace, et al., 2006), despite the time, energy and planning required of nurses to provide care for each individual patient. This is another example of how nurses are collectively oppressed through health care organizations such as hospitals and the overall culture of the health care industry. Nurses facilitate making the needs and interests of the dominant group possible. Nurses follow through with physician orders even when they may ethically or morally disagree with an order written by a physician. Finally, nurses understand the perspective of the dominant role as well as their own perspective, while the dominant group usually remains oblivious to their empowerment by the oppressed group. This can be seen in many providers being unaware of the nursing point of view and denying hierarchies that exist in hospitals today. (Risjord, 2010).

Nurses who report feeling empowered in their workplace function more effectively (Andrews, Burr & Bushy, 2011). According to Kanter’s theory of structural power, empowerment is defined as having the ability to formally or informally make changes and have access to resources to accomplish one’s work (Laschinger, Sabiston, & Kutscher, 1997). Nurses who perceive themselves as empowered in their workplace have the potential to effect change and improve patient outcomes. Some recent studies have shown that nurses who work in hospitals with high nurse-to-patient ratios and peer-assessed national recognition programs such
as Magnet status experience have better patient outcomes, including improvement in 30-day mortality rates (Silber, et al., 2016). It could be argued that empowered nurses who are able to successfully improve patient outcomes have the potential to also improve the overall perception and reputation of all nurses, which could be a significant contribution to the discipline.

Being viewed as a professional by others strengthens one’s professional identity (Johnson, Cowin, Wilson & Young, 2012). Professional identity is the perception of self in relationship to the work that one does. It has been demonstrated that those with strong professional identity have great confidence, collaboration and ability to work effectively within health care teams than those who have a weaker sense of professional identity. Adams, Hean, Sturgis, and MacLeod-Clark (2006) surveyed 1,254 first-year health care professional students including pharmacists, physical therapists, physicians, social workers and nurses with their Professional Identity Scale (See Appendix). Based on responses to the survey, the researchers found that physical therapists had the strongest professional identity with high levels of cognitive flexibility, team understanding, and knowledge of their own profession and work experience, while social workers had the weakest professional identity, with nurses being found in the lower middle of the scale. Nurses and other health professionals need a strong sense of professional identity in order for there to be a balance in their work and inter-professional team participation as they care for the patient. Therefore, more knowledge is needed to better understand how nurses view themselves and their work as professionals.

**Statement of the Problem**

No studies have focused on the lived experiences of nurses working in a hospital environment and how that environment impacts their sense of professional identity including how patient care is delivered. Therefore, the problem to be explored by this study was to better
understand how a nurse’s perception of their professional identity impacts their functioning within a hospital setting including patient care in the voices of the nurses themselves. Although some research has been done related to professionalism in nursing, it has often been limited to where nurses are located within the structural or organizational components of the institution such as turnover and staffing (Laschinger, Sabiston, & Kutscher, 1997).

**Purpose of the Study**

The purpose of this study was to explore the phenomenon of the lived experience of nurses working with patients in hospitals and, with that information, to identify meaningful themes and patterns of how their workplace environment impacts their sense of professional identity. Philosophical hermeneutics was used as the methodology to study this phenomenon. Philosophical hermeneutics is “based on interpretivist epistemology and aims at developing understanding” (Willis, 2007, p.104). Researchers from this philosophical perspective seek to gain knowledge by interpreting the everyday experiences of those being studied in an effort to better understanding their world and to identify what shows itself as meaningful. Ultimately, philosophical hermeneutics believes that there is revealed truth in every human experience, not simply one universal truth to be revealed. Therefore, this methodology seeks to reveal a deeper understanding of how nurses create a professional identity for themselves in the work that they do with their patients through the narratives or voices of the nurses themselves.

**Research Question**

The research question for this study was, “What does professional identity mean in the lived experience of nurses working with patients in a hospital environment?” By specifically including patient care in the research question, nurses were asked to consider how the work that they accomplish with and on behalf of their patients affects their experience as professionals.
Specific Aim

The specific aim of this study was to describe, interpret and, therefore better understand the lived experience of nurses working with patients in a hospital environment and the meaning of this phenomenon as it relates to their professional identify.

Locating the Researcher in the Research

For the purpose of openness related to the research methodology, philosophical hermeneutic phenomenology, it is essential for the researcher to describe their biases and how they will impact their work and their overall research process. It is essential for the researcher to identify any biases that they may have related to phenomenon (Smythe, 2002). This author’s background as a registered nurse of 11 years, who primarily worked in an acute-care, hospital setting who has worked with diverse patient groups and health care professionals. I have completed certifications in Medical/Surgical nursing, completed Masters of Nursing and is a certified Clinical Nurse Leader. I have worked with many different types of health care providers in a variety of settings such as nurse taking orders from physicians to working collaboratively in project teams with physicians, pharmacists, and physical/occupational/speech therapists.

Related to the ideas of oppression and power. I do believe that nurses as a group are oppressed by the health care system and popular media/culture in which we practice. I am proud to work as a nurse but believe that more can be done to elevate role of nurses in the view of the public. It with theses biases in mind that I will bring to the interpretive team in the philosophical hermeneutic research process.

Summary

Nursing has the potential to be redefined and evolved further by nurses in professional practice. The purpose of this study was to determine the meaning of professional identity in the
lived experience of nurses working with patients in a hospital environment. Nurses play an important role in the health care system but at the same time, their professional identity continues to be undermined by more dominant players on the health care team of providers. In order to reverse this process, an important consideration for nurses is needed to consider how their own experience of power along with the public’s perception of nurses as professionals can impact the care they provide to patients. In an effort to support nurses, it is vital to understand the work that they do with patients and how they act as professionals. The qualitative methodology of philosophical hermeneutics supported this purpose by capturing the everyday experience of being a nurse working with patients in the hospital setting. The results of this study, when shared with nurses, other health care professionals, will yield a better understanding of the profession of nursing as explicated in the real work of nurses.
CHAPTER TWO
LITERATURE REVIEW

Summary of Nursing History

Prior to 1860, nurses were commonly lower-class women without formal training who performed unskilled tasks (Malka, 2007). Florence Nightingale formalized the role of the nurse by reforming the education in diploma training programs, standardizing the role and skills required, and by elevating the reputation of nurses in the mind of the public. The role of the nurse then further advanced; with the development of modern medicines and a better understanding of human physiology. Consequently, nurses were better able to formalize the care that they provided for their patients (Malka, 2007). With the impact of the World Wars, nurses transitioned from predominantly private care settings (i.e. being hired by patients or their families directly) into hospital care as employees. Nurse education evolved beyond hospital based nurse training or the diploma program model and eventually transitioned into college and university settings. The Feminist movement also influenced nursing during the 1960s and 1970s, motivating nurses to move forward in their education and autonomy by supporting the role of women in the workforce (Malka, 2007). As health care has further developed, particularly with technological advancements, so has nursing, with additional roles, such as nurse practitioners, informatics experts, researchers, and leadership positions within health care organizations (Malka, 2007).

Current Nursing Workforce

In the United States, there are approximately three million nurses; the median age of licensed registered nurses is 50 (U.S. Bureau of Labor Statistics, 2015). The majority of nurses are female (93%) and white or Caucasian (83%). Most nurses in the United States (63%) are
employed in the hospital setting (Minority Nurse, 2017). In the current United States health care system, hospital nurses’ salaries are determined as part of the daily room and board cost for patients. Nurses do not charge patients for their professional services like physicians charge patients for procedures and diagnoses. As a result, there is no current way to accurately determine the specific cost of nursing care per patient (Jenkins & Welton, 2014).

Nursing scope of practice is legislated by individual state nurse practice acts which usually include “assessment of patients or clients, determining a nursing diagnosis, setting goals for patient care, planning care strategies, implementing care, delegating care to qualified others, supervising those who are delegated to, evaluating the patient plan of care, teaching patients, managing care, maintaining client safety, and collaborating with other health care members” (Washington State Legislature, 2016). One Australian study interviewed 20 nurses about their scope of practice and how they delivered care to patients using a critical incident technique. Schluter, Seaton and Chaboyer (2011) reported that the nurses worked hard to provide excellent care to their patients but also were working below their scope of practice and were often forced to choose whether to blindly follow the physician orders and support the medical model or instead practice to the fullest extent of their nursing scope including nursing assessment and care coordination (Schluter, Seaton, & Chaboyer, 2011). Similarly, in the United States, the high medical work demand of hospitals results in most nurses not being able to work to the fullest extent of their scope of practice, but instead, to limit their activities to supporting the medical model (IOM, 2008).

**Historical Summary of Nursing Education**

Historically, nurses were primarily trained in hospital-based, hospital-owned and administrated diploma programs (Benner, Sutphen, Leonard, & Day, 2010). With the first
baccalaureate program starting in 1948 and the first associate degree program in 1958, diploma programs began to decline and by the 1970s nurses educated in diploma programs was equal to those educated through a community college, college or university (Benner, Sutphen, Leonard, & Day, 2010). In 2013, only 23% of nurses received diploma training, with the majority obtaining either an associate degree (39%) or bachelor’s degree (38%). To be an accredited baccalaureate nursing program, a college or university must follow the American Association of Colleges of Nursing (AACN), Essentials of Baccalaureate Education for Professional Nursing Practice (2008). The AACN has nine essentials that must be included in the curriculum:

1. Liberal Education for Baccalaureate Generalist Nursing Practice
2. Basic Organizational and Systems Leadership for Quality Care and Patient Safety
3. Scholarship for Evidence Based Practice
4. Information Management and Application of Patient Care Technology
5. Health Care Policy, Finance, and Regulatory Environments
6. Inter-professional Communication and Collaboration for Improving Patient Health Outcomes
7. Clinical Prevention and Population Health
8. Professional and Professional Values
9. Baccalaureate Generalist Nursing Practice

Nursing education, therefore, strives to prepare students to enter the profession of nursing with a specialized knowledge of nursing practice and nursing theory, equipped to assess, plan, implement and evaluate holistic care of patients and populations.
In 2008, the IOM, in conjunction with the Robert Woods Johnson Foundation, began a 2-year study to examine how nurses can best be prepared for their future in health care in the United States. There were four main conclusions from this report:

1. Nurses should be able to practice to the fullest extent of their education and training.
2. Nurses should be able to seek higher levels of education through access to an improved education system.
3. Nurses should be full partners, with physicians and other health care professionals.
4. Nurses must collect better data and information to support a stronger and more effective workforce planning and policy formulation.

The IOM *Future of Nursing* report is a foundational study for nurses because it supports the important role that nurses play in health care and provides evidence for furthering the role and scope of nurses as professionals. The Future of Nursing report also supports the mission and goals of AACN by stressing the importance of educational advancement of nurses from baccalaureate to doctoral levels. By advancing the educational level of nurses, the IOM report and AACN believe that more nurses will be encouraged to work to the fullest extent of their scope of practice and will additionally motivate more nurses to lobby for advancement of nursing scope of practice in state legislation (AACN, 2014).

**Nursing Power within the structure of the Health Care System**

It is important to understand what nurses think of their own profession and how they perceive their work. Many hospital nurses love their profession and the care that they provide to patients but they also feel powerless because they do not have the legal ability to diagnose patient’s medical conditions and must provide care to hospitalized patients based upon physician orders (Pijl-Zieber, 2013). This lack of control is based on a hierarchy that is common in US
health care, i.e. it creates an environment in the hospital setting where physicians can exert considerable power over nurses. This is further re-enforced by the actions of hospital administrators and state legislators who limit nurse scope of practice (Group & Roberts, 2001).

Hospital patient care is based on the premise of the medical model of care. The medical model is care provided to the patient based solely on their physiological symptoms and treatment (Dossey & Keegan, 2013). For example, a patient is diagnosed with pneumonia, admitted to the hospital, given intravenous antibiotics and oxygen, improves and is subsequently discharged from the hospital. This is how health care is provided in the US hospital system (Group & Roberts, 2001). Another way to view patient care is the holistic model of care. The holistic model examines all aspects of a patient to determine their needs in order to treat the whole person (Dossey & Keegan, 2013). For the patient that has been diagnosed with pneumonia, a health care provider using the holistic model would assess how the person contracted pneumonia, their nutrition, appropriate housing, and exposure to environmental hazards. The holistic model would also address issues such as, whether or not the patient can afford the hospital admission, whether they can afford their discharge medications, what is the plan for the patient after discharge and how is the patient coping with their diagnosis, emotionally and spiritually. The holistic model of care is cited as a common nursing model of care for patients (Dossey & Keegan, 2013) but may not be able to be actualized in the hospital setting by nurses because the medical model is primarily the standard method of care and reimbursement (Group & Roberts, 2001).

Power is defined as: the ability to act in a particular way; the ability to direct the behavior of another; physical strength and/or the energy that is produced in mechanical or electrical devices (Stevenson, 2010). For the purpose of this discussion, power is the ability to act on one’s
own volition and the ability to influence the behavior and/or core values of others. Nurses have historically lacked power as a profession, beginning in the early 1900s, when nursing education was primarily controlled by hospitals and physicians and limited to the medical model view of illness. This lack of power persists today because of the hierarchal nature of our health care system that supports the power of physicians and hospital administrators over nurses (Matheson & Bobay, 2007).

Power often leads to oppression. Oppression is defined as: unfair, unjust, cruel governance or use of power; to denote feeling of burden, mental distress; and/or a pressing down of one’s spirit (Dong & Temple, 2011). The phenomenon of oppression has been witnessed and experienced by most nurses throughout the world (Rooddenhghan, Yekta, & Nasrabad, 2015). Despite this, Matheson and Bobay concluded in their 2007 literature review, that oppression in nursing has been “inconsistently and inadequately studied” (p. 232).

The Standpoint Theory of Nursing seeks to explain how individuals or groups in an oppressed position view the world (Risjord, 2010). There are four conditions of the Standpoint theory:

1. One role, such as the nursing role, must be oppressed by a more dominant role. For example, hospital nurses are paid by an hourly wage, while physicians usually bill for their patient services. Because of this, physicians are typically paid more, given more authority or power by hospital administration and are seen by the hospital organization as more important than other health care professionals.

2. The role that is oppressed must be largely controlled by the needs and interest of the dominant role, for nurses this relates to physician orders. Physicians write orders for patients and nurses implement these orders. Often physician do not consider the
amount or quality of work involved with implementing orders and take the work that is completed for granted.

3. The oppressed role facilitates making these needs and interests possible, commonly in an unseen way for the dominant group. For example, nurses’ work is almost always non-billable and therefore it is often seen as invisible and unable to qualify for reporting to hospital administrators, insurance companies and state/federal agencies.

4. The oppressed role understands the perspective of the dominant role as well as their own perspective, while the dominant group usually remains oblivious to their empowerment by the oppressed group (Risjord, 2010). While many physicians work well with nurses, physicians as a whole, still do not understand their empowerment by nurses and believe that they hold power over nurses as a right through the standard sociological hierarchy of the medical model. By contrast, nurses consistently strive to understand how the doctor is thinking in order to implement physician’s orders well.

It is through this oppressed point of view that nurses often become socialized to view the world. If this oppression changes their core value of holistic nursing care, i.e. their “standpoint” view of their workplace, they, their co-workers and their patients become altered in attitude. Instead of valuing the expanded role of nursing as promoted in the AACN Essentials, these nurses are more likely to think of themselves as skilled workers whose job it is to simply support the medical model by following physician’s orders.

It is important to note that oppression of any group leads to three behaviors in the oppressed group. According to Freire (1970) these are: self-hatred of one’s own group, low self-esteem and internalization of the oppressor’s values. Said another way, blame, shame and
becoming an oppressor or bully oneself are symptoms of oppression. Examples of all three can be seen throughout nursing practice.

Rooddenhghan, Yekta, and Nasrabadi (2015) sought to better understand equity in healthcare. In purposively sampling experienced clinical nurses in Iran, the researchers interviewed 18 nurses and used thematic analysis to obtain their results. Questions asked of the participants included, “What are your experiences of equity in healthcare?”, “Which tasks do you regard as providing equal healthcare?”, “Which tasks do you regard as providing unequal healthcare?”, and “What do you believe can affect equity in healthcare?” The two main themes that resulted from the analysis were that oppressed nurses existed within the health care system and the resulting behaviors of oppressed nurses on patients manifested itself by the nurses becoming oppressive themselves. Subthemes for the oppressed nurse included nurses’ dissatisfaction with their work and physicians’ receiving preferential treatment from hospital administrators. Subthemes for the oppressive nurse included examples of poor communication with patients, inappropriate delegation, and neglect of patients. All of the themes identified by Rooddenghgan, et al. support the four conditions of the Standpoint Theory.

Self-hatred of one’s own group or blame can be seen in the number of nurses who are currently planning on leaving their job or the profession itself. Without a way to resolve issues of power and oppression, nurses often blame their surroundings and leave their positions in hopes of finding a better work environment on another unit, hospital or in another profession. Twenty to fifty percent of currently working registered nurses reported intent to leave their current job in the next year; a similar fraction (20–40%) reported planning to leave the nursing profession (Breau & Rheame, 2013). Nursing staff turnover can cost a single hospital between $5.9 and 6.4 million per year (Kovner, Brewer, Fathei, & Jun, 2014). In 2007, hospital leaders reported 13–
40% registered nurse attrition within the first year of employment (Kovner, Brewer, Fathei, & Jun, 2014). The RN-Work Project, a 10-year longitudinal study of new registered nurses funded by the Robert Wood Johnson Foundation, is currently following three different cross-sectional groups of nurses across the United States. One portion of the RN-Work Project used data from these groups to examine patterns related to nurses and turnover. According to the three groups surveyed, 1-year turnover rates ranged from 13.4% to 22.8% (Kovner, Brewer, Fathei, & Jun, 2014).

Shame or low self-esteem as a result of oppression can be seen in the number of nurses who view their work as done inadequately or feel powerless in their work. Using a descriptive phenomenological approach, Kornhaber and Wilson (2011) interviewed seven nurses with at least three years of experience who worked on a burn unit in Australia. The interview began with one open-ended question: “What is it like to care for a severely burnt patient?” The interviews were then transcribed and analyzed for recurring themes. The main theme of the interviews was powerlessness, with four subthemes emerging: inadequacy, apprehension, vulnerability, and frustration. Many of these themes stemmed from the idea that nurses felt powerless to help reduce their patients’ pain and suffering during necessary and curative procedures such as debridement and dressing changes. The nurses reported a high level of knowledge and confidence in their ability to treat burn victims but described an inability to improve patient outcomes.

Finally, internalizing the oppressor’s values, oppressing one’s own group or bullying is frequently seen in the profession of nursing as a result of systemic oppression. When bullying behavior is demonstrated from nurse to another nurse, it is defined as horizontal violence. Horizontal violence is defined as a harmful or distressing behavior of one worker to another who
is of equal status within the hierarchy (Purpora, Blegen, & Stotts, 2012). Horizontal violence can occur at all levels of the hospital hierarchy but for the purpose of this definition, nursing will be used as an example. *Vertical violence* is defined as harmful or distressing behavior of one worker to another who is of a higher status with the hierarchy (Purpora, Blegen, & Stotts, 2012). *Vertical violence* is not well documented in nursing literature compared to horizontal violence and bullying. In a quantitative comprehensive literature review related to nursing violence, Spector, Zhou and Che (2014) reported 66.9% rate of nonphysical violence and 39.7% rate of bullying.

Johnson and Rea (2009) used a convenience sample of 249 members of the Washington State Emergency Nurses Association to survey nurses with the Negative Acts Questionnaire to measure workplace bullying. The Negative Acts Questionnaire was created in Norway to study workplace bullying. With a Cronbach alpha of 0.89, the reliability of the tool is well documented. The survey is a checklist of negative workplace behaviors. Respondents are asked how frequently these behaviors occur, with choices ranging from *never* to *daily*. Finally, the survey respondents are provided a definition of bullying and asked whether they consider themselves bullied at work and, if they did, who they bullied or were bullied by at their workplace. Bullying was defined as, “A situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation wherein the target of bullying has difficulty in defending himself or herself against these actions” (Johnson & Rea, 2009, p.85). Slightly more than 27% of nurse respondents indicated that they were bullied in their workplace. Half of those who were bullied identified their manager as one of the bullies, 25% identified their charge nurse, 38% identified co-workers, and 29.5% physicians. Researchers also asked the nurse respondents whether they intended to leave their workplace. Nurses who identified themselves as bullied
were twice as likely to respond that they were intending to leave their workplace in the next 2 years as nurses who did not identify themselves as bullied ($\chi^2 = 15.2$, $df = 2$, $p < 0.01$). This study provides evidence that nurses experience both horizontal and vertical workplace violence.

A random sampling of 175 hospital nurses in California were surveyed with the 12-item Nurses Workplace Scale (NWS) to measure perceptions of oppression in the workplace and the Negative Acts Questionnaire-Revised (NAQ-R), measuring horizontal violence in the workplace. Of the 175 nurses who responded to the survey, 21.1% reported horizontal violence in their workplace. This study also found that among nurses with higher levels of internalized beliefs related to oppression such as sexism and minimization of self, horizontal violence also increased with themselves as perpetrators ($0.434$, $p < 0.05$). This supports the idea that horizontal violence is a problem in the nursing workforce (Purpora, Blegen, & Stotts, 2012).

Freire’s (1970) model of oppression suggests that oppression is achieved through the educational system that supports the ideas of the dominant group. According to Freire, oppression leads to “assimilation, marginalization, self-hatred, low self-esteem, submissive-aggressive syndrome, and horizontal violence” (Matheson & Bobay, 2007), which can be seen in the previously explained examples and research. In order to be liberated from the grip of oppression, there are Roberts (2000) outlines five steps necessary. The initial stage is for the oppressed person to acknowledge the oppression; the second stage is experiencing an experience that causes a change in the way the person views the world. The third stage is immersion-emersion, where the person separates him or herself from the dominant culture and immerses him or herself in the oppressed culture. The fourth stage, internalization, is when the person develops a new confidence in his or her “new” culture of reaffirming his or her original core values and begins to re-incorporate into the dominant culture; and finally, in the fifth stage,
commitment, the person focuses on social justice and improving the wellbeing of his or her oppressed community (Roberts, 2000). Nurses need to begin to first acknowledge their oppression in order to move out of their position of oppression and begin the liberation process. By acknowledging fear of questioning unsafe physician orders, reporting unethical behaviors to hospital administration or calling out the hierarchical nature of hospital culture, nurses can acknowledge oppression in their work place. Oppression can also be combated when health care professionals, including nurses seek to build personal and professional relationships between hospital staff members from different health care fields. Nurses must move forward in their efforts to liberate themselves from oppression by developing their professional identity and speaking up to improve the public’s perception of nurses.

**Structural Empowerment of Hospital Nurses**

Nurses who perceive themselves as empowered in their workplace work more effectively and have the potential to effect change and improve patient outcomes as compared to those who do not perceived themselves as empowered in their workplace (Andrews, Burr, & Bushy, 2011). Researchers conducted a narrative thematic analysis of 106 nurses’ by utilizing the additional written comments at the end of a nursing survey about their workplace experience. Major themes included feeling overworked and overwhelmed, inefficiency in workforce and hospital protocols and policies, paperwork frustrations, lack of respect, too many responsibilities, interference in the nurse-patient relationship, lack of time and compromised personal health and wellness. Almost 30% of the nurses wrote positive comments about nursing as a professional practice, but this was matched with 42% describing being overwhelmed, 25% reporting a lack of support from their supervisors, and 20% describing negative behaviors towards nurses by physicians. These
conflicting perceptions lead to feelings of powerlessness and to nurses being less engaged in their work and patient care.

Kanter’s theory of structural empowerment is described in her 1977 book, *Men and Women of the Corporation*. This book states that workplace empowerment comes from formal and informal power structures. Kanter describes three main empowerment structures: the structure of opportunity, the structure of power, and the structure of proportions (Laschinger, Sabiston, & Kutscher, 1997). The structure of opportunity refers to a person’s ability to grow in responsibility within his or her work; the structure of power means access to information, support and resources; and the structure of proportions refers to equal standing of those in the same position in the workplace. Empowered workers have availability and access to all three structures, equally.

Kanter’s (1977) work was used for several years in the work setting, but it was Genevieve Elizabeth Chandler (1986) who used Kanter’s theory in her dissertation, studying 268 nurses and their perception of power in their work role. Chandler created the first version of the Conditions of Work Effectiveness Questionnaire as a tool based on Kanter’s theory. From her dissertation research, Chandler concluded that nurses had low scores of empowerment, particularly in access to opportunity and power structures. Heather K. Spence Laschinger continued the work of Kanter and Chandler to look further at nurse empowerment and work effectiveness. Laschinger originally used Chandler’s version of the CWEQ but through a decade of research and psychometric testing decided to alter the CWEQ-1 to the CWEQ-II. The original CWEQ-I had 58 questions, now reduced in the CWEQ-II to 21 questions with same psychometric properties and measurement results (Laschinger, 2012). Laschinger and her colleagues’ research examined nurses and empowerment, organizational commitment, burnout,
work satisfaction, and leadership styles. Nurse population groups included were acute care nurses, operating room nurses, rehabilitation nurses, military nurses, public health nurses, and nurse managers (Laschinger, Sabiston, & Kutscher, 1997). (See Appendix)

Overall, Cronbach’s alpha reliability coefficients for the CWEQ-II are as follows: opportunity (α = 0.81), information (α = 0.80), support (α = 0.89), resources (α = 0.84), and overall (α = 0.89) (Laschinger, Wong, McMahon, Kaufmann, 1999). Compared to the original CWEQ Cronbach’s alpha: opportunity (α = 0.80), information (α = 0.86), support (α = 0.88), resources (α = 0.81), and overall (α = 0.93) (Laschinger, Finegan, Shamian, & Casier, 2000). Other researchers have also published their Cronbach’s alpha reliability, which ranges from α = 0.85–0.91 (Sarmiento, Laschinger, & Iwasiw, 2004) to α = 0.82–0.85 (Laschinger et al., 1997). These Cronbach’s alpha scores represent a high level of correlation and reliability in participant responses.

The Conditions of Work Effectiveness Questionnaire-II (CWEQ) measures nurses’ perceptions of empowerment in their workplace. There are four subscales in the CWEQ-II: opportunity, information, support, and resources. “Opportunity” is defined as a person’s prospects or ability to move or grow with an organization or “opportunity” to grow in knowledge and skill. “Information” relates to a nurse’s ability to work effectively based on formal and informal knowledge of the workplace setting. “Support” is defined as a person’s assistance and feedback from peers and superiors to do his or her work. “Resources” is related to a person’s ability to work based on availability of supplies, time, and finances (Laschinger, 2012).

Each item of the 19-item questionnaire is rated on a 5-point scale, in which 1 = None, 2 and 3 = Some, and 4 and 5 = A lot. There are two additional items that measure global empowerment, for a total of 21 questions in the CWEQ-II. (See Appendix for an example of the
CWEQ-II.) Subscales are summed and averaged to provide a subscale score. These subscale scores are then summed for an overall score (Armstrong & Laschinger, 2006). Higher subscale scores represent stronger perceptions of access to opportunity, information, support, resources, and overall empowerment (Breauch & Rheumé, 2014; Laschinger, 2012).

In one of Laschinger’s earlier studies (1997), the CWEQ tool was used to evaluate and compare two groups of nurses. The first group was a random sample of 101 nurses from a large urban acute care teaching hospital, while the second group was 233 nurses from an urban teaching hospital in another city and a rural community hospital nearby (Laschinger et al., 1997). Statistical analysis of the CWEQ demonstrated that both groups perceived moderate empowerment in their work; group 1 \( (M = 11.20, SD = 1.90) \) and group 2 \( (M = 11.18, SD = 2.13) \). There was some variation in the subcategories among the groups, but overall they remained in the middle range \( (M = 2.60–3.04, SD = 0.54-0.71) \) for all subcategories. There were no statistically significant differences between the two groups.

Another study that used the CWEQ tool focused on nursing educators’ perception of empowerment (Sarmiento, Laschinger, & Iwasiw, 2004). After 89 nurse educators were surveyed with the CWEQ, the researchers concluded that they were only moderately empowered in their work \( (M = 12.18, SD = 2.27) \). Subcategories were similarly moderately scored: opportunity \( (M = 3.56, SD = 0.61) \), information \( (M = 3.16, SD = 0.75) \), support \( (M = 2.88, SD = 0.83) \), and resources \( (M = 2.58, SD = 0.66) \). These results were similar to those of previous studies with hospital-based nurses, but overall the researchers concluded that nurse educators had a higher level of empowerment than the hospital nurses previously studied by Laschinger.

Zurmehly, Martin, and Fitzpatrick (2009) surveyed 1355 nurses about work empowerment using an online survey (CWEQ-II) and about their intent to leave their position.
The researchers concluded that nurses with high levels of empowerment were less likely to leave their positions. A statistically significant relationship was reported between nurses with low empowerment scores and their intent to leave their current position ($F = 80.08, p < 0.001$) and their intent to leave nursing entirely ($F = 75.99, p < 0.001$). These empowered nurses reported higher satisfaction in terms of organizational opportunities, support, information, resources, and formal and informal power.

Breau and Rhemue (2014) surveyed 533 Intensive Care Unit (ICU) nurses about their perceptions of empowerment. Similar to previously studied groups, ICU nurses had a moderate level of empowerment but did have higher levels of opportunity ($M = 3.57, SD = 0.73$) and a higher overall empowerment score than previously surveyed groups ($M = 15.16, SD = 0.59$). Additional findings within the subscales identified that those nurses with 20 or more years of experience had significantly higher overall empowerment scores, and nurses with more education had a higher perception of access to resources.

In regard to how nurse empowerment can affect patient satisfaction and patient care, two studies have applied the CWEQ-II to patient satisfaction and patient safety values such as exemplified in Magnet hospitals. Armstrong and Laschinger (2006) surveyed 40 nurses using the CWEQ-II and the Lake’s Practice Environment Scale of the Nursing Work Index, which measures Magnet hospital culture, including nursing participation in hospital administration, leadership attributes, staffing and nurse/physician relationships. Overall, empowerment was positively related to all Magnet hospital professional practice attributes ($r = 0.32–0.61$). The total empowerment score was most strongly related to the use of a nursing model of care ($r = 0.61$). Another study compared nurses’ structural empowerment scores on the CWEQ-II with Press Ganey patient satisfaction scores (Donahue, Piazza, Griffin, Dykes & Fitzpatrick, 2008). The
researchers reported that bedside nurse total empowerment scores and Press Ganey overall satisfaction score had a significant positive relation \((r = .17, p < .05)\). (See Appendix)

Overall, it can be concluded from these studies that nurses only have a moderate amount of structural empowerment in their workplace. What is not well understood is what does structural empowerment mean to nurses in their professional work? Clearly more can be done to improve the empowerment of nurses in their workplace but many of these interventions only quantify a nurses feeling of empowerment. Quantitative data does not describe what empowerment looks like in the lived experience of the nurses. It is important to note that none of the studies specifically referred to the voices of interviewed nurses themselves about their experiences of empowerment or powerlessness in their workplace. Andrews, Burr and Bushy (2011) examine written comments at the end of a survey but nurses were not specifically interviewed about the phenomenon of empowerment and professional identity that they experienced as they provided nursing care to hospitalized patients.

**Professional Identity Among Nurses**

According to Abraham Flexner’s definition of a profession, an occupation becomes a profession when the group has specialized knowledge, theoretical foundations, applies that knowledge and theory to human and social problems, uses rigorous science to create new knowledge, passes that knowledge on to new professionals, has established criteria for practice and conduct, and has an “altruistic spirit” (Buhai, 2012, p. 243). By this definition, nursing should be considered a profession. However, nurses often find it difficult to express the impact and implications of their practice in a way that other professionals understand (Andrew, 2012). Most nurses perceive their independent practice or autonomy as expressed through client advocacy (Wade, 1999). It is generally believed that registered nurses have an opportunity as
professionals to use client advocacy to improve patient outcomes and define their professional practice, but, as Shannon has pointed out, nurses are not the only health care providers who advocate for their patients (Shannon, 2016). The question remains, what do hospital nurses believe that professional identity means for them and does professional identity include an expanded role beyond following physician orders to implement the medical model of care?

All accredited nursing programs provide education about professionalism and professional values (AACN, 2008). All emphasize that being viewed as a professional by others strengthens a person’s professional identity (Johnson, Cowin, Wilson, & Young, 2012).

Professional identity is the perception of self in relationship to the work that one does. Adams, Hean, Sturgis, and MacLeod-Clark (2006) surveyed 1,254 first-year health care professionals, including pharmacists, physical therapists, physicians, social workers, and nurses, with the Professional Identity Scale and other surveys. The researchers concluded that physical therapists had the strongest sense of professional identity and that social workers had the lowest, with nurses falling in the lower middle. This survey suggests that more knowledge is needed to better understand how nurses view themselves and their work as professionals.

**Impact of nurse professional practice and empowerment on patient care in hospitals**

Being able to practice to the fullest extent of a nurse’s scope of practice has been linked to improved work satisfaction, reduced turnover, and lower hospital mortality rates in patients (Laschinger et al., 1997). Yarbrough, Martin, Alfred, and McNeill (2016) surveyed 67 nurses from a mid-sized hospital in the Southwest United States about their professional values, job satisfaction, career development, and intent to stay at their workplace. The researchers used the Nurses Professional Value Scale-Revised (See Appendix) to measure each nurse’s professional values of caring, activism, trust, professionalism and justice, The Nurse Job Satisfaction Index,
and the Perceived Development Climate Survey were used to determine what opportunities for professional development existed and that the participants knew about at their workplace (See Appendix). They concluded that there was a strong correlation between nurses who have strong professional values and career development opportunities \((r = 0.39, p < 0.01)\) and between job satisfaction and job retention \((r = 0.39, p < 0.05)\), further supporting the idea that nurses who work to the fullest of extent of their scope and education will improve the work environment and job retention.

Another study sought to examine the relationship between hospital nurses’ perceptions of empowerment and patient satisfaction (Donahue, Piazza, Griffin, Dykes, & Fitzpatrick, 2008). The authors reported a significant positive correlation between hospital nurses’ perception of empowerment and patient satisfaction \((r = .052; p = .05)\), suggesting that by supporting nurses’ professional practice by hospital administrators, patients receive a better level of care. By identifying experiences in which nurses performed patient care as professionals, nurses can influence many different arenas, including workplace safety and patient outcomes.

**Gaps in the Literature**

Nursing education frequently encourages student nurses to be “patient-centered” and asserts that nurses provide “caring” that other health professionals do not provide for patients. In a computational text analysis of PubMed abstracts from 1986 through 2013, Bell, Campbell, and Goldberg (2015) examined 234,926 abstracts for words related to nursing identity and nursing concept. The analysis found that words frequently were related to the nurse identity and quality assurance, implementation, and workforce development, but were not related to patient, family, or community-centeredness. In addition, a 2013 literature review by Hoeve, Jansen and Roodbol searched MEDLINE, CINAHL and PsycINFO from 1997 through 2010 with the keywords
nurse(s), perception, public image, professional image, stereotype, self-concept, power, public opinion, and social identification. Eighteen articles were ultimately chosen for analysis. Although some participants described imagery as positive, many of the articles found that the general public views nurses as “lower” level health care workers with less education and autonomy than physicians (Hoeve, Jansen, & Roodbol, 2013). Clearly, there is a disconnect between how nurses practice and how the general public, academia, and health care organizations perceive that practice. If nurses want to further develop their professional identity, they must determine how they want professional nursing to be perceived by the general public. In order to do this, nurses must first articulate to themselves what professional practice means or “looks like” in their own practice.

From this literature review it can be demonstrated that the profession of nursing is caught in the cycle of oppression. Oppression, inevitably leads to shame, blame and oppressing others through horizontal violence or bullying (Risjord, 2010). The process of oppression is interwoven through the history and current environment of nursing. Individuals and groups in power, are able to, and often do use their power to alter and ultimately change the core values of any profession with less power, including nursing. Nurses are educated to be professionals but often socialized into the medical model as they prioritize agency rules and protocols higher than patient advocacy. To change this reality, nurses need to acknowledge their oppression, if it exists in their own professional lives, and publically promulgate what they do as professionals. This will help to liberate nurses by developing a positive professional identity as well as socializing the general public to their role (Roberts, 2000).

The existing literature does not explore the lived experience of nurses working in the hospital setting with patients and how that environment impacts their sense of professional
identity including how they deliver patient care. The question remains: “What does professional identity mean as enacted and described in the lived experience of nurses working with patients in the hospital environment?” To answer this question, it is necessary to explore the phenomenon of professional nursing in a hospital setting as it is experienced by the nurses themselves. What nurses do as they practice in hospitals is embedded in a web of meaning that is largely taken for granted by hospital administrators, other hospital personnel, physicians, patients and nurses themselves. New possibilities about what professional nursing in a hospital situation may emerge as the result of thinking deeply about this phenomenon. The results of this study will help nurses to better understand the experience of professional nursing as practiced by nurses with patients in the hospital setting. By sharing this experience with nurses, it is the hope that this research will encourage nurses toward more professional nursing practice and in some way aid to liberate nurses from their historical structural oppression in hospital settings.
CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Study Design

Phenomenology was selected as the methodology to answer the question, “What does professional identity mean as enacted and described in the lived experience of nurses working with patients in the hospital environment?” This methodology is well suited to help researchers better understand the first-hand experience of individuals and interpret the phenomenon (Mackey, 2005). The study design and methodology consists of hermeneutic phenomenology, guided primarily by the philosophical work of Martin Heidegger and Hans Georg Gadamer. By interviewing nurses about their work through the philosophical hermeneutic approach, a better understanding of the phenomenon is gained. Philosophical hermeneutic phenomenology is particularly appropriate for studying nursing practice because nursing practice, “is complex and situational” (Dowling, 2007, p.135). Therefore, sharing the information from nurse participants to other nurses will be useful for application to theory and practice. Philosophical hermeneutic phenomenology is a qualitative methodology that employs one-on-one interviews and transcript analysis of those interviews, by an interpretive team, for themes central to the phenomenon.

History of the Philosophy and Methodology

The word hermeneutics originates from the character Hermes from Greek mythology. As a messenger of the gods, Hermes brought words from the gods to the people (Cohen, Kahn, & Steves, 2000). Similarly, the concept of hermeneutics was applied to the study of sacred texts like the Talmud or Bible (Willis, 2007). Monks and clerics translated or interpreted ancient texts in order to share the message it contained with lay-people. The purpose of hermeneutics was to interpret language and context to determine the meaning of the writings. These translations or
interpretations were necessary because these sacred texts were written over a period of time, in many language translations, and over many thousand years.

Hermeneutics then evolved with the work of German philosopher, Wilhelm Dilthey as a way to interpret phenomena in a more scientific fashion (Diekelmann, & Magnussen Ironside 2006). Hermeneutics moved further into the philosophical realm through the work of Edmund Husserl as well as Heidegger, Gadamer, and Merleau-Ponty (Creswell, 2013). These four philosophers, Husserl, Heidegger, Gadamer and Merleau-Ponty are the foundational thinkers of phenomenology, but did not specifically describe the research methodology of philosophical hermeneutic phenomenology.

Edmund Husserl (1859-1938) is considered to be the founder of phenomenology (Earle, 2010) and it is he who defined phenomenology as, “the science of pure consciousness” (p.287). Husserl was considered a positivist (Dowling, 2007). One of his main conclusions about phenomenology was the idea of intentionality, meaning that being aware of something in the world allows one to become more part of the world and the experience of living. Reduction is another important concept of Husserl’s phenomenology. Reduction means being able to distill the world into a pure phenomenon (Dowling, 2007). In an effort to describe this aspect of investigation, Husserl supported the philosophical idea that the philosopher must “bracket” their personal assumptions and knowledge as part of the distillation process. This idea is controversial in phenomenology and will be discussed later in the chapter.

Martin Heidegger (1889-1976), a German philosopher, sought to discover, describe, and interpret the human experience and what it means to be human. Heidegger altered the philosophy of Husserl in his main work, Being and Time (1962/2008). Heidegger disagreed with the idea of intentionality and focused on the idea of temporality, meaning that the human experience is
constantly moving and changing much like the horizon (Earle, 2010). A central concept of Heideggerian hermeneutics is the idea of “dasein” (Heidegger, 1927/1993, p.20). Dasein is a German word, not easily translated into English but essentially means, “being there” in “human existence” (McConnell-Henry, Chapman, & Francis, 2009, p.4). Human existence or experience can be interpreted and understood by examining language, culture, social situations, historical backgrounds and the everyday experience of those being studied (Benner, 1994). Heidegger sought to discover what it means to “be-in-the-world” as a human and better express that experience (Heidegger, 1927/1993, p.20).

Another important concept developed by Heidegger was fore-structure. Fore-structure is the pre-understanding or prior awareness one possesses before interpreting a phenomenon (Mackey, 2005). This fore-structure helps the interpreter to define their own background, knowledge and experiences, as these relate to the phenomenon. Fore-structure is also an important component of understanding or interpreting the phenomenon in the hermeneutic circle. Heidegger describes the act of interpreting phenomenon as “a process of moving dialectically between a background of shared meaning and more finite, focused experience” (Mackey, 2005, p.182). It is through understanding the fore-structure that interpreters can move beyond the literal experience and find themes associated with a given phenomenon.

Two more important ideas associated with Heidegger are time and space. According to Heidegger, time is, “as the horizon for the understanding of Being” (1927/1993, p.39). Time provides the framework in which all human beings view their lives whether it be past, present or future. In the same way, wherever humans specifically place experiences in relation to themselves, time can add to the meaning of the experience. For example, what is placed in the fore-ground of the space or story (horizon) or what is placed in the background in relation to the
horizon can have significant implications for the meaning of the experience (Mackey, 2005). When a participant shares an experience, and describes the phenomena in terms of time such as being in the past, or where others are placed in the space compared to the participant or even being able to recall a specific event based on time all add importance to the interpretation.

Hans-Georg Gadamer (1900-2002) moved hermeneutic phenomenology forward as a constructivist (Dowling, 2007) in his writing, *Truth and Method* (2013). Gadamer’s two main concepts were *prejudgment* and *universality* (Earle, 2010). *Prejudgments* are one’s preconceptions based on the person’s experience. This is in direct opposition to Husserl’s idea of bracketing. Gadamer believed that *prejudgment* added to the depth of expression in the phenomena. *Universality* speaks to sharing of language and experiences creating a communal understanding of human experience and existence. Gadamer also refined and defined the idea of the *hermeneutic circle*, a concept referring to the interpretive process of hermeneutics shared by the members of the interpretive team (McConnell-Henry, Chapman, & Francis, 2009).

Another important concept developed by Gadamer was the *fusion of horizons*. *Fusion of horizons* builds on the concepts of Heidegger’s time, space and the horizon (Walsh, 1996). Both the researcher or researchers and the participants have their own ideas and understanding about their experience and affirm that “Understanding takes place when the horizon of the other intersects or fuses with one’s own horizon and changes or extends one’s range of vision” (Walsh, 1996, p.235). Therefore, the *fusion of horizons* is a philosophical concept in which the researcher acknowledges their own background, knowledge and biases but, at the same time, in combination and contemplation with the point of view of the participant is better able to express an objective understanding of the phenomenon.
This study used philosophical interpretive hermeneutics as the methodology. Philosophical hermeneutics is “based on interpretivist epistemology and aims at developing understanding” (Willis, 2007, p.104). Researchers from this philosophical perspective seek to gain knowledge by interpreting the everyday experiences of those being studied to better understanding their world. Ultimately, philosophical hermeneutics believes that there is truth in every human experience, not simply one universal truth to be revealed by a research study. Philosophical hermeneutic phenomenology uses team interpretation and incorporates the concept of allowing the research team’s own fore-structure to enter into the interpretive process. Interpretive hermeneutics, therefore, differs from descriptive hermeneutics as described by Husserl.

Application of Philosophical Hermeneutic Phenomenology to Research

The ideas of philosophical hermeneutic phenomenology became particularly appealing and useful for nursing research in the 1970s (Mackey, 2005). Phenomenology pairs well with many fundamental concepts related to nursing theory and practice, including allowing the participants to share their story and allowing the story to illuminate the human experience. (Mackey, 2005). This has led nurses and nurse researchers to think of philosophical hermeneutic phenomenology as an ontological or philosophical ideal.

There are many examples of nurses who have employed philosophical hermeneutic phenomenology. One example is the work of Karlsson, Sidenvall, Bergh, and Ernsth-Bravell (2013), who sought to interpret how certified nursing assistants perceived pain in people with dementia in nursing care practice. The researchers interviewed 12 CNAs who were employed in dementia care units. Three themes or phases were identified through interviews and interpretation: “being in a facing phase,” “being in a reflective phase,” and “being in an acting
phase.” Karlsson, Sidenvall, Bergh and Ernsth-Bravell (2013) linked the work of the nursing assistants to the work of Husserl and Gadamer, noting their understanding or, “… relationship to their patients made it possible to connect to each person on a deeper level, enabling them to perceive unfamiliar expressions and compare these with familiar ones” (p.1886). This ability to perceive allowed the nursing assistants to identify pain in those patients that they were familiar with and supports the nursing practice and policy of patient assignments based on continuity.

Another important study completed by nurses that employed hermeneutics is the work of Armitage, Severtsen, Vandermause and Smart (2014). The purpose of this study was to better understand the experience of postpartum, active duty women who were training to pass their fitness assessment exam. 17 participants were interviewed, the digitally recorded interviews were then transcribed and the research team interpreted the transcripts using the methodology of Heideggerian hermeneutic phenomenology. The two main themes that came from the analysis were, “Striving to perform under pressure through profound life transitions of childbirth” and “Seeking understanding from others” (Armitage, Severtsen, Vandermause, & Smart, 2014, p.771). It was clear from the interviews with the women that it was difficult to transition back to active duty and pass the fitness assessment after childbirth. These two themes gave insight into the experience of these women and the implications for female airmen, health care workers and Air Force policy. Ultimately the Air Force changed its policy related to the fitness test after pregnancy based, partly at least, on this study.

Finally, the hermeneutic work of Holliday and Vandermause (2015) related to teens’ experience in the Emergency Department following suicide attempts provides another example of how researchers employ Heideggerian hermeneutic phenomenology. The aim of this study was to describe the experience of the teens and better express the meaning for them of being
suicidal. Six adolescents were interviewed about their experiences. These interviews were then transcribed and interpreted by a team of methodology experts. Two main themes were identified, “attempting as communicating” and “attempting as transforming” (Holliday and Vandermause, 2015, p.169). These two themes detailed the teens struggle to share their suicidal thoughts with their family, friends and health care providers and how their suicide attempts aided their overall recovery by being a facilitator of change. Similarly, to the previous studies discussed, Holliday and Vandermause (2015) provide implications for nursing practice and policy change based on the experience of that their participants.

**Study Design**

Although much has been written by philosophers about philosophical hermeneutic phenomenology, it was not originally conceptualized as a research methodology. Consequently, there were no specific rules about how the research should be collected and interpreted. In fact, many in the field rejected the idea of formalizing the research process because it stops the process of thinking beyond “already there” understandings. However, an iterative process has formalized the methodology to some degree at this time. For the purpose of this dissertation, a general framework of the methodology outline was used in order to maintain rigor and trustworthiness in the research methodology process.

Philosophical hermeneutic methodology is based primarily in the idea of interview and interpretation. Study participants were interviewed in an open fashion with one main question to begin the interview in order to engage the interviewee in a dialogue about the phenomenon. The opening question for this study was, “Is there a particular experience that stands out in your mind as nurse working with patients that made you feel like a professional?” Other questions used in the interview include, “What was that like?” and “Can you give me an example?” See Appendix
for the specific details about the interview questions. The style of the interview was open and reflexive, utilizing the interviewer as an instrument of the hermeneutic method. (Vandermause and Fleming, 2011). The interviewer engaged the participant in a way that encourages the participant to share their experience, in their own words. Interviewers should not influence the interview but rather facilitate sharing of information by the participant. (Simons, Lathlean, & Squire, 2008). Interviews were audio recorded and transcribed for analysis with subject identifiers removed. After the transcription, audio recordings are then destroyed.

The researcher gathered a group of other methodological or subject experts to form an interpretive team. Each member of the team read the interview to identify important concepts, quotes and teams. The group then gathered together and shared their interpretation of the transcript. The researcher gathered these interpretations and compared the ideas to provide a comprehensive interpretation of the participant’s story. The interpretive team then warrants the interpretation that all have agreed upon as valid as a correct understanding of the phenomenon.

**Sample**

Philosophical hermeneutics phenomenology uses purposeful sampling of participants. Recruitment was completed through online advertisement on Facebook as well as through word of mouth recruitment of nurses who were familiar with the study. Eligible participants included individuals who are registered nurses in Washington State, provide care to patients in the hospital setting, speak fluent English, and were to be digitally voice-recorded. Participants were always aware of the topic of the interview before they have consented to participate. There was a total of 12 participants for the study including two participants from the pilot study. The primary investigator was the sole interviewer; interviews were usually face-to-face or over the phone and participants were only interviewed once. Interviews with participants continued to be added until
meaningful themes and patterns emerged that suggested a common understanding of the phenomenon had been reached. Some experts recommend five to ten interviews are needed for interpretation (Creswell, 2013), while other recommend more than ten (Smythe, 2011). To maintain confidentiality and protect their identity, participants were asked to assign themselves pseudonyms. Participants were given a $25 gift card as compensation for participating in the study.

**Data Collection**

Interviews began with one open ended question that focused around the research question and experience of the participant. Other questions that are commonly used in the interview include “What was that like?”, “Is there an example that comes to mind?” and “Can you give me an example?” to further expand on the participant’s experience and return the participant to their story (Holliday & Vandermause, 2015). Another important aspect of the interview is listening. Listening attentively and remaining silent while moving the interview forward is a special skill with this methodology (Vandermause & Fleming, 2011). By actively listening to the participant, the interviewer allowed the conversation to remain fluid and led by the participant, instead of being influenced by the direction of the interviewer.

Overall it is important to be mindful of the foundational concepts of the philosophical hermeneutic approach throughout the interview and analysis process. Interpretation took place with a group of methodological or content experts as well as others who wish to learn this interpretive method. This group was known, collectively, as the interpretive team. Team members met together to analyze the text and discuss what content emerges as meaningful. These patterns and themes were warranted as valid by the team; this activity is known as the hermeneutic circle. The final result of this process is a, “culmination of a multilayered text”
(Holliday & Vandermause, 2015). Results from a philosophical hermeneutical analysis are intended to stimulate new, previously unattended thinking that generates questions and recognizes the hidden or overlooked (Vandermause, 2012).

**Data Analysis**

Once the interviews were completed, the text was examined for interpretation of the phenomena. A unique feature of philosophical hermeneutics is the analysis and in particular, the concept of the hermeneutic circle (Willis, 2007). Hermeneutic interpretation and the hermeneutic circle involve a team of people reviewing the text of the interviews and identifying themes in individual interviews and themes across the interviews (Diekelmann, & Magnussen Ironside 2006). Each team member brought with them their background and expertise. Each team member also brought their own pre-understanding of the phenomenon based on their previous life experiences and it is with that pre-understanding that each team member interpreted the transcript (Smythe, 2011). Prior to the team meetings, each team member reflected on the interview text, and then shared their interpretation with the group. The group then discussed the various interpretations together, noting common themes/patterns emerge as well as differences. This philosophical hermeneutic interpretation was circular, open to new ideas and involved rereading and reexamining the text, as it shows itself throughout the analysis. The themes, patterns and common understandings were then deemed as valid based on the group’s interpretation of the interviews completed by the researchers.

Philosophical interpretive hermeneutic phenomenology analysis commonly follows the following steps for interpretation of the transcribed interview texts:
1) The primary investigator creates an analysis team with methodological or content experts as well as other readers such as students who study the transcripts and provide interpretation.

2) Each team member reads the transcript.

3) The team member then notes concepts, statements or situations that stand out as meaningful.

4) The team members then gather to share each person’s analyses comparing ideas, concepts, quotes, themes and other categories that stand out.

5) The primary investigator then creates notes and lists of emerging patterns of ideas emerging from the conversation of the team members, until saturation of themes occurs, based on the team conversations.

6) As additional transcript texts are read together interpretations and patterns are always subject to enlargement and/or revision.

7) Final results include a summary and interpretation of each common understanding, theme and pattern. Taken together, these aspects form the essence of what stands out as meaningful for the participant in response to the question asked at the beginning of the process. (Vandermause, 2012).

**Evaluation of Rigor and Trustworthiness**

There are several ways in which to evaluate qualitative research and in particular, philosophical interpretive hermeneutics phenomenology. According to nursing literature, there are numerous authors who have written texts for evaluation including Benner (1994), Crist and Tanner (2003) and de Witt and Ploeg (2006). Criteria include evaluating validity of the research question, methodology, sampling, interpretation, and conclusions drawn from the analysis.
Participants can also be contacted to evaluate the analysis results and themes to further validate that the team’s interpretation matches the participant’s experience.

There are also several proposed frameworks for evaluating the rigor of interpretive phenomenology including Sandelowski (1986), Madison (1988) and van Manen (1997). For this dissertation, the five main criteria of Madison (1988) outlined in further detail by de Witt and Ploeg (2006), will be utilized to describe how best to evaluate interpretive phenomenology research and results. Rigor in interpretive or philosophical hermeneutic phenomenology can be examined by assessing the study’s balanced integration, openness, concreteness, resonance and actualization within the text (de Witt & Ploeg, 2006).

Balanced integration relates to the how well the research, methodology and results are related to the philosophical foundations described by the author/researcher (de Witt & Ploeg, 2006). For example, does the author relate the common understandings, themes and patterns of the research directly back to the philosophical concepts described previously in the text?

Openness is about how a researcher’s ability to describe the steps of their research process including a step-by-step process of recruiting to analysis of results and the specifics of their decisions and rationale for those decisions (de Witt & Ploeg, 2006). This accounting of the recruitment, interviewing, transcribing, analyzing and interpreting are detailed in this chapter and supported by the work of Vandermause (2012), Diekelmann and Magnussen Ironside (2006) and Smythe (2011).

Concreteness is the author/researcher’s ability to express their interpretive findings and describe the phenomenon in a way that readers identify and understand. This is accomplished by providing the reader with concrete examples of quotes from participants in order to more specifically illustrate their lived experience (de Witt & Ploeg, 2006).
Resonance is the idea that the readers feel emotionally connected with the author's results. Although some readers may not have experienced the same phenomenon as the research participants, the researcher needs to be able to connect with readers in a meaningful way that represents common human experiences (de Witt & Ploeg, 2006).

Actualization can be difficult to assess in interpretive phenomenological research because readers may see or experience the same phenomenon weeks to years later and not report their insight. Actualization is the "future realization of the resonance" (de Witt & Ploeg, 2006, p.226).

**Ethical considerations**

Ethical concerns need to be considered while evaluating this and all other studies. Institutional Review Board approval was obtained prior to beginning this research study. This hermeneutic study that utilized interview methods included informed consent, the requirement for the participant to use a pseudonym for the interview, and the understanding that portions of the interview may be redacted to maintain confidentiality (Vandermause, 2008). In addition, care was taken to protect participants from manipulation or coercion and ensure psychological safety and confidentiality throughout the interview and interpretation process.

**Strengths and weaknesses of method**

Strengths and weaknesses of the philosophical hermeneutic method must be addressed to aid in the evaluation of this study. Several strengths have already been previously mentioned including the interview structure and analysis process. Interviews are open in style and typically contain a great deal of information for analysis, when done appropriately. (Vandermause, 2008). With this wealth of information and multiple participants in the analysis team, the interpretation of the text is more likely to be accurate in its identification of themes (Benner, 1994).
Some critics consider the open-style to be a weakness of the methodology because the interviews are not replicable. This raises the question of objectivity. However, other researchers defend the methodology as objective (Palmer, 1969) stating that the philosophy behind the methodology allows the researcher to be aware of preconceptions while, at the same time, pursuing an honest representation of the participant’s experience as warranted by the hermeneutic team.

Critics of hermeneutics and other qualitative methodologies point to other weaknesses in the method. Positivists, in particular, may find hermeneutics difficult to understand because there is no claim of absolute truth in the themes and conclusions reported (Willis, 2007). Some critics of philosophical hermeneutic phenomenology struggle to even define how one critiques the results of phenomenological research if absolute truth does not show itself, however, it can be argued that rigor is similarly relative as well (de Witt & Ploeg, 2006).

**Human Subjects Review**

Institutional Review Board (IRB) approval was obtained from Washington State University before conducting any research. Informed consent (see Appendix) was obtained from each participant before initiating the interview. Participants were recruited from an online advertisement through a social media website and through word of mouth. Eligibility criteria included being a registered nurse in Washington state, currently working directly with patients in a hospital setting, speak fluent English and willing to be interviewed and recorded. Before the interview began, the participants were asked to give themselves pseudonyms to conceal their identity. After the pseudonym was assigned to the participant, all recordings and files were associated with only that fictitious name to further protect the participant’s identity. The only form that bore the participant’s legal name was the consent form which was kept locked and
separate from the pseudonym recording and transcript. In addition, any information shared during the interview that may identify the participant was redacted from the written transcript. Recordings and transcripts were kept on a password protected, secure website used by Washington State University, College of Nursing. After transcription, all audio recordings were destroyed. Only the researchers and analysis team had password-protected access to the written transcripts.

Risk to human subjects was minimal in this study. Some participants may find that retelling stories containing trauma and/or abuse, was upsetting to the participants. If participants expressed discomfort during the interview, a list of support services was made available for participants and the interview was discontinued at the request of the participant. It was anticipated that participants would benefit from this study by helping to express their authentic feelings of professional identity in their work. It was also hoped that this research will describe the valuable work of nurses and, as a result, improve the public’s perception of professional nursing.

Pilot Study

A pilot study was conducted with the support of Dr. Billie Severtsen before the larger study was instigated. The purpose of this small study was to determine if the research question and methodology were accurately capturing the experience of the phenomenon being studied. Participants were recruited, consented, interviewed, recorded and transcribed in the same way as the full study. IRB approval was received for this pilot study. A total of 2 interviews were conducted using the same open ended question and in the same style as the larger study. The research team determined that the research design and process were adequate to respond to the
research question. It was further determined that the pilot study interviews could be enfolded into the larger study.
CHAPTER FOUR

RESULTS

This chapter presents the findings of the hermeneutic phenomenological interpretation of this study. Each of the twelve participants shared experiences in which they felt like a professional nurse in their hospital workplace in their direct care of patients. These results fulfill the specific aim of this study, which is, to describe, interpret and, therefore better understand the lived experience of nurses working with patients in a hospital environment and the meaning of this phenomenon as it relates to their professional identify.

Background and Demographics

A total of 12 participants were interviewed for the study, including two participants from the pilot study. This number of participants meets the guidelines described by Smythe (2011) and Creswell (2013) needed to achieve consistency of themes or saturation across participants. All twelve participants were licensed registered nurses in the state of Washington who were currently working in direct-care with patients in a hospital setting. All participants gave verbal and written consent for the interviews and recordings per Institutional Review Board (IRB) guidelines. All interviews were audio-recorded and transcribed by an IRB-approved transcriptionist. After transcription, all recordings were destroyed. Transcripts of the interviews were then shared and interpreted through the hermeneutic circle, i.e. interpretive team detailed in the previous chapter.

The participants had diverse backgrounds and nursing experience, but common themes and patterns were still identified based on their common experiences as nurses working in the hospital-setting. According to Smythe, “While all will have experienced a common phenomenon, the researcher may choose to purposely select people with a variety of experiences. This is to
spark thinking, not make comparative statements about different categories” (2011, p.41). Participants were asked four simple demographic questions at the conclusion of their interview which included age, years of experience, gender and highest level of education. While these demographics are not essential to a philosophical hermeneutic phenomenological study, a brief historical summary of each participant will be described in order to add greater depth of understanding of their experiences. Table A contains the average and range for “Age” and “Years of Experience.” Two of the 12 participants identified themselves as male. 11 of the 12 participants had a Bachelor’s degree as their highest education, with one participant with an Associates as their highest degree. Although not specifically asked for in the demographic questions during the interview process three of the 12 participants identified as non-White. Each participant also shared during their interview the type of hospital unit they worked on as well as the shift they typically worked i.e. day shift, night shift, etc. See Appendix for specific details about each participant.

Table A: Age and Years of Experience of Participants

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<thead>
<tr>
<th></th>
<th>Age</th>
<th>Years of Experience</th>
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<tbody>
<tr>
<td>Average</td>
<td>39.83</td>
<td>11.5</td>
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<tr>
<td>Range</td>
<td>24-69</td>
<td>1-41</td>
</tr>
</tbody>
</table>

Common patterns and themes

Interviews were transcribed and shared with a hermeneutic team of methodological and content experts. The interpretative team included methodological and content experts and numbered three to six members depending on their availability for each meeting. Each member of the team read the interview and wrote up an individual summary to identify important concepts, quotes and themes based on their background and understanding of the topic. The
same analysis group met together to share their individual interpretations with the group and the group then discussed the individual interpretations as well as how each interpretation compared and contrasted to provide a more robust overall interpretation. The researcher used field notes to gather these interpretations so as to provide a comprehensive interpretation of each participant’s story and how each participant connected with other participants. Common ideas, themes and patterns were then developed based on these interpretations and shared with the interpretive team. All hermeneutic team members agreed that these patterns and themes represent a valid understanding of the meaning of this phenomenon for the participants.

All participants shared many common and diverse ideas throughout each of their interviews. Most shared that they were proud to be nurses and enjoyed aspects of their workplace, patients and co-workers despite sharing some of their struggles in the hospital environment. Most expressed a feeling of commitment or mission to the profession of nursing during their interview. After being asked the opening question, “Is there a particular experience that stands out in your mind as a nurse working with patients that made you feel like a professional?” participants would typically share a story about a patient that made a profound impact on them as a nurse. For several, it was the story of a difficult patient death, for others it was an experience in which they worked very hard to help a patient improve during their hospital stay and discharge safely from the hospital.

In contrast to the idea of commitment to the profession, no specific skill or task was ever mentioned as a reason they felt like a professional. All the nurses mentioned their ability to assess patients and critically think about what skill or intervention was required to care for the patient but a particular skill or task was never described as a way that a nurse defines themselves professional. Each nurse interviewed described experiences in which they felt like professionals
when they spent time speaking with a patient, formed a connection with a family or were valued as a member of the health care team. This finding suggests that working with patients or people is more important as a source of professional identity than expertise at a particular skill or intervention.

It is important, according to the philosophical hermeneutic phenomenological methodology to highlight the critical component of interpretation in the methodology of this research study. The aim of this study was to describe, interpret and better understand the phenomenon. Therefore, the researcher and analysis team must “make an interpretive leap” (Smythe, 2011, p.48) and describe the phenomenon in order to better understand the nurses’ experience. Within the interviews and by re-reading the interviews as an analysis group, meaning was interpreted about what is the experience of a professional nurses and how nurses view themselves as a professional when working with patients in the hospital workplace setting. This interpreting of participant transcripts leads to “naming of text” (Benner, et al., 1996, p.367). For the purpose of these results, the word “pattern” will be used to describe overarching “qualities of meaning” (Benner, et al., 1996, p.367). “Sub-theme” will be used to describe experiences or concepts that build or add to overall patterns.

Four patterns were identified by the analysis team from all 12 interviews analyzed. Under each pattern are sub-themes seen within the pattern. See Appendix for a table of common patterns and themes. The four main patterns are:

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Being validated as an expert by more powerful providers within the healthcare system who value and trust the wisdom of the nurse</th>
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<tbody>
<tr>
<td>Pattern One</td>
<td>Working well as a valued member of a team trusting the other team members and being trusted by them</td>
</tr>
</tbody>
</table>
Pattern Three | Advocating for the patient’s needs within a system where the power of the nurse is not as great as the power of the provider or hospital rules and regulations

Pattern Four | Valuing human-ness in the patient and in the nurses’ practice

**A Paradigm Case**

A paradigm case identified during this study was with participant, Karron. Paradigm cases are used in philosophical hermeneutic phenomenology when a participant shares a particularly meaningful and poignant experience that relates to all other participant experiences and themes identified in the analysis and interpretation (Benner, 1996; Crist & Tanner, 2003). Karron is a nurse participant with the longest and most diverse career. She shared many profound ideas and made connections in her narrative that resonated in some way with all of the other interviews. When she was asked what made her feel like a professional, Karron stated that any instance where she was able to: “help the light go on for the patient or the patient’s family” (l. 18) made her feel professional. This type of professional interaction was further detailed by Karron throughout her interview:

*I really love that part of the professionalism of nursing. And, um, be able to, like I said before, incrementally inch by inch walk them through what we were looking at on a daily basis as progress” (l.112-114) and that nursing is, “Directing them to the right resource. You are not the answer. You are not the total answer. (l. 155-156)*

*When the family realizes you’re taking it seriously, they realize they’re in a safe place. (l. 70-74)*

*You can help them hang onto hope. (l. 116).*

*True professionalism is hope given in any discipline. (l. 119)*

*The team provides a place to bring them (patients) alongside and work with them - - it has its rewards. (l. 197)*
There is something that goes to healing and wholeness that nurses pick up on, ah, when we take care of people. (l. 308)

I don’t even think about life without nursing. (l. 135)

Because Karron will be used as a paradigm case, her quotes and the stories she shared will be used as an exemplar with all four patterns and throughout these results followed by quotes made by other participants.

**Pattern One: Being validated as an expert by providers with often more power, who value and trust the wisdom of the nurse.**

Nurses shared experiences when they felt like professionals when they used their assessment skills and nursing interventions in an appropriate and effective manner. This professionalism becomes magnified when validated by other nurses, co-workers such as physicians and patients/family members. Common themes seen in this pattern were: exceptional assessment skills, seeking out information like a “detective” about a patient, knowing what do before being prompted or an order to do so, and quickly identifying subtle changes and life-threatening situations in patients.

**Karron:** And, um, usually – the ones that come to mind readily are the ones whereby I would say it helped the light go on for either the patient or the patient’s family. And what I mean by that is that I can think of an incident in intensive care where the patient had been on a ventilator for a long period of time related to not just a chronic, but a very acute respiratory process. And it was very difficult weaning the patient, and the progress was incrementally just inch by inch. And it – there was just a sense of not only professionalism – indeed professionalism – but the ability to, um, help this family and that patient walk through that with understanding and reassurance that we were moving in the right direction and that it did – it took a lot of reassurance. It took a lot of explanation and knowledge coming alongside of the physician. (l7-28)

**Sub-theme: exceptional assessment skills and “detective”-like work**
The common theme of exceptional assessment skills and “detective” like work was identified in the first interview of the pilot study with Katie. Katie used the words, “like a detective” (l. 160) during her interview but also mentioned the immediate recognition of a patient dying (l.149-151) and intuition about a patient coding (l. 760-769, l. 797-802). Other examples of acting as a detective, included stories about missed medications, wrong doses, and identifying a patient who was without a bowel movement for two weeks. Katie also shared a story about a patient who did not speak English and did not yet have an interpreter available, “She didn’t have anyone’s address written down, and so I was really playing detective to try to figure this out” (l. 427-429).

For CJM, she also shared her enjoyment of the detective work of professional nursing in conjunction with her assessment skills:

**CJM:** “And I’ve always felt that – that giving myself to that moment – whatever it is – to try to be open and flexible and – and aware of what’s going on with the patient – the patient’s body” (l. 11-14) [...] “It’s like detective work, of course” (l. 16). “And if you become a very good assessor, which I would say professionally that’s my gift is I have fought very, very hard through the years – but there’s a lot of burnout in nursing – not to give up my stethoscope around my neck and be there and assess that patient as soon as I can, get the information I need” (l. 18-22) [...] “So taking care of the whole patient. (l. 27)

Similarly, Beth spoke about how, as a nurse, she is always looking at all the details of a patient’s medical story and with that knowledge be able to notice small subtle changed that may impact that patient’s overall outcome:

**Beth:** ...you have to do in depth you, the nitty-gritty of – you’re looking at their x-rays. You have the time to look at your lab trends and really like get down to it (Beth, 297-301) “and critical thinking skills to really, um, to be sensitive to the small, subtle changes that you start seeing in your patients. Anyways, so – so that is definitely a component of the professional role that, um, you know, I-I enjoy. I think it speaks highly to the responsibility that we’re trusted with. (l. 169-173)

**Sub-theme: knowing what to do before being prompted or an order to do so**
Along with having exceptional assessment skills and seeking out additional data about their patient, many of the participants shared they felt professional when they were able to act on their nursing intuition, often sharing their knowledge or knowing the next step with another member of the health care team, usually the patient’s physician, and were acknowledged for their expertise and ability to determine next steps without being ordered to do the next step.

For Dawn, the first story she shared was about a newly delivered mother who was hemorrhaging after giving birth. As a relatively new nurse, Dawn was able to assess her patient appropriately, contact the physician and intervene appropriately:

**Dawn:** And I knew what to do even before the doctor said – you know, she said, “I want you to turn up the Pit.” And I said, “I already did.” “I want you to turn up the LR.” “I already did that.” “Have you massaged her?” Have you blah, blah, blah. We’d already done all those things. (l. 48-53)

For Dawn, this was the first time in her career that she could remember this kind of interchange happening. She felt like a professional for knowing the correct action to take and for being acknowledge by the physician as being knowledgeable and skilled as a nurse.

Keltan, another participant, recalled an experience in which she was able to assess that a patient was not doing well after surgery and, despite being told by a hospitalist that the patient was fine, continued to call the surgeon:

*And called the hospitalist. I think vitals were falling. He was an abdominal surgery of some kind. Um, and the hospitalist just really kind of pooh-poohed me and, um, so I called the surgeon. Um, and I was like impressed and proud that they like came right down and like took one look at him and took him back to the OR. And one of them had said to me like, um, “The next time that you call me and tell me a patient’s crumping, I’m coming.” (l. 315-321)*

This acknowledgement by the surgeon gave Keltan confidence in her assessment skills and her ability to discern the best action for herself and her patient.
Sub-theme: quickly identifying subtle changes and life-threatening situations in patients

In a different story with Katie she shared an experience in which she identified a patient was having a seizure with the physician at the bedside. Despite the presence of the doubting physician, Katie decided to call a “Code Blue” and was found to have correctly identified a seizure:

*I’m like, “No, like he’s having a seizure and he’s not maintaining his respiratory status, so what are we going to do about that? Okay, you want to intubate? Okay we’re calling a Code Blue.” You know?… So it was just kind of running it until the intensivists came and took over. And like, “No, it’s - that is a seizure.* (l. 698-704)

To trust her assessment skills and continue to pursue calling a Code with a physician at the bedside can be difficult for a nurse to do because of the power differential in this situation. Katie felt like a professional in this experience because she trusted her expertise and put patient safety as a highest priority.

In a similar fashion, Mary and Moses shared stories about situations in which they were working with physicians and their knowledge including their assessment and intuition was valued and trusted:

**Moses:** *And I just walked into this room – this patient that I saw him this morning – and he looks totally different. And I told her it’s not the PCA. I asked my – the doctor who wrote the recommendation, and he said, “Can you check the vitals?” His blood pressure was very low. Temp was high. He was in sepsis.* (l. 613-619)

**Mary:** *Um, and so she – she saw me, you know, like talking with the doctors, being able to recall, okay, this is the patient’s history. He’s postop day nine. This is his current, you know, situation with his surgery, but this is what’s going on, you know, psychosocially. This is his family. You know, so I was able to just, um, be able to be very precise and – and, you know, um, like discuss, you know, articulately with the doctors and with the other, um, rapid response team.* (l. 129-136)
Pattern Two: Working well as a valued member of a team trusting the other team members and being trusted by them.

When sharing stories of when they felt like a professional, participants talked about times when they worked collaboratively within a team of nurses or as the nurse member of an interdisciplinary team. This idea of working within a team does not mean nurses are simply included in a team situation but that nurses are active members in a team whose assessment, opinion and recommendations are taken into account when determining the patient’s plan of care. Common themes under this pattern included nurses who worked well in Code or other emergency situations, “Coming alongside” physicians in partnerships and report functioning within positive teams of co-workers on their nursing unit led by supportive managers.

Karron: [...] the ability to, um, help this family and that patient walk through that with understanding and reassurance that we were moving in the right direction and that it did – it took a lot of reassurance. It took a lot of explanation and knowledge coming alongside of the physician. (l. 25-28)

Sub-theme: working well in Code or other emergency situations

For this pattern, teams can mean many different mixes of groups of people including nurses with nurses, nurses with other health care providers and nurses with administration or management. Several of the participants shared stories when they felt like professionals in emergency situations, particularly emergencies in which all members of the team worked well together:

Clara: There was this one where this patient was sixty-five went into – he just kind of like went into rigors all of a sudden...and the nurses were like – the doctors were across the hall seeing another patient. Like they had just been in and everything had been fine. And, you know, it’s ten minutes later and now they’re across the hall. And I just remember going like across the hall and opening the door and being like, “I need you to come here now,” and then coming and coming and then just – they were in the room doing the – you know, putting the orders in the computer. But it was just like three nurses were doing – like one’s taking vitals, two are boosting up the patient, one’s, you know, going to get the meds. And it was just like definite nurse teamwork. Like there was a doctor in the room.
doing things, but it was like a pretty smooth – like the nurses responded and someone
was drawing their meds. And we got the right meds and gave ‘em to him. And, you know,
within a couple minutes, like everything was pretty – lookin’ pretty good. (l. 254-271)

Clara: ‘Cause the blue uniforms and everyone comes pouring in. And then someone’s
taking the vital signs and someone’s helping boost up and someone’s pulling a computer
in and looking up and checking on things and someone else is paging. And so I think it’s
– it’s not just me when I think of that. It’s more I think of moments of a group of nurses
that have worked together really well to – to handle a situation. (l. 287-293)

Katie: [...] I was basically – like running the code, being the recorder. Being like,
“Okay, it’s been – you know, you have thirty seconds left to CPR. Okay who’s next up for
CPR? Okay, (name reference), are you – you know, it’s been two minutes since the last
epi.” You know? ... “Pause, rhythm check, pulse check. Nothing. Resume CPR.” So that
was – so I kind of ran the code in conjunction with the physicians. (l. 677-684)

Sub-theme: “Coming alongside” physicians in partnership

The idea of “coming alongside” a physician was first introduced in an interview with
Karron, but after re-reading and discussing several of the interviews, it was clear that many other
participants had shared a similar experience of working well with physicians using different
words.

Karron: [...] the ability to, um, help this family and that patient walk through that with
understanding and reassurance that we were moving in the right direction and that it did
– it took a lot of reassurance. It took a lot of explanation and knowledge coming
alongside of the physician. (l. 25-28)

Katie: We were working on an admission together, and I’d be like, ‘Oh, do you want
me to put an order in for this? And he was like, ‘Sure.’ You know, kind of going back and
forth. And after the doctor left, the patient said, ‘I can tell you two get along like really
well. Like you guys are a good team.’ (l. 627-631)

Katie: I think it’s a combination of being independent and collaborative with the
physician. (l. 532-533)

Beth: [...] the team component is really important and we all do really want to see each
other, you know, succeed and flourish” [...] “they (doctors) put a tremendous amount of
respect and trust in what we have to say, and it’s just like such a great rapport working
together.” (l. 270-271)
Sub-theme: positive teams of co-workers on their nursing unit and support from their managers

Also mentioned in this pattern of feeling like a professional when working well as a valued member of a trusting team is the concept that each nursing unit has a great deal to do with whether or not nurses felt valued as professionals. For Mary, working well in teams was what she identified as when she felt most like a professional in her workplace. Particularly when she was able to help other nurses on her unit, “Hey, you know, colleagues, let me help you. I am good for the next hour with pain meds. How can I help you? (l. 204-205). Mary also appreciated the relationships she had formed with the other nurses on her unit:

Mary: You know I think that’s what I love - besides caring for patients - - love the most is the culture of nursing growing bonds, you know, over the years. And, you know, I really just love that because it brings so much joy to my heart. (l. 498-501)

Other participants shared similar ideas about the culture on the unit they worked as being supportive and collaborative:

Moses: If you need something, you just say, um, you know, “I need this. Can you help me?” Everybody like works as a team. (l. 320-321)

Dawn: And it’s so highly emotionally charged that you – you have to know that your manager has your back. (l.452-453)

Keltan: [...] have a positive attitude and [say], ‘I’m here. How can I help?’ After all, nurses are nurses, no matter where they are. (l. 437-438)

Being a valued member of the nursing unit and feeling connected and supported on the unit, gave many of the nurses interviewed an overall feeling of connection and trust that supported their work as a professional and their ability to work well in their workplace setting.

Pattern Three: Advocating for the patient’s needs within a system where the power of the nurse is not as great as the power of the physician or hospital rules and regulations.
Nurses often spoke about “working around” the provider to get what you need for your patient. This can also be referred to as advocacy. The nurse identified a patient concern or a patient care need and advocated for the patient with the physician until a solution was found, the patient was transferred to another unit or the patient passed away. Working around also contains the element of negotiating with people whose power is greater than the power that the nurse has. Common themes related to this pattern are advocating for the patient in the face of direct opposition and advocating to get what they felt the patient needed for patient safety.

Karron: There’s a way to approach, there’s a way to appeal, and there’s a professional way to act. And, ah, no matter what my estimation is of how the other person is functioning in their position, that’s not the thing that can alter where I’m at. (l. 250-253)

Nurse shared these experiences as times when they felt like professionals because they were thinking autonomously, despite not having any power to change the physician orders or the outcome. One participant, Keltan, felt that part of her role of being a professional nurse was “being their advocate and – I mean, I have no problem speaking out for patient concerns or – you know?” (l.163-164) and “I will call the doctor fifty times if I have to for the sake of what’s good for the patient” (l. 219-220). Many participants shared similar feelings that despite what may be ordered or be a hospital rule or regulation, a nurse will ignore the directive and, instead, advocate for their patient, if their safety is at stake.

Sub-theme: advocating for the patient in the face of direct opposition

In a story shared by Clara, she spoke about a dying patient and his wife who wanted to go home on hospice but despite their requests were unable to make it home and he died in the hospital. Despite this narrative being a story where she was unsuccessful to help her patient, Clara felt that the story exemplified an experience where she felt like a professional because she never stopped advocating for what the patient and his wife wanted, even in direct opposition:
Clara: I don’t know. I don’t know if this is a good story -- about me being a professional because it’s not exactly a success story --- which is why I was trying to decide if this was the story to tell or not. I probably have other ones that are better, but it was in that I felt like I stood up for my patient and I advocated for my patient like the whole time. (l. 170-178)

Sub-theme: advocating to get what they felt the patient needed for patient safety

Sarah also shared a story in which she was confident that the patient was not doing well after surgery. When she met resistance, she negotiated to have labs drawn on the patient and revealed that her assessment and recommendations were correct and appropriate orders were then entered for the patient:

Sarah: She looked terrible. Um, so I – I pushed back and I remember kind of getting in a little bit of an, um – I wouldn’t say an argument, but kind of some words with the physician. And they finally agreed to draw labs on her. And, um, it came back her lactic acid was really high. I don’t remember what it was. But after that situation, I kind of realized that, oh, hey, I have some – I have some, um, power from, you know, my mind and my knowledge and my experiences to make a difference and to work with physicians. That it’s not just me caring for patients and following out orders. It’s me actually kind of dictating the direction that a patient’s care goes. Um, and that was probably the time where I was like, oh, hey, this is—kind of what being a nurse is all about. (l. 29-41)

In another story with Sarah, she had difficulty reaching a physician assistant, because of an incorrect phone number, to write discharge orders for a patient. When the provider came to the unit, he belittled Sarah for not having the patient ready to be discharged. Sarah had to advocate for herself as a professional in this situation:

Sarah: I do feel like when we’re at the bedside and we’re caring for people all the time and we have a really – you know, I don’t want to say – we have an emotionally charged profession – where we empathize with patients all the time. I kind of felt like that was being taken advantage of in that aspect. He felt that it wouldn’t matter how he talked because he wasn’t going to get – you know, it didn’t matter. I was just a nurse and I should’ve done better. Yeah, I – that was a situation where, um, I really felt like standing up for myself, and I felt proud that I did that, um, and proud that I kind of defended not only myself, but my license as well. (l. 94-106)
Finally, Whitney, a nurse in her first year of nursing, shared a story in which she, “[…]
wasn’t getting what I wanted” (l.15) for a patient and after repeatedly asking a provider for new
orders, waited until the provider’s shift changed to a new provider and got what the patient
needed:

**Whitney:** *I finally asked for the one that I like kind of know.* (l.126) *[…]* I like
presenting all the facts and then kind of looking at the whole picture versus just like what
the family thinks or the friends think that like this one thing is happening. ‘Cause a lot of
them might not know.” (l. 90-93)

**Pattern Four:** Valuing human-ness in the patient and in your practice.

Nurses shared that when they felt the most professional was when they formed human
relationships with patients, families and co-workers. There is a commitment to the patient and
their family that every nurse takes on every shift, for some nurses that can mean simply
providing good daily care but for others it can mean forming deep connections with patients and
families but every professional nurse is committed. Common themes are forming special
relationships with patients, families and co-workers, remembering great amounts of detail related
to the patient cases despite no longer caring for these patients and, in many stories, choosing to
help the patient in relational ways “out of the scope” or responsibilities of a nurse. This is also
known as “invisible work” (Allen, 2015).

**Sub-theme: forming special relationships with patients, families and co-workers**

**Karron:** *She was going to see them through this. And if they needed any piece of
information, just like you would sit down in front of a lawyer or you would sit down in
front of a teacher and be given the information that made it possible for your loved one.
And when you, as a family can walk (them) through the process in a professional
manner. (l. 40-46). […] that kind of knowledge is very hard to explain. Don’t put that
in your narrative. (l. 48-50)*

When Karron mentions not to put this kind of “knowledge” in the “narrative” she meant
that the time spent forming a trusting relationship with a patient and/or family was not something
you would write about in your chart note. This is an example of the “invisible work” that Karron attributes to the professional work that nurses do with every patient.

In every interview, the participant shared stories about a patient and their family or friends. The nurses typically knew a great amount of information about a patient including medical history, labs and dates and times of their progression in their hospital stay. Participants remembered these facts because they formed a connection with these patients that was beyond what is medically indicated or necessary for a nurse caring for a patient. These nurses felt like professionals when they experienced the human-ness of their patient and formed a relationship with them in order to better care for them.

Sub-theme: helping the patient in relational ways “out of the scope” or responsibilities of a nurse, also known as “invisible work”

One way that nurses value the human-ness of their patients is by doing work that is considered non-nursing tasks sometimes referred to as “out of scope” or invisible work.” Katie, shared experiences in which she felt like a professional staying over her shift to help a dying young mother with breast cancer write goodbye letters to her children (31), helping an elderly man in the emergency department get a rental car after a car accident (248-251), helping another family get to their hotel by having them follow her in her car (280-284), reaching out to a patient’s family through social media when she was unable to communicate with the patient (481-485). These are all experiences that are “invisible work” or “out of scope” but many nurses find these types of actions to be holistic care for patient that is fundamental to the work of a professional nurse. At one point in the interview Katie shares a story of a patient dying and says, “I just don’t think anybody should die by themselves, I just held his hand (l. 100).
Similarly, other participants shared similar feelings of professionalism when they were being human with their patients. Alex shared a story of a patient who he cared for several months and was able to leave the hospital despite a poor prognosis:

**Alex:** *He was in the hospital for two or three months, but through a lot of care he actually got better. He actually walked out of the hospital. I helped him leave the hospital...I’ve actually been, ah, to his house a few times and, ah, really good friends with the family.* *(l. 35-37, 39-40)*. *And funny enough, the wife, who I’m really good friends with, the thing that she remembers the most is me shaving his face.* *(l. 61-62)*. *She invites me to barbecues all the time, and I was like, “I only shaved his face.”* *(l. 68-69)*

Another aspect of this pattern is that nurses felt like professionals when their own humanness was valued by others with more power, like physicians. Katie shared that, “Being called by your first name and being able to call a physician by their first name” *(l. 584-588)*, made her feel like a professional. Having mutual respect to call another person by their first name instead of a title in a working relationship, built trust between the nurse and physician. Another nurse, Clara, shared that being treated respectfully by physicians, patients, and patients’ family made her feel like a professional:

*It’s kind of weird to think that being respected by the doctors is what makes me think or feel like a professional ‘cause I don’t think that’s right. But maybe when patients respect you, too, and when patients or patients’ family members notice that you’re - doing a lot.* *(l. 239-234)*

It was important for Clara to know that her knowledge and hard work were being acknowledged and appreciated by those she was working with in the hospital setting.

**Summary of Results**

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<th>Pattern</th>
<th>Being validated as an expert by more powerful providers within the healthcare system who value and trust the wisdom of the nurse</th>
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<td>Pattern</td>
<td>Working well as a valued member of a team trusting the other team members and being trusted by them</td>
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For nurses, times when they had experiences where they felt like professionals were important in order to support their professional identity but for many participants and many nurses these experiences of professionalism are matched with negative experiences of being ignored, voiceless and dehumanized. As a role that is primarily filled by women, who work in shifts around the clock, and are busy caring for multiple, acutely ill patients, nurses work very hard to be recognized for their expertise and their importance. Nurses feel professional when their expertise and knowledge are validated in an act of human respect.

**CJM:** So you’re finding this balance, balance, balance all the time. And nurses – I love nursing and love nurses because they’re trying to do something that’s impossible. (l. 719-721)

As previously mentioned, Kanter describes three main empowerment structures: the structure of opportunity, the structure of power, and the structure of proportions. Empowered workers have availability and access to all three structures, equally. Power has a great deal to do with how nurses view themselves and their work, as previously detailed in the Standpoint theory (Risjord, 2010). As a health care professional with less power than their physician partners, nurses often use advocacy for patients, an even more powerless role, as a way to express their autonomy and exert some type of power in their role. Consequently, it is important for hospital
managers and administrators to understand how to support nurses in their professional identity in order to support patient safety and nurse workforce issues.

Overall, these four patterns provide better insight into the work of what it means to be a professional nurse. By being validated as an expert by providers with more power, and who value and trust the wisdom of the nurse (Pattern 1), the nurse’s education, knowledge and expertise are acknowledged in a meaningful way. With the validation of a nurse’s expert knowledge of their patient the next step in the health care workplace is to be a valued member of a team and being trusted by them (Pattern 2). Another way a nurse feels like a professional is by advocating for the patient’s needs (Pattern 3). Often this is within a system where the power of the nurse is not as great as the power of the physician or hospital rules and regulations and the nurse must step out of their traditional role and speak-up in order to get what is necessary to keep their patient safe. Finally, the most important pattern seen across all of the interviews was that nurses felt like professionals when they gave value to the human-ness of a patient (Pattern 4) or when another person valued their human-ness and gave them respect.
CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

Meaning of Results

The meanings which emerged as the result of this study; i.e., the lived experience of nurses working with patients in a hospital environment as it relates to their professional identity are the following: Being validated as an expert by providers, often with more power, who value and trust the wisdom of the nurse; working well as a valued member of a team, i.e., trusting the other team members and being trusted by them; advocating for the patient’s needs within a system where the power of the nurse is not as great as the power of the physician or hospital rules and regulations; and valuing human-ness in the patient and in the nurses’ practice. These results describe the common understandings of the experience of a nurse working with patients and other health care providers in the hospital setting that emerged from the interpreted interviews of the participants and the discussions of the interpretive team in this study.

Most people become nurses because they want to help people (Eley, Eley, Bertello, & Rogers-Clark, 2012). This goal of wanting to help people profoundly defines how nurses view themselves and their work. For the nurses involved in this study, their work revolved around their patients and the human to human contact that they had with those patients and their significant others. All of the nurses interviewed started their interviews with stories about patients, not about themselves or the people that they worked with in the hospital. The interaction with patients and families made a profound impact on how the nurse recalled whether (a story) an interaction was successful or difficult.

The research also provided insight into the way that nurses practice. The results provided examples of how nurses spend time with their patients, families and co-workers in ways that
revealed the “invisible” work of bedside hospital nurses (Allen, 2015). There is a public perception of what a nurse does in the hospital setting based on media representations and personal experiences of former patients (Heilemann, 2012). What is typically thought of as “visible” nurse work includes assessing patients, caring for their basic needs and specific skills related to the performance of nursing tasks (Allen, 2015). “Invisible” nursing work is work not seen by patients, conducted behind closed doors, or work that is not seen as essential to the medical model of diagnosis and intervention, such as conversations with or time spent in the presence of patients and families. These typical glimpses of a nurse’s work are not a full picture of the work that a nurse does each shift and this research provided a better representation of what a professional nurse does every day.

Nurses are skilled health care providers (Andrews, Burrs & Bushy, 2011). Some nurses emphasize the psychomotor skills that they must have to practice as a nurse, for example: nasogastric tube insertion, catheter insertion, etc. (Aldridge, 2017). Interestingly, no nurses interviewed in this study spoke about any specific nursing skill that they used which made them feel more like a professional in their work. Most participants, instead, spoke about their assessment skills and ability to quickly discern a change in the patient’s condition. For acutely ill patients in the hospital setting, a nurse’s ability to accurately access a subtle change in their condition could mean the difference between life and death. Because these subtle changes, first noted by the nurse are then intervened upon by the entire team of providers caring for the patient, this early assessment work by the nurses may be acknowledged by other members of the provider team, but, is rarely noticed by the patient or acknowledged in a way that can be identified by hospital managers or administrators. Consequently, the “invisible” work or a “catch” by the nurse is seldom called out in a public or visible way that supports the practice of
the nurse and is never reimbursed in a monetary way that further supports the nurse’s practice (Allen, 2015).

Another type of “invisible” work done by the nurse is spending time building relationships with patients and families (Allen, 2015). Spending time with a patient and building a relationship of trust with the patient is frequently seen as a low priority activity in the hospital due to the acuity of patients’ illnesses and an emphasis by hospitals on “lean” staffing ratios (Mohammadipour, Atashzadeh-Shoorideh, Parvizy, & Hosseini, 2017). When nurses spend time with patients or do “out of scope” tasks to build trust with their patients, many times they are doing so as a professional activity instead of as a medical intervention (which can be reflected in a fee for service code). A simple example is when a nurse encourages a patient to share more about their life and story with the goal of giving the patient more holistic care. For example, Karron shares a story about a patient that she was caring for that had an estranged relationship with his son (l. 256-279). She encouraged him to reach out and reconnect with his son because she correctly assessed or “knew” that would improve his ability to recover. For some people, these relationships with patients may appear as a waste of a nurse’s time or professionally inappropriate but for many of the study participants, building relationships with patients and families gave them great professional satisfaction and were integral in how their developed their professional identity.

Advocating was another topic that came up in all of the interviews. Nurses frequently cite advocacy as an important responsibility that they have as nurses (Wade, 1999). Advocacy is defined as the nurse “voicing responsiveness” to promote patient autonomy, empowerment and safety (Vaartio, Leino-Kilpi, Salanterä, & Suominen, 2006, p.291). Although most health care professionals also cite advocacy as an important service that they provide for patients, nurses
spend more time at the bedside with patients than other providers. Being an advocate for a patient and/or family is a way that nurses can express autonomy in their practice (Wade, 1999).

Many of the nurses felt like professionals when their expert knowledge was valued in informal settings, e.g. conversations at the nurses’ station as well as in formal inter-collaborative team environments such as a care conference. Nurses hold a great deal of information about their patient. In fact, several participants shared that patients frequently told them information that they would not share with other health care providers, such as doctors because they were embarrassed or did not think it was important information to be shared. This speaks to the trust that patients have in nurses and is further validated by the fact that nurses are annually voted as the most trusted profession in nationwide polls (Gallup, 2017). It further suggests that information from nurses should be included by any health care team that is involved in decision making about the patient. Instead, what is frequently seen in the hospital setting is that nurses are not involved in team decisions or even present with other members of the team visit or round on the patient in the hospital (Lewin & Reeves, 2011). Nurses are frequently left out or perceived as an afterthought, in much of the hospital work (Tang, et al, 2013).

Power is a final idea needing discussion in relation to the work and workplace of a nurse. As previously explained in the introduction and literature review of this dissertation by the Standpoint theory, (Risjord, 2010), nurses fulfill a role that has less power than other health care providers in hospital settings and are oppressed in their role:

For centuries, physicians have dominated the practice of medicine. […] The sites of nursing care (hygiene, wound care, monitoring, regulation of medication, interaction with hospital systems, and so on) are all determined by the needs of the patient, given the prescribed treatment regime. Even as they have gained autonomy within the health care
system, nurses’ responsibilities have been harnessed to the physician’s treatment regimen. (Risjord, 2010, p.71-72)

Risjord postulates and this study confirms that because of this power imbalance, nurses work tirelessly to feel that they have some sort of power in their work place particularly in their work with patients. When other health care providers, such as physicians, involve nurses in the care planning for patients and value their expert knowledge, they give nurses validation that improves their professional identity. Many of the nurses in this study described their struggle to not want to have to be validated by another provider or even by a patient but, for them, it often represented the only way to feel validated. Being validated by another provider is not the only way to build professional identity but it is a phenomenon that can be seen in other professions. Power levels in health care are well-established and publically acknowledged as true (Tang, Chan, Zhou, & Liaw, 2013). These levels of power have been built through historical and cultural ideas of typically male physicians having more knowledge and power over the traditionally female nurse role. Power still continues to play a huge role in the hospital setting despite years of women empowerment and evolution of the workforce in the United States (Tang, Chan, Zhou, & Liaw, 2013). An example of this, mentioned in several interviews, was the fact that physicians are called “Doctor” while nurses go by their first name and some physician do not allow nurses to use the physician’s r first name in conversation (Pijl-Zieber, 2013). These large power differentials do not foster a healthy workforce or work environment. It has also been shown that these power differentials can lead to unsafe conditions for patients, due to poor communication between health care providers (Tang, Chan, Zhou, & Liaw, 2013). It was seen in participant interviews that nurses interviewed who were able to effectively collaborate with their physician partners, used the nurse’s “expert power” and knowledge of the patient to add to the patient plan
of care as well as using their name in communication felt that they could freely communication about the patient’s needs (Lewin & Reeves, 2011) and these experiences were examples of times when the nurses feel like a professional.

**Implications for Nursing Practice**

According to Kanter’s (1977) theory of workplace structural power and Laschinger’s work with workplace empowerment (Laschinger, Sabiston, & Kutszcher, 1997), nurses who perceived themselves as empowered in their workplace have the potential to effect change and improve patient outcomes. These findings are supported by the results of this study that nurses felt professional when they could make effective change in teams and improve patient outcomes through advocacy.

An estimated 30% of nurses leave their jobs within the first year of employment and 27% of nurse’s report being bullied in the last six months, the majority identifying that the bullying was from managers, directors or charge nurses (Johnson & Rea, 2009). Nurses who report feeling empowered in their workplace function more effectively (Andrews, Burr & Bushy, 2011). The results of this research support the ideas that nurses feel professional when their practice focuses on their expert knowledge and assessment, on working well in teams, on advocating for patients and spending time building relationships with patients and families. It also suggests better patient outcomes occur when hospital administrators and managers support nursing practice in their continuing education and encourage nurses to spend time with patients, families and co-workers.

Another implication for nursing practice revealed by the research results was time spent building a relationship with a patient, also referred to as nursing presence (Mohammadipour, Atashzadeh-Shoorideh, Parvizy, & Hosseini, 2017). The Hospital Consumer Assessment of
Healthcare Providers and Systems (HCAHPS) is a survey of patient’s experience with their hospital care. In this document, patients are surveyed about their communication with doctors and nurses, responsiveness of hospital staff as well as other questions related to the hospital environment (CMS, 2017). Hospital which do not report quality in these areas have their financial reimbursement reduced (CMS, 2017). This is an area that nurses could positively impact by building relationships with patients and families, ultimately influencing how patients report their perception of communication and responsiveness. Nurses who spend time building relationships with patients could impact a patient’s HCAHPS score through time spent at the bedside. Nursing presence needs to be reconsidered as a formal nursing skills that nurses bring to their practice instead of “wasted” time.

**Implications for Nursing Education**

One implication for nursing education, based on these research findings is that nurses would benefit from education about communication skills for building relationship with co-workers as well as with their patients and families. The American Association of Colleges of Nursing states in the, “The Essentials of Baccalaureate Education for Professional Nursing Practice” (2008) in the sixth essential: “Inter-professional Communication and Collaboration for Improving Patient Health Outcomes,” This essential for undergraduate education mandates that a new graduate nurse should be able to effectively communicate and collaborate with other health care professionals. This skill, according to the essentials document, is absolutely necessary for safe patient care. However, these communication skills are typically seen as lower level priorities than psychomotor clinical skills by nurses (Ray & Overman, 2014) in nursing education. These improved communication skills could have the ability to increase a nurse’s professional identity and ultimately provide safer patient care.
Another implication for nursing education that would increase a nurse’s professional identity would be inter-professional and team education. Inter-professional education has recently become a component in many nursing programs but is not a requirement in all programs and for many nursing programs there are no other health care providers available on their campuses to be involved in inter-professional education (Wong, Wong, Chan, Chan, Ganotice, & Ho, 2017). Providing inter-professional education for student nurses allows them to practice communicating in group situations and practice advocating for patients in difficult situations before entering practice.

As previously described, being viewed as a professional by others strengthens one’s professional identity (Johnson, Cowin, Wilson & Young, 2012). In order to develop professional identity even before formally entering the nursing profession nurses need to have additional opportunities to be involved in the health care environment through inter-professional team training and by building relationships with other health care providers who are not nurses. By being involved in inter-professional training, student nurses and practicing nurses can practice the skills necessary to develop a stronger sense of professional identity and working relationships in order to benefit patients. (Adams, Hean, Sturgis, & MacLeod-Clark, 2006).

**Implications for Policy**

For the patterns of *Being validated as an expert by providers, often with more power, who value and trust the wisdom of the nurse and Advocating for the patient’s needs within a system where the power of the nurse is not as great as the power of the physician or hospital rules and regulations;* power was a significant component of how the pattern “showed it-self” to the analysis team. Therefore, there are implications for policy related to power in the health care system and hospital environments. First, in order to capture a nurse’s expert patient knowledge
and involve nurses in more inter-professional teams with nurses need to be included in more hospital shared governance committees and decision-making positions. Barriers also need to be removed in order to include nurses to participate more fully in these kinds of activities, such as having meetings during non-work hours or allowing nurses to attend from home through phone or other computer modalities. The only way that the power differentials in health care can be eliminated is by allowing nurses to have a voice and a vote in how health care is administered in the hospital setting.

Another implication for policy related to these research is the protection of staffing ratios in order to allow nurses to spent time with their patient, families and co-workers in collaboration. Nurses reported that they felt professional, when they had time to talk and build relationships with patients and in inter-professional teams. This cannot occur when a nurse has a large patient load. In fact, some studies have shown an increase in patient mortality with high patient to nurse ratios (Shekelle, 2013). Nurses who work in hospitals with high nurse-to-patient ratios and peer-assessed national recognition programs such as Magnet status experience have better patient outcomes, including improvement in 30-day mortality rates (Silber, et al., 2016).

Implications for Future Research

Based on the methodology and results of this research study, new questions were generated from the results. This study focused on nurses that provided direct patient care to patients in the hospital setting. It would be interesting to focus on more specific nursing groups, such as male nurses or nurses of different ethnicities and compare their experiences with the experiences of these nurse participants. In addition, not all nurses in the United States practice in a hospital setting. Interviewing nurses from different outpatient and academic practice settings about the ways in which they feel professional would also provide insight into how these nurses
practice as professionals. In the same way, it would be interesting to study student nurses and how they believe they are developing their professional identity through their education.

Finally, one topic that was raised by many of the participants but did not develop into a pattern or theme because it was unrelated to the research question was how difficult patient scenarios impacted their (the nurses’) professional identity. Several of the participants mentioned working with patients who had mental health diagnoses including addiction that required inpatient hospitalization. Many of the nurses struggled with these patients because they did not have a straight-forward hospital trajectory focused on cure which made their cases difficult due to the uncertainty of a positive or obvious outcome. This was a struggle for these nurses and led to many questions for the interpretive team about how nurses view their role as effective hospital nurses and the implications related to chronicity, holistic health and high-level wellness. These questions generate implications for future research.

**Conclusion**

It was this researcher’s hope that by sharing the experiences of nurses, these narratives will encourage nurses toward more professional nursing practice and aid to liberate nurses from their historical structural oppression in the hospital setting. The results of the study can help nurses and the consumers of health care to better perceive and understand the experience of professional nurses who practice with patients in the hospital setting. The nurses included in this study provided examples of the hard work that nurses take on in every shift to expertly assess, communicate with and advocate their patients in order to bring them back to wholeness. These nurses do this in an environment fraught with poor communication, power differentials and oppression but continue to strive “inch by inch” toward the “impossible” for their patients.
**Karron:** “I really love that part of the professionalism of nursing. And, um, be able to, like I said before, incrementally inch by inch walk them through what we were looking at on a daily basis as progress” (l.112-114) and that nursing is, “Directing them to the right resource. You are not the answer. You are not the total answer.” (l.155-156)

**CJM:** So you’re finding this balance, balance, balance all the time. And nurses – I – I love nursing and love nurses because they’re trying to do something that’s impossible. (l. 719-721)
REFERENCES


Grady, A.B. Hamric, & N. Berlinger (Eds.), Nurses at the table: Nursing, ethics, and health policy. (pp. S43-S47). John Wiley and Sons.


with qualitative data. *Qualitative Health Research, 18*(1), 120-132. doi: 10.1177/1049732307310264


APPENDIX

Appendix A

Definition of Terms

**Horizontal/lateral violence:** harmful or distressing behavior of one worker to another who is of equal status within the hierarchy (Purpora, Blegen, & Stotts, 2012).

**Holistic Model of Care:** examines all aspects of patient to determine what a patient needs to order to treat the whole person (Dossey & Keegan, 2013).

**Medical Model of Care:** care provided to patient based solely on their physiological symptoms and treatment (Dossey & Keegan, 2013).

**Oppression:** unfair, unjust, cruel governance or use of power; to denote a feeling of burden, mental distress; and/or a pressing down of one’s spirit (Dong & Temple, 2011).

**Power:** the ability to act in a particular way; the ability to direct the behavior of another; physical strength and/or the energy that is produced in mechanical or electrical devices (Stevenson, 2010).

**Professional Identity:** the perception of self in relationship to the work that one does (Adams, Hean, Sturgis, and MacLeod-Clark, 2006).

**Structural empowerment:** formal and informal power structures of the workplace. The structure of opportunity, the structure of power, and the structure of proportions (Laschinger, Sabiston, & Kutscher, 1997). The structure of opportunity refers to a person’s ability to grow in responsibility within his or her work; the structure of power is access to information, support and resources; and the structure of proportions refers to equal standing of those in the same position.
in the workplace. Empowered workers have availability and access to all three structures, equally.

**Vertical violence:** harmful or distressing behavior of one worker to another who is of a higher status within the hierarchy (Purpora, Blegen, & Stotts, 2012).
## Appendix B

### CONDITIONS FOR WORK EFFECTIVENESS QUESTIONNAIRE-I

#### How much of each kind of opportunity do you have in your present job?

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<td>3. Access to training programs for learning new things</td>
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<td>4. The chance to learn how the hospital works</td>
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<td>5. Tasks that use all of your own skills and knowledge</td>
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<td>6. The chance to advance to better jobs</td>
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<td>7. The chances to assume different roles not related to current job</td>
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#### How much access to Information do you have in your present job?

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<tr>
<td>1. The current state of the hospital</td>
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<td>2. The relationship of the work of your unit to the hospital</td>
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<tr>
<td>3. How other people in positions like yours do their work</td>
<td>1</td>
<td>2</td>
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<tr>
<td>4. The values of top management</td>
<td>1</td>
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</tr>
<tr>
<td>5. The goals of top management</td>
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<tr>
<td>6. This year’s plan for your work unit</td>
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<tr>
<td>7. How salary decisions are made for people in positions like yours</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>8. What other departments think of your unit</td>
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#### How much access to support do you have in your present job?

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<td>2. Specific comments about things you could improve</td>
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</tr>
<tr>
<td>3. Helpful hints or problem solving advice</td>
<td>1</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Information or suggestions about job possibilities</td>
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<td>3</td>
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</tr>
<tr>
<td>5. Discussion of further training or education</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>6. Help when there is a work crisis</td>
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<td>4</td>
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<tr>
<td>7. Help in gaining access to people who can get the job done</td>
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<td>8. Help in getting materials and supplies needed to get the job done</td>
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<td>9. Rewards and recognition for a job well done</td>
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#### How much access to resources do you have in your present job?

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<td>2. Time available to do necessary paperwork</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Time available to accomplish job requirements</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Acquiring temporary help when needed</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>5. Influencing decisions about obtaining human resources (permanent) for your unit</td>
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<tr>
<td>6. Influencing decisions about obtaining supplies for your unit</td>
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<tr>
<td>7. Influencing decisions about obtaining equipment for your unit</td>
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### In my work setting/job: (JAS)

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<td>1.</td>
<td>the amount of variety in tasks associated with my job is</td>
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<td>2.</td>
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<td>3.</td>
<td>the rewards for innovation on the job are</td>
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<td>4.</td>
<td>the amount of flexibility in my job is</td>
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<tr>
<td>5.</td>
<td>the number of approvals needed for nonroutine decisions are</td>
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<td>6.</td>
<td>the relation of tasks in my job to current problem areas of the organization is</td>
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<td>7.</td>
<td>my amount of participation in educational programs is</td>
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<td>8.</td>
<td>my amount of participation in problem solving task forces is</td>
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<td>9.</td>
<td>the amount of visibility of my work-related activities within the institution is</td>
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### How much opportunity do you have for these activities in your present job: (ORS)

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<th>5 = A Lot</th>
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<td>1.</td>
<td>Collaborating on patient care with physicians</td>
<td>1</td>
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<tr>
<td>2.</td>
<td>Receiving helpful feedback from physicians</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Being sought out by physicians for patient information</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>4.</td>
<td>Receiving recognition by physicians</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>5.</td>
<td>Having physicians ask for your opinion</td>
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<tr>
<td>6.</td>
<td>Being sought out by supervisor for ideas about ward management issues</td>
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<td>2</td>
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<td>7.</td>
<td>Having Immediate supervisor ask for your opinion</td>
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<td>2</td>
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<td>4</td>
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<td>8.</td>
<td>Receiving early Information of upcoming changes in work unit from your Immediate supervisor</td>
<td>1</td>
<td>2</td>
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<tr>
<td>9.</td>
<td>chances to increase your Influence outside your unit e.g., nomination to influential committees by supervisor</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>10.</td>
<td>Seeking out ideas from auxiliary workers on the unit, e.g., secretaries, ward clerks, housekeeping</td>
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<td>11.</td>
<td>Getting to know auxiliary workers as people</td>
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<tr>
<td>12.</td>
<td>Seeking out ideas from auxiliary workers outside of the unit, e.g., admission clerks, technicians</td>
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<td>13.</td>
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<td>14.</td>
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<td>15.</td>
<td>Having peers ask your opinion on patient care issues</td>
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<td>Being sought out by peers for help with problems</td>
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<td>Exchanging favours with peers</td>
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<td>18.</td>
<td>Seeking out ideas from professionals other than physicians, e.g., physiotherapists, occupational therapists, dieticians</td>
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**CONDITIONS FOR WORK EFFECTIVENESS QUESTIONNAIRE-II**

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<tr>
<td>2. The chance to gain new skills and knowledge on the job</td>
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<td>3. Tasks that use all of your own skills and knowledge</td>
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<td>2. The values of top management</td>
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<td>3. The goals of top management</td>
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<tr>
<td>1. Specific information about things you do well</td>
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<tr>
<td>2. Specific comments about things you could improve</td>
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### How much access to resources do you have in your present job?

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<td>1. Time available to do necessary paperwork</td>
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<tr>
<td>3. Acquiring temporary help when needed</td>
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In my work setting/job: 

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<td>2. the amount of flexibility in my job is</td>
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<td>3. the amount of visibility of my work-related activities within the institution is</td>
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**How much opportunity do you have for these activities in your present job:** (ORS)

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<tr>
<th>1 = None</th>
<th>2</th>
<th>3 = Some</th>
<th>4</th>
<th>5 = A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaborating on patient care with physicians</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Being sought out by peers for help with problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Being sought out by managers for help with problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Seeking out ideas from professionals other than physicians, e.g., physiotherapists, occupational therapists, dieticians</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
# GLOBAL EMPOWERMENT

**How much of each kind of opportunity do you have in your present job?**

<table>
<thead>
<tr>
<th>1 = Strongly Disagree</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, my current work environment empowers me to accomplish my work in an effective manner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Overall, I consider my workplace to be an empowering environment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
### Appendix D

**Negative Acts Questionnaire (NAQ-R) items**
*(Einarsen, Hoel, & Notelaers, 2009)*

<table>
<thead>
<tr>
<th>Factor</th>
<th>NAQ-R item</th>
<th>Item wording</th>
<th>Factor loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work-related bullying</td>
<td>1</td>
<td>Someone withholding information which affects your performance</td>
<td>.71</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Being ordered to do work below your level of competence</td>
<td>.77</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Having your opinions ignored</td>
<td>.88</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>Being given tasks with unreasonable deadlines</td>
<td>.85</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Excessive monitoring of your work</td>
<td>.82</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Pressure not to claim something to which by right you are entitled (e.g. sick leave, holiday entitlement, travel expenses)</td>
<td>.77</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Being exposed to an unmanageable workload</td>
<td>.81</td>
</tr>
<tr>
<td>Person-related bullying</td>
<td>2</td>
<td>Being humiliated or ridiculed in connection with your work</td>
<td>.86</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks</td>
<td>.86</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Spreading of gossip and rumours about you</td>
<td>.84</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Being ignored or excluded</td>
<td>.83</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Having insulting or offensive remarks made about your person, attitudes or your private life</td>
<td>.87</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Hints or signals from others that you should quit your job</td>
<td>.93</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Repeated reminders of your errors or mistakes</td>
<td>.90</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Being ignored or facing a hostile reaction when you approach</td>
<td>.88</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Persistent criticism of your errors or mistakes</td>
<td>.95</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Practical jokes carried out by people you don't get along with</td>
<td>.85</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>Having allegations made against you</td>
<td>.92</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Being the subject of excessive teasing and sarcasm</td>
<td>.94</td>
</tr>
<tr>
<td>Physically intimidating bullying</td>
<td>8</td>
<td>Being shouted at or being the target of spontaneous anger</td>
<td>.88</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Intimidating behaviours such as finger-pointing, invasion of personal space, shoving, blocking your way</td>
<td>.86</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>Threats of violence or physical abuse or actual abuse</td>
<td>.83</td>
</tr>
</tbody>
</table>
Appendix E

Nurses Workplace Scale (NWS) DeMarco & Roberts (2004)

**Directions**

Please read the following statements representing possible behaviors, feelings, or beliefs as they apply at work. Indicate how frequently these statements apply to you by circling the numbers 1 to 5 using this scale:

1. Never
2. Rarely
3. Sometimes
4. Frequently
5. Always

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Said &quot;it's really hard to work with a bunch of women&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Believed that it is impossible, or at least very difficult for women to reach a consensus</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Said or felt that most of your friends were men… or you just can't trust women</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Said you always prefer a male boss over a female one?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Believed that men have more natural leadership ability than women</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Prefaced statements with phrases such as &quot;I know this is a really stupid question&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Found it difficult to accept compliments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Felt or said that you were &quot;unworthy&quot; of an honor or reward</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Constantly compared yourself with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Changed your story according to the professional audience</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Complained about a problem to your fellow workers but did nothing to confront the person you believe is causing the problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Found yourself more frequently making comments (either positive or negative ones) about other nurses rather than to the other nurses that were the focus of your comments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Appendix F
Overall, how satisfied are you with your current position?

- Highly Satisfied
- Generally Satisfied
- Generally Dissatisfied
- Highly Dissatisfied

How likely are you to recommend your current employment setting to your nurse colleagues as a desirable place to work?

- Highly Likely
- Somewhat Likely
- Somewhat Unlikely
- Highly Unlikely

Knowing what you know now, if you had to decide all over again whether to take the job you have now, what would you decide?

- Would definitely take the same job
- Would probably take the same job
- Would probably NOT take the same job
- Would definitely NOT take the same job

To what extent are you fairly rewarded considering the responsibilities you have?

- Not at all
- To a slight extent
- To some extent
- To a considerable extent
- To a very great extent

Information from report/article about Nurse Job Satisfaction Scale:

Instruments: SATISFACTION LEVELS

Job satisfaction was measured by the summed score of four key questions: 1) How likely are you to recommend your current employment setting to a colleague as a
desirable place to work? 2). Knowing what you know now, how likely are to take this same job again? 3). To what extent are you fairly rewarded considering the responsibilities you have? 4). Overall, how satisfied are you with your current position? Each response was a four-point scale. Higher scores mean higher job satisfaction. The sum score ranged from 4-17 (M = 11.97, SD = 2.8). Alpha reliability was 0.854. Factor analysis supported the items measured a single component.

Nurses Professional Values Scale-R ©

Indicate the importance of the following value statements relative to nursing practice. Please circle the degree of importance.

(A = not important to E = most important) for each statement.

<table>
<thead>
<tr>
<th></th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Important</th>
<th>Very Important</th>
<th>Most Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>1. Engage in on-going self-evaluation.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>2. Request consultation/collaboration when unable to meet patient needs.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>3. Protect health and safety of the public.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>4. Participate in public policy decisions affecting distribution of resources.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>5. Participate in peer review.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>7. Promote and maintain standards where planned learning activities for students take place.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>8. Initiate actions to improve environments of practice.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>9. Seek additional education to update knowledge and skills.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>10. Advance the profession through active involvement in health related activities.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>11. Recognize role of professional nursing associations in shaping health care policy.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>12. Promote equitable access to nursing and health care.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>13. Assume responsibility for meeting health needs of the culturally diverse population.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>15. Maintain competency in area of practice.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>16. Protect moral and legal rights of patients.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>17. Refuse to participate in care if in ethical opposition to own professional values.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
</tbody>
</table>
Nurses Professional Value Scale, ©

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<th>Very Important</th>
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<td>A</td>
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<td>B</td>
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<td>D</td>
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<td>E</td>
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</table>

18. Act as a patient advocate.  
19. Participate in nursing research and/or implement research findings appropriate to practice.  
20. Provide care without prejudice to patients of varying lifestyles.  
21. Safeguard patient's right to privacy.  
22. Confront practitioners with questionable or inappropriate practice.  
23. Protect rights of participants in research.  
24. Practice guided by principles of fidelity and respect for person.  
25. Maintain confidentiality of patient.  
26. Participate in activities of professional nursing associations.

**Please feel free to make comments:**
Appendix H
Recruitment Advertisement

This advertisement will be associated with WSU, College of Nursing Facebook page.

Are you a registered nurse who works with patients in the hospital? Are you proud of the work that you do as a health care professional? Would you like to contribute to nursing research?

If you answered YES to the questions above, then you could be eligible to participate in a nursing research study.

Tullamora Diede, MN, RN-BC, CNL is a PhD student at Washington State University and is interested in the professional work of nurses who work with patients in the hospital.

If you chose to participate, you will be asked to take part in an one-on-one interview for about one hour. Information from the interview will be confidential. If you are interested in participating, please contact Tullamora Diede at 509-863-5986 or tullamora.diede@wsu.edu
Appendix I
WASHINGTON STATE UNIVERSITY
College of Nursing

Research Study Consent Form

Study Title: Professional Identity in the Lived Experience of Hospital Nurses

Researchers:

Principal Investigator: Dr. Billie Severtsen, Associate Professor, College of Nursing, Washington State University, 509-324-7286

Co-Principal Investigator: Tullamora Diede, Doctoral Student, College of Nursing, Washington State University, 509-863-5986

You are being asked to take part in a research study carried out by Dr. Billie Severtsen and Tullamora Diede. This form explains the research study and your part in it if you decide to join the study. Please read the form carefully, taking as much time as you need. Ask the researcher to explain anything you don’t understand. You can decide not to join the study. If you join the study, you can change your mind later or quit at any time. There will be no penalty or loss of services or benefits if you decide to not take part in the study or quit later. This study has been approved for human subject participation by the Washington State University Institutional Review Board.

What is this study about?

This research study is being done to explore the lived experience of nurses working with patients in hospitals and, with that information, identify meaningful themes of how their workplace environment impacts their sense of professional identity.

You are being asked to take part because you are a nurse who works in the hospital in direct patient care.

Taking part in the study will take about 60-90 minutes.

You cannot take part in this study if you are not a Registered Nurse in Washington State, do not provide care to patients in the hospital setting, do not speak fluent English, and/or are unwilling to be digitally voice-recorded.

What will I be asked to do if I am in this study?

If you take part in the study, you will be asked to share your experience as a registered nurse providing patient care in a hospital setting. The opening question for the interview will be, “Is there a particular experience that stand out in your mind as a nurse working with patients that made you feel like a professional?” Subsequent question related to your work as a nurse will follow during the interview process. You can choose to refuse to answer any question(s) at any
point during the interview. At the end of the interview you will be asked demographic questions. The interview will be digitally recorded throughout the interview. Before the interview begins, you will be asked to give yourself a pseudonym or “fake” name to disguise your identity. Recorded interviews will be stored on a secured computer and transcribed. After transcription, audio recordings will be destroyed to further protect your identity. Results from the study will be available to study participants at their request at the completion of the research study.

**Are there any benefits to me if I am in this study?**

The potential benefits to you for taking part in this study are: an increased awareness of your professional identity in your nursing practice by sharing these experiences. It is the hope that this research will better describe the valuable work of nurses and subsequently improve the public’s perception of professional nursing.

**Are there any risks to me if I am in this study?**

The potential risks from taking part in this study are the mild emotional and/or psychological impact to your health. Some may find that retelling stories or experiences, such as traumas, difficult situations, and/or abuses, may be upsetting. If this occurs during the interview, a list of support services will be available for study participants.

If, during the interview, you disclose feelings of wanting to hurt yourself, others or abuse, then the researcher(s) must report this to the appropriate state and local authorities.

**Will my information be kept private?**

The data for this study will be kept confidential to the extent allowed by federal and state law. No published results will identify you, and your name will not be associated with the findings. Under certain circumstances, information that identifies you may be released for internal and external reviews of this project.

Before the interview begins, you will be asked to create a pseudonym or “fake” name for yourself, in order to protect your identity. Interviews will be voice, digitally recorded and transcribed. Any identifiable information will be not included in the written transcript. Recordings and transcriptions will be kept on a password protected, secure website used by the Washington State University, College of Nursing. Only the researchers, analysis team, and transcriptionist will have access to the transcripts. Analysis team members and transcriptionists involved in the study will also sign confidentiality agreements.

The results of this study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous.

The data for this study will be kept for 3 years.

**Are there any costs or payments for being in this study?**
There will be no costs to you for taking part in this study.

You will receive a $25 Amazon gift card for taking part in this study. If you chose to receive payment for taking part in this study, you may be asked to provide your home address or social security number.

Who can I talk to if I have questions?

If you have questions about this study or the information in this form, please contact the researcher: Dr. Billie Severtsen, SNRS 222B, P.O. Box 1495, Spokane, WA, 99210, 509-324-7286, severt@wsu.edu; Tullamora Diede, SNRS 235, P.O. Box 1495, Spokane, WA 99210, 509-863-5986, tullamora.diede@wsu.edu. If you have questions about your rights as a research participant, or would like to report a concern or complaint about this study, please contact the Washington State University Institutional Review Board at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Albrook 205, PO Box 643005, Pullman, WA 99164-3005.

What are my rights as a research study volunteer?

Your participation in this research study is completely voluntary. You may choose not to be a part of this study. There will be no penalty to you if you choose not to take part. You may choose not to answer specific questions or to stop participating at any time.

What does my signature on this consent form mean?

Your signature on this form means that:
- You understand the information given to you in this form
- You have been able to ask the researcher questions and state any concerns
- The researcher has responded to your questions and concerns
- You believe you understand the research study and the potential benefits and risks that are involved.

Statement of Consent

I give my voluntary consent to take part in this study. I will be given a copy of this consent document for my records.

__________________________________  ___________________
Signature of Participant  Date

__________________________________
Printed Name of Participant

Statement of Person Obtaining Informed Consent
I have carefully explained to the person taking part in the study what he or she can expect.

I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of participation.

I also certify that he or she:

- ☐ Speaks the language used to explain this research
- ☐ Reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her
- ☐ Does not have any problems that could make it hard to understand what it means to take part in this research.

__________________________________________  _______________________
Signature of Person Obtaining Consent   Date

__________________________________________  _______________________
Printed Name of Person Obtaining Consent   Role in the Research Study
Appendix J

Interview Questions

Attachment – Interview Questions September 8, 2016

WSU Exempt IRB Application PI: Severtsen

Philosophical hermeneutics methodology is based primarily in interview and interpretation. Study participants are interviewed in an open fashion with one main question to begin the interview in order to engage the interviewee in a dialogue and increase participation in the interview. The style of the interview should be open and reflexive, utilizing the interviewer as an instrument of the hermeneutic method. (Vandermause, 2008).

The interview will begin with the main opening question, “Is there a particular experience that stands out in your mind as a nurse working with patients that made you feel like a professional?”

Interviews begin with one open ended questions that focuses on the research question and experience of the participant. Other questions used in the interview include “What was that like?” and “Can you give me an example?” to further expand on the participant’s experience and return the participant to their story (Holliday & Vandermause, 2015). Another important aspect of the interview is listening. Listening attentively and remaining silent while moving the interview forward is a special skill with this methodology (Vandermause & Fleming, 2011).

Demographic question will be asked the end of the interview:
1. What is your current age?
2. What do you identify as your gender?
3. How many years have you been a registered nurse?
4. What is your highest level of education?

References


Introductory Script

1. **Explanation of Study:** I am a registered nurse currently in school to obtain my PhD. This study is being conducted for my doctoral dissertation. I am interested in the experience of nursing working with patients in the hospital and what they do in their daily work that makes them feel like a profession. The results of this study will be reported through a written manuscript and may be publish or presented at conferences. No information about your identity will be disclosed through the sharing of the study results. You may choose to not answer certain questions that are asked during the interview and you may stop the interview at any time. Have you had a chance to read over the consent forms? Do you have any questions or concerns at this time?

2. **Reminder of Disclosure:** This interview will be remain confidential and any information made public from the interview such as publications and presentations will contain your pseudonym. However, if during the interview you share information that you are being harmed, considering harming yourself or are harming others, I will be required to report this information to the proper authorities. In addition, if you have a medical problem during the interview, you will be referred to an appropriate medical care provider.

3. **Pseudonym:** Before the interview begins, you will be asked to assign yourself a pseudonym or “fake” name in order to protect your identity. The only place your legal name will be documented will be on the consent form.

4. **Reminder of Audio Recording:** This interview will be audio recorded. Do you consent to audio recording?

5. **Explanation of Interview Style:** Because of the style of research that I am using, the interview will open with one board question about your experience. There may be additional questions but there is not a list of questions that I have prepared to ask you. There may be moments of silence during the interview but the purpose of this interview is for you to share your experience in your own words.

6. **Consent Form Signatures:** Do you have any additional questions before you sign the consent form? If you are comfortable, please sign the consent form at this time.
Appendix K

Participant Demographics

Katie is a registered nurse with 10 years of nursing experience. Katie identifies as female and is 33 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working as a resource nursing on the day shift at her hospital.

Kelton is a registered nurse with 10 years of nursing experience. Kelton identifies as female and is 33 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working as a float nurse on day shift at her hospital.

Beth is a registered nurse with 11 years of nursing experience. Beth identifies as female and is 40 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working in an Intensive Care Unit on day shift at her hospital.

Alex is a registered nurse with seven years of nursing experience. Alex identifies as male and is 31 years old. His highest degree is a Bachelor’s of Science in Nursing. He is currently working in an Intensive Care Unit on night shift at his hospital.

Clara is a registered nurse with nine years of nursing experience. Clara identifies as female and is 37 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working on a Progressive Care Unit on night shift at her hospital.

Whitney is a registered nurse with one year of nursing experience. Whitney identifies as female and is 24 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working on an oncology unit on night shift at her hospital.

Kelton is a registered nurse with eight years of nursing experience. Kelton identifies as female and is 53 years old. Her highest degree is an Associate’s degree in Nursing. She is currently working on a Labor and Delivery unit on day shift at her hospital.
Mary is a registered nurse with eight years of nursing experience. Mary identifies as female and is 31 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working on a medical unit on night shift at her hospital.

Sarah is a registered nurse with seven years of nursing experience. Sarah identifies as female and is 30 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working on a medical unit on day shift at her hospital.

Karron is a registered nurse with 41 years of nursing experience. Karron identifies as female and is 69 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working in post-op recovery though most of her background is in cardiac care. She works day shift at her hospital.

Moses is a registered nurse with three years of nursing experience. Moses identifies as male and is 31 years old. His highest degree is a Bachelor’s of Science in Nursing. He is currently working on a nephrology unit on evening shift at his hospital.

CJM is a registered nurse with 23 years of nursing experience. CJM identifies as female and is 66 years old. Her highest degree is a Bachelor’s of Science in Nursing. She is currently working on a rehabilitation unit on evening shift at her hospital.
### Appendix L

#### Table of Patterns and Themes

<table>
<thead>
<tr>
<th>Common Understandings</th>
<th>Themes</th>
<th>Pattern (gerunds)</th>
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<td>Nurses feel like professionals when they use their skills such as assessment, medication interventions and procedural skills in an appropriate and effective manner. This professionalism becomes magnified when validated by other nurses, co-workers such as physicians and patients/family members.</td>
<td>Exceptional assessment skills, quickly identify subtle changes and life-threatening situations, seeking out information like a “detective” about a patient, knowing what to do before being prompted or an order to do so.</td>
<td>Being validated as an expert. – by providers with often more power, who value and trust the wisdom of the nurse.</td>
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<td>When sharing stories of when they felt like a professional, participants shared stories when they worked collaboratively within a team of nurses or as the nurse member of an interdisciplinary team. This idea of working within a team is different than just being in a team but being an active member of a team whose presence is valued, appreciated and acknowledged by members of that team.</td>
<td>Nurses worked well in Code scenarios, emergency situations. “Coming alongside” physicians in partnership Nurses also reported positive teams of co-workers on their nursing unit and support from their managers.</td>
<td>Working well as a valued member of a team – trusting the other team members and being trusted by them</td>
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<td>Nurses spoke about “working around” the provider to get what you need for your patient. This is can also be referred to as advocacy. The nurse identified a patient concern or a patient care need and advocated for the patient with the physician until a</td>
<td>Advocating for the patient in the face of direct opposition, advocating outside of their scope of practice. Speaking-up to get what they felt the patient needed</td>
<td>Advocating for the patient’s needs within a system where the power of the nurse is not as great as the power of the physician or hospital rules and regulations.</td>
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solution was found, the patient was transferred to another unit or the patient passed away. Working around also contains the element of negotiating with people whose power is greater than the power that the nurse has.

| Nurses shared that when they felt the most professional was when they formed human relationships with patients, families and co-workers. There is a commitment to the patient and their family that every nurse takes on every shift, for some nurses that can mean simply providing good daily care but for others it can mean forming deep connections with patients and families but every professional nurse is committed. | Formed special relationships with, remembered great details of their case and in many stories nurses chose to help the patient in relational ways, “out of the scope” or responsibilities of a nurse, invisible work. | Valuing human-ness in the patient and in your practice. |