EXPERIENCE OF REGISTERED NURSES WHO VOLUNTARILY WITHDRAW FROM THEIR BSN PROGRAM

By
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To the Faculty of Washington State University:

The members of the Committee appointed to examine the dissertation of SAMANTHA A. GIRARD find it satisfactory and recommend that it be accepted.

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EXPERIENCES OF REGISTERED NURSES WHO VOLUNTARILY WITHDRAW FROM THEIR BSN PROGRAM

Abstract

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The need for a more highly educated nurse workforce has never been more evident as researchers are beginning to examine the effect of higher levels of nursing education and skill mix on nurse-specific indicators of patient care. National organizations along with preeminent nurse scholars agree that increasing the number of baccalaureate-prepared registered nurses is critical, at this time more so than ever before. This increase is due to the challenging and complex health care environments in which nurses function and the evolving and dynamic nature of the United States Health Care System. Despite the numerous interventions aimed at reducing attrition and increasing retention in nursing programs, graduation rates have remained virtually unchanged. There is a gap in the literature on attrition decisions and experiences of registered nurses, who voluntarily withdraw from RN-BSN programs prior to completion. Embedded in the significance of this study are the critical needs to understand the experiences of RN-BSN student non-completers, examine influences on RN-BSN students’ decisions to voluntarily withdraw from nursing school, and understand the interplay among such influences so that barriers to degree completion may be eliminated. A Heideggerian hermeneutic approach was used to interpret the meaning of the experiences of RNs, who prematurely withdraw from their BSN programs. Two overarching patterns of understanding emerged: Withdrawing as Revisiting Failure and Withdrawing as Impasse: On One Side of the Divide.
The factors that influence whether or not a nurse finishes a BSN program are many, but the effect on dignity and well-being are immeasurable. Place-bound and stuck, these incompletions affect not only the nurse but also the profession, leaving a deficit. Understanding the meaning of withdrawing from a RN-BSN program is the first step toward interpreting extant data in the context of experience and is expected to guide improvements in nursing education, research, and practice.
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Dedication

You give voice to those who cannot speak,

Stand up for those who cannot, and bear

Witness to life’s deepest and most profound moments.

Those who Nurse!
CHAPTER ONE
INTRODUCTION

The Nursing Workforce Shortage: Supply and Demand

The nursing shortage is a complex multidimensional problem. This problem has led to the critical analysis of factors affecting the supply and demand for highly skilled nurses and an examination of factors that impede registered nursing students from persisting to graduation and entering the profession. Estimates from the Bureau of Labor Statistics project that by the year 2020 there will be approximately one million vacant registered nurse (RN) positions in the United States. The shortage is partly due to an aging RN population, decreased nursing program enrollments, shortages in the number of nursing faculty, and the overreliance on international and temporary nurse travelers (Buerhaus, Staiger, & Auerbach, 2000; Goodin, 2003). A more recent study of nurse workforce trends indicates the nursing shortage has abated to some degree. However, the trend is considered temporary because over two-thirds of the RNs entering or re-entering the profession between 2000-2003 were either 35-49 years-old or foreign-born (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005; HRSA, 2010).

The nursing shortage has reached global proportions not only because foreign-born nurses are migrating from their home country to fill gaps in the United States and Western European countries where pay and working conditions are better, but also because nursing is “not attractive to the youngest people with potential,” leading fewer to pursue nursing as a profession (International Organization for Migration, 2010, p327; Buerhaus, et al. 2000a). Nurse shortages are reported in Canada (a shortfall of over 78,000 by 2015), in Australia (over 90,000 short by 2025) (Buchan, May, & Dussault, 2013), in India (over 2.4 million short currently) (World Health Organization, 2010), in China (about 350,000) (Wang et al., 2013) and in the
Philippines which is the largest global exporter of nurses (Littlejohn, Campbell, Collins-McNeil, & Khayile, 2012).

A report from the Washington Center for Nursing (WCN) projects that the demand for RNs in Washington State will exceed supply by 2017. The authors attribute this disparity to an aging population in Washington State as well as an aging RN population, in which approximately 40% of RNs are currently 55-years of age or older. An increase in the utilization of healthcare services due to the implementation of the Patient Protection and Affordable Care Act (ACA) increases the demand for registered nurses. The ACA provides access to health insurance to approximately 300,000 previously uninsured Washingtonians. Higher rates of chronic disease and budget gaps which have decreased funding to the educational system are also expected to negatively affect the supply of registered nurses (Skillman, Andrilla, Tieman, & McCook, 2011).

Problem statement

Nursing is an impacted major at most academic institutions, and the number of qualified applicants far exceeds the number of spaces available in nursing programs. As such, institutions may be highly selective in deciding whom to admit. The competition among qualified applicants is fierce; therefore, identifying who is more likely to succeed, why students withdraw from nursing programs, and identifying evidence-based interventions that have demonstrated success in retaining students, are of utmost importance. It is widely believed that competitive admission processes must be a fair, valid and reliable method of selecting the most “qualified, top-caliber students who are suitable, motivated, and have both academic and clinical aptitude” (Timer & Clauson, 2010, p601).

Newton, Smith, Moore, and Magnan (2007) suggest that even with highly qualified students, attrition continues to persist. To date, the majority of the literature examining attrition,
persistence, and retention in nursing education focus on academic and personal factors from the perspectives of students who persist in nursing programs or of faculty who teach in nursing programs. Despite numerous interventions implemented to reduce attrition and increase retention, graduation rates from nursing programs have remained virtually unchanged exacerbating the nursing workforce shortage even further.

Currently, there are only a handful of studies that examine factors related to attrition, persistence and retention from the perspectives of those who ultimately drop out of pre-licensure or graduate nursing programs. (Andrew et al., 2008; Perry, Boman, Care, Edwards, & Park, 2008; Wells, 2007) There are no published studies that examine attrition factors and the experiences of RN-BSN non-completers who voluntarily drop out of BSN programs.

**Background and Significance**

**Driving the degree: The need for a highly educated workforce**

Numerous trends have led to an increasing need for nurses with not only an RN license but also RNs with a baccalaureate degree (BSN). The Future of Nursing: Leading Change, Advancing Health (Institute of Medicine, 2010) report recommends increasing the percentage of nurses with a baccalaureate degree to 80% or above by 2020. This recommendation is in response to the “demands of an evolving health care system and to meet the changing and complex needs of patients” (American Association of Colleges of Nursing, 2013, p2). The Tri-Council for Nursing, a coalition of four organizations, the American Association of Colleges of Nursing (AACN), American Nurses Association (ANA), American Organization of Nurse Executives (AONE), and National League for Nursing (NLN) issued a consensus statement. This statement called for all RNs to pursue higher levels of education because the need for delivering
safe and effective patient care is critical (AACN, 2010) and went so far as to articulate, “that without a more educated nursing workforce, the nation’s health is at risk” (p.3).

In 2009, Dr. Patricia Benner and a team from the Carnegie Foundation for the Advancement of Teaching published a study indicating that nursing students are inadequately educated to meet the practice demands across healthcare settings. The authors called for a radical transformation in how nursing students were being educated to meet these demands (Benner, Sutphen, Leonard & Day, 2009). Research identifies an association between factors such as nursing skill mix and nurse work environment, and nurse-sensitive patient outcomes measured by the Agency for Healthcare Research and Quality Patient Indicators (AHRQ, 2003). A landmark study published in 2003 by Aiken et al. suggests that a 10% increase of baccalaureate-prepared or higher (RN skill mix) decreased surgical patient mortality rate and failure to rescue by 5%. Similar findings were reported in another study by Aiken and colleagues in 2008 (Aiken, Clarke, Sloane, Lake, & Cheney, 2008).

Higher percentages of BSN prepared nurses, adequate staffing and resources, use of protocols to guide patient care, nurse-reported care quality, and satisfaction with nurse work environment have also been associated with lower 30-day risk-adjusted surgical patient mortality and mortality from congestive heart failure (Kutney-Lee, Sloane, & Aiken, 2013; Blegen, Goode, & Park, 2013; Tourangeau et al., 2006). The incidence of pneumonia, decubitus ulcers, deep vein thrombosis, and pulmonary embolism are likely decreased, and patients experienced shorter lengths of stay due to greater percentages of BSN-prepared or higher nurses in acute care settings (Blegen, et al., 2013).

Nurse leaders assert that a baccalaureate degree is a requirement for nurses to maintain equal professional standing in society with other healthcare professionals (Joel, 2002). A position
statement from the AACN articulates that “a highly educated nursing workforce improves the quality of patient care, improves patient safety (AONE, 2005), and lowers patient mortality rates” (AACN, 2010). An evaluation of healthcare professions revealed that nurses are the least educated of all major healthcare professionals (Nelson, 2002). Occupational therapy, social work, speech pathology, and counseling have established a master’s degree as the minimum educational level required for entry into professional practice (Nelson, 2002) and pharmacy requires a professional doctorate (PharmD.) as the minimum entry into practice (Washington State Medical Association, 2002).

Multiple pathways into the profession

There are several pathways to obtain a BSN degree. The first pathway is a traditional pre-licensure baccalaureate degree program or BSN in which two years of liberal arts and two years of professional nursing courses are required to complete the degree. The second is an RN-BSN program, in which nurses with a diploma or associate degree in nursing complete liberal arts and professional nursing courses at the university level, building upon their clinical knowledge and experience. The third method is frequently referred to as a bridge or an accelerated program, in which students with a baccalaureate degree in science or a related field enter into an accelerated nursing program to complete professional nursing coursework. Completion of an accelerated nursing program results in either a second baccalaureate or in some cases a graduate degree (Raines & Taglaireni, 2008).

Increase the number of RNs with baccalaureate degrees

With a major push to establish the BSN degree as the minimum educational level required for entry into practice, the need to expand access and capacity to BSN and RN-BSN completion programs is significant. Approximately 60% of new RNs enter the profession with an associate degree (Health Resources and Services Administration, 2013; AACN, 2007). Program
capacity gaps have been identified as a barrier to increasing the number of RNs with a baccalaureate degree throughout the United States.

In 2005, researchers estimated over 37,000 qualified applicants were turned away from associate degree programs (Kovner & Djukic, 2009). The AACN (2010) estimates that the number of qualified applicants turned away from BSN programs rose gradually from approximately 3,600 in 2002 to over 52,000 in 2010 and dramatically to over 75,000 in 2011 (AACN, 2012). The Master Plan for Nursing in Washington State (WCN, 2009) recommends expanding capacity at the baccalaureate level. This is because “there is a substantial gap between the current production of associate degree nurses and RN-BSN program capacity” (p. 4). Trends suggest that if “educational capacity expanded to meet enrollment demands,” approximately 30,000 RNs per year would be added to the profession, “virtually eliminating the nursing shortage” (Allan & Aldebron, 2008, p. 287).

Efforts to increase the number of BSN-prepared nurses are underway. Articulation agreements between nursing education programs are an important mechanism that has been shown to increase access to RN-BSN programs. An articulation agreement is negotiated between faculty from associate degree (ADN) and baccalaureate degree programs to ensure equivalency between community college and university level courses. These agreements are meant to eliminate barriers and streamline entry into baccalaureate programs. Currently, 32 states and the District of Columbia maintain articulation agreements between ADN and BSN programs and, according to the AACN (2005), the remaining 18 states have individual institution-to-institution agreements.

Streamlining academic progression in nursing has been identified as another measure to increase the percentage of BSN-prepared nurses. The Robert Wood Johnson Foundation awarded
the Tri-Council for Nursing $4.3 million to spearhead the academic progression in nursing initiative, in part, to advance regional strategies to increase the number of BSN-prepared nurses (AACN, 2013). The Regionally Increasing Baccalaureate Nurses is one such alliance between New York and North Carolina initiated to create a seamless pathway to a baccalaureate degree for nurses in ADN programs. Buerhaus suggests that although individual and multi-state initiatives have positively impacted the supply of RNs, associate and baccalaureate prepared alike, “the government must step up and do its part” (as cited in Murdock, 2006. para. 15). To that end, Buerhaus urged Congress to appropriate funds to correct issues associated with the nursing shortage.

Title VIII of the Public Health Service Act provides federal funds to nursing programs through the Nursing Workforce Development program aimed at increasing the number of BSN-prepared nurses, increasing the number of masters and Ph.D. prepared nurse faculty, and increasing nurse workforce diversity (ANA, 2014). As a result of the efforts of national nursing organizations, public and private foundations, and leaders within the nursing profession, the push to increase the number of BSN-prepared nurses in individual states may be having an effect. At the national level, however, the Health Resources and Services Administration Bureau of Health Professions workforce analysis conducted in 2013 indicated the number of RNs entering the profession with a diploma or associate degree remained at 60% (2013).

**Static attrition and graduation rates**

It is estimated that those with a baccalaureate degree earn on average 60% higher or approximately $1.2 million more over their lifetime than those without the degree (Day & Newberger, 2002). There is a high cost associated with failing to graduate from college born by students, families, taxpayers, and society. Over half of college and university students fail to graduate with a baccalaureate degree with an associated cost of “$3.8 billion in lost income;
$566 million in lost federal income taxes; and $164 million in lost state income taxes” (Schneider and Yin, 2011, para. 4). Approximately 65% of students who drop out of college will never return (American Council on Education, 2014, para. 1).

For students, the financial impact of failing to complete a degree program is significant. College dropouts experience greater rates of unemployment and debt burden. A report published by Harvard University indicated the average student loan debt in 2001 was about $28,000 and in some cases was much higher (Harvard University, 2011). Students become saddled with debt and often did not realize that the financial aid dollars they received to fund their education must be paid back even if they failed to graduate.

The psychological impact of dropping out of college is great, leading to decreased self-esteem and self-efficacy, depression, and sense of well-being (Luke, 2009). In 2000, 38% of Americans aged 25 to 34 held a degree from a community college or a four-year institution, putting the nation in fourth place among its peers in the Organization for Economic Cooperation and Development (2014). By 2012, the graduation rate had inched up to 44%, but the nation’s ranking had slipped to 11th place” (Porter, 2013, para. 5).

The Department of Education began collecting graduation rate data in 1996. For more than two decades, policy makers and consumers have relied on graduation rates as a benchmark for educational program success (Feldman, McElroy, & Lacour, 2003; College Board Advisory, 2009; Cook & Pullaro, 2010). Academic institutions receiving Title IX federal funding are required to report completion rates under the Students Right to Know Act of 1990 (United States Department of Education [DOE], 2012). Graduation or completion rates are institutional snapshots and are calculated at 150% of the required time to complete a degree program. This calculation was based on the number of full-time freshmen who graduated within six years at
four-year colleges and three years at two-year colleges. By the very nature of their enrollment status, part-time students would not complete a degree program within the established 150% timeframe. Those within post-secondary education called into question the use of graduation rates as a measure of student success. This is because over 40% of students enrolled in post-secondary institutions were attending part-time (Feldman et al., 2003, Bailey et al., 2011).

Using graduation rates as a critical measure of student success is problematic. National databases used to collect graduation rate information are incomplete and do not account for all students within an institution. A recent report finds there is an increased focus on measures of institutional accountability, such as graduation rates, coupled with other changes in reporting which are as follows (Cook & Pullaro, 2010):

- “the American Graduation Initiative called for all states and colleges to establish quantifiable target for improving graduation rates in order to receive federal funds”;
- “the 2008 Higher Education Opportunity Act called for a wider disclosure of institutional graduation rates for consumer information”;
- “a 2009 report from the American Enterprise Institute states that graduation rates convey important information…and should be the beginning of a deeper inquiry into college success.”

Calls for dramatic changes in higher education are occurring at the highest levels of government. In 2011, the United States Secretary of Education articulated that a shift from addressing input measures (access and enrollment) to output measures (persistence and attainment) needed to occur (Committee on Measures of Student Success, 2011). This statement reflected an understanding that graduation rates are not the only means for identifying student
success and that factors that enable or inhibit students from persisting to graduation must be identified.

Low graduation and high attrition rates in nursing programs continue to be a national problem. Pre-licensure and baccalaureate nursing programs consistently report that although graduation and attrition rates are improving slightly they remain lower than expected, exacerbating the nursing shortage even further. According to the education commission and the California Board of Registered Nursing, in Los Angeles County, one-quarter of nursing students enrolled in nursing programs fail to graduate (Sodders, 2005). In Texas (Dallas Nursing Institute, 2012) and New York (CUNY, 2011) nursing student graduation rates are approximately 55% and 58% respectively. The Florida Center for Nursing (2003) reports approximately 40% of RN-BSN students who expected to graduate in 2012, did not. Nurse researchers have also called into question using graduation rate as a benchmark of program success. This is because the calculation does not take into account the complex nature that is characteristic of RN-BSN learners nor the context of their unique needs (Robertson et al., 2010).

**Statement of the Purpose, Research Questions, and Definitions**

**Purpose statement and research questions**

Extant literature presented in the literature review addresses the concept of attrition; however, the phenomenon of non-completion in RN-BSN students remains unexplored. The purpose of this study is to develop an understanding of the lived experience of registered nurses who voluntarily drop-out of their RN-BSN programs and to interpret the factors that influence attrition decisions. The specific research aims were to generate a comprehensive understanding of (1) the experiences of RN-BSN non-completers (2) the meaning non-completers ascribe to the experience of dropping out and (3) the interplay between factors that influence dropout
decisions. The dissertation study was conducted using an interpretive phenomenological approach deemed the most appropriate method to answer the research question.

Definitions

Associate degree (ADN) is defined as an award that requires completion of an organized program of study of at least 2 but less than 4 years of full-time academic study or more than 60, but less than 120 semester credit hours (National Center for Education Statistics, n.d.).

Attrition is defined as failing to re-enroll at an institution for two or more consecutive academic terms (Jeffreys, 2012).

Baccalaureate degree (BSN) is an award that normally requires at least four but not more than five years of full-time equivalent college-level work (National Center for Education Statistics, n.d.).

Diploma is defined as a formal document certifying the successful completion of a prescribed program of studies (National Center for Education Statistics, n.d.).

Graduation rate is defined as the number of students entering the institution as full-time, first-time, degree/certificate-seeking undergraduate students in a particular year (cohort), by race/ethnicity and gender; the number completing their program within 150 percent of normal time to completion (National Center for Education Statistics, n.d.).

Non-completer is defined as a student who does not complete a degree program (National Center for Education Statistics, n.d.).

Nontraditional student is defined as: 25 years or older, delayed enrollment, attends part-time, works 32 hours or more a week, is financially independent, has children and/or dependents other than a spouse, and is a single parent (United States Department of Education, 2002).

Involuntary attrition is defined as occurring when a student drops out of a program due to academic reasons either failure or dismissal (Jeffreys, 2012).
**RN-BSN student** is defined as a registered nurse with an associate degree or diploma in nursing who is enrolled in a post-licensure baccalaureate degree in nursing program.

**RN-BSN program** is defined as a post-licensure baccalaureate degree completion program in an academic setting.

**Retention** is defined as a measure of the rate at which students persist in their educational program at an institution, expressed as a percentage (National Center for Education Statistics, n.d.).

**Stop-out** is defined as a break in continuous enrollment for one or more academic terms excluding summer sessions or intercessions (Jeffreys, 2012).

**Voluntary attrition** is defined as occurring when a student decides to drop out due to personal or non-academic reasons (Jeffreys, 2012).

**Summary**

A health care crisis looms on the horizon as the nursing shortage continues to reach unprecedented levels. Nurse vacancy rates are estimated to reach 1-million by the year 2020 (Buerhaus et al., 2000a; Goodin, 2003). The shortage is a complex multidimensional problem that has led to critical analysis of factors affecting the supply and demand for highly skilled nurses. The need for a more highly educated nurse workforce has never been more evident because research studies are beginning to examine the effect of higher levels of nursing education and skill mix on nurse-specific indicators of patient care (Aiken, et al., 2008). The ANA, the NLN, the AACN, the AONE, preeminent nurse scholars, the IOM, the Robert Wood Johnson Foundation, and the Carnegie Foundation agree that increasing the number of BSN-prepared nurses is critical at this time more so than ever before. This recommendation was prompted by the challenging and complex health care environments in which nurses function and the evolving and dynamic nature of the U.S. health care system.
There is a gap in the literature on attrition decisions and experiences from the perspectives of RNs, who voluntarily leave RN-BSN programs prior to completion. Embedded in the significance of this study is the critical need to understand the experiences of RN-BSN student non-completers, to examine influences on RN-BSN student’s decisions to voluntarily withdraw from nursing school, and to analyze the interplay among such influences so that barriers to degree completion are eliminated.
CHAPTER TWO
LITERATURE REVIEW

This literature review presents the theoretical applications and the empirical basis for this dissertation study. The review includes major categories of literature addressing: (a) RNs who pursue a baccalaureate degree (b) definition of attrition and retention (b) overview of attrition and retention (d) summary of attrition studies related to nursing (e) conceptual model used to study nursing student attrition.

RN-BSN Learners: Why go back?

RN-BSNs who return for a BSN degree describe themselves as employees who go to school. Most maintain full-time work hours and attend school either part-time or full-time. This population of nursing students often describe difficulties in staying the course. For many, the decision to return to college for a BSN degree is not one that is arrived at easily. Nurses who choose to pursue advanced education report little support from employers and even less from colleagues. Registered nurses who return for advanced education take financial and emotional risks, and in some cases, they are criticized by their peers (Cullen & Asselin, 2009). Cullen and Asselin (2009) interviewed 11 experienced RNs to determine their motivations for pursuing a BSN degree. Nurses reported that their peers often asked why they bothered to get a BSN or what value could be gained from the courses when they already had many years of experience. Respondents reported they experienced negative attitudes from peers and that they “learned right away that certain people did not want to talk about school” (p 33).

Lillibridge and Fox (2005) conducted a study in a state university system using BSN program evaluation survey data from 1997-2001 to determine the value nurses credit to BSN education and the motivational factors that influenced them to pursue the degree. A sample of 41 respondents reported receiving personal and professional benefits by completing the BSN
program; however, many of them reported being told by their nursing peers that experience counted much more than education. The researchers concluded that perhaps the rift over educational levels may be re-conceptualized so that nurses embrace the value of all levels of education without devaluing foundational entry-level nursing education.

Zuzelo (2001) surveyed 35 RN-BSN nursing students in a large metropolitan area to determine what had influenced their decision to pursue a BSN degree. The study also explored the impact that RN-BSN education had on the nursing practice patterns of RN-BSN graduates. Respondents reported that they felt pressured to return for the BSN degree and felt negatively about the perceived necessity or utility of the degree. Respondents felt betrayed by the professional organizations that proposed the BSN degree as a professional entry to practice while diploma nurses expressed resentment that their basic nursing courses were not accepted for college credit by BSN programs.

Mangubot (2005) conducted a study of 120 nurses in an urban hospital of which 43% pursued RN-BSN education. Additionally, 30 study participants were randomly selected to be interviewed to collect qualitative data aimed at determining barriers to pursuing and staying in a BSN program. Barriers identified in the study were: situational, institutional, and dispositional. Situational barriers were more likely to hinder the nurses’ ability to complete a BSN program. These barriers were reported as family priorities, major life changes, cost, time constraints, work responsibilities, and lack of childcare. Institutional barriers, though less likely to cause student attrition in non-traditional RN-BSN students, were nonetheless, influential in the decision to pursue a BSN. These factors were noted as difficulty navigating the educational system, scheduling, and perceptions of irrelevant coursework. Dispositional factors that hindered
completion were: low self-perception and feelings of inadequacy, lack of motivation, and feeling that they were too old to learn.

Respondents from the Mangubot (2005) study reported that their family was the most influential factor in returning to pursue the BSN degree, and it was family support that kept them motivated throughout the program. It may be concluded from this study that although little may be done to remove situational or dispositional barriers, removing institutional barriers may improve potential students’ response to situational barriers. Providing financial support for scholarships, a streamlined registration process, knowledgeable academic advisors, flexible scheduling, convenient location (work site location), partnerships with facilities to support student participation (employer support), flexible work schedule, and pay differentials were identified as ways to support persistence in these students. Also, providing strong emotional support through peer/cohort and mentorship, improved self-efficacy that, in turn, may combat dispositional barriers (Mangubot, 2005).

In summary, the decision to return to college to earn a BSN degree is not made easily for some. RNs who chose to go back to school faced challenges, which they described as lack of peer and employer support (Cullen & Asselin, 2009) and skepticism about the utility of the degree (Lillibridge & Fox, 2005; Zuzelo, 2001). These challenges created barriers that may influence some not to return (Mangubot, 2005). Competing priorities, lack of finances, navigating the college milieu and feeling unprepared for university study influenced the decision to return as well (Mangubot, 2005). The need to increase the percentage of BSN-prepared nurses is established in the literature. However, only two studies shed light on the motivations for going back, with even fewer studies that identify what is needed to help RN-BSN students stay the course and complete their programs. There is a paucity of literature on the RN-BSN population
in general and none on the experiences of RN-BSN students from the viewpoint of the students themselves. The lack of research on the RN-BSN population signifies a need to examine the meaning of withdrawal and how the phenomenon is experienced by RNs, who return to college to complete a BSN degree.

**Definition of Attrition and Retention**

The most widely used concepts that examine student departure and academic achievement in educational research and practice literature today are attrition (withdrawal) and retention (persistence). One of the difficulties in studying student attrition and retention is that researchers have used various terms interchangeably to describe the phenomena. Early research used student mortality (Gekowski & Schultz, 1961; McNeely, 1937;), college dropouts (Spady, 1971; Summerskill, 1962; Tinto, 1975), student attrition (Panos & Astin, 1967; Pantages & Creedon, 1978; Sexton, 1965; Tinto, 1993), and college retention (Berger, 2002; Braxton & Mundy, 2002; Iffert, 1957; Tinto, 1990). More recently, student persistence has been used in the literature to describe the phenomena of attrition and retention (Berger, 2002; Berger & Milem, 1999).

Most scholars agree that retention and attrition are associated; in essence, they are two sides of the same coin. If a student was not retained in an academic program, they attrite or drop out (Seidman, 2012). More recently the definitions of attrition and retention have achieved some consistency in the literature (Seidman, 2012). The most commonly used definition of attrition describes a student who leaves college and does not return, also known as a non-persister or non-completer (Seidman, 2012). In contrast, retention occurs when a student enrolls in college and remains enrolled until degree completion (Seidman, 2012).
A Historical Overview of Theories of Attrition and Retention in the General College Population

It is important to understand how attrition and retention theories used in post-secondary education have evolved because present day iterations of these theories are situated within nursing attrition and retention literature. Attrition and retention theory has evolved from basically a “way to weed out undesirables” in the 1940’s (Seidman, 2012, pg.18) to a complex process of explicating factors associated with student departure (Tinto, 1971) and non-traditional student attrition (Bean & Metzner, 1985). Work in this area focused on institutional (McNeely, 1937; Meyer, 1970; Tinto, 1975) and non-institutional factors (Summerskill, 1962) believed to influence student departure decisions.

These early studies attempted to draw causal relationships between student mortality and student withdrawal behaviors (McNeely, 1937). Others examined how internal and external motivational factors influenced retention (Summerskill, 1962). From a strictly sociological and psychological perspective, student’s attitude, behavior, and satisfaction were thought to heavily influence retention decisions. To a great degree; if a student adopted the attitudes, beliefs and culture of the institution they were less likely to depart. Still other researchers examined student and institutional factors related to retention from a sociological perspective (Spady, 1970). Spady posited that institutional practices coupled with a lack of social connectedness caused students to drop out. He concluded that successful interactions between the student and college academic and social systems mitigated dropout.

In 1971, Vincent Tinto published a graphic model (Figure 1.) identifying factors believed to be associated with student departure. His Interactional Theory of Individual Student Departure (Tinto, 1971) is the most widely used in attrition and retention studies to date. Tinto’s (1971)
theory suggested that what happened within the academic institution had far greater influence on student departure decisions than what went on outside the institution. From his perspective, a student needed to integrate fully into the formal, and informal academic and social communities at the college and how effectively a student integrated within the those communities determined successful retention within that milieu.

Tinto (1975) further suggested that students used cost-benefit theory to inform persistence decisions explicating that, “individuals will direct their activities toward those areas of endeavor that are perceived to maximize the ratio of benefits to costs” (p. 39). From this viewpoint, a student may decide to discontinue academic pursuits if they determined their time and money would be better spent elsewhere on an activity that would yield greater benefits relative to cost.

In Tinto’s theory (1971, 1975), pre-college attributes (family background, skills and abilities, and prior schooling) “influence the expectations and motivations for additional education which individuals bring with them into the college environment” (p.41). Given these individual characteristics, integration into the college system through academic achievement and social avenues that occur within the campus environment led to a greater commitment to the college and commitment to the goal of college completion. Finally, he conceded that although external events may impact retention, it is primarily the academic and social structures within the academic institution that have the greatest impact.
There are two main criticisms of Tinto’s theory. The first is that it placed critical importance on the institutional environment related to departure decisions for traditional college students. These students are likely residential, younger in age, financially dependent on parents or significant others, and they are less likely to be employed (Bean & Metzner, 1985; Braxton, Jones, Hirschy, & Hartley, 2008; Karp, Hughes, O’Gara, 2008; Falcone, 2011; Melguizo, 2011). The second criticism at that time, was that the theory was based solely on qualitative descriptive research and that it was not derived from any empirical studies.

Even with these criticisms, Tinto’s interactional theory of student departure remains the most cited work on retention theory to date. His two seminal works, Dropout from higher education: A theoretical synthesis of recent work and Leaving College: Rethinking the causes and cures of student retention were cited over 13,000 times since initial publication (Google Scholar accessed February 2015). A brief sample of studies that have used Tinto’s theory to
determine if demographic, student characteristics, academic factors, institutional factors, and psychosocial factors influence academic persistence is presented.

Using Tinto’s theory, demographic studies examined: age, class, race and ethnicity, and gender (Aragon & Johnson, 2008; Bocchi, Eastman, Swift, 2004; DeBerard & Julka, 2000; Lohfink & Paulsen, 2005; Muller, 2008; Pascarella & Terenzini, 1998; Reason, 2009). Studies have also explored the impact of student characteristics and academic factors on retention using Tinto’s model. Student characteristics are identified in the literature as sexual orientation (Pascarella & Terenzini, 1998), attending school full or part-time, international or residential student status, adequacy of financial support, hours of employment (full or part-time), level of family responsibilities, marital status, and first generation college student status (Braxton et al., 2008; Hart, 2012; Jeffreys, 2012; Kasworm, 2008; Lyons, 2004; Pike & Kuh, 2005).

Tinto described academic factors related to student departure such as high school and college grade-point average, SAT scores, prior academic record, academic advising, course availability, and flexibility of assignments (Wolfe & Johnson, 1995). Psychosocial variables studied in the literature included: smoking, drinking, health-related quality of life, social support, maladaptive coping strategies, stress, educational goals, motivation, absenteeism, social connectedness (DeBerard, Speilmans, & Julka, 2012; Kessler, Greenberg, Mickelson, Menedes, & Wang, 2001; Jeynes, 2002).

Recognizing the need to explore retention factors for non-traditional students, the research team of Bean and Metzner (1985) began to study this unique population. Through their work, a graphic representation of the (Fig. 2) factors thought to be associated with retention and persistence present in non-traditional adult students was developed. Non-traditional students comprise a large percentage of adult college students and the majority of post-licensure
registered nursing students (Washington State Department of Health Nursing Care Quality Commission, 2011). A landmark study by Bean and Metzner (1985) posited there are distinct differences between traditional and non-traditional college students.

According to Bean and Metzner, non-traditional students had three or more of the following characteristics: older than 25-years of age, non-residential, having dependents, working more than 20 hours per week, attending college part-time, and belonging to social groups external to the campus environs (Bean & Metzner, 1985; Jeffreys, 2012; Rovai, 2002, U.S. Department of Education, 2012). Results from their study indicated environmental factors external to the institution had the greatest impact on student retention. This finding conflicted with Tinto’s original theory because non-traditional students were less likely to interact socially on campus due to multiple competing priorities outside the campus environment. This characteristic is also unique to RN-BSN students.

Figure 2. Bean and Metzner (1985) Conceptual Model of Nontraditional Undergraduate Student Attrition (reprinted with permission).
Additional research suggested the following factors influenced academic persistence of non-traditional college students: age, enrollment status, residence, educational goals, ethnicity, gender, study habits, academic advising, absenteeism, course availability, finances, hours of employment, outside encouragement, family responsibilities, grade point average, utility, satisfaction, goal commitment, and stress (Bean & Metzner, 1985; Fishbein & Ajzen, 1975; Jeffreys, 2012; Robb, Moody, & Abdel-Ghany, 2011; Rovai, 2002; Spradlin, Rutkowski, Burroughs, & Lang, 2010).

Finally, Seidman (2005) used Tinto’s (1971) theory as a basis for his retention studies. He recommended the use of retention programs that relied on identifying student deficiencies (possibly before college or immediately at the time of application) to improve student retention. Identifying students with deficiencies early on allowed individualized targeted support to occur immediately upon college entrance. These interventions were monitored by continuous follow-up – a sort of “nip it in the bud” approach until the deficiency no longer put the student at-risk for attrition. Seidman (2012) concluded that preventative and proactive approaches require both student and institutional involvement.

Without a doubt, attrition and retention studies continue to predominate post-secondary education. Although, there is an extensive body of knowledge in this area, retention rates continue to lag and attrition rates, while somewhat stable, have not decreased significantly in the past several decades (Seidman, 2012). Numerous researchers have studied attrition and retention in the general undergraduate student population; however, attrition and retention has yet to be fully explored in the non-traditional nursing student population. This is significant to nursing education because the majority of nurses who return to college to pursue a BSN degree are considered non-traditional.
Attrition in Nursing Programs

An extensive review of the literature was conducted to uncover extant literature on nursing student attrition and to identify attrition factors associated with this population. Cumulative Index to Nursing and Allied Health Literature, Google Scholar, PubMed, and The Cochran Library and ProQuest dissertation databases were searched using single words and a combination of these key terms: RN-BSN attrition and retention, RN student persistence, nursing student attrition and retention, and nursing program non-completion. A total of 41 studies published or in press between 2003 and 2014 were selected for review. Studies published prior to 2002 were excluded because of significant changes in nursing student cohorts that have occurred over the past decade. One dissertation was reviewed and included in the literature review because it uses the conceptual framework most widely used in nursing education attrition and retention studies.

It is posited that nursing student attrition is multifactorial. Students rarely withdrew due to one single factor but did so because of a combination of factors that build upon one another until a breaking point is reached (Shelton, 2012). The multifactorial nature of attrition adds to its complexity. The majority of published literature has attempted to identify causal relationships between non-academic and academic factors associated with attrition. Some studies predicted who is more likely to achieve academic success and/or pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN). There is no published study that investigated the multifactorial nature of RN-BSN attrition.

Non-academic factors: Age, gender, race, and ethnicity. Non-academic and personal factors associated with attrition are as follows: demographics (age, race/ethnicity, and gender), family and work commitments, stress, finances, personal problems and life crisis. Studies suggest age, gender and race/ethnicity may be associated with academic success in nursing
students. However, research reporting an association between age, gender and academic success should be interpreted with caution. This is because some researchers defined older students as being over 22 years of age (Daley, Kirkpatrick, Frazier, Chung, & Moser, 2003; Trofino, 2013) and some defined older students as being 25 years or older (Ali & Naylor, 2010; McCarey, Barr, & Rattray, 2007; Mullholland et al., 2006; O’Brien, Keogh, & Neenan, 2009; Prymachuk et al., 2008; Salamonson et al., 2014). With some exceptions, older students, those over 25-years of age (Mullholland et al., 2006; Prymachuk et al., 2008; Salamonson et al., 2014) and female students (Ali & Naylor, 2010; McLaughlin, Muldoon, Mountray, 2010) were more likely to experience higher progression and program completion rates.

Salamonson & Andrew (2006) found that age was positively related to academic performance for nursing students who were older than 25-years of age. The researchers reported that older students were more likely to achieve higher pathophysiology and nursing practice assessment scores than younger participants in their study. Similarly, Wray, Barrett, Aspland, and Gardiner (2012) found that as age upon entry increased, the odds of program discontinuation decreased (OR=0.938, p <0.001). Age was found to be a significant predictor of academic performance in a study of 154 pre-registration nursing students (McCarey et al., 2007). The researchers reported that students who were over 26 years of age achieved “higher marks in coursework and examinations than their younger peers” (p. 357).

McCarey et al. (2007) also found that females achieved higher scores in a year-two Care Study course (t = -2.516, p= 0.013) while males achieved higher marks in one first-year examination (t = 2.54, p = 0.026). Conversely, a study by Batykefer-Evans (2013) of 122 minority BSN students predicted that younger males had a higher intent to complete than females, non-minorities, and older students. The researcher noted that her study was not designed
to determine if [emphasis added] the participants actually completed their programs, only their intent [emphasis added] to complete them. Although only one study, Batykefer-Evans (2013) challenged the assumption that intent to complete was one of the strongest predictors of attrition (Fishbein & Ajzen, 1975) because a far greater number of studies concluded that older students (Daley et al., 2003; McCarey et al., 2006; Mulholland et al., 2008; O’Brien et al., 2009; Salamonson et al., 2006; Trofino, 2013; Wray et al., 2012) and female students (Ali & Naylor, 2009; McLaughlin et al., 2010; Mulholland et al., 2008; Pryjmachuk et al., 2008; Salamonson et al., 2014) experienced greater academic success.

Various studies reported mixed results on whether age or gender impacted academic success. When examining predictors of NCLEX-RN success in BSN and ADN students, Daley et al., (2003) and Trofino (2013) reported that students who were older than 22 years of age were more likely to pass the NCELX-RN. In both the Daley et al. study (2003) and the Trofino (2013) study, gender was not a predictor of NCLEX-RN pass rates. A qualitative study of 28 older nursing students (>25yo) by O’Brien et al., (2009) described the challenges of first-year nursing courses and the need to balance home and university demands. Females in the study reported greater difficulty “carrying out the same household duties that they had completed prior to undertaking the course” (p. 638) and that support from male spouses waned when students spent more time studying than time together as a couple.

On the other hand, males in the O’Brien et al. (2009) study reported strong support and encouragement from their female spouses stating that “I had a very supportive wife…she played a big part in my survival” (p. 638). These findings were significant because the majority of nursing students attritioned out in the first year (Andrew et al., 2008) and literature suggested
support from family was critical to academic persistence (Bowden, 2008; Crombie et al., 2013; Johnson, Johnson, Kim, & Mckee, 2008).

Finally, several researchers found no association between either age or gender and academic success (Dante, Valoppi, Saiani, & Palese, 2011; Mancini, Ashwill, & Cipher, 2014; Rochford, Connolly, & Drennan, 2009). Dante et al., (2011) and Rochford et al., (2009) concluded that a limitation of their respective studies were small sample sizes, so generalizability was problematic. Finally, a study by Mancini et al., (2014) concluded that an online delivery method may have had a greater impact on completion of an online RN-BSN program than either age or gender.

Ethnically diverse nursing students experienced a trifecta of factors related to attrition and reported significant difficulties persisting in nursing school (Robbins & Hoke, 2013). These students tended to be first-generation college students with a higher percentage being in a lower socioeconomic status group. Literature linked lower socioeconomic status with poorer academic preparation for college (Abriam-Yago, 2002; Hurd, 2000). Specific barriers to their success identified in the literature arose from difficult academic and social adjustment (Robbins & Hoke, 2013), few faculty role models, and lack of role models at work (Zheng, Everett, Glew, & Salamonson, 2014). Family and peers of first-generation college students often did not understand the challenges of higher education (Childs, Jones, Nugent, & Cook, 2004). Therefore, they may not have fully understood ways they could support family members who attended college (Robbins & Hoke, 2013). Ethnically diverse students tended not to seek academic support early on and waited until it was too late to achieve any level of success; subsequently, more of these students ended up dropping out (Baker, 2010; Batykefer-Evans, 2013).
Non-academic factors: Competing priorities. Attrition literature suggests that commitments outside the college environment impacted nursing student attrition (Bowden, 2008; Perry, Boman, Care, Edwards, & Park, 2008). Students reported that they had every intention to stay in school but that “life got in the way” (Andrew et al., 2008, pg. 869). Faced with the difficulty of juggling family, work, financial and other life commitments, they decided to withdraw. These same themes are commonplace in attrition studies, which find that family responsibilities and unexpected life crisis severely restrict academic achievement (Jeffreys, 2007). For example, an investigation by Dante et al., (2011), found that along with going back to school, caring for children, and elderly family members was associated with academic failure.

Competing priorities is associated with attrition and in some cases predicted who is at risk of withdrawing from nursing school. Approximately 22% of participants in a qualitative study by Bowden (2008) seriously considered leaving nursing school on one or more occasions. Participants in the study cited they would not have left school based upon a single factor alone, “rather, a combination of dealing with their problems and coping with the other stressors of student life” (p. 53) would most likely cause them to withdraw. Additionally, fear of failure and stress from personal problems such as divorce, ill health or death in the family, contributed to academic failure (Bowden, 2008, Perry et al., 2008).

A novel study by Johnson et al., 2008 used the Personal Background Preparation Survey (PBPS) to predict nursing students at-risk for attrition based upon the presence of certain risk factors. Participants in the study were asked to identify personal, family, academic support, and/or financial risk factors, and whether or not they had leadership experience and/or if they experienced discrimination. Results indicated the PBPS consistently predicted adverse academic events from first-year to second-year nursing students about 75% of the time. The researchers
reported the tool’s sensitivity and specificity ranged from 70-81% and 68-78% respectively. This finding was significant because identifying risks early in an academic program allowed early intervention that decreased student attrition (Seidman, 2005).

Study findings supported the notion that most college students needed to work at least part-time to finance their living and college expenses (Rochford et al., 2009; Salamonson & Andrew, 2006). Students reported the reduced income from going to college brought financial stressors stating, “…my biggest problem was the money” (Steele, Lauder, Caperchione, & Anastasi, 2005, p. 576). Work commitments proved detrimental to nursing students’ performance and the number of hours worked per week was predictive of academic performance. Research suggested that students who worked more than 16 hours per week were three times (OR 3.550) less likely to graduate (Dante et al., 2011) compared to those who worked 15 hours or less per week or did not work at all. Students working less than 15 hours per week were also found to have a higher intent to complete their nursing program over those who worked more hours (Batykefer-Evans, 2013).

A study of 267 BSN students by Salamonson and Andrew (2006) found that about half of the participants in their study worked more than 16 hours per week. These participants achieved lower mean scores in a pathophysiology course \[F(2, 218) = 5.99, p = 0.003\] and lower assessment scores in a nursing practice course \[F(2, 218) = 5.45, p=0.005\] compared to participants who worked 1-15 hours per week and those who did not work at all. This finding is similar to Rochford et al., (2009) whereby undergraduate nursing students in their study who engaged in term-time employment of more than 16 hours reported negative outcomes in clinical course achievement, students’ experience of college, and course grades. Participants in each of the studies reported they had no choice but to work and that the financial impact of going to
college factored into their decision to remain in school (Bowden, 2008), take a temporary stop-out (Rice, Rojjanasrirat, & Trachel, 2013) from their programs, or to withdraw completely (Perry et al., 2008).

**Academic factors: Pre-program qualifications.** Numerous studies identified academic factors thought to influence nursing student attrition. These factors were: nursing program prerequisite grade point average (GPA), nursing course GPA, entrance and exit exam scores, general education completion time, Academic College Test (ACT), Scholastic Aptitude Test (SAT), clinical placement, critical thinking test scores, program factors, and cognitive risks.

Nursing programs typically used pre-program qualifications such as nursing prerequisite GPA, general education course GPA, college entrance exams (SAT, ACT), nursing school entrance exams such as the Test of Essential Academic Skills (TEAS), the Health Education Systems, Inc. (HESI), or the Nursing Entry Test (NET) to identify applicants who were more likely to graduate and pass the National Council License Exam for Registered Nurses (NCLEX-RN). Studies have found that students entering nursing school with higher GPAs in both prerequisite courses and general education courses were more likely to progress further in their programs. They also had greater completion rates and more of them successfully passed the NCLEX-RN (Abele, Penphrase, & Ternes, 2011; Ali & Naylor, 2009; Gregory, Krupp, & Williams, 2013; Hinderer, DiBartolo, & Walsh, 2014; McCarey, Barr, & Rattray, 2006; Mul holland, Anionwu, Atkins, Tappern, & Franks, 2008; Newton, Smith, Moore, Magnan, 2008; Pry machuk, Easton, & Littlewood, 2008; VanRooyen, Dixon, Dixon, & Wells, 2006; Yin & Burger, 2003). In addition, studies have also found that higher GPAs coupled with higher scores on the TEAS, HESI, and NET exams produced an additive effect on program completion and

An exploratory study of 327 pre-licensure BSN students conducted by Abele et al. (2011) found that lifespan psychology GPA significantly ($B = 0.47$, $df = 1$, $p < .001$) predicted program completion in students on academic probation. The researchers reported that with each full letter grade rise, participants were 60% more likely to complete their program. Similarly, a retrospective study of 325 associate degree nursing students by Yin and Burger (2013) found significant correlations between psychology course grade ($t = 3.09$, $p < 0.002$), science grade ($t = 2.45$, $p < 0.018$) and NCLEX-RN pass rates.

A more recent study of 89 BSN students by Hinderer et al. (2014) reported that both science grade ($B = 2.438$, $df = 1$, $p < .05$) and preadmission GPA ($B = 3.341$, $df = 1$, $p < .05$) significantly predicted timely progression in the nursing program. Although, a study by Newton et al. (2007) of 162 first-year BSN students also sought to determine if scholastic aptitude (preadmission GPA) predicted academic progression, they also examined nursing aptitude (TEAS entrance exam score) and its impact on academic progression. Much like Abele et al. (2011) and Hinderer et al. (2014), Newton et al. (2007) reported that preadmission GPA accounted for variances in first-semester GPA ($F = 29.874$, $p < .001$) and were a more important predictor of first-semester GPA than the TEAS score ($B = .227$, $p < .001$). This finding was significant because research has shown that attrition was more common in the first year of a nursing program.

A study by Daley et al. (2003) of 224 BSN students sought to evaluate if academic factors were predictive of NCLEX-RN success. The study found statistically significant differences between participants who successfully passed the NCLEX-RN and those who did
not. Results indicated that participants with higher pre-requisite GPA ($3.3 \pm .4$ vs. $3.1 \pm .3$, $p = .005$) and higher ACT scores ($23.6 \pm 2.9$ vs. $19.6 \pm 3.4$, $p < .005$) passed the NCLEX-RN in greater numbers. The researchers also reported that students who were successful on the NCLEX-RN exam had higher nursing course GPAs ($3.1 + .6$ vs. $2.4 + .5$, $p = .004$) and higher overall GPAs ($3.3 + .3$ vs. $3.0 + .02$, $p = .04$).

Several other studies report similar associations between the pre-entry qualifications of nursing students and academic progression, completion, and NCLEX-RN-success (Ali & Naylor, 2009; Mulholland et al., 2008; Pryjmachuk et al., 2008); however, a correlational study by Sayles et al., (2003) of 68 ADN students reported that non-nursing course GPA did not correlate with NCLEX-RN pass rate, but that composite scores on the NET exam did ($r = 0.45$, $p < .001$).

**Nursing course grade point average (GPA).** Nursing course GPA was found to be associated with NCLEX-RN success and program withdrawal in nursing students. Literature suggested that nursing students who have nursing course GPAs of $3.4 \pm .6$ or higher, passed the NCLEX-RN more often than those who had lower nursing course GPAs (Daley et al., 2003). In a retrospective correlational study of 218 ADN students, aimed to predict factors that assist nursing programs in determining admission criteria. Gilmore (2008) similarly reported that participants who were successful on NCLEX-RN first attempt had a higher mean (of $.3$) nursing GPA. A previously mentioned study by Sayles et al. (2003) reported similar findings as Gilmore (2008) where GPA in the final nursing course had a small correlation to NCLEX-RN success ($r = 0.28$, $p = 0.001$) in 83 ADN students.

A larger study of 775 ADN students by Trofino (2013) found that participants with higher grades in an advanced medical-surgical nursing courses were $6\%$ more likely to pass the NCLEX-RN exam ($p = .03$). In a study of 280 BSN students aimed at identifying predictors of
program success and withdrawal, and NCEX-RN success, Uyehara et al. (2007) found that pathophysiology grades alone significantly predicted program withdrawal (p < .0001) and that unlike studies by Trofino (2013) and Gilmore (2009) other nursing course grades did not predict NCLEX-RN pass rates. When compared to the Uyehara et al. (2013) study, Seldomridge and DiBartolo (2004) also reported that pathophysiology grades (r = .377, p = .000) coupled with NLN exit exam scores (r = .452, p = .000) accurately predicted 94.7% of NCLEX-RN success and 50% of NCLEX-RN failures in 186 BSN students.

**Standardized test scores.** Heavy reliance on standardized exam scores to determine admission to nursing programs is considered somewhat controversial (Newton et al., 2006). Controversial because, students who were poor test takers or suffered from test anxiety were more likely to earn substandard scores. Although the reliability and validity of such exams had been established due to the sheer numbers of college students who took them, the use of exam scores as the sole indicator of academic success should be considered with caution because the practice may exclude certain populations of diverse students especially lacking within the nursing profession (Batykefer-Evans, 2013).

Literature suggested that along with pre-nursing program GPA, the standardized testing and entrance and exit exams were a powerful predictor of academic success. The odds of academic success were sometimes up to 50% higher for students who entered nursing programs with higher ACT (Gilmore, 2008), HESI, (Chen & Voyles, 2012), and NET (Sayles et al., 2003) entrance exam scores. Elsevier’s HESI is a standardized exam meant to assess readiness for higher education in nursing and healthcare programs. Researchers from one of the largest community colleges in California collected HESI composite scores on 506 associate degree nursing students (Chen & Voyles, 2012). Results indicated higher HESI composite scores
positively correlated with first-year nursing course grades \( (r = .604, p < .05) \). This finding was significant because nursing students were more likely to attrite out of their programs within the first year (Chen & Voyles, 2012) and first year progression was predictive of program completion (McCarey et al., 2006; Underwood et al., 2013). Adding to the confusion of what factors predicted academic success, a 2014 study by Hinderer et al. concluded there was no correlation between HESI scores and timely program progression.

Gilmore (2008) found that higher standardized exam scores were indicative of greater rates of program completion. Her study found that higher ACT English sub-scores were a statistically significant predictor of program success \( (p = .022) \). A smaller study of associate degree nursing graduates \( (N = 68) \) examined if the NET was an appropriate screening tool for admission to the ADN program, if the Pre-RN exam was a reliable predictor of NCELX-RN success, and if there was a relationship between student performance on the NET and Pre-RN and NCLEX-RN pass rates. The researchers reported that composite scores on the NET (math and reading) and higher Pre-RN exam scores improved the likelihood of NCLEX-RN pass rates \( (p <0.001) \) (Sayles et al., 2003). Conversely, a logistic regression analysis of 775 ADN students by Trofino (2013) determined that only the Math sub-scores of participants pre-entrance TEAS test was a significant predictor of NCLEX-RN pass rates and that ACT and SAT were not. Conflicting results among the previously mentioned research studies only strengthen the argument that exam scores alone should not guide nursing program admission decisions.

Standardized exit exam scores were also used to predict who was more likely to pass the NCLEX-RN and pre-licensure BSN students who scored higher on the NLN-Comprehensive Achievement Test for Baccalaureate Students (NLN-CATBS) exit exam were more likely to pass the NCLEX-RN exam on the first attempt (Seldomridge & DiBartolo, 2004). Another study of
280 pre-licensure BSN students found a minimal correlation between exam scores on the Mosby Assess Test \( r = .24, p < 0.001 \) and first-time NCLEX-RN pass rate. This same study examined predictors of withdrawal and reported that only pathophysiology grade was a significant predictor of program withdrawal.

For the most part, similar findings were reported overall in most of the studies listed above, in that, higher pre-admission qualifications coupled with higher nursing course GPA and exit exams are associated with higher progression, completion, and NCLEX-RN pass rates. Major limitations were that each study was conducted at lone institutions, within a small geographical area, with a relatively homogenous sample comprised mostly of white, females enrolled in traditional pre-licensure programs; therefore, generalizability and applicability to non-traditional students and minority student populations is somewhat limited.

Of note, the typical participants included in previously mentioned studies are either enrolled in associate degree, pre-licensure BSN programs, or graduate nursing programs. None of the participants in the previous studies were RN-BSN students. There were only a few published studies, also known as, autopsy studies that examined attrition from the perspectives of those who had withdrew from their programs (Andrew et al., 2008; Perry et al., 2008, Wells, 2007). Wells (2007) interviewed 11 undergraduate BSN students (10 females, one male) to examine reasons they dropped out of the nursing program. In the study population, “student departure was a result of cumulative effect of academic, social, and/or external environments” (Wells, 2007, pg. 439). Students described being initially excited about pursuing a BSN and that overall they had positive relationships with peers and nursing faculty. Disillusionment with the nursing profession, the nursing program itself, campus life and the environment, coupled with family and/or personal stressors influenced participants’ departure decisions.
Andrew et al., (2008) conducted an autopsy study to determine differences in attrition between first and second semester BSN students. Seven students who had left the BSN program after the first semester and ten students who had left the BSN program after the second semester were interviewed. Responses from participant interviews suggested that students who leave after the first semester decided quickly that the nursing program was not for them. These students described feeling unprepared for university study, felt disappointed with the courses and with themselves, and experienced difficulty managing family, health, and finances as reasons they left the program prematurely. Participants who withdrew from the nursing program after the second semester told researchers they wanted to stay but had no other choice but to leave because combining study with work became too overwhelming. They also described a definite tipping point where life crisis got in the way, prompting their withdrawal (Andrew et al., 2008).

Finally, an autopsy study conducted by Perry et al., (2008) identified two major reasons graduate nursing students enrolled in an online program withdrew from their studies. These reasons were classified into two categories, personal (life or work commitments) and program (learning style and career fit). Participants conveyed that increased job demands coupled with study demands were not sustainable. Further, participants reported that they preferred face-to-face study and that their career aspirations had changed, making a graduate nursing degree unnecessary for career advancement.

Results from Wells (2007), Andrew et al. (2008), and Perry et al. (2008) bolster the notion that nursing student attrition is multi-faceted and the need to fully explore the phenomenon remains significant. More importantly, these three studies were the first of their kind that sought to understand attrition from the perspective of students who withdrew from their programs. While the Wells (2007), Andrew et al., (2008), and Perry et al. (2008) studies added to
extant literature on student attrition and factors that influenced attrition decisions; there is still a need to uncover how these factors interact and how RN-BSN students who withdrew experience the phenomenon of dropping out of nursing school. Despite a comprehensive search of the literature, this researcher was unable to find a single published study in which RN-BSNs, who withdrew from their nursing programs were the focus of the study. Because the phenomenon of withdrawal and the lived experiences of RN-BSN non-completers has yet to be fully explored or understood, a gap in the literature exists.

**Conceptual Model Used to Examine Nursing Student Attrition**

While research has done much to identify factors associated with attrition and retention, little is known about the interplay between such factors especially in the non-traditional college student population or within the experiences of RN-BSN non-completers. Although several attrition models used predominantly in the general college population (Astin, 2005; Bean & Metzner, 1985; Tinto, 1975) exist, a model which aligns more closely with factors affecting attrition and retention in non-traditional college students has been developed.

Marianne Jeffreys, a prominent nurse researcher, has spent over 20 years researching student retention and extensively testing factors associated with this issue. It is this work that served as the foundation for her Nursing Undergraduate Retention and Success (NURS) model. Jeffreys (2002) developed a synthesized NURS model underpinned by Astin (2005), Bean & Metzner (1985), Braxton (2001), Jeffreys (1993, 1995, 1998, 2001, 2002, 2007a, 2007b), Spady (1970), and Tinto, 1993). Her model identified that student satisfaction was a critical component that influenced attrition decisions (Jaradeen, Jaradat, Safi, & Tarawneh, 2012). The more satisfied students were with the program, the more likely they were to stay in the program.
High student satisfaction was related to the intent to persist, improved retention rates (Jeffreys, 2012), and decreased attrition rates. Literature suggested numerous factors influenced a student’s satisfaction with their nursing program. Student profile characteristics, student affective factors, academic factors, environmental factors, professional integration and socialization, and academic and psychological outcomes (Jeffreys, 2012) were posited to influence student retention. Many of these same factors were identified by other retention researchers as influential to retention and persistence (Bean & Metzner, 1985; Spady, 1970; Tinto, 1971, 1993).

Jeffrey’s NURS model (2004) identified student profile characteristics as age, ethnicity and race, gender, language, prior educational experience, family educational background, prior work experience and enrollment status. Similar, factors had been identified in nursing student attrition literature as influential to student success (Abele et al., 2011; McCarey et al., 2006; Pryjmachuk et al., 2006; Salamonson & Andrew, 2006; Wray et al., 2012). Student affective characteristics were shown to impact retention and persistence in nursing programs (Orgun & Karaoz, 2014). These characteristics were described as positive attitudes, values, and beliefs about education, nursing, and high self-efficacy. Similar characteristics were found to impact nursing student retention rates (Peterson-Graziose, Bryer, & Nikolaidou, 2013; Robertson et al., 2010; Williams, 2010; Wood, Saylor, & Cohen, 2009). Academic factors in the model included personal study skills, personal study hours, flexible class schedule, high levels of general academic support services (Wray et al., 2012). These same factors were identified by other researchers as integral to student retention (Davidson, Metzner & Lindgren, 2011; Gilmore & Lyons, 2012; Robertson et al., 2010).

Environmental influences on nursing student success were identified as: financial status, family financial support, increased levels of family emotional support, balanced family
responsibilities, reliable child care arrangements, stable family home life, consistent employment hours, reasonable employment responsibilities, encouragement by outside friends, stable living arrangements, and reliable transportation (Jeffreys, 2012). These same influential factors explicited in the NURS (Jeffreys, 2012) model aligned with nursing attrition research studies conducted by Andrew & Salamonson (2008) who suggested that reasonable family commitments and being able to manage financial commitments supported retention, and that flexible work schedules also supported retention (Batykefer-Evans, 2013; Dante et al., 2011; Rochford et al., 2009).

Professional integration and socialization influences on nursing student retention were: high faculty engagement, advisement and perception of helpfulness (Shelton, 2012), opportunity to attend professional events for networking, cohort model structure, and peer mentoring and tutoring (Ousey, 2009). Yet again, these same influencing factors were studied in nursing student retention and attrition literature (Carthon, Nguyen, Chittams, Park, & Guevera, 2014; Fontaine, 2013; McKendry, Wright, & Stevenson, 2014). The sheer number of nursing retention and attrition studies identifying academic and non-academic factors associated with student attrition and retention is staggering; however, the interplay between factors and lived experiences of nursing students who withdraw has yet to be fully explored or understood.
Jeffreys (1993) early work focused on self-efficacy and the relationship of selected academic and environmental variables on student retention. The aim of an exploratory descriptive study she conducted in 2001 was to determine the effect of an enrichment program (EP) on academic outcomes, psychological outcomes, and to identify factors that restrict retention (Jeffrey, 1993). Jeffrey used the Student Perception Appraisal-1 (an investigator-developed tool; Cronbach alpha, 0.79) to measure how restrictive or supportive respondents perceived select academic and environmental variables were on retention. She used a second investigator developed tool, the Student Satisfaction Questionnaire (Cronbach alpha of 0.87) to measure student’s general satisfaction (nursing as a career, faculty advisor, and peer tutor/mentor) and other types of satisfaction with the EP.

Results indicated participants who were regular users of EP services had higher pass rates, lower failure rates, and lower withdrawal rates. Ninety-seven percent of the participants
reported they were satisfied with nursing as a career choice, the college in general, faculty advisors, and overall enrichment services. Finally, students in the EP group said the most restrictive variables were non-academic, environmental variables such as family crisis, lower financial status, a demanding job, increased family responsibilities, and childcare arrangements (Jeffreys, 2001).

In 2006, Jeffreys conducted a retrospective study to track the progression, graduation, and licensure characteristics of associate degree nursing students to identify progression and retention trajectories. The results of this study found three trajectories present in program retention (program completion in the required time and sequence), continuous retention (completion in five or more semesters without stop outs), and interim retention (five or more semesters with one or more stop outs).

Jeffreys (2007) used her NURS model as the conceptual framework for a multisite study to explore non-traditional student’s perceptions of variables influencing retention. She again used an investigator-developed Student Perception Appraisal-Revised tool (Cronbach alpha of 0.82) to measure supportive and restrictive variables. This revised version of the SPA-1 included professional integration and socialization items. Results from this second study again indicated that non-academic factors moderately or greatly influenced retention. Family emotional support, peer groups both inside and outside the college environment, and select campus resources supported retention. Moderately or greatly restrictive factors were perceived to be environmental in nature and were identified as family responsibilities, financial status, employment responsibilities, hours of employment, and family crisis.

A phenomenological study by Rudel (2006) used Jeffrey’s framework to describe social influences on retention in associate degree nursing students. Similar to Jeffreys own studies, non-
academic variables (peer support, social support from a spouse or significant other, and community support) were found to be major themes identified in the study. Rudel (2006) called for further research in non-traditional student persistence due to limited research in this population. A study Gregory, Krupp, and Williams (2013) used the NURS model as the conceptual framework to study general education course enrollment patterns in a community college baccalaureate RN-BSN program. The researchers found that students who completed general education graduation requirements before beginning BSN coursework were more likely to graduate from their RN-BSN program within the three-year expected time frame. The Gregory et al. (2013) study was conducted at a single institution where general education enrollment patterns were similar for each participant; this was noted as a limitation of the study.

Social integration within the context of professional role socialization and career development was added to a more recent iteration of Jeffreys (2004) model. In a quasi-experimental study using the social influences on retention component of the NURS model, Colalillo (2007) examined the influence of mentoring and nursing faculty support on nursing student retention. The respondents reported “feeling more confident, less stressed and better prepared” (p. 32) after mentoring sessions, and 70% found faculty support was highly influential in their success and the success of the program. A limitation of this study was that participation in the mentoring program was voluntary and may have included only those students who were more “motivated and committed to improving academically” (Colalillo, 2007, p. 32).

A dissertation study (Alden, 2008) used the NURS model to determine if early academic success and program completion is predicted by the presence of selective cognitive, non-cognitive, and demographic characteristics of pre-licensure baccalaureate students. Results indicated science GPA, math skill, and reading comprehension were statistically significant at
predicting early academic success. Reading comprehension, math skills, and prior degree were found to be predictive of program completion. No other variables tested were statistically significant in predicting early academic success or program completion. This study provided evidence that cognitive factors (GPA and prior college experience) present in the NURS model had an impact on academic success and retention towards graduation.

Pence (2011) used the NURS model to underpin her study aimed at predicting retention in associate degree nursing students. The researcher sought to determine if a relationship existed between emotional intelligence, motivation, and retention. Findings from the study indicated several subscales on the Motivated Strategies for Learning Questionnaire were statistically significant in predicting retention, but that emotional intelligence did not predict retention. The researchers recommended using other theoretical or conceptual frameworks and replicating the study in a larger, more diverse group of nursing students.

A correlation study by Fontaine (2014) evaluated the effects of selected retention interventions on associate degree nursing students’ persistence in obtaining a nursing degree using the NURS model as the guiding framework. In alignment with the Jeffreys studies, Fontaine hoped to shed light on the connection between the numerous variables inherent within the retention puzzle. This study tested seven retention interventions (stipends, learning communities, comprehensive orientation, individualized academic planning, counseling, peer tutoring, and community nurse mentoring) and the impact on retention rates. Although the retention rate increased by 10%, the researcher was unable to determine if one intervention specifically influenced the retention rate or if it was a combination of interventions.

population of nursing students to determine supportive and restrictive influences on retention. Kern used a non-experimental, descriptive study design in one setting with registered nurses enrolled in an RN-BSN program. All of the factors tested (environmental factors, college facilities factors, personal academic factors, institutional integration factors, and friend support factors) supported retention. However, unlike Jeffreys study, Kern found that environmental variables were the least supportive and support from family and friends was the most supportive. The author suggested several avenues for future research and further suggested that qualitative studies capturing RN-BSN students’ perspectives of retention and attrition would add to the limited body of knowledge in this area. Furthermore, the researcher recommended revising the SPA-R survey tool (Jeffreys, 2004) so that it would be more applicable to the RN-BSN population and recommended using it with a larger sample size.

In conclusion, the number of nurse researchers using Jeffreys NURS model to underpin their studies is steadily increasing. This increase may add to the model’s dependability in explaining nursing student attrition and offer nurse researchers a way to examine the complex and dynamic relationship between such factors.

Summary

The first steps in understanding the challenges of RN-BSN education programs are underway. However, why RN-BSN students continue to withdraw from nursing school has yet to be fully understood, and the lived experiences of these nurses remain unexplored. This is significant because attrition rates while they have remained stable, have not significantly decreased in the past ten years (CUNY, 2011; Dallas Nursing Institute, 2012; Sodders, 2005). A handful of studies reported the reasons nurses decided whether or not to return to college to obtain a baccalaureate degree (Cullen & Asselin, 2009; Mangubot, 2005). Other studies asked nurses who subsequently earned a baccalaureate degree the value it brought to them...
professionally and personally (Lillibridge & Fox, 2005; Zuzelo, 2001). While adding to what is known about why RNs return to college and the value they attributed to the degree, these studies did not explain why some nurses who were previously successful in college by virtue of earning their initial RN degree, voluntarily withdrew prior to completion.

Although many studies broadly defined attrition in both the general college population and the nursing student population as student mortality (Gekowski & Schultz, 1961; McNeely, 1937) or college dropouts (Spady, 1971; Summerskill, 1932; Tinto, 1975) consensus has not been reached on how the phenomenon might be consistently measured. Most studies measure the rate of attrition by calculating the number of students who did not complete their academic program in 150% of the time (the inverse of graduation rate) (U.S. Department of Education, 2012); yet researchers called into question the applicability of this definition to the non-traditional student population because the majority of non-traditional students do not attend college on a full-time basis (Robertson et al., 2010). By the very nature of their enrollment status, part-time students would not complete their academic programs within 150% of the estimated time frame.

Much work has been done to examine attrition related to pre-licensure nursing students as evidenced by the studies mentioned previously. While this work adds to what is known about which factors play a role in academic success, the majority of studies seek to predict who will be successful in progressing to completion and who is more likely to pass the NCLEX-RN. Identifying who is more likely to succeed in pre-licensure nursing programs is critical to increasing the number of registered nurses in practice; however, this information has little to do with understanding why nurses who have already proven they are successful in their pre-licensure programs are subsequently unsuccessful in completing RN-BSN completion programs.
The state of the science related to student attrition theory in the traditional college population is well-developed and widely used, as evidenced by over 13,000 citations of Tinto’s Interactionist Theory of Student Departure since it was first published in 1975. As the attrition rate of non-traditional college students increased, the need to identify what contributed to the increase was established. To that end, Bean & Metzner (1985) developed a model that identified factors more closely associated with the non-traditional student population; as did Jeffreys (2002) who developed the NURS model specifically designed for use in the nursing student population.

Although the NURS model created by Jeffreys (2002) appears to be a solid representation of the factors associated with nursing student retention, it has been used in only six other published nursing studies (Colalillo, 2007; Fontaine, 2014; Gregory et al., 2013; Kern, 2014; Pence, 2011; Rudel, 2006) and one dissertation (Alden, 2008). Rudel (2006), Colalillo (2007), Alden (2008), Pence (2011) and Gregory et al. (2013) used the NURS model (Jeffreys, 2004) as the conceptual model to guide their analysis while Kern (2014) used both the NURS model and Jeffreys (2004) SPA-R tool in her descriptive study of RN-BSN students. The NURS model has been used on a limited basis; nevertheless, because the model is solidly fixed on the work of Tinto (1975) and Bean & Metzner (1985) its applicability in understanding nursing student attrition is established. Understanding the meaning of withdrawing from an RN-BSN program is the first step toward interpreting extant data in the context of experience and is expected to guide potential interventions in nursing education.
CHAPTER THREE
RESEARCH DESIGN, METHODOLOGY, AND METHOD

Methodology
This research study was done to understand the lived experiences of registered nurses who prematurely withdraw from a baccalaureate degree program; for this reason, a phenomenological interpretive methodology was the most appropriate line of inquiry. Interpretive phenomenology seeks to determine “that the phenomenon exists, what it exists as, and how the phenomenon is experienced by an individual” (Ironside, 2005, p. x). Phenomenology illuminates the specific to identify phenomena through how they are perceived by the individual (Ironside, 2005).

Historical and Philosophical Underpinnings
Edmund Husserl, known as the father of phenomenology, believed that epistemology or knowing comes from awareness and consciousness in objectivity. These states were central to one’s perception; whereby, subjects/persons are conscious of objects/thoughts (Beyer, 2013). Two important philosophers greatly influenced Husserl’s philosophical and epistemological ideology, Rene Descartes, and Franz Brentano. Descartes’ Cartesian duality posits that the mind controls the body, and the body influences an otherwise rational mind, acting out of passion is an example of this way of thinking. For Husserl, the subject/object proposition forms the basis for his interconnected part-whole theory and provides a basis for phenomenological reduction or reductio’. In essence, Husserl concerns himself with the methodological procedure by which one is “led from the natural attitude, where one is involved in the actual world and its affairs, to the phenomenological attitude, in which the analysis and detached description of the content of consciousness is possible” (Beyer, 2013, para.3).
Husserl uses Brentano’s notions of intentional inexistence, to describe that mental phenomena are intentionally directed at an object of inner perception, further explicating his intentionality of perception theory (Beyer, 2013). For Husserl, the essence of a phenomenon will “show itself, in itself” if one uses the technique of bracketing or *epoche’* to hold prior knowledge about the phenomenon under study in abeyance so that the phenomenon may be perceived more clearly (Creswell, 2007, p. 59).

Taking Husserl’s philosophy of phenomenology in another direction, Martin Heidegger, who studied Husserl’s work, began to reject the notion of phenomenological reduction. This shift in thinking led Heidegger to move away from understanding how we know what we know (epistemology) to understanding what it means to be human (ontology) (Krell, 1993). Heidegger explained that consciousness is temporal and relational and experienced not through an objective lens but through subjective experiences rooted in historical and social contexts (Heidegger, 1962). From an ontological perspective, Heidegger explains that one cannot be “separated from being in the world… and bracketing (*epoche’*) is considered, ultimately, an untenable project” (LeVasseur, 2003, p. 415).

**Heideggerian philosophy.** Prior to Heidegger, many philosophers assumed that being was a universal concept, but for him, being or what it means to be human is expressed as *Dasein*, meaning life or meaning in everyday existence. Dasein is temporal in the sense that three ontological structures exist and that what it means to be is derived from the past, present and future (Ironside, 2005). Temporality is not tied to time in the strictest sense as in the hours, minutes, and seconds on a clock but that the state of being exists as a means for accessing the past, present, and future. Heidegger represents the past as *thrownness* where ‘being’ was limited to a historically conditioned environment, or the phenomenon of being is having-been. In
fallenness, Dasein exists in the “midst of beings that are both Dasein and not Dasein” (Korab-Karpowicz, n.d., para 2). Heidegger explains that “being-with or being alongside” (para 2.) accounts for Dasein by the presence of those beings within-the-world (Korab-Karpowicz, n.d.).

Existence, as Heidegger explains, represents the future; in that, one has the “potentiality-for-being” (Korab-Karpowicz, n.d., para 2). Going back, coming forwards, and being-with constitutes what it means to exist as a human being in the world. For Heidegger, meaning is situated, interpreted, and understood in the context of pre-understanding and the “insight that is being becomes meaningful to us only through language” (Stenstad, 2006, p. 41). Subsumed in language, speaking and saying are distinct concepts in that, “one may speak endlessly and say nothing at all; on the other hand, not speak at all and say a great deal” (Heidegger in Krell, 1993, pg. 408). Together, speaking and saying allow something to appear, to be seen, to be heard and therefore, meaning may be interpreted.

Phenomenological inquiry, language and text. Phenomenological inquiry is rooted in the concept of vocatio’, which means to call, to address, to bring speech (van Manen, 2011). Though vocatio’ text speaks, expressing ideas cognitively and conjures up feelings within the reader. The text has cognitive meaning while, at the same time, the words may incite emotion. An important tenet in interpreting text requires not only the writing down of the spoken word but also attention to tones embedded within the act of listening and the act of writing (van Manen, 2011). Vocative tone fixes powerful imagery to the text. When vocative tone is considered, the true essence and the deeper meaning of the experience of a phenomenon may be revealed.

The process of examining qualitative text requires the reader to take on phenomenological turns or ways of thinking. Derivatives of vocare: convocative, evocative, invocative, provocative, and revocative turns open up fundamental insights of a
phenomenological text, where meaning-making “is more likely found in the communal realm of the other” (van Manen, 2011, Convocative turn, para. 2). Through evocative ways of thinking, layers of meaning are embedded within the text through the recollection of the experience. Invocative ways of thinking bring ‘presence’ and allow the ‘seeing’ of something. It is this ‘seeing’ that reveals the experience to the reader.

van Manen (2011) explains that intensification of text (invocative) implies that the meaning of the text becomes more universal. He uses the example of, “this poem, this text, it speaks to me!” (van Manen, 2011, Phenomenological Turns, para. 2). In essence, the reader asks herself, “What meaning does this text stir up for me?” (provoke in me) or “Is there a sense of universality of meaning that has conjured up this feeling?” Finally, the revocative turn does not mean to call or draw back, but to bring “lived-throughness, or through anecdote and imagery, bring experience vividly into presence, making it immediately or unreflectively recognizable” (van Manen, 2011, Phenomenological Turns, para. 1). Hence, assuming phenomenological turns, the researcher interpreted the meaning of the experience of registered nurses who voluntarily withdrew from their BSN programs. Hermeneutic interpretation was the method used to interpret text generated in this study.

**Hermeneutics and the Deconstructed Circle**

Hermeneutics comes from the Greek root word (v.) hermneuein meaning to interpret. Hermeneutics is commonly associated with the interpretation of biblical exegesis and legal texts but extends to other texts as well (Willis, 2007). The hermeneutic interpretive approach makes evident, that understanding what it means to be in the world moves beyond the mere interpretation of text but from a “post-positivist stance, it is a scientific way of understanding the truth” as it exists in the life-world of the subject (Willis, 2007, p. 104).
Background, pre-understandings, co-construction, and interpretation are integral concepts in interpretive research using the hermeneutic circle. An individual’s background is “handed down and presents a way of understanding the world” (Koch, 1995, p. 831) and as Heidegger points out, background meanings may not be completely known (1962). History, culture, and language exist prior to our understanding of it and humans enter into a situation already possessing this pre-understanding (Koch, 1995). Human beings are living in a world that has been constructed for us and by us. In this way, we are co-constructing understanding through our experiences of living and being in the world (Heidegger, 1962). Humans are self-interpreting beings, and the world cannot be known separate from our interpretation of it and of ourselves in it (Heidegger, 1962).

In this Heideggerian hermeneutic study, the text is interpreted through the use of the hermeneutic circle. For the purposes of this study, the process is described as circular; in actuality the process is best represented as movement- a back and forth and between text, interpretation, and understanding. In this circle, self-understanding and world understanding are inextricably woven together. The process begins with examining the whole text, then its component parts, and in context, relating understanding back to the whole (Debesay, Naden, & Slettebo, 2008). Engaging with the text around the circular process uncovers the hidden or renders the unclear clear creating a fusion between pre-understanding and new understanding (Gadamer in Debesay et al., 2008).

**Heideggerian Hermeneutics in Nursing**

Nursing is a human endeavor and as such, phenomenological inquiry is well-suited to understand how human beings experience phenomena under study. Phenomenology has been used in nursing research, practice, and education. Benner (1984) was instrumental in explicating the merits of phenomenological inquiry to understand the practice of nursing. She proposed that
health, illness, disease, and quality of life are phenomena that must be understood as they are experienced subjectively.

In her seminal work, *From Novice to Expert*, Benner based her phenomenological inquiry on the work of Heidegger and Gadamer. She studied experiential learning in nursing practice to “make the caring practices that are integral to excellent nursing practice visible” (Benner, 1994, p. vi). Interpretive phenomenology was used to understand the caring experiences of nurses working in critical care (Allen, 1995), to understand the meaning of comfort care in hospice nurses (Evans & Hallet, 2007), and to understand the experiences of advanced practice nurses in primary care settings while assessing women with alcohol use disorders (Vandermause, 2007).

Several prominent nurse researchers used a Heideggerian hermeneutic approach to gain an understanding of the lived experiences of nursing students and educators. Nancy Diekelmann and Pamela Ironside contributed greatly to the field of nursing education through studies which delved deeply into how students experience nursing education and how educator’s practices were shaped by pedagogy (Diekelmann, 1993; Ironside, 2003; Ironside, Diekelmann, Hirschmann, 2005). Diekelmann (2005) interviewed nursing students and educators to elicit narrative accounts of events that stood out as being particularly meaningful to them in the context of testing and evaluation.

Situated in Heideggerian philosophy, Diekelmann and her interpretive team used a systematic process to analyze narrative data to identify shared practices and common meanings. First, the team read written transcripts to gain overall understanding, and then; coding began using a qualitative software program to identify possible themes. Next, the team read select transcripts, prepared written interpretive summaries and analyzed the summaries for emerging themes. Discussion followed, and disagreements of interpretations were resolved by returning to
the text (Diekelmann, 1993). The process continued as movement in, around, and through the hermeneutic circle allowed identification of major themes. In 1993, Diekelmann used the same philosophical underpinnings and the hermeneutic circle to understand how nursing students and educators experienced behavioral pedagogy. Interpretation of the narrative data collected from students and teachers “point towards how our practices as nurses and nurse educators set up some possibilities of learning how to be a nurse and limits others” (Diekelmann, 1993, p. 74).

According to Diekelmann, what matters most in her study was how nurse educators created their teaching practice and how that practice played out in the lives of students. These two studies were integral to the development of narrative pedagogy which is used in nursing education today (Diekelmann & Diekelmann, 2009).

Informed by Diekelmann’s studies, Ironside (2003, 2005) used Heideggerian hermeneutics to understand how educators taught using narrative pedagogy and how that teaching approach influenced how nursing students thought. Ironside and her interpretive research team used the same technique described by Diekelmann above to identify common patterns and shared meaning. Informed by her 2003 study, Ironside (2005) conducted a second study to understand phenomena embedded in teaching and learning in nursing education. The study aimed to understand experiences surrounding how nurse educators used narrative pedagogy to teach thinking as opposed to teaching students rote memorization.

Similar to the studies mentioned previously, this dissertation study used Heideggerian hermeneutics as the guiding methodology. The goal of such research is to obtain an understanding of the experiences and interpret deeper meanings of a given phenomenon across texts; therefore, Heidegger’s tenets served as the foundation for the researchers’ philosophical
way of being and understanding the lived experiences of RNs who withdraw from BSN programs prematurely.

**Research Design**

This research study used a cross-sectional, qualitative, descriptive design. Telephone interviews were conducted using a Heideggerian hermeneutic methodological approach. Through Hermeneutic interviewing, data were gathered through narrative story-telling to “understand meaning and make sense of the experience” (Vandermause & Fleming, 2011). Phenomenology is the philosophical undergird used to understand the lived experiences of registered nurses who withdrew prematurely from BSN programs.

**Sample and Sampling Plan**

**Recruitment and selection.** A purposive sample of research participants was recruited using a snowball sampling technique because this is the most appropriate method for recruiting participants known to have experienced the phenomenon under study (Portney & Watkins, 2009). Recruitment flyers (Appendix A) were distributed to academic colleagues who taught in RN-BSN programs. This technique yielded two participants. Afterwards, an information request was sent to the Washington State Department of Health to approve the release of a list of registered nurses licensed in Washington State. The request was initiated to reach a wider pool of potential participants. This request was granted, and the researcher emailed the recruitment flyer to potential participants. Participants who met inclusion criteria were asked to contact the researcher via email or phone if they were interested in participating in the study. After determining eligibility, the researcher emailed the consent form to the potential participant. If after reviewing the consent the participant still wanted to participate, an interview was scheduled. In all cases, participants chose to have the interview conducted via telephone as opposed to face-to-face because it was more convenient for them to participate in this way.
Inclusion criteria were: registered nurses from any race or ethnicity who were over 25 years of age, spoke and understood English, who enrolled and voluntarily withdrew from a BSN program prior to completion. Exclusion criteria were: registered nurses who did not speak or understand English, who were younger than 25 years of age and involuntarily withdrew from a BSN program due to academic failure. A total of 14 participants who met inclusion criteria were interviewed for this study.

Data Collection

Data were collected through telephone interviews that were digitally recorded. Notes taken during the interview recorded vocal intonation, pauses in the conversation, and other cues (Crist & Tanner, 2003) which helped the researcher guide the conversation and generate a complete understanding of the experience. Interviews were transcribed verbatim and de-identified using pseudonyms, securing participant’s anonymity. Protecting participants identify is vital and the choosing of a meaningful pseudonym may provide insight and avenues for further interpretation (Vandermause & Fleming, 2011). Some participants selected a pseudonym closely related to self-identity, one that represented an idealized self, or one that held significance for them in some way. Others did not select a pseudonym but asked the researcher to choose one for them.

Interview. Conducting hermeneutic interviews is a complex process. Each interview was conducted in a manner that allowed the participant’s story to emerge. The researcher maintained active listening concentrating and internalizing the substance of what was being said (Seidman, 2006). Further, she listened astutely for the [emphasis added] inner voice when unguarded thoughts and feelings were shared, while remaining cognizant of the interview process (Seidman,
2006) as was occurring. The interviewer was careful to consider the time taken and distance covered while assessing for cues that participant was approaching fatigue.

The interview began with a broad, open-ended question posed to elicit the narrative. Participants were told the nature of the study and asked, “As someone who has withdrawn from a BSN program, please tell me about what that experience was like for you?” The researcher used other prompts as needed to move the interview along. These prompts were, “Can you elaborate on that?” “Can you give me an example of…?” “Tell me more about that” or “Was there a moment that stood out as being particularly significant to you during that time, can you tell me about it?” Questioning in this manner gave participants a wide berth to reflect and “think as they articulated their experiences” (Vandermause & Fleming, 2011, p. 372).

Using open-ended questions, setting the tone, using incomplete sentences, and looking for assent (Vandermause & Fleming, 2011), the researcher brought the participant back to the story (Dinkins, 2005) ensuring that what was being said was fully understood in context (see Appendix C for interview question prompts). A well constructed hermeneutic interview takes on a conversational tone and opens up time and space for immediate reflection as Heidegger explains the “silence that enables us to listen is more significant than all the noise of signification (Krell, 1993, pg. 395).

One hermeneutic interview was conducted with each participant. As the interview proceeded, shared meaning between the researcher and participant was created, complete with the richness of detail and context that shaped the experience (Dinkins, 2005, p. 113). Listening and questioning are important aspects of hermeneutic interviewing (Ironside, 2005) and engaging in dialog in this way allowed the story to take its own course. As new ideas emerged, a shared and deeper meaning of the experience was revealed (Ironside, 2005). A delicate balance between
thoughtfully guiding the interview and respecting the ebb and flow of the conversation as it unfolded was maintained.

**Data Management**

Telephone interviews were digitally recorded and transcribed verbatim into a Microsoft Word document by an experienced transcriptionist educated in research ethics and confidentiality. The text was line coded and participants were identified using pseudonyms. All references to geographic location, healthcare facility or unit, and academic program was redacted from the transcript. The professional transcription service used a password-protected platform for all electronic transmissions of the digital files and transcribed documents. The researcher independently verified the accuracy of the transcribed document against the digital recordings. All digital recordings, transcriptions, and work products created during the research study were kept in a password protected share-point website sponsored by Washington State University (WSU).

Washington State University Office of Research Compliance required all electronic files to be stored on a secure server. Members of the research team ensured that work products on their computer, be it digital recordings or transcript documents, were accessible only to them and were password protected. Printed copies of transcripts and the master codebook with participant identifiers and demographic information were kept separate in a locked filing cabinet at the primary researcher’s home. The primary researcher had the only key. Digital recordings will be kept for three years and then deleted from the share-point site. De-identified transcripts will be kept indefinitely for future analysis or for use in educational settings.
Data Analysis

The text from each interview was analyzed for common ideas and interpreted to uncover meaning using a Heideggerian hermeneutic approach. The research team utilized data analysis techniques described by Vandermause (2012):

1.) Read the text thoroughly, carefully, and completely from start to finish
2.) Read the text line-by-line, mindfully
3.) Take notes of concepts that stand out in some way
4.) Review notes observing for general categories or related ideas that emerge, taking note of frequency and position in text, identify the response, and any patterns or mannerisms evident
5.) Create a list of emerging patterns
6.) Review the transcript with these patterns in mind
7.) Name patterns of ideas
8.) Summarize the transcript with enough rich detail to convey a plausible and coherent expression of findings. Retell the account, describe the emerging patterns, and include personal thoughts, reactions, and interpretations.

As each transcript was read, and re-read and common ideas began to emerge and build overarching patterns through an iterative process (Vandermause, 2012).

The data analysis team consisted of the primary researcher and a dissertation member experienced in interpretive phenomenology. The research team carefully considered and weighed assumptions that may have influenced the interview or interpretive process (Crist & Tanner, 2003). This action was deliberate and explicit, often referred to as the “forward arc of the hermeneutic circle” (Crist & Tanner, 2003, p. 203).
Managing data and presenting interpretations. After completing data analysis of several transcripts (see data analysis steps 1-8) storage units were identified according to named patterns of ideas. The text was then deconstructed across transcripts into verbatim phrases that represented named patterns where areas of overlap were identified (Vandermause, 2012). The texts were read and re-read to gain overall understanding of the participant’s story, staying true to the tenants of hermeneutic interpretation. Transcripts were then read again paying special attention to patterns and use of language and position in the text along with significant concepts that hint at broad working patterns of understanding. A second level interpretation of six transcripts was generated, as a deeper understanding of the withdrawal experience began to emerge.

At this juncture of the interpretive process members of the research team engaged in a validation exercise, a variation of member-checking. Two dissertation members not directly involved in interpreting all 14 transcripts read a selected transcript along with the data analysis team’s interpretation of those two transcripts. They noted any areas of the transcript and interpretation that stood out for them and whether or not the interpretations made sense to them. The entire dissertation team met approximately midway throughout the data analysis phase and discussed the summary of the initial six interpretations. As the research team moved in, around, and through the hermeneutic circle during this time, ambiguities in emerging ideas and patterns were identified and discussed. This process resulted in clarity and consensus of the emerging ideas and patterns for the dissertation team.

The eight remaining transcripts were read and interpreted using the same process outlined above. Interpretations were generated using the emerging patterns as a guide. The data analysis team remained flexible and open to identifying additional patterns that emerged. Overarching
patterns that represented common ideas embedded within the text were then named. Exemplars from the transcripts were extracted to illustrate overarching patterns and underlying ideas embedded within the withdrawal experiences of the participants.

**Establishing trustworthiness of the findings**

Establishing rigor of qualitative findings is sometimes challenging because the creativity that allows meaningful stories and insights into human experience found through qualitative inquiry must not be stifled by the methodological rigidity that sometimes predominates scientific inquiry (Sandelowski, 1993). Keeping the necessity to remain reflexive in mind, Whittemore, Chase, and Mandle (2001) explicated primary and secondary criteria used in qualitative inquiry to ensure validity and that the “researcher is not conjuring up concepts…that do not authentically represent the phenomenon of concern” (Whittemore et al., 2001, p. 526).

**Primary criteria.** Credibility and authenticity are concepts used to describe the accuracy of interpretations and the meanings derived from them. In this way, Thorne suggests that the researcher evaluate if the results reflect the experiences of the participants in a believable way and reveal “some truth external to the investigators’ experience” (as cited in Whittemore et al., 2001, p. 530). Authenticity was ensured during this study because the researcher deliberately and intentionally remained acutely aware of the participants’ voice and that of her own. The researcher’s voice was not allowed to overshadow or prejudice that of the participants as verified and confirmed by all members of the research team. Maxwell reminds the researcher to ask herself, “Has a representation of the emic perspective been accurately portrayed and at the same time, accounted for the investigator’s perspective?” (Whittemore et al., 2001, p. 530). This question remained in the forefront for the researchers mind during the interpretive phase of the study.
Critical analysis of the investigative process during all phases of the research study added to its validity (Whittemore et al., 2001). The researcher engaged in checking her assumptions and biases and strived to explain ambiguities in the data. The sheerest form of critical analysis required the researcher to make evident interpretations that substantiate the participants’ experiences in the most truthful way possible. This process was validated by the methodological expert, Dr. Vandermause, as well as the participants who frequently voiced whether the story when recounted, “rang true for them.”

**Secondary criteria.** Explicitness, vividness, creativity, thoroughness, congruence, and sensitivity are secondary criteria used by Whittemore et al. (2001) to evaluate validity in qualitative studies. In essence, the investigative process was made explicit to the participants, the data collection and interpretation yielded thick and rich description of the experiences of nurses who withdrew from their BSN programs through imagination and creative ways of organizing, analyzing, and presenting these experiences. Data analysis was comprehensive, thorough, and complete allowing the phenomenon to be fully explored at the ground level. The research question, line of philosophical inquiry and methods aligned. Congruency is crucial in establishing the validity of the findings (Whittemore et al., 2001). Lastly, the researcher remained sensitive to the fundamental purpose of qualitative inquiry by ensuring respect for the process and for the individuals who informed the study.

**Limitations**

Geographical location limited the study; therefore, telephone interviews became necessary. The researcher anticipated and experienced a second limitation in accessing the population. This population was somewhat difficult to find because nursing programs did not consistently follow-up with students who withdrew or have current contact information for those who did not complete academic programs. To complicate recruitment further, access to student
contact information was not granted to external researchers because this practice constituted a violation of the Family Education Rights and Privacy Act (FERPA). To address the FERPA issue and geographical location limitations, as well as to gain access to a notoriously difficult to find population of registered nurses, the researcher (following approval requirements) sought and was granted access to a list of registered nurses licensed in Washington State. The use of this list by the researcher was restricted for use in this dissertation study only.

**Human Subjects**

Institutional Review Board (IRB) review was obtained through WSU prior to conducting any part of this research study. Informed consent was obtained (see Appendix B) from all participants prior to being interviewed. Participants were informed that digital audio recordings and de-identified transcripts would be created and that confidentiality of their participation in the study was ensured. Participants were informed of their right to discontinue participation in the study at any time, for any reason.

**Risks and Benefits**

Risks may occur both during and after the interview. The researcher ensured the location of the interview was quiet and private so that the conversation was not able to be overheard by happenstance. During or after the interview, there was always a risk of suffering emotional distress when participants were asked to recall experiences that were negative or experiences where they did not achieve or accomplish a goal they set for themselves. Indeed, many nurses who told their stories expressed regret at not accomplishing their goal of completing a BSN program. The level of emotional distress participants experienced varied according to their individual coping mechanisms and according to the meaning they assigned to the experience.

The researcher carefully listened for verbal cues that the participant was experiencing distress. On two occasions, the researcher became aware that participants were experiencing
anxiety or discomfort while telling their story. As was appropriate, the researcher paused the interview and allowed participants to express what they were feeling at that moment.

The researcher reminded both participants they could stop the interview at any time, for any reason. After a brief pause in the conversation, both participants expressed a desire to continue the interview. The researcher followed up at the end of the interview to make sure both participants were comfortable and were able to express concerns with any issues that came up for them during the interview. Both agreed to check-in with a family member or follow-up with a healthcare provider if they felt they needed additional support.

Benefits of participating in the study allowed participants gain new understandings of their experiences and to feel better for having being listened to. Allowing participants’ voices to be heard added to the body of knowledge and furthered the state of the science in nursing research, education, and practice.

**Pilot Study**

A pilot study was conducted by the primary researcher in consultation with a dissertation team member experienced in interpretive phenomenology, Dr. Roxanne Vandermause. IRB approval from WSU was obtained (Exempt #14240) prior to conducting any research activities. The purpose of the pilot study was two-fold. First, the study assisted the primary researcher in determining if the methodological design, procedures, sampling plan and recruitment activities would support the research question of the dissertation study. Second, because interviewing techniques are critical to obtaining high-quality data, conducting a pilot interview allowed the primary researcher to gain practical experience in hermeneutic interviewing. Additionally, the primary researcher participated in qualitative seminars at WSU along with experienced interpretive phenomenologists and other doctoral students. The purpose of participating in these
qualitative seminars was to create a community of interpretive scholars and to develop a deep understanding of interpretive phenomenology, hermeneutic interviewing, and text interpretation.

Participants for the pilot study were recruited by posting recruitment flyers (Appendix A) in areas where registered nurses frequent and also by the primary researcher asking her peers if they know of anyone who might be interested in participating in the study. One participant was included in the pilot study. Informed consent was obtained, and the pilot interview was conducted via telephone. The interview was digitally recorded, transcribed, and analyzed using the process outlined above. Dr. Vandermause assisted the primary researcher in analyzing her interviewing techniques and identified strategies for improvement.

Made evident after the pilot interview, the methodological design, procedures, sampling plan and recruitment activities supported the research question. The researcher was also able to refine interviewing techniques based on input from Dr. Vandermause. Because no major changes to the research design were needed, the researcher began recruiting participants for the research study. A total of 14 participants were interviewed for the study and the findings are presented in the following chapter.
CHAPTER FOUR
FINDINGS

Overview

Background of the Participants

The withdrawal experiences of each of the 14 nurses who participated in this study were unique in their own right; however, similarities across each experience emerged. The breadth and depth of experience these nurses expressed deepen the understanding of the withdrawal experience for this unique population. 13 of the nurses in this study were registered nurses licensed in Washington State and one was licensed in California at the time of the interview. All had at least six years of experience to over 40 years of experience as registered nurses, an average of 17.5 years of nursing practice.

Nurses in the study worked in a range of private, public, and government healthcare facilities from long-term care, home health, and community health, to acute care, outpatient and special procedure units, and primary care areas. They functioned in various roles such as staff nurse (some with specialty certification), unit manager, case manager, risk manager, and patient navigator. 12 nurses resided in Washington State, one was currently living and working as a civilian contractor on a United States military base in Germany, and one resided in California. Eight nurses had an associate degree in nursing; one of these completed an LPN to RN associate degree step-up program prior to enrolling in a BSN program, and two had a nursing diploma.

Demographics. Ten nurses chose to answer demographic and informational questions posed after the interview, one nurse gave partial answers, and four nurses chose not to disclose this information. Results are compiled in Table 1.
Table 1: Demographic and Informational Questions (N=10)

<table>
<thead>
<tr>
<th>Age at the time of study</th>
<th>Race Eth.</th>
<th>Gen.</th>
<th>Marital Status</th>
<th>No. of Children</th>
<th>Employment Status during BSN program</th>
<th>Student Status during BSN program</th>
<th>Financial Aid, Received</th>
<th>First Gen. College Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. 46.6 28-63</td>
<td>White, NH, NL 10</td>
<td>F, 9 M, 1</td>
<td>M, 2 S, 4 D, 4</td>
<td>None, 3 1-2, 3 ≤3, 4</td>
<td>F/T, 8 P/T, 1 PD, 1</td>
<td>Full-time, 4 Part-time, 6</td>
<td>Yes, 4 No, 5 Did not answer, 1</td>
<td>Yes, 4 No, 5 Did not answer, 1</td>
</tr>
</tbody>
</table>

*reported by participants

**Overview of program participation.** Descriptions of baccalaureate degree programs participants attended varied in delivery method, length, courses, and degree requirements.

Several nurses were enrolled in fully online programs, some in hybrid programs (a combination of face-to-face and online), and some in traditional face-to-face programs. They described program length as being one, two, or three-year programs or variable according to their individual plan of study.

Nurses in the study withdrew at various time points during their BSN programs, and one enrolled but withdrew prior to attending the first course. One withdrew after a month, and some withdrew after completing the first term or first few courses. Two withdrew after completing the majority of the program. These two participants were either within a few courses or about 12 credits shy of completion. One nurse withdrew after taking one course which solidified her decision to leave the profession altogether.

Nurses who withdrew early on in the program said delivery method (online, hybrid, face-to-face), the amount of time and commitment required to attend class or complete assignments, inflexible schedules, or irrelevant coursework were significant factors in deciding whether or not to stay or withdraw. As one describes, “my heart wasn’t in it 100%, and I didn’t research the
program very well before I started” (Participant Ten). Nurses who withdrew later in the program cited competing priorities, less than supportive family members, or inadequate finances as factors that led to a decision to withdraw.

Nurses in the study questioned the value and relevancy of taking required courses such as dancing, swimming, and Greek mythology and how those courses advanced their nursing practice. To be clear, every nurse described a passion and deep love of learning, and credited knowledge gained beyond the confines of formal academic programs as being meaningful and valuable to their everyday bedside nursing practice. Two nurses are certified in critical care, and another is certified in medical-surgical nursing. Many said it was not unusual for them to complete more continuing education credits than the WA Department of Health or California Board of Registered Nursing required for maintaining their nursing license. As Traveler said, “the more I’ve lived and traveled I see education in a much broader perspective, politics, other cultures and there are areas you can grow in and learn and add to your life…you can grow in different ways…getting a degree is not the only way to learn- satisfy that need for learning.”

Nurses described their BSN programs as having restrictive and supportive features. Nurses chose online BSN programs because they were advertised as being flexible with individualized learning, a go-at-your-own-pace style of program. These nurses found online programs to be cost prohibitive and in most cases, inflexible. Online programs with cohort models and excessive group work were harshly criticized by some nurses because their work schedules made it difficult to complete group projects. Others said that group members were not at the same academic level of preparedness as they were, often causing them to take on an additional role of instructor, English teacher, and/or group leader.
Furthermore, online group members were described by some participants as being poor planners, who often waited until the last minute to complete their portion of the group project. These delays increased anxiety and affected everyone’s grade. Instructors were often described as inaccessible and difficult to contact or gave very little direction or feedback on assignments. One exception was noted, and one nurse described that her online mentor was “very supportive and helpful,” so much so, that this nurse expressed feeling guilty for withdrawing because it “might make a black mark” on her mentor’s statistics (Participant Ten).

On the other hand, face-to-face (FTF) programs were described as being more conducive to learning, and nurses felt more comfortable interacting with their peers in this setting. They also said it was easier to interact with their professors and that they felt like they were a part of a community of learners. A drawback of FTF programs was that they were located too far away from work and home causing some nurses to travel over 2½ hours each way to attend classes.

Irrespective of individual program features that either restrict or support nurses who return for a baccalaureate degree, the decision to withdraw does not come easily even with the best supports in place. What lies underneath these accounts is the belief that their nursing experience, regardless if it is six years or 41 years at the bedside, has somehow become insufficient. Each nurse articulates, forcefully and profoundly, that this conundrum is at the core of their withdrawal experience.

**Hermeneutic Patterns and Ideas: The Way Through**

Interpretive analysis of text is an iterative process. The researcher is both witness to the *telling* [emphasis added] and walks alongside the participant as the story unfolds. Just as the story is co-constructed during the interview, it is deconstructed during hermeneutic analysis to reveal the essence of the experience. Deconstructed elements are then held up against the whole to form a basis for understanding the experience as it lives within the participants. Each
participant was asked to reflect on their withdrawal experience and express what stood out as being of particular significance to them during that time. Every transcript began with reason(s) for withdrawing followed by reason(s) they pursued a BSN and their personal account of the experience.

The essence of experience did not emerge from one single text. As the research team engaged with and dwelled within the text, common ideas began to emerge, and these ideas began to bubble up as subsequent texts were interpreted. These initial ideas were somewhat muddy and vague until further texts were interpreted by using this same iterative process. As common ideas formed, broad patterns began to take hold. As broad patterns took hold, overarching patterns that encompassed these ideas were named (Figure 3.)

Beginning with the initial pilot interview and present within each story, having multiple and competing demands upon the participants time and energy was an early idea evident within the text. As subsequent texts were interpreted, multiple competing priorities, heightened during the withdrawal period, were recounted over and over. Regardless of the actual demand, whether it was a lack of childcare for some or being overloaded at work for others, each participant described this push and pull as a balance that was difficult to maintain. These common ideas formed the basis for the broad pattern of juggling balls and spinning plates.

**Red:** (pilot interview) *I had to tend to others needs at the time.*

A second idea began to show up early on in the interpretive process. This second idea was distinct but also overlapped with juggling balls and spinning plates. Common across all transcripts was the notion that a failure loomed over the participants. Each used different descriptors of failure according to the meaning they assigned to it. Some felt regret at not completing a life’s goal, some said they were not living up to the standards they set for
themselves, and some flat out said they failed when they should not have. What was common across the withdrawal experience as that a level of failure participants were unaccustomed to was present; a loss was felt. This failure, this loss also came from not being able to balance everything that they felt they must to be successful. Balls drop, and self takes a hit, the second broad pattern that emerged.

**Red:** *I felt like a failure...that is not someone like me, I don’t usually quit.*

Transcript after transcript, similar patterns were present as the research team began to understand that each participant revisited the failure in some way. Some spoke about the failure in the context of time holding the resultant feelings at bay, and others spoke about the failure as if it were yesterday, experiencing the full weight of it as they told their story. Regardless of when the failure occurred what remained common was how the failure showed itself across texts. *Revisiting Failure* was one overarching hermeneutic pattern embedded within the withdrawal experience.

A third idea began to show up after the initial interpretations of the text. This idea emerged more slowly as nurses recounted reasons they chose to pursue a BSN. Linked to the withdrawal, was the notion that they might be terminated without a BSN. They also articulated that they felt others were judging them as being lesser nurses without a BSN. These perceived pressures were present in the minds of each participant, expressed in multiple forms, constituting the third broad pattern of threats from within and out.

**Charlotte:** *If I get laid off, if I go back to the hospital, they’re going to be looking for a bachelor’s…that’s all they want nowadays.*

**Belle:** *So you know, I’m not getting a BSN, but I’m certainly still getting a lot of education...It’s just not in college.*
**Mary:** It doesn’t matter what degree you have….if you can’t cut it, if you’re not good at it, and if you’re not professional about it, you’re not going to make it.

The fourth idea that emerged was a complex and dynamic weighing of options. As nurses in the study described, their withdrawal experience was a fusion of wanting to complete the BSN, coupled with the threat they would lose their job if they did not, which was weighed against its cost on multiple levels (money and time) and the benefit of having the degree. The relevance of the coursework was questioned, and the perceived real-world impact on their bedside nursing practice fell short of their expectations. This confluence of events was revealed within the text as broad and overlapping patterns of *threats from within and out* and *being valued, cost versus benefit and the relevancy of the degree*.

**Grace:** I see charge nurses who are Associate degree nurses. And no difference at all.

The two places that I’ve been, you only get a dollar more in pay per hour. The only real incentive is that you could possibly lose your job.

Nurses in this study who returned to university for a BSN degree expressed an understanding that having it would lead to personal or professional growth in some way. For them, it would satisfy a personal goal or open up opportunities to do “something further within the realm of nursing” (Twelve) unavailable to them without a baccalaureate degree. Nurses considered the BSN a career pathway; not having the degree left them place-bound, at an impasse on one side of the divide. This *Impasse, On One Side of the Divide*, was the second overarching pattern that emerged from the texts.

The withdrawal experience was both propelling and limiting- a paradoxical and paralyzing situation for nurses who want but don’t want or can’t continue forward. They were in a circular and static situation that was unhappy and unfulfilling. As we’ve come to understand,
embedded within the withdrawal experience for nurses who described the profession as a calling and in their blood, was the thought that without a BSN they were somehow lesser nurses, were becoming obsolete, were not valued for their experience, and were un-hirable beyond their current employer.

Figure 4. Illustration of Patterns of the Withdrawal Experience

**Pattern 1: Withdrawing as Revisiting Failure**

Withdrawing as revisiting failure manifested in overlapping ideas of the *self takes a hit* and *juggling balls and spinning plates*. *Self (being) takes a hit* showed itself as regret, ambivalence, letting oneself or others down, being successful- then not, and being strong and not needing to be coddled. *Juggling balls and spinning plates* was revealed as life gets in the way, balancing competing priorities, giving all one is able, and running on empty. The *self takes a hit* showed that nurses who withdrew from BSN programs suffered many losses; the experience took a toll on non-completers. Nurses who withdrew intimated it costs more than time and money when one does not complete a BSN program.

**Wild:** *Money is the least expense in the program from my opinion. It costs you the assurance that you are already good enough as a nurse. For me personally, that’s what it cost me. It cost me someone telling me you’re trying to become a professional. No, I was*
a professional before I came here...and it costs you your relationship with your fellow nurses...there’s a cost on the time with your family...I had a young child, and I was not married at the time.

An emotional toll was exacted on nurses who withdrew. Regret and the feeling they had let themselves and others down as a little piece of me [emphasis added] became lost along the way. This regret stood out as significant because this [the accomplishment] was something left undone, an unfulfilled desire; to this day, the desire to return is strong for some. Self-esteem, feeling like a failure, and loss of pride hit hard as nurses said,

**Charlotte:** *It was a personal goal-I can do this...then I felt that I let myself down for dropping out.*

**Mary:** *I just felt like I wish I could’ve finished...because going back after something like that is difficult...and so I think I just gave up.*

One participant expressed disbelief when one of his professors said,

**Denver:** “I’m sorry, but I believe that nursing is traditionally a woman’s profession” and that I felt like I didn’t have any real defense on that because discrimination doesn’t exist for me [being a white male].

Participants expressed anger, betrayal, ambivalence, bitterness, anxiety, complacency, and sadness as they reflected back on the withdrawal experience. Although lessened with the passage of time, these emotions surfaced as the self takes a hit; its resonance throughout these stories was deafening. After 15 years and three withdrawals, one participant described overwhelming anxiety experienced during the withdrawal period.

**Denver:** *...it took me a long time after I got out of school, facing debt and just the anxiety since I had gone to school...it impacted me profoundly...I get a little tight just talking*
about it here...It’s little balls of stress, and you get hit with so many little balls of stress it starts to become one big ball of stress and I was at a point...it was like I was traumatized from going to school.

For others, failure was not part of their DNA which made the withdrawal all the more significant and meaningful for them. Red described her withdrawal as:

Devastating...I felt a little bit like a failure...because I don’t see that as one of my personality traits. I don’t usually quit...especially in school...when I start something, I like to finish...and I was really looking forward to it. And – and the worst part was is that was for me. The thing I had to give up was the thing that was for me.

Similarly, another nurse said,

I couldn’t handle the embarrassment...and I did not grow up that way. I did not grow up to turn away from a challenge...that’s really not my personality” and “I went there three times...I’m not the kind of person that will give up easily...I see the goal, and I go for it...and so to have had that experience and dropped out, that’s an unusual thing for me...how I reflect about my person and my being and the failure.

And finally,

**Grace:** I think at the time, I felt like I failed. Absolutely. I felt like there was a way to make it all work –that I’m not doing...technically I feel like I should be able to do everything...it was definitely a bad time for sure...if you fail, you do feel like, why am I not making it work? Why is this not coming together like I thought it would?

Nurses described the weight another failure might carry for them. Concerned about what might happen if they tried again was expressed by some.
Fourteen: And I realized I can’t commit to something like that...if I know I’m not going to be able to follow through... I’m not going to put myself in that situation to feel like I’m failing...because I know right now before I even get started that it’s not going to work.

Charlotte: What if I try it again, and I fail again? ...maybe the trying and failing part gets me...but I’ve come to accept that...the only person that’s judging me is me, and, I really wanted to do it and I was doing it, and I still want to do it, but even now I find myself- I can’t concentrate.

Denver: It used to be that I had no fear about going to school but the experience stunted me...one or two professors said to me, “you know, maybe nursing is just not for anybody,” after having worked as a nurse for nine years.

These statements are excellent representations from the text of the self takes a hit. Loss and regret were weaved throughout these accounts and for one, the decision to withdraw still chips away 25 years later, “if he really loved you, he’ll wait for twelve credits” (Hydrangea). Self takes yet another hit as nurses came to realize they could no longer handle everything on their plate.

Juggling balls and spinning plates painted a vivid picture of the withdrawal experience. BSN coursework was not too challenging for these nurses; it was competing priorities that prompted withdrawal for some. “Life got in the way,” (Red) an idea represented in the withdrawal experience as juggling balls and spinning plates. Balancing the demands of family, work and school were significant challenges, antecedents to withdrawal (Mangubut, 2005).

School became secondary when confronted with the push and pull of putting their family needs and work requirements above their own desires. Secure in the knowledge they had been successful in doing this same juggling act every day at home and work, the balls and plates
began to drop one by one until a tipping point was reached, the dam was breached, and withdrawal became unavoidable. The feeling that came from dropped balls overlapped with the sense of failure that showed up as self takes a hit. Balance meant success; imbalance equated with failure. It is not uncommon for most non-traditional students who must figure out a way to balance multiple demands of living and working while continuing to maintain high levels of service at home and elsewhere.

Grace: Having a job and a family life at home. And having to rely on so many other people to get work done...that was the biggest significant thing that made me withdraw...we’re a military family, and my husband was deploying. I think a tipping point is a really good way to explain it. It was just like, okay, we’re making it. I can push through. And I was like, oh, gosh. I’m drowning. I can’t keep swimming any longer. I’m doing all these things, I’m wearing all these hats, and I’m coping, but somehow it’s my fault that it’s not coming together.

Interviewer: [for context] Is that a fair?

Grace: ...in some ways, no, but that’s the way I felt.

Nurses described themselves as strong and highly capable individuals who work in challenging and often difficult situations, a common thread that binds nurses. The inability to manage their circumstances during the withdrawal period ate away at their resilient interiors.

Wild: They threw me out like yesterday’s trash... the way I look at it is that I rarely ask for help because I’m a helper. Right? We’re the nurses. We’re the helpers. So I have exhausted my vast amount of resources to deal with my life. And I have to be forced against my every grain to ask for help. God, let somebody help me. Because it’s already
taken everything I have to ask for help, and then for them to go, you’re not getting any help, to me it was a betrayal.

**Denver:** So I had the passion for it…and I was going to school…being told nursing is not meant for everybody…college isn’t meant for some people…here I am living off of my income that comes from nursing…my confidence is established in being a nurse…to be faced with maybe, you shouldn’t be in nursing…so what do you do then? And I didn’t have an answer for that…so if you had to go find something else where do you start? Work was my identity. Being a nurse was my identity.

Nurses who withdrew described having to deal with ill family members, inadequate daycare arrangements for young children, spousal addiction, divorce, and the unimaginable death of a child. Nevertheless, many of these nurses considered these reasons to be inadequate for withdrawing.

**Red:** Someone like me is expected to do everything, be everything, succeed at everything regardless if it is reasonable or not, and, I had to give up something that was for me…as a mom, wife, you generally put everybody before yourself, and finally I made the choice to do something for me.

**Belle:** And then my scholarship was gone…the funds weren’t there… I felt like I got cheated out of it—by the State and by my husband…I got busy in my own nursing career and raising my family and just did not pursue it after the scholarship money was gone…and I only needed a year of classes to get my BSN.

**Fourteen:** Between trying to manage my home – which I was divorced by that time and my son and my daughter who would be home on vacations – she was in college –I just couldn’t do it.
Several nurses started back to school only to find themselves in jobs that demanded a great deal of time and energy, and they did not feel they could devote their attention to school. This was a paradox because, although they wanted to advance their careers, their jobs seemed to get in the way. As one related,

**Fourteen:** *Between my work hours and my call hours, I was only not responsible for the department forty-eight hours a week...I had a lot of overtime and my son was still in high school at the time...I wish I’d been able to follow through...and I was frustrated that I wasn’t able to do that because of my job. So I felt I needed the extra education to do my job better, but then my job was keeping me from being able to get the education.*

And finally, personal tragedy forced this nurse to increase her work hours, leaving little time for school.

**Charlotte:** *My ex was never going to come back and just went crazy. I was only working part-time – maybe fifteen hours a week... I’ve got to, see if I could find a full-time job. And luckily my work didn’t want me to leave, so they combined my job with two other jobs. So I play receptionist, I play medical assistant, and I play nurse...obviously if I went back to the hospital and did floor nursing I could get paid a lot more than what I’m making here, but I wouldn’t have the flexibility I need to have with my daughter, and that’s something I really need.*

As we have come to understand, nurses have various reasons for pursuing the BSN and explicate various reasons they withdrew. What is significant and meaningful about these accounts is that, regardless of the reasons, embedded within these experiences is a common understanding that these nurses suffered a loss. This loss led to self-doubt and regret that
originated from a life goal left undone, unfinished, unaccomplished and as the balls began to drop, yet another hit to the self takes place.

Pattern 2: Withdrawing as Impasse: On One Side of the Divide

This pattern showed itself in the text as threats from within and out overlapping with being valued, cost versus benefit and the relevancy of the degree. Withdrawing as threats from both within (the profession) and out (outside the profession) was understood to mean that nurses without a baccalaureate degree were not as professional as those with the degree, experience counted for little, they were less valued, they were a lesser nurse, and they represented a lower standing within the profession and society. Being stuck on one side of the divide left nurses feeling less valued and this feeling, as well as weighing cost versus benefit of the degree, was juxtaposed against its relevance to their bedside nursing practice. These nurses are the embodiment of unrealized potential, limited career mobility, divided ranks, pitting one side against the other, mentally, emotionally, and career-wise stuck, and unable to move forward.

Ideas embedded within this pattern were value and relevancy of the degree, weighing cost vs. benefit of completion coupled with both threats from within and out. These final patterns emerged more slowly, evolving as the transcripts began to reveal perceived threats from both within and out along with the deep divisions and resentments bubbling up leaving nurses stuck, at an Impasse– On One Side of the Divide. These patterns were much more difficult to understand, to tease out, to interpret, and overlapped to some degree.

Motivations for pursuing the degree operated within an undercurrent of threat. Nurses heard through the grapevine that employers were threatening to terminate associate degree and diploma nurses unless they begin a BSN program within an allotted timeframe. External organizations (IOM, 2010, Washington Center for Nursing, 2000 ) also set the 80% or above as a BSN benchmark. Although a more recent phenomenon yet to be explored, these nurses
considered the threat of termination in light of the practicality of firing a majority of the nursing staff, those without a BSN. Uncertainty about the future was felt, coupled with the perception that they were viewed as lesser nurses, something other than professional, and technical skill-based workers.

Twelve: I’m really stuck at a crossroads here with what direction to go...you have to have a BSN to go into an ARNP program, and it doesn’t put you in a position where you’re valued if you don’t have it.

Experienced bedside nurses, experts according to Benner (1985), were prevented from advancement because being a non-completer barred some of them from pursuing the jobs they might want in the future as nurse practitioners, nursing instructors, school nurses or community health nurses and, in some cases, led to job insecurity.

Ann: And within thirty seconds, we were off the phone and it was over with. And I just sat there and thought it was going great. I know I would’ve landed that job. I could tell the way the interview was going she was itchin’ to hire me. But the minute she realized I didn’t have my BSN, it ended the whole thing dead in the water. Well, it made me feel like thirty years counted for nothin’. I said, look, I’m not trying to be rude here, but I’ve been out thirty years. I have dealt with all ages from neonates to geriatrics. I’ve done inpatient, outpatient, home health, and hospice. There’s nothing a BSN is going to give me at this point. But, I mean, she just completely stopped the whole thing and ended it. Just bam. Interview is over with ‘cause you don’t have your BSN. And I’m just sittin’ there looking at the phone receiver like wow. But she’ll find some BSN nurse who’s been out a year or two and give her the job when I can probably work circles around her.
Confounded, nurses questioned the value and utility of the BSN degree because they all worked with BSN nurses who were not as professional, had less knowledge and skill, yet, were viewed by some as more professional. Feeling that the degree was supposed to classify nurses as professional was weighed against the perception that a BSN curriculum taught them nothing about how to better care for their patients. Each nurse described a level of professionalism and expert knowledge honed throughout their years of experience and was skeptical that a BSN made a tangible difference in that regard.

**Hydrangea:** How you improve and how you grow depends upon the opportunities you’re given and what opportunities you take as you move from job to job or position to position.

**Grace:** And I think my favorite nurses, most of them do not have a BSN –but they do have years of experience and they have a confidence that has grown naturally. No matter how much schooling you have, until you get that hands-on experience, until you get your own patients and have your own sense of responsibility...I remember a big milestone for me was handing out my first narcotics to somebody.

**Mary:** You know they want professional nurses. Well, what is that really? What is a professional nurse? I’m a professional nurse. I’m probably a lot – well, sometimes I feel more professional than a lot of BSN nurses –because I’ve felt like I’m the one who had to train them how to be a nurse. They don’t really come out thinking I have to empty that bedpan or clean the patient up or whatever. So really, what is a professional nurse? I know a lot of AA nurses that are more professional than some BSN nurses...so yes, it’s nice to have a professional degree. And what does that mean? Does that mean only a
BSN, or an MSN now, or what? I just think for myself, it wouldn’t make me feel like I’m more professional because I’m professional now.

As these nurses pointed out, a nurse’s educational background [BSN] does not necessarily change the level of responsibility or the tasks expected of her. Rather, her work on the hospital floor is perceived to be the same and may be superior to that of her BSN colleagues. Without question, what is revealed across all transcripts was that the time and effort it took to complete the degree must be worth the price, must be value-added, and must teach working nurses something they don’t already know or do.

**Denver:** What part of the education includes a person’s ability to actually do the job?

You can go to school, you can get your degree, you can pass the test, and you can state what the book says. You can use research. But can you actually work with the patient?

A paradigm case that says it all, Wild’s accounting of the state of the profession echoes other non-completers in this study as she weighed the cost and benefit against the value and relevancy of the BSN degree stating,

**Wild:** I would make an excellent nursing instructor...but I’ll never be a nursing instructor because I will never have a Master’s degree and they’ll never let me be a teacher because of it...it’s sad...it’s a waste...a Bachelor’s degree of nursing is a useless piece of paper in the profession really. What does it get me? It doesn’t get me enough pay increase in most places to cover the student loan cost that it’s going to cost me to get it. It doesn’t get me any higher up the ladder...some places will require you to have a Bachelor’s degree...the current hypocrisy in the nursing profession is enough to make me want to scream. Oh, ADN nurses need to get their Bachelor’s degree. Why? Does it teach me anything different about patient care? Does it make you take a different set of
boards? No, it doesn’t. So the nursing profession themselves, we are causing a rift in our own profession by making the same test for Bachelor nurses or Associate nurses to get into the profession.

Others questioned the value of having a BSN, pointing out the professional inequities that exist.

**Wild:** And then after everyone has their license we say- Oh, but you’re a lesser nurse, even though you just passed the same entrance exam. You’re a lesser nurse because you only have an Associate’s degree, and I’m a superior nurse because I have a Bachelor’s degree. Okay, well... if we’re both working as floor nurses, you tell me how you’re using your Bachelor’s degree more than I’m using my Associate’s degree.

Further, nurses questioned the fairness of unequal pay for equal work within the workplace and the perceived division this practice created.

**Wild:** We have Bachelor’s nurses, Master’s nurses...they’ve been there twenty-six years. So we have the whole spectrum, and we work under the same protocol, we are all required to do the same job, and we are all rewarded unequally. Because the Bachelor’s nurses get a percentage bonus...and they’re tasked with the same tasks. They’re held to the same standards...if you boil it all down and look at the benefit or the – the negatives to the nursing profession overall, in my humble nursing opinion, the Bachelor’s degree of nursing is a dividing wedge in our profession, not the empowering tool that everyone wants it to be.

Nurses expressed concern about the direction the profession is heading and the alienation that comes from classifying nurses without a BSN as *lesser than* [emphasis added].

*And I believe it’s because of who I am to be told by a less capable nurse...that I am an inferior nurse to her because it says BSN after her name and it only says RN after my*
name...anywhere in the nursing profession that became an okay thought process...that’s the rift...and if the nurses that we’re producing now are the nurses of the future, we should all be scared. We just got a new nurse at work who’s been out of nursing school for a year and he does not know how to note a written order. They did not teach him that in nursing school.

Grace: I have the experience, but I – you know, my degree somehow says that I don’t.

Nurses vacillated between the value and relevancy of having a BSN and how it advanced their nursing knowledge.

Twelve: I started the BSN program hoping to gain more...I felt like that if I was going to go to school, that it was going to be to further my education...but I thought the BSN program was more philosophical...it doesn’t look into what’s new and what’s going on in medicine...if I was going to spend more time in school, it better be something that had me be a higher wage-earner or further my education so that I could do more in the realm of nursing...I make the same whether I have a Bachelor’s degree or I don’t...my job doesn’t change that much...But I definitely don’t want to put forth the effort and the money to travel over two-and-a-half hours each way – in order to get a degree that doesn’t serve me, that doesn’t promote me, that doesn’t help me get ahead at this point.

And,

Nurses are scientists by nature and the bachelors program for nurses seriously underplays the intelligence of the nursing profession...that we are secondary to ones that know things and that we’re muted into only thinking about the portion of the human being that wants to receive, genuine caring or genuine hand-holding, helping people get
through stuff. We’re relegated to this portion of education...we can do research, but does it really help humanity including writing papers on caring? (Twelve)

Another nurse tried to make sense of what the BSN was supposed to do and what it actually would do to improve bedside practice.

**Denver:** That’s my anxiety about it...how much actually do you get out of your education? Is it a matter of are you getting an education or are you going through hoops to satisfy a curriculum? I have quite a bit of experience... and I question those people that have the education that believe that they are the experts without the experience...believe they are the professional and yet don’t have those experiences.

Nurses considered the cost versus benefit of the degree in their decision-making process and the usefulness of taking irrelevant coursework.

**Hydrangea:** When I went back for my BSN, I felt like I was filling in blanks just to make you a more rounded student. So I took logic and dancing and swimming.

**Ten:** Completely irrelevant...I don’t have an interest in Greek mythology and I understand the point of a Bachelor’s degree and what makes it different than an Associate’s degree...the classes and the classwork that involves actual nurse study or clinical hours or clinical write-ups or anything that actually involved my field of work, I was more than happy to accommodate and to do. And now I’m flooded with an English class, a history class...things that do not pertain to nursing whatsoever...it was really easy to get discouraged and tell myself this is not worth my time.

Some nurses described the impetus for getting a BSN was coming from a perceived threat that hospitals would not hire ADN or diploma nurses, that forced them (a select targeted group of nurses) to go back and get a BSN. One nurse had “living proof that this could really happen” as
she related the story of an LPN she worked with who never wanted to go back for her RN and who now works as a unit clerk (Participant Ten). Nurses spoke of this threat consistently throughout their accounts, real or imagined; neither confirmed nor denied explicitly, there is evidence that the threat they spoke of existed.

Ten: There’s a lot of hospitals that won’t hire you unless you have a Bachelor’s degree…the culture is coming…it does kind of exist out there. These threats were to ever come true and it meant that I would not be able to work anymore unless I got a Bachelor’s degree, of course I would get my Bachelor’s degree. But this wasn’t going to change anything for me on my end other than it was going to give me a dollar-an-hour raise. …I guess maybe because I have worked as a nurse on the floor for so long…I know how to be a nurse, and I’m really good at being a nurse.

Grace: …and I also don’t feel like I have much of a choice. I think BSN is the way to go. A lot of people aren’t even hiring Associate-degree nurses right now. So I think it’s super important to get it. And so you have a lot of competition…if you have a lot more BSN nurses…you don’t have to hire the Associate-degree, and then it looks better for you overall to have the higher-education nurses on board…but I don’t necessarily think it equates to – like for me personally, seeing a BSN versus an Associate-degree on the floor, you would never know the difference.

Mary: The likelihood that you’re going to lose your job is probably slim, but there is always that kind of voice in the back of your head saying, but what if? I don’t want to be fifteen years in my career and be forced to either get my Bachelor’s degree when it’s not convenient for me or lose my job. I would’ve gone back to school. But when she said,
“No, we can’t do anything; we can’t pay you”...I just felt like, you don’t value me as an employee, so why should I even bother?

Finally, Mary summed up what many nurses in this study alluded to, “we are a dying breed...there are not a lot of people that are still working that went to nursing schools and trying to better ourselves along the way and finding these roadblocks.”

The impasse is solid, the nurse is affected. There is the sense by some that the BSN entry is what the discipline needs and that these nurses will be replaced by the next generation of BSN prepared nurses. What must be considered, however, is the effect on the discipline of disillusioned nurses who have expertise and nursing knowledge that is unique and valuable, that a part of the profession loses when some of its members are disenfranchised.

Summary of Findings

The two overarching patterns that emerged from the interpretive analysis of transcripts were: Withdrawing as Revisiting Failure and Withdrawing as Impasse: Stuck on One Side of the Divide. These patterns describe what it means to exist as a registered nurse who experiences a withdrawal from a BSN program prior to completion. These patterns embody common and overlapping ideas of understanding embedded within the transcripts of the participants.

Withdrawing as Revisiting Failure manifested in overlapping ideas of the self takes a hit and juggling balls and spinning plates. Self (being) takes a hit showed itself as regret, ambivalence, letting oneself or others down, being successful- then not, being strong and not needing to be coddled. Juggling balls and spinning plates was revealed as life got in the way, balancing competing priorities, giving all one is able, and running on empty.

The second overarching pattern to emerge is Withdrawing as Impasse: On One Side of the Divide. This pattern showed itself in the text as both threats from within and out, overlapping with being valued, cost versus benefit and the relevancy of the degree. As nurses reflected back
on what was occurring at the time of withdrawal as well as on events that had occurred in the clinical environment and their personal circumstances since then, they continued to question the value and relevance of BSN education and its effect on their bedside practice.

Weighing the cost vs. benefit in financial terms and personal, family life sacrifices they had to make to complete the degree, they described feeling pushed to go back for a degree that they felt was simply not worth their time and effort. Registered nurses in this study expressed there was very little, if any, professional incentive for getting a BSN degree, and this consideration factored into their withdrawal decision. The issue of not having a BSN fueled an undercurrent of threat and the threat of future job insecurity for these nurses.

As these nurses considered their nursing practice within the context of BSN education, a great deal of conflict predominated their thinking. On one hand, they heard that the BSN was supposed to bring a level of professionalism to their nursing practice. On the other hand, these nurses felt they were professionals already, some with over 25 years of service to the profession. Many of these nurses said they were more professional than their BSN counterparts. This contradiction was the crux of the withdrawal experience. Feeling they are stuck and place-bound because they did not have a BSN, they could not get it, and in some cases they did not want it. They explained it offered little or no value to them because it did not get them any more money or did not cause them to care for their patients differently.

In light of the findings of this study, the factors that play into whether or not a nurse finishes a BSN are many, but the effect on dignity and well-being are immeasurable. Place-bound and stuck, these incompletions affect not only the nurse but also the profession, leaving a deficit. It is felt by these nurses, even if not completely understood.
CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

The purpose of this study was to understand how withdrawal is experienced by registered nurses who do not complete a BSN program. Hence, the meaning of the lived experience of RNs who withdraw from a BSN program can be described as *Revisiting Failure and Impasse: On One Side of the Divide*. There is a toll to pay when the goal to continue education is unfulfilled. This is a relatively invisible problem because it has not been previously examined. Education, outside of university settings, is an elusive institutional process for some. Individuals cannot appreciate what it is they do not have, only that they do not have it. Many of the participants in this study have structured accounts and reasons they did not continue to program completion. They also related rationales for why they couldn’t finish. These reasons are important and may drive improvements in nursing education, but these reasons become secondary when trying to understand the meaning a withdrawal holds for registered nurses.

What is striking is that this study offers a glimpse into what information RNs consider and what thoughts and feelings they experience when it comes time to make the decision to withdraw from a BSN program. Despite differing barriers to completion expressed in these accounts, what remains common to the experience is that it is illogical to expect nurses to pursue any form of education if the perceived benefits do not outweigh the perceived costs. It is conceivable that if the value and worth of the degree (whether tangible or intangible) is questioned, and if the rewards of completion remain elusive or non-existent, RNs won’t see the need to pursue the BSN degree. Therefore, not pursuing a BSN in the first place or not completing the BSN when one does decide to pursue it, impacts the number of baccalaureate-prepared nurses in the profession. This issue sits in direct opposition to the recommendations by
the IOM (2010) and others to increase the number of baccalaureate-prepared nurses to 80% or above by 2020.

Findings from this study add depth to our understanding of nursing student attrition studies reported in extant literature. This study affirms the reasons RNs chose to return to the university for a BSN and offers a new perspective of the withdrawal experience, previously unreported in the literature. Further, findings from this study shed light on the dynamic interplay among factors that influence RN withdrawal. Finally, findings reveal new insights on the value, relevance, and usefulness of the BSN degree from the perspectives of the participants and how these insights influence withdrawal decisions.

**Returning for the Degree**

Extant literature reported that RNs who return for a BSN degree do so for personal reasons or to further their career in some way (Lillibridge & Fox, 2005). Registered nurses in this study expressed these same professional reasons for pursuing the degree by saying that they believed that having the degree would allow them to do more within the nursing profession. In addition, findings from this study indicated that, although they never completed the BSN, some worked in community health settings and school nursing without it. Several RNs in this study held speciality certifications and expressed little or no desire to go back to get a BSN when they felt satisfied with their nursing positions. Despite what RNs are being told, some of the RNs in this study were able to work in areas typically reserved for BSN-only prepared nurses.

There is literature that asserts that nurses feel pressured to return for a BSN degree (Zuzelo, 2001). Findings from this study affirm that similar pressures to return were present for these participants and also revealed a new dimension embedded within the withdrawal experience- the existance of an undercurrent of threat. RNs in this study expressed that they felt threatened by employers to return for a BSN because the employers would either not hire them
without one or they would terminate them if they did not complete a BSN program within three to five years (Somerville in Trossman, 2015). It is plausible that the threat of termination is a motivating factor for greater numbers of RNs who are pursuing a BSN degree, more so than nurse educators are aware of.

**Attrition is Multifactorial**

Nursing attrition studies emphasized that attrition is a complex multifactorial problem influenced not only by the college milieu but also personal circumstances and professional issues. Wells (2007) found that student departure was a result of a cumulative effect of academic and social responsibilities. Findings from other studies affirmed there was a dynamic interplay at work between balancing life and work commitments and going back to school (Andrew, 2008, Perry, 2008). Feeling unprepared for university study, family priorities, major life changes, financial concerns (Mangubot, 2005) and working full-time influenced attrition (Dante et al., 2011, Salamonson & Andrew, 2006, Rochford et al., 2009). Many of these same competing demands were experienced by the RNs in this study.

For example, RNs in this study report they enrolled in a BSN program to improve their nursing practice but that working full-time stood in the way of attending class and being able to complete assignments. Another said that her daughter was in college at the time and that she was unable to afford for both of them to continue taking courses at the same time, so she had no choice but to withdraw. Another participant RN said during the time she was going to school, she had also taken on the role of primary caregiver to her elderly mother. This added family responsibility made it impossible for her to continue in the BSN program and she withdrew.

Although there are similarities between extant literature and the findings from this study, this study brings forth a new level of understanding of the meaning and impact that competing priorities have on the withdrawal experiences of RNs. As RNs in this study explain, once they
went back to school everything in their life became more complicated. This was not an unexpected finding; however, the impact of not being able to balance all of life’s demands meant they had failed in some way. This failure was the meaning of the withdrawal experience for RNs who do not complete and is a new finding that has not been previously reported in the literature.

Initially, balancing the demands at home, work, and school were manageable but at some point they became overwhelming and unsustainable. One RN in the study described feeling like her life was like a house of cards and when the wind blew, the house collapsed. It is understandable that this cascade of events left some RNs doubting they would ever be able to return to school. The self-doubt that was described by the RNs in this study is another new finding previously unreported in the literature.

Literature suggests that academic factors influence attrition (Bowden, 2008, Perry et al., 2008, Jeffreys, 2004) and that higher nursing course GPAs were associated with higher pass rates (Gilmore, 2009, Trofino, 2013). Although I did not actively collect nursing course grades from the participants for this study, several indicated their GPA in the BSN program at the time of withdrawal was 4.0. Further, all of the 14 study participants were passing their courses at the time of withdrawal. This finding further suggests that RN withdrawal is multifactorial and is not merely based on academic success or failure.

A Model to Understand Nursing Student Retention

Understanding the connection between the factors that influence nursing student attrition and withdrawal is somewhat aided by using Jeffreys conceptual NURS model (2004). There are points of convergence and points of divergence between Jeffreys model and the findings from this study. Similar to Jeffreys (2006), this study found that family crisis, financial stressors, and demanding jobs influenced attrition. RNs in this study expressed they had to withdraw after a divorce or a death in the family. They also withdrew because they were already working full-
time and could not find additional funds to pay for their BSN program, findings that were consistent with Jeffreys model.

Additionally, Jeffreys (2006), Rudel (2006), and O’Brien (2009) found that social support from significant others influenced attrition. Contrarily, RNs in the current study said that although they had this type of support, they withdrew anyway. This finding, again, suggests that RN withdrawal occurs as a result of the many events, circumstances, and situations that happen while RNs are in school. It is possible that these events, circumstances, and situations together with the stress and anxiety they experienced created an additive effect which pushed student RNs towards a tipping point. This tipping point became their impetus for withdrawal.

Jeffreys (2007) and others posited that the more satisfied a student was with their program, the more likely they were stay in the program (Jaradeen et al., 2012). Further, Jeffreys used the model to explain, that the presence of certain factors (Literature Review, Chapter 2, p. 37) influenced how satisfied students were with their nursing program. Findings from the current study affirmed that the presence of some of Jeffreys factors did indeed influence attrition. The factors reported in this study that align with Jeffreys were: professor support and mentorship, commitment to student success, positive attitudes towards learning, academic success, motivation, and self-efficacy. It is notable however, that even when RNs in this study expressed they were mostly satisfied with their BSN programs, they withdrew anyway. It is possible that high levels of satisfaction are not significant enough to mitigate the combination of factors which influence the decision to withdraw from a BSN program. I am beginning to see that the literature that links satisfaction and grade success with respective programs and BSN completion does not provide a full picture of the experience of returning RNs. Participants in this study, who did not complete despite program satisfaction or grade success, show us an expanded view related,
perhaps, to a deeper lack of satisfaction not seen in extant literature. This raises new questions about whether or not the experiences of RNs who are like the participants in this study should be considered further in the nursing academy.

Adding credence to the assertion that higher student satisfaction is associated with lower attrition, some RNs in the current study described that although they were mostly satisfied with many aspects of their BSN program, they were strongly dissatisfied with the BSN curriculum itself. This is a significant finding not previously reported in the literature. RNs in this study said they saw no need to take courses that, in their opinion, were not directly related to improving their bedside practice. Once they rationalized that the education was not useful to them, they expressed that it was a bit easier to withdraw. This finding opens up the likelihood that experienced RNs consider other factors not contained in Jeffreys NURS model (2004) when deciding to stay or withdraw from their nursing programs. Identifying these factors requires further study.

**Weighing the Cost And Benefit of Completion**

Putting student satisfaction aside, a key to understanding RN withdrawal may stem from having RNs perform a cost-benefit analysis prior to enrolling in a BSN program (Tinto, 1975). Tinto (1975) argues that students use this type of analysis to inform persistence decisions, finding that,”individuals direct their efforts towards activities which (sic) maximize the ratio of benefits to cost” (p. 39). A confirmatory finding from this study was that RNs do consider the cost/benefit, and relevance of completing the degree when they decide whether or not to withdraw, maybe moreso, than their satisfaction with the BSN program.

From this perspective, some of the RNs in this study decided to withdraw because they determined that their time and money was better spent getting a specialty certification and attending specialty nursing conferences. It is conceivable that differences between a university
education and specialty certification through continuing education are not fully understood in this population of RNs. The influence of BSN education on the nursing practices of experienced RNs has not been explored in the literature thus far, and remains a hidden aspect of the benefits of completing a BSN degree.

Further, what may not be widely known by this population is that the findings of a more recent study by Kendall-Gallagher, Aiken, Sloane, & Cimiotti (2011) reported that, “hospital proportion of baccalaureate and certified baccalaureate staff nurses were associated with mortality and failure to rescue” and that “no effect of specialization was seen in the absence of baccalaureate education” (p. 188). What this means is that having both a BSN and a specialty certification together, “decreased the odds of adjusted inpatient 30-day mortality by 6% and 2%; results for failure to rescue were identical” (p. 188) as opposed to having specialty certification alone or BSN alone.

In some cases, RNs with a BSN may earn more than RNs without a BSN. Some RNs in this study said that having a BSN would earn them only one dollar more an hour if they stayed in their current position. Others said having a BSN would have no effect on their salary at all. It is possible that any increase in salary RNs would receive would not cover the cost of attending a BSN program. It is reasonable to assume that a negative return on investment would influence RN’s decision to pursue a BSN.

Questions About Differences in Nursing Practice

Although it is suggested there is a difference in the nursing practices between RNs with a BSN and those without (Aiken et al., 2003, Aiken et al., 2008, Blegen et al., 2013, Kutney-Lee et al., 2013, Tourangeau et al., 2006), the RNs in this study opposed this notion. They reported that they saw no difference between the nursing practices of BSNs, ADNs and Diploma nurses. In fact, most of the RNs in this study were expected to train new graduate nurses regardless of the
new graduate nurses education level. It is conceivable that when these RNs weigh the cost of getting the BSN and the dollar more an hour they might be paid for having it against the sacrifices they have to make in order to get it, completing the BSN degree may not be thought to be worth the effort. RNs in this study did say said that if they felt the BSN degree would improve their nursing practice they might see some value in having it.

Findings from this study support the idea that RN withdrawal is a complex phenomenon that can be described by the patterns Revisiting Failure and Impasse: One Side of the Divide. Evidence from this study affirms what extant literature reports, that nursing student attrition and withdrawal are multifactorial in nature. That is, the interplay of factors that influence withdrawal in this population are many and are interrelated. Adding to what is known about nursing attrition, the experience of withdrawing from a post-licensure BSN program connotes failure and the RNs who do not complete suffer a loss and are left on one side of the divide.

Summary

Embedded in the meaning of withdrawal is that, to some degree, failing to complete the BSN program was an assault to the self and weighed heavily on some RNs, even to this day. Further, that the threat of losing their job exists in the minds of RNs in this study who voluntarily withdrew from BSN programs prior to completion. The withdrawal left them stuck on one side of the professional divide. Finally, findings from this study imply there are improvements that may be made in nursing education, research, practice, and within the profession itself.

Implications for Nursing Education

The nurses in this study expressed a love of learning and believed that continued learning leads to exceptional patient care, especially in an advanced technological healthcare environment. However, that also said that they did not want to complete irrelevant assignments in their courses. This does not mean that they did not want to further their education. This
sentiment is true for all of the nurses in this study because they all expressed that they valued education and described themselves as life-long learners. What does this mean in the context of nursing education? Does nursing education need to occur in a formal academic setting to be considered worthwhile and valuable, and if it must, what makes it relevant to the bedside nurse? These questions present avenues for further study.

It is likely that the academic structures that inhibit nurses from completing BSN programs should be examined and addressed. Findings from this study indicate delivery method was a precursor to withdrawal for some of the participants. Perhaps, face-to-face programs need to be offered not only near work or home but also need to have flexible class schedules. Literature suggests that flexible schedules and convenient locations were facilitators of program completion (Mangubot, 2005).

It is suggested that online programs that rely heavily on group work should consider offering intensive orientations to learning management systems and promote strong, positive cohort interaction. Literature suggests that these interventions support staying the course (Mancini et al., 2014). Hybrid programs typically have more flexible schedules and low residency attendance requirements. Further, hybrid programs that use hospital or facility classrooms were deemed most convenient for working nurses. Mangubot (2005) found that making it easier for working nurse to attend class supported nursing program completion.

This study illuminated the issue that some registered nurses believed that a broad education was unnecessary in a professional discipline. What was evident from the findings in this study was that these nurses wanted a BSN education that they deemed relevant and useful to them. They valued an education that enhanced their bedside practice and furthered their knowledge in both nursing and medicine. Expressed by the nurses in this study, completing
liberal studies courses was not a value-added exercise. This is important because it is generally accepted that a broad general education is an essential for BSN preparation. If skilled working RNs do not value aspects of the BSN curriculum, there is reason to re-examine the manner in which a broad general education is offered. Only then will it be clear whether or not there are potential pedagogical improvements that would be relevant to RNs like those in this study, improvements that offer a broad educational base while also addressing practical needs for this group.

A liberal education is a focus of most baccalaureate programs including nursing and as such, is a requirement for graduation (AACN, 2008). Literature reported RNs in post-licensure BSN programs perceived that the liberal studies courses added to their nursing practice in the following ways: “a way to advance and improve self, academic growth, acceptance of diversity, global thinking and a well-rounded knowledge base” (De Brew, 2010, p. 51). These same perceptions were found in a secondary analysis of data from a study aimed at uncovering the value of RN-BSN education from the perspectives of diploma and associate degree nurses (Girard & Baroni, 2010). It is possible that the perceived benefits of a liberal education and the perceived effects on nursing practice are not fully known or understood by this population of nurses. If known, this information might influence withdrawal decisions of RNs who are in the midst of considering the cost vs. benefit of attaining a BSN degree.

Academic institutions enforced degree requirements that were deemed superfluous by working bedside nurses. One such requirement, a year or equivalent of a foreign language to graduate was considered unnecessary and erected a barrier to program completion. Perhaps offering alternate coursework that would fulfill the foreign language requirement is necessary. It is recommended that nurse educators work with university curriculum committees to design
alternate coursework because foreign language is usually a university requirement for students in other disciplines.

If possible, working nurses should partner with nursing programs and serve on advisory boards within those institutions. The benefits of such partnerships include gaining the perspectives of real-world working nurses to determine gaps in education. This activity would accomplish two important goals. First, expert nurses are a wealth of knowledge (Benner, Kyriakidis, & Stannard, 2011). This knowledge may be used to inform curricular designs that enhance the development of clinical wisdom and judgment. According to Benner et al. (2011), expert nurses develop clinical wisdom and judgement over time, so using this wisdom and judgement to develop BSN curriculum might make the curriculum more relevant to this population of nurses. Second, while experienced nurses do have deep, historical, and experiential knowledge, they too have educational gaps. These gaps have not been thoroughly explored in the literature.

Similar to this study, literature confirms that the majority of registered nurses pursuing a BSN degree attrite out in during the initial term or within the first year of their programs (Andrew et al., 2008). This period, therefore, becomes a critical time of transition for nurses who return to university for a BSN. This is because many of them have graduated from their initial nursing program years earlier. Therefore, it is recommended that nursing program administrators, educators, and the academic institution itself develop strong support systems and build these systems not only into transition courses but also into a formal transition program.

Currently, most RN-BSN programs already require nurses to complete a BSN transition course typically as their first course. Even with this required course, nurses continue to attrite early on in their programs. It is conceivable that a one-size-fits-all transition course is not
meeting all of the students’ needs especially for working nurses who have been away from academia for some years.

Perhaps more must be done to support nurses during this critical transition period. A formal transition program complete with academic and social support is needed. The program could include a readiness assessment, academic skills assessment, student mentorship, and extensive orientation to technology. Literature suggests these types of interventions support student retention (Jeffreys, 2004, Seidman, 2012). The readiness assessment would help nurses understand the time and effort typically required to complete each course. Knowing this information prior to beginning the program could help nurses decide whether or not they have the time to devote to BSN study. Academic skill assessments will help nurses and program administrators determine what academic support (e.g. writing) is needed before beginning the BSN program and whether structured support should continue during the program.

Student mentorship could take many forms and be formal or informal. New students could be paired with graduating students, with nursing professors, or with nurse leaders in their own healthcare facility. Mentorship provides an opportunity to make connections and build a network of support (Jacobs, Atack, Ng, Haghiri-Vijeh, & Dell’Elce, 2015).

Nurses who return for the BSN degree many years after completing their initial nursing program need extensive orientations (Gilmore & Lyons, 2012, Jeffreys, 2004). Orientations to the campus, to the nursing program, and to learning management systems help students understand what is expected of them, where they may find on-campus academic and social support, and how to use learning management systems (Bean & Metzner, 1985). It is likely that a formal transition program coupled with a BSN transition course will add the additional level of support nurses need before and throughout their BSN programs.
Implications for Nursing Practice and the Profession

What would it mean to have at least 80% of the 3 Million registered nurses practicing in the United States educated at the baccalaureate level? Although studies are beginning to assert that higher educated nurses have quantifiable impacts on patient outcomes, more research is needed to determine the direct effect of education on nursing practice. The experienced nurses’ clinical wisdom gained through time at the bedside cannot be underestimated, undervalued, or ignored. Regardless of education level, the effect of clinical wisdom on patient specific indicators of quality care must be examined further to determine its effect on patient outcomes. Perhaps Benner and her colleagues who called for a radical transformation (2009) in how [emphasis added] nurses are educated could be extended to include what [emphasis added] experienced RNs need to be taught in the context of their unique needs.

Literature that asserts a nurses’ education level alone has an effect on patient outcomes should be considered in context. There simply is not enough information to conclude that this is so. Aiken et al. (2003) did indicate that a mixture of RN education levels, what she called “RN skill mix” resulted in a 5% decrease in 30-surgical mortality rates, however, more research is needed to understand the direct effect of education level on patient outcomes. Aiken and colleagues further report that nurse work environment and education level and specialty certification has an additive effect on patient outcomes rather than education level alone. Participants in this study stated strongly that any education, formal or informal, must be immediately applicable to bedside nursing practice if it is to maintain its appeal to practicing nurses. As one nurse suggested, “the bedside nurses are the ones who hold the units up” and another expressed, “what I learn must be something that teaches me to be a better nurse in some way, this knowledge is vital to any nursing job.” (Grace).
Nurses report they experience financial hardships while trying to obtain a BSN (Mangubot, 2005). If healthcare facilities want registered nurses educated at the baccalaureate level, they must be willing to offer financial assistance in the form of grants and scholarships. It is likely that offering tuition assistance alone is not enough to entice nurses to return for the degree especially if the pay differential does not offset tuition costs. Nurses in this study identify this issue as a barrier to degree completion.

Issues of equity arise in a two tiered entry-to-practice system as was pointed out by the RNs in this study. Of special concern, was that RNs in their workplace with BSNs performed the same duties and had the same responsibilities as they did. Many questioned the fairness of a pay differential for baccalaureate-prepared RNs when there was no role differential. RNs in this study said that this practice fueled discontent with salary inequities.

Role differentiation associated with education level does exist within the nursing profession as the Public Health Nurse role and School Nurse role. Public Health nurses and school nurses are required to have a baccalaureate degree in order to work in these areas. Perhaps role differentiation could be enacted within the hospital setting to offset pay inequities that exist. Nurse executives and the nursing profession itself needs to uncover the justice of pay differentiation without role differentiation. What are the unintended consequences of this practice? Is this in part, contributing to the devaluing of highly experienced nurses who do not hold a BSN degree?

Differentiated practice models provide an opportunity for healthcare delivery organizations to capitalize on the education and experience provided by varied educational preparation. The registered nurse can “practice to his or her potential, taking full advantage of educational preparation” (AACN, Differentiated Nursing Practice, 2002). Often, differentiated
models of practice are supported by a clinical ladder or defined steps for advancement within the organization based on experience in nursing, additional education, specialty certification, or other indicators of professional excellence. Several of these differentiated practice models are listed in Appendix A.

Further, if nurses are expected to get a BSN or face termination, employers should be willing to partner with nursing programs and dedicate on-site classroom space at their place of employment. It is recommended that at a minimum healthcare employers should partner with other facilities to offer a common classroom hub in a central location. This practice is currently taking place in the central Seattle area; however, program and student outcomes have yet to be reported.

**Implications for Nursing Research**

This study raises important questions for nursing research because there is very little published on the needs of this specific population of registered nurses. It raises the issues of what education is relevant for professional nursing practice despite differences in diploma, associate and baccalaureate degree nursing programs. If this population of nurses, RNs who do not complete BSN programs, are relegated to one side of the educational and practice divide, what losses does the profession suffer?

Further research is needed to understand what a relevant BSN education should look like from the perspectives of the working nurses themselves. More research is needed to understand the effects of practice/role differentiation on patient outcomes. Research that explores the effects of having a BSN on bedside practice is needed. And finally, the concept of job hopping was mentioned as a potential problem by one of the participants. Job-hopping may be an unintended consequence of the rule that employers use as a basis for terminating diploma or associate degree nurses because they have not completed a BSN program within three to five years of hire.
Evidence that termination of RNs who fit this category is actually occurring, is lacking. Employment trends need to be analyzed to identify if job hopping is occurring and also if RNs without BSN degrees are being terminated.

**Conclusion**

Nursing research aimed at quantifying the effect of educational level on nurse specific indicators of quality of care is underway; nevertheless, there is some evidence that shows an association between nurse skill mix and patient outcomes. Nursing program attrition studies are inadequate to shed light on the complex and dynamic interplay of factors that support and restrict program completion in the non-traditional registered nurse population that return to university for a BSN degree. Without a doubt, the pursuit of a BSN degree for experienced registered nurses is plagued with unknowns that require further exploration. Understanding the phenomenon of BSN withdrawal for this unique population of registered nurses has not been examined in the literature thus far.

Findings from this study draw attention to this unique group of nurses and give voice to the withdrawal experiences of this minority population. A minority cohort of participants who represent the 1-19% of RNs projected by the IOM (2010) as a group who will not complete the BSN by 2020 and is not included in the goal of 80% baccalaureate-prepared nurses as a disciplinary aim. The focus on this group is important because it calls this discipline to a conversation about what *is* [emphasis added] essential in baccalaureate education. It prompts a revisiting of the outcome and methods (pedagogies) needed to improve RN education and practice because it illuminates the perception and experience of a vulnerable group of practicing nurses.

This Heideggerian hermeneutic study serves as a first step in understanding how BSN program withdrawal is experienced by registered nurse non-completers. Further, it illuminates
two overarching hermeneutic patterns of understanding embedded within the experience as Withdrawal as Revisiting Failure and Withdrawal as Impasse: On One Side of the Divide. These overarching patterns encompass ideas of juggling balls, spinning plates and self takes a hit along with both threats from within and out and the weighing of options, value, relevance, and cost versus benefit of obtaining the degree.

Perhaps, findings from this study could be used by nurse educators to rethink what a relevant BSN education for registered nurses who pursue the degree would look like. Findings may be used to assist academic administrators in identifying academic structures and graduation requirements that create barriers to completion. Findings may be used by nurse researchers to deepen their understanding of the withdrawal experience from the nurses themselves. This understanding may guide further research in this area.

Finally, findings from this study validate that the phenomenon of withdrawal exists and is uniquely experienced by registered nurses who do not complete BSN programs. For them, this study lets them know they are not alone and that others think and feel similarly about the withdrawal experience. Having gone through it and telling their story is a priceless contribution to nursing education science.
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pre-registration nursing student progression into Year 2—A retrospective cohort study.


## APPENDIX A

### REGISTERED NURSE ROLE DIFFERENTIATION

<table>
<thead>
<tr>
<th>BSN outside the hospital setting</th>
<th>BSN within the hospital setting*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health Nurse:</strong></td>
<td>The Colorado Experiment (NOADN &amp; AONE, 1995)</td>
</tr>
<tr>
<td>The public health nurse is a professional registered nurse who has a baccalaureate degree in nursing and a public health nursing certificate with an emphasis in community health.</td>
<td>Utilization of nurses with varying educational credentials and degrees of experience and a differentiated pay scale.</td>
</tr>
<tr>
<td>Public health nurses provide nursing services in the home and community, including case management, client advocacy, community resource information and assistance with accessing health care.</td>
<td>The Healing Web Project (NOADN &amp; AONE, 1995)</td>
</tr>
<tr>
<td>Nurses in the public health nursing division provide services in a variety of programs that target specific populations and or health needs.</td>
<td>Assessment-based and education-based practice differentiation with specific competencies for direct care provision, communication activities, and management were developed as part of role-specific job descriptions.</td>
</tr>
<tr>
<td><strong>School Nurse:</strong></td>
<td>The South Dakota Experience (NOADN &amp; AONE, 1995)</td>
</tr>
<tr>
<td>School nursing is a specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students.</td>
<td>ADN students are paired with BSN students for one full year of clinical experiences. Differentiation occurs and is evaluated in a seminar format.</td>
</tr>
<tr>
<td>To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning.</td>
<td>CNEWS Competencies (2002)</td>
</tr>
<tr>
<td></td>
<td>Identifies differentiated roles of ADN &amp; BSN educated nurses in the following categories: decision maker, user of information technology and communication, teacher, manager of care/collaborator, professional values and behaviors, professional role development, research, leadership.</td>
</tr>
</tbody>
</table>
APPENDIX B
RECRUITMENT FLYER

Experiences of Registered Nurses Who Voluntarily Withdraw From Their BSN Programs

Interested in contributing to nursing science? Let your voice be heard!

This study is being conducted by Samantha Girard, registered nurse and PhD. Student at Washington State University. She is interested in the experiences of registered nurses who return to school to obtain a BSN.

Participants in this study will be asked to engage in a face-to-face or telephone interview that should take about an hour. A second interview may be needed in some cases and should take about a half-hour of your time. Your name and all information collected during the interview will be kept confidential. If you are interested in participating or know someone who is, please contact Samantha Girard at (619) 218-4866 or samantha.girard@wsu.edu.
APPENDIX C
CONSENT FORM
WASHINGTON STATE UNIVERSITY
College of Nursing

Research Study Consent Form

Study Title: Experiences of Registered Nurses Who Voluntarily Withdraw From Their BSN Program.

Researchers:

**Principle Investigator:** Dr. Roxanne Vandermause, Director of Ph.D. Program and Associate Professor, College of Nursing, Washington State University. Phone: (509) 324-7281.

**Co-Investigator:** Samantha Girard, Ph.D. Candidate, College of Nursing, Washington State University. Phone (619) 218-4866.

**Co-Investigator:** Dr. Renee Hoeksel, Professor, College of Nursing, Washington State University. Phone: (360) 546-9621.

**Co-Investigator:** Dr. Linda Eddy, Associate Professor, College of Nursing, Washington State University. Phone (360) 546-9625.

You are being asked to take part in a research study being carried out by Dr. Roxanne Vandermause and Samantha Girard. 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 at a later date. 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 help nurse educators understand the experiences of registered nurses who return to school to pursue a baccalaureate degree in nursing (BSN); more specifically, the experiences of registered nurses who return and subsequently decide to withdraw on a voluntary basis before completing the BSN program. You are being asked to participate because you have voluntarily withdrawn from a BSN program before completing it. Taking part in this research study should take no more than an hour of your time with the possibility of a brief follow-up interview which should take no more than 30 minutes of your time.

You can take part in this study if you are a registered nurse, are 25 years of age or older, speak and understand English and are willing to have your 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 talk about your experiences of being a registered nurse who returned to college to obtain a BSN degree. The interview will be like a conversation with only a few questions asked by the researcher to help the researcher understand your story. At the end of the interview the researcher will ask you a series of demographic and informational questions. The researcher will be using a digital audio voice recorder to record the entire interview for later analysis. Prior to the interview, you will be asked to choose a pseudonym or “fake” name. The researcher will use this name to refer to you in the interview and in any excerpt from the interview used in the research study.

Examples of questions the researcher might ask are as follows:

- For the purposes of the interview, what name would you like to use? This will be your name for the interview, and no one will know that this name belongs to you except for yourself and the researchers.
- As someone who has withdrawn from a BSN program, please tell me about what that experience was like for you?
- Is there a moment that stood out as being particularly significant to you during that time, can you tell me about it?
- Is there anything in particular that you would like to share about your experience of withdrawing from your BSN program?

Demographic and informational questions:

- What is your current age?
- What was your age when you enrolled in a BSN program?
- What is your race/ethnicity?
- What is your gender?
- What is your marital status?
- How many children do you have? What are their ages?
- What is your current education level?
- How many years have you been a registered nurse?
- How many years did you nurse before deciding to return to college to get a BSN?
• How long did you wait between making the decision to go back and when you actually enrolled in a BSN program?
• How many hours a week do you work?
• Were you a full-time or part-time student in the BSN program?
• How many credits had you completed in the BSN program prior to withdrawing?
• Did you receive financial aid that enabled you to return to college?
• Are you the first in the first generation in your family to go to college?

You may refuse to answer any questions, and if at any time during the interview you feel uncomfortable or would like to stop the interview, you may tell the researcher that you wish to discontinue the interview. Also, you can withdraw from the study at any time before the interview is completed.

Are there any benefits to me if I am in this study?
The potential benefits to you for taking part in this study are:

You may feel better by having the opportunity to share your story. Also, you may help others in the future to better understand their own experiences.

Are there any risks to me if I am in the study?
The potential risks from taking part in this study are:

It is possible that you may feel uncomfortable sharing parts of your story. If you disclose that you are having emotional or physical discomfort during the course of the interview then the researcher will give you information about how to seek treatment if needed. Also, there are some things that the researcher is obligated to report by law if they are made known to her. For example, if you disclose that you are seriously considering harming yourself or others then the researcher must report this to the appropriate authorities. While reporting incidences to the appropriate authorities, the researcher will also refer you to treatment.

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. All interviews will be kept private and will not be discussed with anyone outside of the research study. Voice recordings and transcripts will be kept in locked filing cabinets or password protected computer files that only the research team has access to. Audiotapes will not be labeled with your name or personally identifiable information with the exception of the “fake” name that you chose. The research team includes: Roxanne Vandermause, Samantha Girard, Renee Hoeksel, Linda Eddy, Washington State University College of Nursing faculty and graduate students involved in qualitative research studies, and the Washington State University Institutional Review Board.

Digital audio recordings from this study will be kept for three years and then destroyed. De-identified transcripts from this study will be kept indefinitely for the purposes of further research.
studies or used for educational purposes. Results from this study may be published or presented at professional meetings or conferences, but the identities of all research participants will remain anonymous.

**Are there any costs or payments for being in the study?**

There are no costs to you for taking part in this study. You will not receive any money or any other form of compensation for taking part in this study.

**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 Samantha Girard by phone: (619) 218-4866 or by email: samantha.girard@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) 335-368, or email: irb@wsu.edu, or by regular mail at: Albrook 205, PO Box 643005, Pullman, WA 99164-3305.

**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 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**

________ (initials) I understand that my interview will be audio recorded.

I give my voluntary consent to take part in this study. I will be given a copy of this consent form 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 she or he can expect.

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

I also certify that she or he:

- 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 her or him.
- 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 D

INTERVIEW QUESTIONS

Attachment – Interview Questions (May 2015)

WSU (#14240, Exempt) IRB Application: PI: Vandermause

Experiences of Registered Nurses Who Voluntarily Withdraw From Their BSN Program

This study will be conducted using interpretive phenomenology as informed by Heidegger. In Heideggerian phenomenology, the purpose of the interview is to understand the lived experiences of the participant through the interpretation of the narrative text. A list of specific predetermined questions is not the best approach for eliciting participants’ stories and experiences. Research literature recommends that the researcher begin with a general question that encourages the participant to tell their story. This general question is then followed up with clarifying questions to prompt a rich description of the experience.

The initial question posed to the participant is:

“I am interested in finding out about the experiences of registered nurses who return to college to get a BSN degree, and more specifically, as someone who has withdrawn from a BSN program, please tell me about what that experience was like for you? Is there a moment that stood out as being particularly significant to you during this time, can you tell me about it?”

An example of clarifying questions that may be asked are:

“Is there anything in particular that you would like to share about your experience of withdrawing from your BSN program?”

“You said that ____________________, can you tell me more about that?”
APPENDIX E

DEMOGRAPHIC AND INFORMATIONAL QUESTIONS

Demographic questions will be asked at the end of the interview.

1. What is your current age?
2. What was your age when you enrolled in a BSN program?
3. What is your race/ethnicity?
4. What is your gender?
5. What is your marital status?
6. How many children do you have? What are their ages?
7. What is your current education level?
8. How many years have you been a registered nurse?
9. How many years did you nurse before deciding to return to college to get a BSN?
10. How long did you wait between making the decision to go back and when you actually enrolled in a BSN program?
11. How many hours a week do you work?
12. Were you a full-time or part-time student in the BSN program?
13. How many credits had you completed in the BSN program prior to withdrawing?
14. Did you receive financial aid that enabled you to return to college?
15. Are you the first in the first generation in your family to go to college?
APPENDIX F

INTRODUCTORY SCRIPT

1. Explanation of the Study: Hi. I am a registered nurse and Ph.D. Student at Washington State University. I am conducting this research study to fulfill a requirement for my doctoral dissertation. I am interested in finding out more about and understanding the experiences of registered nurses who return to college to get a BSN degree and subsequently withdraw from their BSN programs prior to completing them. This research study is not being influenced by any particular college or university that offers a BSN program to registered nurses and in no way do I, as the researcher, represent a specific BSN program or any particular institution. The results of this study will be reported through written manuscripts or at educational conferences, but no identifying information will ever be disclosed. You may choose not to participate at any time until the interview is completed. Have you had a chance to review the consent form? Do you have any questions at this time?

2. Reminder of Disclosures: The confidentiality of everything you say will be maintained during the interview, and any information that is publically visible will only be identified by the pseudonym that you choose. However, if at any time during the interview you disclose anything that indicates you are being harmed, considering harming yourself, or considering harming others, I am obligated to report this to the appropriate authorities. If you disclose you are having a problem that requires medical assistance, I will refer you to the nearest medical facility.

3. Pseudonym: Please choose a pseudonym or “fake” name that will be used to identify all data with the exception of the consent form.

4. Reminder of the Audio Recording: Just a reminder that the interview is being digitally recorded on a voice recorder.

5. Explanation of Interview Style: The purpose of this interview is to offer you the opportunity to tell your story. The interview will feel more like a conversation, and there may be times where silences occur that allow us both to think and reflect on what we want to say. I will start by asking a very general question instead of many specific questions. After the interview, I will ask you demographic and informational questions.

6. Consent Form Signatures: Do you have any questions before you sign the consent form? Please sign the consent for if you are ready to do so.