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**AN INTERPRETIVE STUDY OF THE PROFESSIONAL SOCIALIZATION OF
NEOPHYTE NURSES INTO THE NURSING SUBCULTURE**

DISSERTATION

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May, 30, 1990

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ABSTRACT

An Interpretive Study Of The Professional Socialization of Neophyte Nurses Into The Nursing Subculture

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Making the transition from nursing student to practicing nurse requires the novice to master an array of complex nursing skills in order to care for acutely ill patients. In an era of cost containment, today's hospitals are demanding efficient and effective delivery of nursing services. Nurse administrators are expecting competent, efficient graduate nurses upon entry into the organization.

The transition from school to the work world is characterized by the loss of one familiar social setting and its replacement by a distinctly new culture. The disparity the neophyte experiences between the attitudes, beliefs, and behaviors of school and work divides the new nurse into two subcultures: nursing schools and nurse employing organizations. This division makes the transitional shift from school to work organization, or from student of nursing to professional nursing a difficult one.

The purpose of this study was to understand the

influence of the nursing subculture on the professional socialization of neophytes. The goal of this study was to describe the total systematic structure of the lived experience during the enculturation process into the nursing subculture as perceived and understood by the neophytes entering professional nursing. The methodology involved participant observations and interviews with individuals in their natural context. An analysis of the events observed occurred.

The conclusions drawn are the following: 1).the transition into nursing practice for the neophytes was surrounded by fear of failure, fear of total responsibility, and fear of making mistakes, 2). the subculture de-emphasized psychosocial patient interactions and placed its value on efficiency and task-oriented nursing care which for the novice practitioner was problematic, 3).there was a clash between the neophytes' school bred values and those of the work world, which made integration into the nursing subculture at times unpleasant, 4). the preceptors provided minimal support to the neophytes, largely because they did not understand the preceptor role, 5). articulating the values, norms, beliefs, and expectations to the neophytes was difficult for the preceptors, and 6). the neophytes had difficulty with task self-esteem because of their lack of organizational skills.

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DEDICATION

To the neophytes on unit A and B in their struggle into professional nursing practice.

ACKNOWLEDGEMENTS

Words can not express the experience of a phenomenological study. This project was especially exciting for me because I had this rare opportunity to observe the nursing subculture and clarify my perceptions with neophytes entering the nursing profession. The truly rich experiences shared by the neophytes have added a dimension to my understanding of the enculturation process I could not have gained in any other way. A special note of appreciation to all neophytes for trusting me with their experiences. I am extremely grateful to my friend Debbie Yaddow who became a shareholder in this project. She helped me clarify my perceptions, listened to my frustrations, and shared her thoughts and ideas. Her keen insight into nursing practice and her interest in this work were instrumental in finishing this project.

I am also grateful for the support and encouragement I received from my dissertation director William Foster and from the other members of my committee, June Lowenberg and Mary Scherr. I will always remember June Lowenberg, who's encouragement and feedback helped in shaping the core themes in this document. Finally, I thank my family, friends, and colleagues who have believed in me so I could believe in myself and finish this goal.

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CHAPTER I

STATEMENT OF THE ISSUE

Introduction

Making the transition from nursing student to practicing nurse requires the novice to master an array of complex nursing skills in order to care for acutely ill patients. These skills are necessary to manage the sophisticated technology used in hospitals to treat these patients. In an era of cost containment, today's hospitals are demanding efficient and effective delivery of nursing services. With the intensity of patient care increasing and the shortage of nurses at the bedside, nurse administrators are expecting competent, efficient graduate nurses upon entry into the organization.

While these expectations may seem unrealistic, graduate nurses hold unrealistic expectations as well, making the transition period a difficult one. New graduates enter professional practice with the latest knowledge in nursing theory, a limited mastery of nursing skills, and a basic understanding of disease processes. They enter the work force expecting to perform as an experienced nurse because of their recent education; however, they seriously lack the organizational efficiency and practical experience required to care for multiple acutely ill patients. Most graduates have cared for 1 to 2 patients at a time in nursing school

while hospitals require that a nurse is able to care for 4 to 8 patients depending on the shift worked. As a consequence, graduate nurses lack sophisticated organizational skills, which leaves them often feeling frustrated and incompetent.

As graduate nurses enter their first nursing position, they seek to establish professional identity. According to Kramer (1974), professional identity of neophytes is tied to successful mastery of a variety of individual nursing tasks, which for neophytes is quite difficult. The complexity of managing multiple clinical situations and lack of organizational skills often jeopardizes the neophyte's ability to successfully acquire professional self-esteem and identity in his/her first year of nursing practice. Thus, graduate nurses are in a professionally vulnerable state as they begin their nursing career (Kramer, 1974).

Upon employment the neophyte is exposed to new values and expectations espoused by the bureaucratic orientation of the organization. Having little warning or knowledge of these values and expectations, the neophyte often experiences conflict and confusion during the initial process of learning the new sociocultural system (Benner & Benner, 1975). Graduate nurses must distinguish between the values of school and the work world when entering an organization. During this time there is an attempt by the neophyte to hold on to the school values which often results in troublesome dilemmas.

Nursing school maximizes the ideals of nursing

practice, while the reality of the work world minimizes these ideals and maximizes the practical skills necessary to practice nursing (Myers, 1982). The disparity between attitudes, beliefs, and behaviors of school and work divides the new nurse into two subcultures: nursing schools and nurse employing organizations. This division makes the transitional shift from school to work organizations, or from student of nursing to professional nurse a difficult one.

In addition to learning new values, graduate nurses seek inclusion into both the organization and the nursing subculture (Benner & Benner, 1975; Kramer & Schmalenberg, 1977; Schein, 1985). Integration into the nursing subculture involves demonstrating competency and proficiency in patient care which for the novice is difficult (Meyer, 1982). Often when seeking entry as a novice, graduate nurses are treated as outsiders. For some graduates, this results into a disinheritance of school-bred values as a means of being accepted by the group. For others, feelings of indifference and hostility emerge towards the members of the nursing subculture (Hardy & Conway; 1978; Kramer & Schmalenberg, 1977; Schein, 1985).

As the preceding discussion suggests, the transition from school to the work world is often painful for graduate nurses. This period is characterized by the loss of one familiar social setting and its replacement by a distinctly new culture. There is an inherent clash between school and work values often leading to feelings of ambiguity,

frustration, anxiety, and cultural shock (Kramer, 1974; Myers, 1982).

Bridging the gap from student to professional nurse begins with assimilation and socialization into the nursing subculture of a hospital. Effective socialization usually means that the newcomer has changed some basic attitudes and beliefs and thus internalizes a commitment to the organization, rather than simply compliance with organizational practices (Wanous, 1980). The basis of the socialization process is the understanding of how people's attitudes change. According to Bakke (1953), organizational socialization has been described for over 25 years as a two-part fusion process. The first is the organization's socialization of the newcomer, and the second is the newcomer's personalization of the organization.

Schein (1978) views organizational socialization as a three stage model of entry, socialization, and mutual acceptance. This model will be used simply as a lens through which the interpretation of the enculturation process of graduate nurses into the nursing subculture of hospital organizations will be examined. Insights into the concepts, habits, norms, skills, arts, and behaviors of the nursing subculture as perceived by graduate nurses will be obtained. Thus, through the enculturation of these expectancies, appropriate behavior for graduate nurses can be anticipated, acceptable social exchange with others can be explored, and change acknowledged (Bach, 1977; Myers, 1982; Schein, 1985).

The Issue

Contemporary nursing literature pertaining to graduate nurses' transition from educational institutions to hospital work settings has had a problematic focus. Detailed descriptions of transitional difficulties are available; however, there is minimal information or research devoted to understanding the transition into the nursing subculture and professional nursing practice. Studies have measured factors pertaining to transition difficulties with various scales which deal minimally with the personhood of the individual nurse. Using such tools to measure identified difficulties of graduate nurses places little emphasis on individual nurse's perceptions and interpretations during the transition period.

An understanding of graduate nurses' perceptions of the socialization process into the nursing subculture is perhaps a key to facilitating insight into the difficulties associated with this period of transition. By collecting concrete, empirical data about graduate nurses' perceptions of the nursing subculture, professional socialization, and professional nursing practice, patterns can be categorized, themes will emerge and a richer understanding of those factors influencing transition of graduate nurses to professional nursing practice will be discovered.

Purpose Of The Study

In an attempt to gain insight into the enculturation process, a commitment to the task of understanding the influence of the nursing subculture and the meanings

attached to that subculture is essential. By engaging in a close participant observational relationship with those observed in the natural setting of hospitals, more can be learned about the thoughts and meanings attached to graduate nurses' experiences. Significant themes will emerge which can help us understand the everyday reality of graduate nurses during their enculturation into professional nursing. Recommendations can be made addressing aspects of professional socialization and its relevancy to the transition period as experienced by graduate nurses.

Objectives Of The Study

To understand the influence of organizational socialization and of the nursing subculture on the transition of graduate nurses into professional nursing, the researcher will:

1. Identify the dominant values, beliefs, norms, and expectations of the nursing subculture in an acute care hospital setting, as perceived by neophyte nurses during the socialization process.

2. Interpret the influence of the nursing subculture on professional socialization of neophyte nurses.

3. Make recommendations based on these findings to assist organizations in understanding the significance of professional socialization for graduate nurses.

Relevancy To Leadership

In our rapidly changing and increasingly complex nursing environment, the importance of shared experiences to establish meaning, stability and social progress is

imperative. These shared meanings as expressed in the organizational culture make it possible for members to socialize with each other and concentrate on specific tasks of the organization (Schein, 1985). It is the responsibility of leaders to manipulate this environment and provide meaning in the work world.

Throughout the nursing literature, nurses value quality patient care and a respect for human dignity (Christman, 1988; Kramer & Schmalenberg, 1988; Scherer, 1987). As Christman (1988) stated: "It is the delivery of patient care that is the sine qua non of the profession, and every means of improving its quality must be exploited" (p. 2). An environment that provides for excellence is not only valued and respected by the seasoned nurse, but is also of primary importance to the neophyte. However, because the neophyte has difficulty enacting these professional values in the bureaucratic work setting, graduate nurses find it difficult to uphold these ideals. Nursing leaders must manage and shape an organizational culture that fosters excellence and therefore assists neophytes in integrating into the nursing subculture. It is only through an indepth knowledge and understanding of graduate nurses' experiences that a successful blending of professional values and bureaucratic principles can be accomplished.

Definition Of Terms

The following terms will be referred to and used throughout the course of this inquiry. These definitions are designed to add depth and breadth to this study.

Acute Care Nursing Setting: A hospital subunit where both medical and surgical patients are treated during the acute stage of their illness.

Ancillary Personnel: Those employees of hospital departments other than nursing who interact with nurses on a particular unit.

Culture: A set of shared meanings of events shared by and distinctive to a group of people. These meanings are constantly constructed and emerging by human group life and passed on to new group members.

Charge Nurse: A registered nurse with greater than one year of hospital nursing experience with or without formal management training who oversees all direct patient care during an eight hour period.

Enculturation: A process in which a particular cultural tradition is learned (Kramer, 1974).

Experienced Nurse: A staff nurse who has been employed more than one year in the nursing unit of a hospital.

Graduate Nurse, Neophyte, Novice Nurse: A registered nurse who is a graduate of an accredited school of nursing, holds a license to practice as a professional nurse and embarks upon a first work experience.

Nursing: A profession which assists the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that the individual would perform if he/she had the necessary strength, will, or knowledge and to do so in such a way as to help the individual gain independence as rapidly

as possible (Henderson, 1964).

Nurse Manager: An administrator of a nursing unit who has 24 hour responsibility to the daily operations of that unit and its personnel.

Nursing Subculture: A social grouping of hospital nurses within the larger culture of the hospital organization with shared symbolic meanings, values, and attitudes. Aspects of the subculture are peculiar to nursing.

Patient Acuity: Level of intensity of illness, which determines the amount of nursing care hours required per patient per shift.

Staff Nurse: A general category of all nursing personnel who are regularly assigned to a hospital unit and give direct patient care. This position in the nursing hierarchy falls below the nurse manager.

Transition Period: The first six month period of adjustment from being a student of nursing to professional nurse.

CHAPTER II

REVIEW OF LITERATURE

The review of literature will concentrate on three areas pertaining to graduate nurses' transition into professional nursing practice. The first section provides an overview of the difficulties neophyte nurses encounter upon entry into hospital organizations. This section focuses specifically on the differing value systems encountered by graduate nurses and the subsequent effect of experiencing such distinctly different philosophies. School acquired values and work values will be presented utilizing a comparing and contrasting framework. The second section will examine organizational socialization and role making during the enculturation into the nursing subculture. Finally, the last section discusses the significance of this study in light of the present nursing shortage.

The Transition Period

Recent literature on the transitional difficulties of graduate nurses has focused much of its attention on the technical problems experienced by the neophyte in making the transition from student to nurse. Specifically, studies have documented the neophytes' lack of clinical experience which is required to competently enter hospitals and provide comprehensive patient care (Davison, 1987; McCloskey & McCain, 1987; Myrick, 1980). Lack of organizational skills,

fear of making mistakes, inability to care for acutely ill patients, and lack of efficient and effective delivery of nursing care has been cited throughout the literature as major areas of concern for the neophytes (Andrews, 1987; Goldsberry; 1977, Davison, 1987; Lathlean, 1987; Myrick, 1988; Shand, 1987). Both graduates and organizations have identified difficulties with employing neophyte nurses. According to Shand, (1987) 85% of the graduate nurses surveyed viewed the responsibility required to perform competent nursing care as exceeding their expectations. Andrews (1987) interviewed 30 graduate nurses and identified seven areas of concern. Of those seven areas, lack of competent skill level, fear of total responsibility for patient care, lack of constructive feedback, and lack of understanding and acceptance by experienced nurses were of most concern to the graduates studied. Organizations have expressed doubts as to the entry level skills of graduate nurses. According to Myrick (1988) employers believe that graduate nurses are often incapable of assuming full patient-care responsibilities immediately upon employment. With vacancy rates in hospitals on the rise and the numbers of qualified applicants available to fill positions declining, hospitals are being forced to hire neophyte nurses.

In response to this dilemma, employers are spending thousands of dollars annually in formal, preceptored, orientation programs which are designed to facilitate technical competency and professional growth in the new

graduate. The instructional strategy of these programs is to assign an experienced nurse to work with novice nurses anywhere from 6 to 12 weeks. The experienced nurse teaches the policies and procedures of that facility and assists the graduate in the organizational skills necessary to care for multiple patients (Myrick, 1983). Despite the intensity of these programs, there is minimal data that support the conclusion that these programs make a significance difference in shortening the time it takes for a graduate nurse to become an efficient and effective practitioner. A study done by Olsen, Gresley, and Heater in 1984 suggests little significant difference in the clinical performance of graduate nurses who had been preceptored over those who had not been preceptored. What hospitals are beginning to realize is that even with preceptored programs in place, it takes approximately one year for the graduate nurse to truly become a competent bedside clinician and an asset to the organization (Andrews, 1987; Schein, 1968).

Organizational Entry: A Clash In Values

The concept of conflicting school and work values emerged as a result of Marlene Kramer's 1974 qualitative study of neophyte nurses. According to Kramer (1974) nursing schools and nurse-employing organizations represent two different subcultures of the nursing world. The norms, values, and behavioral expectations between school and work differ more drastically than do two different work settings (Kramer & Schmalenberg, 1977). School fosters the values of autonomy, independence of thought and behavior, and

responsibility for self-learning (Myers, 1982). The nursing student values cognitive skills, effective work, and holistic care of 1 to 2 patients (Kramer & Schmalenberg, 1977). In contrast, organizations value some aspects of autonomy, essential care for many patients, responsibility for self and others, efficient work, and technical and organizational skills (Kramer, 1974). The extent to which these two subcultures propagate values, attitudes, and behaviors that are different has an impact on the degree of difficulty an individual desiring to move from one subculture to another will encounter (Myers, 1982).

When neophytes enter organizations, they are faced with conflicting loyalties between professional and bureaucratic value systems. As a result graduate nurses experience reality shock (Kramer, 1974). The consequence of this shock like reaction is that neophytes may choose to become less "professional" with continued employment, or withdraw from the hospital work scene altogether (Bach, 1977; Kramer & Schmalenberg, 1977; Meyers, 1982). Working through this shock like reaction occurs when the neophyte combines the best parts of the cultures of nursing school and nursing practice and moves towards professional identity (Kramer & Schmalenberg, 1977).

Organizational Socialization Into The Nursing Subculture

According to Schein (1968) organizational socialization is a "process of learning the ropes, the process of being indoctrinated and trained, the process of being taught what is important in a organization or some subunit thereof" (p.

2). This process occurs in school and even more dramatically when graduate nurses enter an organization on their first job. It is this socialization that can make or break a career and the organization (Schein, 1964). The speed and effectiveness of socialization determines employee loyalty, commitment, productivity, and turnover (Schein, 1968).

There are, however, inherent dilemmas associated with interfacing the socialization of graduates of nursing in organizations. Schools of nursing socialize their students toward the concept of professionalism. Faculty role models promote an independent, decisive, idealistic nurse. Organizations socialize their new members to be effective members. Employing organizations socialize employees to be dependent, skill oriented staff nurses (Green, 1988). Because these two processes differ, the socialization process for the neophyte proves to be difficult.

Elements Of Socialization

The term socialization refers to the process by which new members learn the values, the norms, and the required behavior patterns of the society, organization, or group which they are entering (Hardy & Conway, 1978). It does not include all learning, however. According to Schein (1968) organizational socialization includes only the learning of those values, norms, and behavior patterns which from the organization's point of view are essential for the new member to learn. Schein refers to this learning as the price of membership.

The values, norms, and behavior patterns characterizing

the nursing subculture include the basic goals of the organization, the means of attaining these goals, the basic responsibilities of the members in the nursing role, the behavior patterns which are required for an effective performance in the role, and a set of rules or principles which pertain to maintenance of the identity and integrity of the subculture (Green, 1988; Kramer, 1974; Kramer & Schmalenberg, 1988).

By what process does the novice nurse learn the required values and norms of the nursing subculture? According to Hardy and Conway (1979), the answer to this question depends in part on the degree of prior socialization. If the novice has correctly anticipated the norms of the organization, the socialization process merely involves the reaffirmation of these norms (Green, 1988). If, however, the novice comes to the organization with values and behavior patterns which are in varying degrees out of line with those expected by the subculture, the socialization process first involves an unfreezing phase (Schein, 1968).

While it is typical for graduate nurses to enter organizations with unrealistic expectations, it is also typical for the members of the nursing subculture to begin unfreezing these expectations. Graduates are sometimes given patient care assignments that are so difficult that failure is certain, thus proving unequivocally to the new nurse that they are not as smart as they thought they were (Kramer, 1974). Or, graduate nurses are initially assigned the menial

tasks; after proving their competence in those, the experienced nurse will give them more responsibility (Kramer & Schmalenberg, 1977).

To confront the difficulties of this unfreezing period, the neophyte begins adopting a role that fits comfortably with the rules and regulations of the employing institution (Green, 1988). Experienced nurses aid in this transition by encouraging compliance with the rules in order to be accepted by peers (Kramer & Schmalenberg, 1977). Thus, organizations socialize their members by creating a series of events which serve in undoing old values so that the person will be prepared to learn the new values. The process of undoing for the neophyte is often unpleasant and therefore requires either strong motivation on the part of the graduate nurse to endure it or strong organizational forces to make the person endure it (Schein, 1968).

How does the novice acquire new learning? Hardy and Conway (1979) suggested that it is through the process of role making. For role making to occur, a role model is necessary (Myers, 1982). According to Riggin (1982) there is a dearth of consistent role models in nursing available to mentor graduate nurses. Despite the fact that there are few role models present, role making can still be achieved if the graduate can consolidate the influences of the role model and all others affecting him/her into one role perception (Hardy & Conway, 1979). Through this process, technical skills, values, attitudes, and beliefs of experienced nurses can be internalized (Cohn, 1981).

Professional role conception refers to occupational principles, role expectations, and role behaviors that transcend location of specific employment. In contrast, bureaucratic role conception refers to the rules, regulations, and procedures that describe and govern the nurse's job and role expectations in specific employing organizations (Kramer, 1974). During role making the neophyte is exposed to primarily bureaucratic role orientations rather than a balance of both professional and bureaucratic conceptions (Kramer, 1974). In 1962 Corwin and Traves studied bureaucratic and professional role orientations and found a discrepancy between the idealistic portrayal of nurses in nursing school and the reality of the hospital situation. This led to disillusionment and a decline in professional role orientations and subsequent increases in bureaucratic orientations of graduate nurses. Green supported Corwin's findings in a 1988 study of 25 graduate nurses. Green's findings suggest that there has been a notable increase in bureaucratic and service orientations and a decrease in professional orientations among neophytes. It was experienced nurses in this study who socialized new nurses into bureaucratic role orientations rather than professional orientations. McCloskey and McCain (1987) found that graduate nurses not only experienced disillusionment as a result of the conflict between professional and bureaucratic values, but if their expectations were not met they became less attached to the job, the organization, and the profession.

Compounding the difficulties in role making is the perception of role expectations held by neophytes. According to Vroom (1964) if expectations of the job are highly unrealistic and there is no correspondence between the needs of the individual, the rewards they seek, and the actual work experience, workers' satisfaction may be adversely affected. Graduate nurses often possess unrealistic expectations of the professional nursing role, and as a result they are often disappointed with the job itself (Benner, 1984; Hardy & Conway; 1979; Kramer & Schmalenberg, 1977; Wanous, 1980). McCloskey and McCain (1987) studied satisfaction, commitment, and professionalism of newly employed nurses and found that during the first year of employment all nurses employed in hospitals reported decreased job satisfaction, decreased organizational commitment, and decreased professionalism largely due to unrealistic expectations held by nurses. There were no reported differences between new graduates and experienced nurses.

In contrast, Oehsle and Landry (1987) studied new graduates and experienced nurses and found more role congruency between role expectations and actual work experience in less experienced nurses than in more experienced nurses. The amount of feedback given by supervisors was cited as the critical element contributing to the lack of experienced nurses' role congruency. While there are studies that support or reject the aspect of role expectations for neophytes, what cannot be disputed is the

fact that role adjustment creates both professional and personal conflicts that neophytes often find devastating (McGrath & Princeton, 1987).

Optimizing The Practice Environment

In 1988 hospitals employed 800,000 registered nurses, which represents a 30% increase since 1980. Patient acuity, sophisticated technology, and lengthening of the life span have generated an increasing need for more nurses. The Department of Labor projects that in the 1990s the need for nurses will increase by 33% (Falter & Smith, 1988). Currently there are 1.7 million licensed registered nurses in the United States with 80% of these nurses actually practicing (California Association of Hospitals and Health System, 1988). As a result, according to the American Hospital Association 77% of the hospitals in the United States are reporting a shortage of nurses (Falter & Smith, 1988).

The available pool of students has generally become more limited with substantial declines in enrollment in schools of nursing, particularly in the private sector. Among those reasons cited for declining enrollment is the influence of the women's movement, which has generated competition for women employment from many other fields and increased competing worksites for nurses (California Association of Hospitals and Health Systems, 1988).

Keeping this in mind, it is easy to see that graduate nurses are truly an investment in the nursing profession's future. They are the profession's most precious resource

that must be cultivated as they make the difficult transition from student to practicing nurse. Efforts must be made to recruit and retain new and experienced nurses to meet the needs for health-illness care within our society.

What kind of hospital environment is necessary to support the graduate's professional needs and facilitate an easier transition into professional nursing practice? According to Kramer and Schmalenberg (1988), a culture which supports both the experienced and neophyte nurse uses the family metaphor, promotes a sense of belonging, and is an environment where graduate nurses can be easily socialized. Hospitals that can view themselves organizationally as an extended family will facilitate a sense of belonging and caring for graduate nurses entering organizations.

According to Peters and Waterman (1982), successful companies possess a people orientation with a true respect for the individual. This respect takes the form of treating people with dignity and providing high performance expectations. A nursing subculture that values a belief in being the best and emphasizes the importance of doing the fundamentals of the job well; believes in the importance of people as individuals; sees the necessity of providing quality service; believes that most people in the organization should be innovators and provides an atmosphere which supports failure; believes in the importance of information to enhance communication; and recognizes the importance of economic growth and profits is an ideal environment in which socialization of graduate nurses into

the culture could be facilitated (Kramer & Schmalenberg, 1988). Providing a practice environment such as this would not only facilitate optimal organizational socialization but would address the professional values and commitment of graduate nurses by allowing them to blend both professional and bureaucratic goals.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

The purpose of this inquiry was to gain an understanding of graduate nurses' perceptions of the socialization process into the nursing subculture during the transition period to professional nursing practice. The questions posed by this investigator embodied the qualitative research tradition, facilitating an understanding of the values, beliefs, norms, expectations, and meanings graduate nurses attach to the nursing subculture and the professional socialization process. The results of this inquiry emphasized an understanding of how graduate nurses spontaneously categorize and placed meaning on their individual experiences of organizational socialization into the nursing subculture and professional practice. A comprehension of such realities for graduate nurses will enable staff nurses and nurse administrators to understand perceptions and meanings attributed by graduate nurses to their transition period and thereby influence this period in a positive manner.

Overview Of Qualitative Method

The qualitative method is a comprehensive term used to cover an array of interpretative techniques which seek to "decode, describe, translate, and otherwise come to terms with the meaning, not the frequency of certain more or less

naturally occurring phenomena in the social world" (Van Maanen, 1983, p. 13). Qualitative data consists of detailed descriptions of people, events, situations, or observed behavior (Polit & Hungler, 1983). Case studies, grounded theory, phenomenology, and ethnography are common qualitative methods. Characteristic methods of data collection include interviews, questionnaires, observation logs, journals, and participant observation as well as a variety of other techniques used to generate rich and meaningful data (Ammon-Gaberson & Piantanida, 1988).

This investigation utilized both phenomenologic and ethnographic methodologies to understand the meanings created as a result of the enculturation process into the nursing subculture and professional nursing practice. According to Tesch (1984), there is a difference between phenomenology and ethnography making these two methods inherently distinct. However, despite their distinction, phenomenology and ethnography do employ interrelated methods which make these two methodologies similar in many ways. Because this study is not purely phenomenological or solely ethnographic, a brief examination of each of these methods will be given.

The Phenomenological Approach

Phenomenology and ethnography are alike in that they describe not external events, but subjective experiences. They are different in that "ethnography seeks to depict a culture. . . while phenomenological research is on individual experiences which does not necessarily need a

social context to be meaningful to the individual "(Tesch, 1984, p. 26).

The phenomenological method is an inductive, descriptive research method. The task of this method is to investigate and describe phenomena, including the human experience, in the way these phenomena appear. To ensure that the phenomena are being investigated as they truly appear or are experienced, the researcher approached the phenomena to be explored with no preconceived expectations (Omery, 1983). The researcher did not seek to validate any preselected theoretical framework or operational definitions. The subjects under study were approached naively with all data accepted. The researcher used this method to understand all data under study from the perspective of the participants in the experience (Omery, 1983).

Phenomenological researchers attempt to understand both cognitive and subjective perspectives of the person and the effect that these perspectives have on the lived experience or behavior of that individual (Jones, 1977). Keeping these perspectives in mind, the goal of this study was to describe the total systematic structure of the lived experience during the enculturation process into the nursing subculture as perceived and understood by graduate nurses entering professional nursing.

According to Cohen (1987) phenomenology concerns itself with individuals and their views studied in their natural context. Study in this science begins by going to the

"things" themselves, beginning with phenomena, not theories. What was studied was phenomena, the appearance of things, and the things themselves (Cohen, 1987). Encompassing this tradition of research is the belief in intersubjectivity. Utilizing this perspective the phenomenologist believes in the existence of others who share a common world as instrumental to the phenomenological method of research (Ammon-Gaberson & Piantanida, 1988). Thus, as Blumensteil (1973) most proficiently stated, "it is the task of phenomenologists to make things whose meaning seem clear, meaningless, and then, discover what they mean" (p. 189).

Phenomenological Data Collection Methods

In order to understand an individual's meaning and interpretation of inner experience, this investigator utilized a variety of data collection methods. The role of the investigator was to place special attention on the natural context in which events occur and have meaning (Cobb & Hagemaster, 1987). There was an emphasis on understanding the social world from the point of view of the participants by utilizing interviews and participant observation techniques. According to Tesch (1984), it is through the experience of immersion in the phenomena and intense dialogic introspection that the researcher begins to understand the social world of the participant. The result of sharing the experiences of the participants was the development of a relationship where descriptive data was gathered to assist in an indepth understanding of the phenomena under study. As a participant observer the

researcher gathered data by participating in the daily life events of the nurses under study, observing behaviors and situations the participants encountered, and engaging in conversations with the participants in order to discover their interpretations of the events observed (Lofland, 1984).

The Ethnographic Approach

Ethnography attempts to understand human behavior by analyzing the framework within which the subjects interpret their thoughts, feelings, and actions (Wilson, 1983). It is my view that knowledge is acquired through an understanding of the meaning of behavior according to the perceptions and interpretations of those engaging in that behavior.

To gain knowledge and an understanding of the meanings, the ethnographer must explore the language of the informants, learn their conceptual frameworks and describe their perceptions of reality. According to Robertson and Boyle (1984), focusing on the informant's point of view is referred to as an "emic" approach. Emic distinctions requires the researcher to enter the informant's world of purpose, meaning, and beliefs. The emic approach is based on the assumption that between the actor and observer, it is the actor who is better able to know his/her own inner state (Harris, 1963). Explication of the meaning underlying behavior enables one to go beyond simply a knowledge about cultural practices to an understanding of the practices (Kay & Evaneshko, 1982). In contrast, some ethnographers are guided by the "etic" epistemology which assumes that the

meaning of an actor's behavior can best be interpreted and explained by the researcher in his/her own theoretical dimensions (Robertson & Boyle, 1984). Utilizing this stance, ethnographers believe that a person's cognitive state is less important than the person's behavior in understanding and interpreting the culture. Utilizing an etic approach to investigating behavior can lend itself to identifying the ideologies and belief systems of people (Harris, 1979).

This researcher has utilized an eclectic research style from both epistemologies. It was through the use of a variety of methods that enough information was acquired to present a well rounded account of the phenomena studied.

In addition to the emic and etic distinction, virtually all ethnographers share an epistemology which supports the belief that human behavior can only be understood within the context in which it occurs (Van Maanen, 1983). Thus, this research was conducted in its natural setting on a medical/surgical nursing unit in a hospital.

Ethnographic Data Collection Methods

Generally ethnographic researchers employ several methods of data collection such as intensive interviews, event analysis, participant observation and unobtrusive observations. Interviews may be solicited from key informants as well as from other members of the culture. The ethnographer may employ a combination of both structured and unstructured interviews.

Participant observation is another major data collection technique utilized by the ethnographer.

Observation activities concentrate on behaviors as well as on the settings and circumstances in which behaviors are seen (Robertson & Boyle, 1984). Participation involves attendance at cultural functions, interactions with persons being observed, observation activities, and in some cases direct participation in events (Van Maanen, 1983).

Participant observation is considerably more than casual observation and participation in events or activities. The ethnographer raises questions and explores relationships. Behavior that is observed and data that are elicited must be methodically recorded during and after the time of occurrence. Preliminary data from participant observations provide the fieldworker with insights and clues necessary for developing later interview questions (Punch, 1986).

It is important to keep in mind that ethnography is primarily an inductive mode of research. Thus, the researcher seeks to avoid a priori standardization of technique and assumptions about data and concepts. Cultures are dynamic, not static entities; therefore it is the researcher's responsibility to remain open to adapting procedures to situations as they unfold in the field as well as create or add new data collection procedures. The primary research instrument in ethnography is, after all, the researcher.

Participant And Site Selection

Phenomenological and ethnographic studies range in sample size from 5-25 participants (Tesch, 1984). According

to Cobb and Hagemaster (1987), "group and cultural studies often use samples based on convenience and/or special interest of the researcher" (p. 140). To obtain indepth information and to develop thick descriptions of graduate nurses' perceptions of the socialization process into the nursing subculture, a convenience sample of medical/surgical graduate nurses was obtained.

Interviews and observations took place on a medical and a surgical nursing unit of an hospital. The sample size consisted of five participants and focussed on the perceptions graduate nurses attached to socialization into the nursing subculture. In addition in depth interviews were conducted with seven graduate nurses at another institution in an attempt to clarify the emerging themes of the study. To collect rich data, the goal of this study was to obtain a sampling that was representative of the full range of phenomena being investigated. Therefore, staff nurses, charge nurses, unit secretaries, unit managers and any other actors who were part of the nursing subculture were observed as part of this study.

Site Selection

To optimize gaining entry in a hospital for observations this investigator wrote a letter to a San Diego County hospital and requested a conference with the president of nursing services. It was emphasized that this researcher would observe neophyte nurses and document their socialization into professional practice. A written explanation of the purpose and objectives of the study was

provided to the organization. The researcher did assure the organization and its members that professional confidentiality of the organization and its participants would be maintained. Written permission to conduct the research project was received from the Director of Medical-Surgical Nursing Services. Findings of this study were shared with the unit under study to assist in future preceptored graduate orientation programs.

Data Collection And Analysis

Data collection methods included participant observation and interviews, both of which aided in understanding the perceptions of the graduate nurses' socialization process into professional nursing and the nursing subculture of hospitals. For approximately eight hours per week beginning in June through December 1989, the researcher conducted observations and informal and formal interviews involving new and seasoned nurses on all shifts. In-depth interviews served to clarify and validate the observations.

Additional data came from informal interviews with preceptors and charge nurse personnel. Experiences, observations, personal thoughts, and ideas about the theory and method comprising field research were written on the unit and then expanded into field notes and typed later that day. Sensitivity to the participants and the affective tone of the unit occasionally required that the notes be written after leaving the unit.

Paper with a wide left-handed margin allowed for coding

of significant themes that emerged as a result of data review. The data was coded with as many themes as possible to ensure full theoretical coverage (Chenitz & Swanson, 1986).

With time and by working with and understanding the data, the themes that emerged initially were collapsed into more refined categories. Perception checks and formal interviews with all participants allowed for validation of emerging themes. The data generated from the interviews with the graduates at the other institution served as a means of substantiating the data gathered through observation. As a result the conditions, causes, and consequences of the socialization process as perceived by graduate nurses became clear.

Ethical Considerations In Field Research

Field research concerns itself with conditions or forces that impinge on people and describes patterns of attitudes, behaviors, physical, and psychological reactions within people. As a result of such inquiry discoveries are made offering people the opportunity for improving their physical, biological, and psychological well-being.

In spite of the benefits of field research, ethical issues are of concern because of the investigative nature and the study of human subjects (Punch, 1986). Specifically the use of surveys, documentary evidence, and observations raise ethical questions for researchers.

Entry

A researcher about to embark on formal study desires

favorable conditions in which to pursue the study. In the process of achieving the study's purpose, the researcher is faced with many moral dilemmas, not the least of which is gaining entry (Krampitz & Pavlovich, 1981). Entering into a community to investigate a group and its lifestyle invades people's privacy. To avoid the inherent problems associated with gaining entry, the researcher fully informed the community under study as to the researcher's identity, and to keep in mind that she is entering the community as a learner so as not to abuse the privilege (Davis, 1986). In conducting this investigation a written statement of purpose was submitted to hospital administrators during a conference designed to gain entry.

Informed Consent

A qualitative researcher may obtain signed consent forms to cover the use of specific instruments, but data collection through on-going association with community residents in a variety of private and public circumstances must depend more on the ethics of the particular researcher than on the concept of informed consent (Robertson & Boyle, 1984). It is the researcher's obligation to explain the aims of the investigation to those interviewed or observed. A written informed consent was obtained for taped interviews in this study.

The Participants

Researchers have the right to study controversial participants, but not the right to deceive, exploit, or manipulate these participants (Punch, 1986). Participants

were informed that they were being researched and they were given information on the nature of the project (Borg & Gall, 1983). Anonymity of the actors was assured through the use of coding reports. Actors were informed that they may withdraw from the inquiry at any time. To ensure the rights and welfare of human subjects in this research study application to the Committee on the Protection of Human Subjects at the University of San Diego was submitted for and approved.

Reporting Findings

When the desired information was culled and the contents analyzed, it remained for the researcher to share the findings with the actors and with the host community (Krampitz & Pavolvich, 1981). Individuals who have participated in the study have the right to profit most from the results. The researcher must weigh possible risks against benefits to the study's population. Thus, in reporting these findings the researcher adhered to a professional code of ethics promoting benefits to both the actors and the institution who participated in the investigation.

Limitations Of The Study

After observing graduate nurses construct meanings during their professional socialization into the nursing subculture of a hospital, the researcher's ability to generalize from a study such as this was difficult. Because this study focussed its investigation on limited nursing units in a hospital, what can be said for other nursing

units in the same hospital? Additionally, each graduate is socialized based on individual realities and perceptions of the nursing subculture. Thus, this researcher will be in no position to make reliable statements about the ability of neophyte nurses to become socialized into the nursing subculture in all hospital settings, in as much as this creation is influenced by the nursing subculture of a particular unit and the individual's experience of it. There are few studies available on how graduate nurses experience the transition period into professional nursing, especially from a qualitative perspective in the natural setting. This study examined the socialization process of graduate nurses in response to their assimilation into the nursing subculture in one setting, an acute care medical and surgical nursing unit. Comparative studies in this and other hospital settings will help determine the extent to which these findings can be generalized.

Because the nursing subculture is influenced strongly by groups of nurses working on a unit, daily staffing patterns can affect the atmosphere of the unit because a different mix of people inhabit the same space. It is impossible to predict how these participants might have, or to what extent their behavior might have affected the total group. For this reason, this study described what happens on a unit and not what might have happened.

Inadequacies of observations limits the extent of interpretations and impressions. Life on a nursing unit extends through 24 hours of every day. One observer is not

able to cover this period in its entirety, thus limiting the generalizability of this study. In spite of these limitations, the present study may serve as an inspiration to others to perform additional systematic investigations into the socialization of graduate nurses during their transition period into professional nursing practice.

CHAPTER IV

OVERVIEW OF THE FACILITY

The Setting

The study took place in a community hospital on two separate units. For purposes of clarity the units will be designated unit A and B. Both units are identical in their physical layout. The nurses station is approached through a long hall. On both sides of the nurses station are several service rooms, utility rooms, a kitchen, patient bath facilities, and conference rooms. These rooms together with the nurses station form an island in the center of the unit. The patient rooms surround this island. Even though both units are similar structurally, the atmosphere on each unit is very different.

Efficiency best characterizes the work ethic of unit A.

The unit is run like a "tight ship" and utilizes this metaphor as its operational descriptor. There is a sense of "hustle and bustle" and a feeling of urgency in the air. Telephones are ringing, as staff nurses are in and out of the patients rooms, getting patients ready for surgery, monitoring post-operative vital signs and performing their nursing tasks. Patients are constantly coming and going on the unit with an average stay of two to three days. The unit functions in a formal, impersonal and rather sterile manner with little tolerance for "small talk".

From my observation it was clear that each nurse knew her responsibilities and performed them to the best of her ability. Many times I sensed tension and high levels of stress on the unit. The culture does however foster nursing care excellence. Deviations from this norm are not tolerated.

During my observations on unit A I often experienced feelings of uneasiness and discomfort. An influencing factor was the cultural expectations of the unit. Because social "small talk" was not valued and idleness was not tolerated it was apparent that a person taking notes or asking questions was not welcomed. This attitude became evident one evening when several telephones were ringing and there was not enough staff available to answer the phones. This presented a conflict for me as well as for the staff. I wanted to answer the telephone but was not sure of my role, while the expectation from the staff was that I would answer the phone. "At least you can answer the telephone", a staff nurse said with irritation in her voice, indicating that if I was going to be on the unit the least I could do was answer the telephone.

During the course of observing I discovered that continuous observations for long periods of time was not productive on unit A. After several hours, feelings of tension and stress interfered with the observation process. I never felt welcome on the unit and more often felt that I was in the way. I frequently had explained the study and nevertheless I was often referred to as a "spy". It was

obvious that my presence was threatening to the staff, but despite this obstacle I continued to observe, document, and clarify as slice of the neophyte's world began to unfold.

Unit B

In sharp contrast to unit A is unit B. Unit B cares for the chronically ill, elderly, and often debilitated patients. There are patients on the unit requiring mechanical ventilation due to lung disease, as well as patients requiring long term hospitalization due to communicable diseases. Thus, the length of stay is longer on this unit due to the severity and chronicity of illness. The patients required specialized nursing care and frequently needed assistance with all activities of daily living. I found the nursing care on unit B emotionally and physically demanding, hence, retaining staff was difficult. There was chronic under staffing of nurses on each shift with an increased use of temporary agency nurses to supplement the poor staffing.

The atmosphere on unit B was chaotic and disorganized. Machines were beeping constantly often mixed with loud cries from confused patients. Equipment lined the corridors giving the unit a cluttered appearance.

From my observations the nurses on this unit delivered nursing care with little enthusiasm for their work. Often nurses were overheard saying "We do the best we can", indicating that under different circumstances nursing care could be better. I felt that because of the complex technology on this unit, the science of nursing was

challenged while the art of nursing was lost. Patients frequently were treated as objects and referred to by their diseases or room number. Some of the descriptors used to refer to patients on ventilators were "the vents" while infectious patients, especially those with methicillin resistant staphylococcus aureus, were called MERSA's. Patients' personal privacy was usually not considered when changing their bed linen or when turning them, leaving their private body parts exposed despite the patients' frequent attempts to cover themselves.

"Anything goes" characterized the attitude of this unit. When a medication was omitted, or errors were discovered, the staff would contemplate the error and, on all but one occasion filed an incident report according to hospital policy. It was apparent in this instance that the nursing staff demonstrated total disregard for hospital policy which was conveyed to the neophytes as well. I was aware of several explanations. Some may include the inability to control the practice environment, anger at hospital administration because errors were the direct result of chronic under staffing, and lack of recognition by physicians and management as being an important contributing member of the health care team. Statements such as, "all they really care about is that you clock out on time" and "oh well, what else is new" said with sarcasm, reflected the general feeling of hopelessness experienced by the staff nurses on this unit.

Although my presence on unit B was often ignored, I

felt more comfortable and less of an intruder on this unit. The general climate of "no one seemed to care" reflected a concentration on just getting the job done. Nurses were eager to share their job frustrations with me and my role as observer at times was therapeutic for some of the staff.

Satellite Units

Both units under study have a satellite unit in another part of the hospital. Unit A's 12 bed surgery specialty unit is staffed with a core group of staff nurses. In the event the satellite unit is short staffed, nurses from unit A will float to the satellite unit as supplemental staff. When nurses from unit A floated to the satellite unit, feelings of being an outsider were expressed, largely because of the unwritten routines of the unit. Neophyte B, who floated to the satellite unit expressed her experience with frustration:

So we got down there and it was like every time we came on shift somebody would be telling us something new, or different, or why didn't you do this or why didn't you do that. This is the way we do things here. In the beginning they were friendly but later they were angry about it.

Unit B's satellite unit only opens when the hospital census increases and when there are no beds available for patients on unit B. It is staffed predominantly with float or agency nurses. Working on a unit staffed by personnel who are not employed by the hospital and are unfamiliar with the hospital's formal and informal functioning, proved to be

difficult for the staff nurses as well as the neophytes who floated to the unit. When one neophyte floated to the satellite unit, she expressed fear and apprehension.

Yesterday I was the resource person on the sister unit. I was there with two pool nurses. Can you believe that? I don't know how to run the computer. It was like the blind leading the blind. I was scared and did not like it at all (said in a tone of voice of disbelief and disappointment).

The neophytes and the nursing staff were reluctant to float to unit B's satellite unit due to the difficulties associated with working with temporary staff. The following incident is illustrative of the difficulties encountered by one neophyte. Neophyte D was caring for a patient who was severely contracted, confused, and had been incontinent of both feces and urine. To change the patient's linen and wash and turn the patient without the assistance of another nurse required nursing skills and practice the neophyte had not mastered. An experienced nurse, who was her preceptor was in charge for the evening and no assistance could be provided by an agency nurse who was not familiar with the hospital routine and was very busy with her own assignment, leaving the neophyte frustrated and overwhelmed.

Both unit A and B have distinctly different personalities. Unit A's culture is characterized as an efficient, task oriented, cold environment while unit B is chaotic and culturally unstable. Because of the amount of temporary personnel and the physical demands required to

work on unit B, nurses within the hospital were not eager to float to this unit. Unit A has more prestige within the hospital as it is a challenging, fast paced nursing environment to work in.

CHAPTER V

AN OVERVIEW OF THE PRECEPTORED PROGRAM

Contact For Employment

A six week preceptored orientation program beginning in June 1989 was coordinated by this hospital in conjunction with a local community college. The purpose of this co-sponsored program was to assist the neophyte nurse in making a smooth transition into professional nursing practice. The prospective neophyte seeking entry into this new graduate program completed an application and submitted it to the medical/surgical nurse educator who coordinated placement of the neophytes on a designated unit. Placement was determined by the nursing unit's need with an attempt to place the neophyte on the unit they requested. If there were no positions available on the unit requested, the neophytes were offered placement on an alternate unit. Most of the neophytes willingly accepted an alternate unit as this was an opportunity to obtain their first year of nursing experience. Once the first year of nursing experience is completed, he/she will readily be employable in any other facility and possibly another specialty of nursing.

Education Of The Neophytes

Twelve neophytes participated in the study. From the twelve neophytes seven were employed at another institution and only took part in interviews to clarify the emerging

themes generated from Unit A and B. Five neophyte shared in participant observation and interviews. Four of the five neophytes completed a formal professional nursing program and were awaiting results of the state board examinations held during the early part of this study. One of the five graduate nurses already licensed was pending graduation from a baccalaureate program once course work was completed in December 1989. Two of the five neophytes were graduates of a baccalaureate nursing program. The three remaining neophyte's were previously licensed as Licensed Vocational Nurses (L.V.N.s) and entered a L.V.N. to Registered Nurse (R.N.) step-up program at a local community college and received an Associate of Science Degree in nursing.

Description Of The Preceptored Program

Neophytes entering this preceptored program were hired by the hospital on a temporary basis. Only after completing five of the six weeks of the preceptored program could the neophyte be offered employment into a permanent staff nurse position. The preceptored program allowed the hospital time to evaluate the neophyte while providing the neophyte an opportunity to gain experience and evaluate the hospital for possible permanent employment. All five of the neophytes under study were hired into permanent positions after completing their fifth week of the preceptored program. Two were hired to work the night shift on unit B and three were hired on unit A. During the preceptored period salary compensation was at an entry nursing level which was considerably less than registered nurses on the units. Once

the neophytes had passed state board examinations their salary was commensurate with that of a beginning staff nurse. Under the guidance of a preceptor or resource person the neophytes were permitted to perform all levels of nursing care.

The two neophytes on unit B were each assigned one preceptor. On this unit I never felt that the preceptors were eager to function in that role but rather because they had precepted previously they were expected to precept again. The following example illustrates this point. Neophyte D's preceptor Sally interacted minimally with her. When I clarified my observation with Sally she replied "when she has a question she will ask me." Comments from neophytes such as "I don't think she wanted to be a preceptor" and "they (preceptors) were so busy themselves that you could not ask too many questions" indicated the neophytes sensed their preceptors' reluctance to precept.

On Unit A one preceptor, who was the clinical nurse educator, was responsible for all three neophytes. When a memo was posted on the unit for the preceptor class she shared her feelings with me.

They want to change to a one to one preceptor for the new grads. I don't know if I like that concept.... The proposed way is that the preceptor carries a full load with the new grad together. If we go over to that I am not going to do it any more. You don't get any extra pay or anything else. It becomes a big nuisance.

Seminars

To facilitate the role transition into professional nursing, weekly seminars were conducted for the neophytes by the college. These seminars provided the neophyte with information on role transition, stress management, organizational skills, and interpersonal communication. In addition there were opportunities for the neophytes to share their feelings surrounding the transition into the work world. The seminars were held in the afternoon from 12:30 PM to 2:30 PM. Neophytes working the evening shift came in to work early while neophytes working the night shift had to make a special trip to the hospital to attend. As a result consistent attendance was problematic for the neophytes.

When observing the seminars I often felt they were held to meet the needs of the college rather than meeting the needs of the neophyte. Topics such as stress management and group dynamics seemed irrelevant to the neophytes who were barely surviving the cultural shock of entry into the work world. When time was set aside to allow the neophytes to express their feelings about their transition into the work world, their eagerness to participate was obvious.

In addition to the seminars the neophytes received two on-site visits by a college faculty member to discuss their progress and/or difficulties associated with their new professional role. Neophytes expressed that these visits were very helpful since they were made during their work hours and a discussion of their problems with an unbiased person was helpful in their transition process.

The Preceptor Role

Theoretically the preceptor role is threefold. According to Meier and Kiefer (1986) preceptors are educators, socializers, and role models to those they precept. Despite this ideal, hospital management did not value these roles, nor did they take the preceptor experience seriously. Preceptors were often required to function not only as preceptors but also as charge nurses. This frequently resulted in either multiple preceptors for the neophyte or the preceptor had to divide her loyalties between the responsibilities of the charge nurse role and the preceptor role. As described by one of the neophytes. "I often have a different preceptor every time. Every preceptor explains things differently. I try to do it their way but it makes it difficult at times." There was frustration and disappointment in her voice.

It was apparent to me that management was only interested in the end product, which they defined as a nurse who gets her work done efficiently. The process or the feelings of preceptors and neophytes did not matter. Half way through the preceptored program there was an announcement posted in the nurses station offering a class for all preceptors. This occurred well into the program and for that reason did little good for the present program. One neophyte remarked laughingly "I was talking with the ward clerk in the nurses station about the preceptor class, (that the hospital offered) I had to laugh because she should have had this class before she started working with us."

As an educator the preceptor is responsible for providing an organized, planned educational program in which there is integration of neophytes into their role responsibility. To accomplish this an assessment of the neophytes learning needs must be completed. After the educational needs of the neophyte are apparent, a planned learning experience with mutual goal setting between the neophyte and the preceptor must be coordinated. Both the neophyte and the preceptor must prioritize the learning needs so that appropriate learning experiences can be provided. Ongoing evaluation of the neophyte's progress must reflect modification of the preceptor's teaching techniques when outcomes are not accomplished.

From my observations there was no structured learning or continuity in the preceptor program. Preceptors did not have a clear idea of what precepting entailed nor were they able to facilitate structured learning which is critical to the precepting role. The neophytes were also confused about the lack of structure and continuity in the program. One neophyte stated: "I never had a clear idea of what the program was all about. It seemed that we performed skills together and after she (the preceptor) knew we could do it and then she would let you do it independently." During my observation, there was never an attempt to determine the neophyte's learning needs and tailor the program accordingly.

Socializer

Socializing the neophytes involves introducing them to

the staff, the formal and informal rules, customs, culture, and norms of their coworkers and work place (Meier & Kiefer, 1986). Informal rules, customs, norms, and values are taken for granted and assimilated through observation and interaction with people and groups. The role of the preceptor is not only to convey the culture but also to validate the neophyte's observations. An example of an unwritten, informal rule on Unit A is the disallowance of "small talk". During one observation Neophyte B was talking in the hall to a L.V.N. about the neophyte's previous employment. The preceptor interrupted the conversation and said to the neophyte emphatically "We need to tape report. Are all our meds given and our I.V.s hung?" It was evident by the preceptor's tone of voice that conversations not related to work were not approved of. It was also apparent by the neophyte's facial expression that the preceptor had made her point.

The integration of the neophyte into the work place is another responsibility of socializing and is exceedingly important. Without integration into this social structure, survival in the culture is difficult at best.

During my observations on Unit B, it was evident that newcomers were not formally introduced to staff or made to feel part of the nursing team. Veteran nurses on Unit B made no attempt nor were they interested in knowing who the new nurses were on their unit. Because of the high turnover of nursing staff on Unit B, increased number of part time nurses, nurses from temporary agencies, and nurses working

12 hour shifts a transient nursing culture exists. The general feeling of nurses on this unit is "I don't know who I am working with tonight but it does not matter as long as it's an able body who can provide independent nursing care." As one veteran nurse shared with me "I like the 12 hour shifts because I have more time off but I never see my friends any more. One of my patients died and I did not know anything about it. Since I had a couple of days off I did not even know."

As a neophyte enters a new environment, it is important that she feels welcomed, accepted, and supported not only by the preceptor but by the rest of the nursing staff. Thus, it is the preceptor's responsibility to introduce her to the staff on their shift and other shifts, to physicians, and ancillary departments within the facility. This however did not happen and was especially evident when neophyte D and E worked their first night shift. Both neophytes were standing in the nurses station waiting for some direction. Neophyte E was embracing her clipboard and shifting her weight from one leg to the other, obviously somewhat apprehensive about her first experience, while neophyte D stood waiting without any observable signs of discomfort. Neophyte D's preceptor had called in sick for the night and the nurse in charge said to another nurse: "I don't know what to do with her (neophyte D) The neophyte responded by saying "I could go home, I don't mind." The preceptor for neophyte E said: "I guess you'll be with me tonight" with hesitancy. Neither of the neophytes were welcomed or supported. While the staff did

realize the neophytes were present no one was eager to work with them and their reluctance was visible to the neophytes

Role Model

It is through role modeling that the neophyte assimilates the staff nurse role. For the neophyte, learning a new role involves internalizing the values and attitudes of the staff nurse role and acquiring the knowledge and skills necessary to carry out that role. Thus, through the use of example the preceptor teaches the neophyte both the formal and informal aspects of the staff nurse role while simultaneously communicating the nursing subculture. The following example occurred on unit A and is illustrative of merging the educational and role modeling aspects of preceptorship. The change of shift report served as a time when the unwritten values of the nursing subculture were communicated. When receiving report from the day nurse, the preceptor often clarified information shared by the reporting nurse. If the vital signs were not reported the preceptor would ask "what are the patient's latest vital signs?" When a patient's blood level of potassium was high the preceptor asked if the potassium was omitted from the I.V. solution. All these questions were used to teach the neophyte how to receive report and distinguish what questions were important to ask. Some of the nursing staff gave report in a somewhat "cavalier" manner. It was important to communicate to the neophytes that giving report in a matter of fact manner was not be tolerated on unit A.

In summery, the preceptor program was a six week

program co-sponsored with a local community college designed to facilitate a smooth transition into nursing practice. Participation in this program included working with a preceptor, attending weekly seminars, and two on-site visits with the neophyte by a faculty member. Despite appearing to be a very structured program, often times the program was disorganized and confusing for the neophytes. The preceptors did not understand their role, and hospital administration did not value this role. Consequently, the program lacked continuity, which contributed to the neophytes' difficulty understanding and integrating into their new role.

CHAPTER VI
EXPOSURE TO THE NURSING ROLE AND SUBCULTURE

Formal Socialization: Hospital Orientation

All new employees must complete hospital orientation prior to beginning work on the unit. Hospital orientation is a four hour formal presentation of hospital policies and procedures, benefits program, infection control, and fire and safety. For the neophytes the remainder of the day was devoted to instruction on intravenous (I.V.) therapy. To comply with the Joint Commission on Hospital Accreditation every employee must repeat hospital orientation annually.

Orientation To Unit A

Orientation of the neophytes to unit A was the responsibility of Ann, the clinical nurse educator. Ann functioned as the preceptor for all three neophytes. Precepting three neophytes simultaneously contradicts the nature of a preceptorship, which by formal definition is a program in which one neophyte is assigned an individual preceptor, thus ensuring a planned educational program. As a result of Ann's multiple roles, orientation to the nursing unit was less than formal and at times confusing for the neophytes.

Neophyte A began her orientation with Ann on the evening shift and after three weeks was joined by neophytes B and C. Spacing orientation of the neophytes allowed the

clinical nurse educator to spend time with neophytes B and C, as neophyte A was well into her orientation process. However, with Ann precepting all three neophytes it was difficult for her to establish priorities and facilitate individualized attention. The following example is illustrative of her dilemma. After surgery a patient developed low blood pressure. The neophyte caring for the patient discussed her concerns with Ann. Ann asked a veteran nurse to repeat the blood pressure test and verify the neophyte's results. All nurses involved discussed the patient's potential problem in detail with Ann. However while the discussion took place neophyte A was waiting for her preceptor's assistance to administer an I.V. medication. In this instance, the patient's medication was administered late because of the multiple demands Ann experienced with precepting three neophytes simultaneously.

Multiple Roles And Responsibilities For The Preceptor.

During the first few days of the neophytes' orientation Ann was assigned charge nurse duties. As the charge nurse Ann was not only responsible for supervising the staff, ensuring quality patient care, but for precepting three neophytes as well. Because of her role as charge nurse Ann did not have time to closely supervise the neophytes and therefore did not give neophyte B a patient assignment. As she describes it: "I don't think that I will be giving neophyte B a patient assignment tonight. She can help the nurses on team three. Since I am in charge tonight, it is just too difficult for me to do both." I sensed frustration

in her voice. While this appeared to be a safe solution to the dilemma, neophyte B was not convinced. She left the nurses station to assume her work but her facial expressions displayed feelings of frustration. Later neophyte B came back to the nurses station and while she gathered some of the patient's charts she said "I just took vital signs on seven patients." I replied, "You don't sound very happy about that". She responded by saying, "Would you find that challenging?" Neophyte B had previously practiced as a L.V.N. and of the three neophytes could most easily have managed a patient assignment. However, because of Ann's multiple roles and responsibilities, precepting the neophytes suffered. While this is an isolated example it repeated itself on many occasions. Neophyte C confirmed this perception by stating that she often felt frustrated because of Ann's multiple roles. "When she is in charge I did not have anybody and I felt I should have had a right to have my total preceptor days. I did not say anything but I should have," indicating that she felt cheated because she did not receive the quality precepting time that she had expected.

Despite being in charge Ann attempted to closely supervise the neophytes. There was an instance during that same evening when neophyte B had an opportunity to insert a foley catheter. Because the neophyte had done this procedure several times as an L.V.N., she assumed she could perform the catheterization independently. Neophyte B did however check with Ann prior to beginning the procedure. Because of Ann's dual responsibilities, she informed the neophyte that

she had to wait until she was able to observe her performing that skill. It was important to Ann that she observe neophyte B's use of sterile technique. Neophyte B interpreted Ann's need to observe her as demeaning and a threat to her clinical competency. As she described it to me:

I'd better ask Ann if I can do this alone. I have this feeling that I better ask her. I have been doing this for eight years but that does not mean anything... See it's a good thing I asked because she wants to watch me do this procedure. I expected to have more challenges.

They still treat me like I don't know anything.

She was obviously frustrated and upset because she did not have a clear idea as to why Ann found it necessary to observe her.

Because of short staffing, Ann at times began caring for those patients newly admitted to the unit. With Ann now assuming a staff nurse role, and the preceptor role, she had doubled her work load and often experienced conflicting priorities. "I am getting ready for a new admission myself and I am also doing all the I.V.s for the L.V.N. on this team, so I am very busy tonight." The result for the neophyte was that there were times that Ann was not available to answer questions and assist them. As a result the neophytes began taking their questions to other staff members. This often led to a lack of continuity in learning for the neophyte.

Their First Day On The Unit

During the first day on the unit, the neophytes made rounds with Ann and were not assigned to care for patients. Ann reviewed the patient's medical kardex in an attempt to expose the neophytes to patients with multiple drains, tubes, and I.V. therapy. Her purpose was to expose the neophytes to the types of patients on the unit and teach them about the complex nursing care that would be required. While making rounds Ann stopped at an isolation cart outside a patient's room and began explaining the equipment contained in the cart in detail. Descriptions about the types of isolation used in the hospital along with proper disposal of isolation contents were presented to the neophytes.

Ann assumed that the neophytes came into practice with minimal nursing knowledge and therefore it was her responsibility to reteach what they might have learned in school. From my observations Ann never attempted to assess what the neophyte actually knew, what they needed to learn, or planned a structured learning program. This observation was validated by the neophytes. Comments such as: "I don't think that Ann has ever challenged my knowledge" or "she (Ann) has never asked me what do you think" and "sometimes Ann thinks that I don't have any skills" are just a few examples of the neophyte's concerns. When I verified my perceptions with Ann she related the following to me:

I have been orienting new grads for a number of years

and have learned to assume that they don't know anything. It seems that they have to learn everything over when they start practicing nursing. Of course their organizational skills also give them a lot of problems. But it would be so helpful if they would not have to concentrate on the basic nursing skills. The first day they usually work on their I.V. skills and may do a dressing change...Simple concepts such as gravity give them problems. It seems that they have to learn everything over when they start to practice nursing.

I further clarified with another preceptor the perception held by veteran nurses that neophytes lack basic nursing skills when entering the work world. She related the following: "these girls are so scared and feel so insecure, what do you teach them in nursing school? The little girl that I worked with was so nervous because she had to give an intramuscular injection and had only done this once while she was a nursing student." In both examples the preceptor had not assessed the nursing skill competence of the neophytes and based their judgement on an isolated experience with a neophyte.

The Patient Assignment

Each neophyte on unit A initially cared for one patient. When all three neophytes were scheduled to work, Ann assisted them with aspects of patient care as often as possible. From my observations patient assignments for the neophytes were carefully chosen by Ann so a balance between

safe patient care and new challenges would be provided. There were times when Ann would assign the neophytes a very complex patient to care for, and instead of assisting and teaching them she would let them "flounder". In an interview Ann shared that she purposefully uses this technique to promote learning.

I will help them with a procedure the first time. If they do it well I'll let them do it on their own. If they don't then I'll watch them do it the next time. I'll let them fumble if they don't know how to do it. I won't step in to help them anymore. This way they learn better.

While Ann's philosophy is that learning takes place if the neophyte is allowed to make mistakes, one neophyte's interpretation of this behavior was quite different. She explained:

Sometimes she will give you an easy assignment and she checks up on you every time. It seems like she wants to have authority. At other times she gives you a complex assignment and lets you stumble. Seems like she likes to see you fall or sets you up for failure. I don't think that is positive learning. I don't like that. I would never do that to people.

Another neophyte expressed her concern by saying:

Sometimes I think that Ann thinks that I don't have any skills, because she has gotten very angry and impatient with me if I take too long... She has said to me I will show you how to do something (skills) because I want

you to learn it right. I will only ask her something if I don't have any other choice. I would rather fumble myself... I do think that Ann assumes you don't know anything and that everything has to be retaught. But I guess she has been "burned" too.

Despite the neophytes' struggle to learn and their discomfort with Ann's methods, all of the neophytes gradually managed a full patient assignment. Their transition to assuming full responsibility for their patients was not without a great deal of difficulty and frustration.

I had three patients on one side of the hall with one patient receiving blood and a new admission on the other side of the hall. Ann said she would hang the blood while I do the admission... I feel that Ann is saying I can't handle this assignment... I'm just not fast enough. The elderly take so much time. They want to talk but I don't have the time. I also don't know how to be rude. When you ask them a question they give you all this information and I just don't have the time to listen to them. This makes me feel terrible!

Delegating Authority And Responsibility

Delegating authority and responsibility to the neophytes was difficult for Ann, in part due to her feelings that graduate nurses have very little knowledge and expertise when entering the work world. An example of this occurred when a physician needed to insert a chest tube in neophyte A's patient. The neophyte gathered all of the

instruments and equipment necessary to assist the physician, and, when he would ask for an instrument, Ann kept reaching for the equipment and handing it him. This made it rather difficult for neophyte A to have the chance to assist with the procedure, leaving her feeling incompetent. As she stated, "I felt that Ann thought I was not capable of providing the assistance required for that procedure. I'm not sure that Ann is very eager to include me." Ann was responsible for ensuring that the procedure would be completed without difficulty for the physician or any untoward side effects to the patient. It was not her intention to exclude the neophyte or imply that she was incompetent. However, the neophyte interpreted her reactions very differently.

A similar experience occurred with another neophyte.

I told Ann that I thought we needed to call the doctor and she had already done it. I think sometimes she likes to communicate with physicians. Another time the doctor was going to do a dressing change on my patient. Ann was walking down the hall with him to do that (procedure) rather than telling me doctor x wants to change the dressing on your patient.

It is my interpretation that Ann's reluctance to delegate authority and responsibility was largely because she felt they lacked experience and none of the neophytes had proven their clinical competency. In nursing, the role of assisting physicians is often associated with status and Ann was not ready to share this status with the neophytes. Additionally,

assisting physicians is considered a skill that requires competency and efficiency. Before Ann was willing to give the neophytes that responsibility, they first needed to "prove" they were competent, responsible, and efficient clinicians. Until the graduates had reached this level it was easier for Ann to delegate menial tasks thus giving the neophytes little responsibility.

The Process Of Clinical Decision-Making

Clinical decision making was very difficult for the neophytes. Research indicates that experienced nurses base their clinical judgments on detailed cues collected from patients, while neophytes don't have the clinical expertise to judge the relevance of all cues. (Itana, 1987) The subsequent example illustrates this process. A neophyte cared for an elderly post operative patient, who had become confused but also had a serum sodium of 133 milliequivalents per liter. The neophyte was eager to call and notify the patient's physician. She did clarify her findings with a veteran nurse but the nurse was very busy and did not give the neophyte the time required to discuss all aspects of the problem. When she placed the call and reported her findings the physician apparently told her to just watch the patient. She was very surprised and said "you want us just to watch her." After she hung up the phone she told the nurse that the physician sounded irritated with her and he had told her that the patient's confusion was probably due to her age and the stress of surgery and not a borderline low serum sodium. In this instance the neophyte had not gathered all relevant

data, but had made an inferential leap, and consequently made the wrong clinical judgement. The process of clinical decision making takes time and experience before a new nurse feels comfortable with her decision-making abilities. It requires that the neophyte be exposed to opportunities in making clinical decisions and feels comfortable obtaining a second opinion from an experienced nurse. By verifying one's clinical observations, judgment is gradually developed.

When neophyte A's patient had a low grade fever, there was no collaboration between Ann and the neophyte on whether the physician should be notified. Ann told the neophyte to call the physician and then proceeded to call him herself. Ann notified the physician of the patient's fever and obtained telephone orders. Allowing the neophyte to interface with the physician would have enhanced her ability to develop clinical decision-making while facilitating the beginning of a professional relationship. Receiving direct feedback from the physician would have validated the neophyte's decision to call. Because calling a doctor is often intimidating for new nurses this could have been a positive experience for the neophyte.

In another instance neophyte C shared the following with Ann: "My patient is not experiencing any nausea and the doctor has said that she could have a dinner tray if she continued to feel good". Ann responded, "I have already ordered a tray." Allowing the neophyte the opportunity to make the decision to progress the patient's diet and order the dinner tray would have been an excellent opportunity for

her to have made an independent appropriate clinical decision rather than feeling that her judgement was not timely.

Initial Introduction To Unit B

Neophytes D and E's orientation began on the day shift with Mary, the clinical nurse educator, reviewing the unit's policies and procedures. That morning the neophytes attended an inservice presented to the staff by Mary. The night shift staff, neophytes, and the unit manager were all present. When the neophytes came into the conference room for the inservice they were not acknowledged by any of the nursing staff in attendance or by the unit manager. I thought at that time it is difficult enough to work on a unit such as this and not to be acknowledged as part of the team was unacceptable. The neophytes sat and listened to their coworkers conversations without participating or being included in the conversation. When the neophytes were on the unit there was no formal introduction to the staff nor was there any eagerness by the nursing staff to acknowledge their presence.

There are multiple factors contributing to the staff's reluctance to include or recognize new employees. Due to high turnover, a large percentage of the nurses working on the unit are nurses who are not employed by the hospital but work for a temporary agency. They have minimal commitment to the facility and the staff. In addition, each day brings a different nurse who must be oriented by the staff to the routines of the unit. Many graduate nurses employed in years

past have quit shortly after having completed their preceptorship. For these reasons recognizing and integrating the neophytes was difficult for the staff. It was not until both neophytes passed their nursing licensure examination and began to prove they could manage a patient assignment with minimal stress on the staff that they were accepted as part of the nursing team.

Transition To Patient Care

The neophytes began their transition to patient care by taking one patient each on their first day of orientation to the unit. Having both neophytes on the unit together meant that Mary needed to divide her time between the two of them. At times their orientation was scattered and often lacked structure. This lack of structure was a significant theme on both units and will be discussed in detail in a subsequent chapter.

The Role Of The Clinical Nurse Educator

The role of a clinical nurse educator on Unit B includes educating the staff and keeping them abreast of changes in technology and nursing care. In addition she is responsible for the orientation of all newly hired employees on the unit.

On their first day Mary and the neophytes made patient rounds during which Mary explained various pieces of equipment that might be encountered when caring for pulmonary patients. This included instruction on how to set up suction machines as well as different types of oxygen administration devices. A brief overview of the patients on

mechanical ventilators was presented; however, the neophytes were not allowed to care for these patients until they had completed six months of employment. After six months a formal class in caring for these patients is offered to the staff.

Following patient rounds Mary reviewed the use of the medication administration records (M.A.R.) with the neophytes. None of the neophytes shared with Mary that they were already familiar with the use of the forms because they had worked with these forms over the past two years in nursing school and Mary did not ask if they understood how to use the form. Mary's explanation was quite detailed.

You must check the old M.A.R. against the new M.A.R. You have to take the physician's order slips, kept in the M.A.R. and check one more time if all orders were transcribed correctly. After that you should throw them away. As you see the last person has not done that. I can tell you that is a bad habit to get into. Don't let anybody interfere when you are checking the MARS because that is how mistakes are made. If a medication has to be given I.V. or if there are parameters for blood pressure you highlight those also.

Despite Mary's role as teacher, there was no initial collaboration with the neophytes to determine their learning needs. As a preceptor to the neophytes this is an essential element to optimize their learning experience. Instead there was a lot of "telling" the neophytes what tasks needed to be accomplished rather than actually teaching them how to

organize their patient care. Simple tasks such as when to take report and when to complete vital signs are examples of what Mary emphasized. While it is true that neophytes have difficulty organizing their nursing care, telling them when to perform basic nursing tasks was demeaning. It was my perception that the neophytes simply did what they were told as if they were afraid to do something wrong. It was easier for them to do as their preceptor requested, rather than to assert their own independence and autonomy and risk jeopardizing their relationships with their preceptor and the staff. The following illustrates one neophyte's reluctance to assert her own judgement and autonomy. Neophyte D was at the nurses station charting her vital signs when Mary approached her and said: "Your patient needs to be fed." The neophyte reacted instantly and jumped up saying: "Oh I did not realize that" and proceeded to promptly go and feed her patient. The ability for the neophyte to make the decision to finish charting the vital signs and then proceed to feed her patient was overshadowed by the preceptor's request that the patient be fed. Wanting to belong and aiming to please, the neophyte responded without hesitation.

After working with the clinical nurse educator for three days the neophytes began working the night shift with their individual preceptors.

The Neophytes First Exposure To Patient Care On Unit B

Neophyte E's preceptor began by sharing the philosophy and routines of the night shift with the graduate. "On this

unit we listen to taped reports...We often work together at night and help each other out...when you have a total care patient you should get a little cart and fill it up with linen and put it outside the door." Once the routines were discussed with neophyte E, the preceptor followed the same pattern that Mary had established by telling the neophyte what needed to be done. "Why don't you take your vital signs and assess your patient.. He probably should have a rectal temp taken. Let me find you the lubricant." At no time was there any assessment of the neophyte's learning needs or any actual teaching by the preceptor. She viewed her responsibility as orienting, not precepting the neophyte. There are major differences in these roles. Orienting a new employee involves sharing the routines of the unit, showing where supplies are kept, and serving as a resource for questions. Precepting involves, or should involve, assessing the neophytes learning needs, providing a planned educational program, and evaluating patient outcomes.

The first interaction for neophyte D with her preceptor was very similar. As the opportunities arose Alice, her preceptor, explained the routines of the night shift. Alice's communication with the neophyte was often disorganized as it centered around situations as they occurred. An example of Alice's communication with neophyte D was at a patient's bedside when Alice showed the neophyte how to fasten wrist restraints. She said, "We usually put a knot next to the wrist and then we tie it to the bed." While still at the bedside she explained how the vital signs

protocol was followed during the night.

If the patient is on routine vital signs and they are asleep and the vital signs have been within normal limits we do not awaken them. If you have to give a medication in the middle of the night you can take their vit!!l signs at that time. However at 5 o'clock we wake up all patients to take their vital signs.

During their first night the preceptor had six patients and the neophyte cared for one patient. When the neophyte had an idle moment she offered her assistance to the preceptor. "Perhaps I can help you or perhaps you can give me some more hints." Rather than taking this opportunity to teach, Alice shared the following:

This unit is difficult to work on and it does not take long to experience "burnout". Patients will ring the bell, and want to get up to go to the bathroom. They want you to make them coffee in the morning when you are busy. They think that you are their servant. This type of nursing is not for everyone.

Neophyte D asked her how many new grads she had oriented, "Many, but a lot of them have left." To have your role model share this information on your first night was overwhelming and left the neophyte feeling insecure about her own professional destiny on unit B. "I am just beginning to practice as a nurse on this unit and the nurses here don't sound very happy in their jobs."

Formal socialization into the nursing role began with hospital orientation. After completing this orientation the

neophytes began their preceptorship. The clinical nurse educators on both units were responsible for precepting the neophytes on the day shift. During the neophytes' preceptorship often times their preceptors were responsible for precepting, assuming a patient assignment, and performing the duties of the charge nurse. For the neophytes this was frustrating as their preceptors were not readily available to assist them.

The preceptors held different philosophies about the neophytes' knowledge, capabilities, and learning ability. For the most part the preceptors viewed the neophytes as lacking the appropriate knowledge necessary to practice nursing, and it was their role to re-teach them. Some of the preceptors had a philosophy that neophytes learned more effectively if allowed to make mistakes. The neophytes however interpreted this philosophy as a lack of support by the preceptor.

Delegating authority and responsibility to the neophytes was difficult for some of the preceptors. Additionally, it was difficult for the preceptors to allow the neophytes the opportunity to develop their clinical decision-making. Most of the preceptors intervened for the neophytes which ultimately inhibited their ability to problem solve. Thus, the socialization into the nursing role varied among preceptors which made the transition into the nursing role difficult for the neophytes.

CHAPTER VII
SOCIALIZATION INTO THE NURSING SUBCULTURE THROUGH SHARING
VALUES AND RITUALS

The Structure And Organization Of Nursing Care

The change of shift report is a significant nursing ritual. Until a verbal, written, or taped patient report is given by the previous shift, nurses cannot begin patient care. Even though report, is an official nursing responsibility, it also serves as an important time to share social and cultural values. Often expectations of nursing performance are expressed, frustrations are verbalized, and uncertainties clarified. It was a time when role modeling behavior could be observed and socialization occurred.

The shift begins with the charge nurse assigning a group of patients to each staff nurse. This assignment is posted on a large board outside the nurses station which lists the names of all the patients, their room number, and the first name of the nurse caring for the patient. When staff nurses arrive they begin their shift by gathering around the assignment board to determine which patients they have been assigned to care for. Although primary care nursing is practiced, for organizational purposes the nurses are split into teams. On unit A there are four teams and three teams on unit B. A nursing team can consist of two

R.N.s and a L.V.N. depending on the patient acuity on the unit. If a L.V.N. is assigned to a team, it is the R.N.s responsibility to determine the patient assignment for the L.V.N. Working with a L.V.N. on a team imposes additional work for the R.N. due to the L.V.N.s limited scope of practice. L.V.N.s cannot perform admission assessments, initiate nursing care plans, or administer I.V. medications. It is the R.N.s responsibility to perform these duties in addition to her own assignment. The R.N. is also responsible for overseeing the care of all the patients on her team. Assuming responsibility for a L.V.N. on a team was a new concept for the neophytes, and integrating this responsibility into their clinical practice required considerable time and experience.

Helpful Hints To Assist The Neophytes: Sharing The Ropes

While waiting for report, nurses would often socialize and engage in social talk. While neophytes waited for report, "small talk" was not their focus, but was a time when the preceptor or veteran nurses would review aspects of patient care or discuss concerns about the previous shift. The following discussion between Ella and neophyte A illustrates Ella's willingness to "share the ropes" in relation to organizing the admission of a patient to the unit. Ella explained to the neophyte, "If one of your patients goes to surgery you can expect to get a new admission. Have you ever 'done' a new admission?" Neophyte A said she had not. Ella did not respond verbally, but her facial expression communicated new admissions were a lot of

work. She continued to explain, "If the (new) patient has a lot of antibiotics (I.V.) it is much easier to take the patient yourself than assign the patient to a L.V.N. The R.N. has to do the patient assessment and all the I.V. piggy backs, so you have to do the work anyway." Ella's willingness to share what worked for her when admitting a patient was an attempt at preventing the neophyte from experiencing organizational difficulty. This was helpful for the neophyte as it contributed to the neophyte's ability to organize her time effectively and ultimately reduced her frustration.

Exposure To Intershift Conflicts: A Slice Of The Nursing Subculture

Prior to beginning report, an experienced nurse was sharing with neophyte C her concerns about receiving patients from the previous shift. The experienced nurse said to neophyte C, "If your patient's I.V. looks funny and her arm is puffy when you get to the floor you need to check it and tell me what you think." Neophyte C said, "Should I go and check it (the I.V.) now?" "Oh, no you can do that later." The veteran nurse replied and went on to say:

They (the day shift) just don't want to change I.V.s when they are obviously infiltrated. You have no idea how many I.V.s I have changed in the first 15 minutes of my shift. I never do this to the night shift but the day shift always does this.

By attempting to share with the neophyte the inappropriateness of leaving an infiltrated I.V., the

veteran nurse also effectively communicated her feelings about the previous shift's lack of initiative and professional commitment. This attitude promoted an atmosphere of distrust and potential intershift conflict. Conveying concerns about infiltrated I.V.s by complaining about the previous shift, rather than teaching the neophyte how to manage the problem by approaching the individual and sharing her concerns, promoted a cultural climate characterized by mistrust and incompetence. This behavior exemplified the nursing subculture on both units.

Throughout my observations the day shift nurses often would find fault in the work of the night shift nurses, while the evening shift staff would find fault in the work of the day shift. Neophyte A shared the following:

There is one nurse on the night shift who really makes me mad. Kathy (the charge nurse) says that this is just the way she is and there is nothing you can do about it. At the change of shift she comes to me and asked me if I could help her pull my patient up in bed. She was actually telling me that I had left this patient in a terrible position and I had just been in the room an half hour before to reposition him (patient). It made me so mad.

It was as if nurses were "looking" to find things wrong or incomplete with the previous shift rather than conveying a genuine concern for positive patient outcomes. This behavior was not unique to this hospital or subculture but is an aspect of the subculture I have observed throughout my

nursing career. In the nursing profession there is a feeling that "your shift" is almost "sacro-sanct and flawless", and other nurses on other shifts are simply not as competent. There is very little tolerance for different approaches to nursing care or deviations from shift norms, and little if any collegial support when deviations occur. It was evident that each shift had designated duties and if these tasks were not accomplished the seasoned nurse would be angry and frustrated with the previous shift. A neophyte's experience supports this aspect of the nursing subculture. Neophyte E said:

There was one night when everything just went bad. I tried the best I could and told the day shift what I didn't do. There was this one patient I didn't get a chance to weigh her and I told this to the day shift and then they got into why do we have to weigh her, this is a big 'hassle' (for us). I know I try the best I can and often they're leaving things for us to do. After a staff meeting the supervisor wanted to talk to me. I kind of figured out that it was about having such a bad night." (shared with a tone of voice and attitude reflecting defeat).

As a means of coping with this experience the neophyte frequently reassured herself by saying, "Oh well, I do the best I can." It was unfortunate the experienced nurse reported the neophyte to her supervisor for having difficulties finishing her nursing care, rather than trying to help the neophyte problem solve how she could organize

her time more effectively. This example is one of many which illustrates the lack of support frequently demonstrated by the nursing subculture. As Meissner (1986) emphasized, veteran nurses do not see neophytes as beginning practitioners and are willing to judge rather than support them. During my observations I found the lack of support for the neophytes evident in nearly every observation.

Several months later during an interview with neophyte E, the experience she had with the day shift nurse was still vivid in her mind. She said:

I think it could have been better if the day shift nurses were more supportive. There were some that looked at you like you didn't know what you were doing. They just looked like they're tired out and needed a vacation. They weren't around to help or support. When you come in and they look at you like, 'here we go again', just as if you were a student again.

Often insignificant events became the focus for conflict between nurses. On one occasion Sally, an experienced relief charge nurse on the night shift was making patient assignments and suddenly turned around to ask a question (to no one in particular) in a loud voice, "who admitted the patient in room 628 bed 1 last night." Kathy, the nurse in charge of the P.M. shift answered, "there is no patient in room 628 bed 1." Sally responded adamantly, "someone who admitted the patient in bed 2 left the scale in the room. At night we don't feel like going in every room looking for the scale" (said with anger and hostility).

Kathy calmly said, "I guess neophyte C admitted the patient in bed 2." As soon as neophyte C heard her name she got up and said apologetically, "I thought I would leave the scale in the room so when you have to admit a patient in bed 1 the scale is already in there." Sally sharply said, "no you won't", turned around and proceeded with making her assignments for the night. Kathy whispered to me, "isn't she awful," while another nurse handed me a piece of paper that read, "nurse ratchet!" Neophyte C said, "I am going to stay out of her way," obviously fearful of any further encounters. What concerned me about this interaction was the insignificance of leaving the bedscale in a patient's room which served as an opportunity for Sally to express her frustrations and anger. Additionally, neophytes view nurses in a charge role as the leaders of the shift and a role model. The behavior demonstrated by this relief charge nurse and the manner in which the other staff nurses dealt with it was inappropriate. From this experience the neophyte observed experienced nurses managing this nurse's attitude indirectly in an attempt to cope with her behavior. However, ultimately the behavior was not directly addressed leaving the nurses with feelings of frustration and powerlessness.

A Neophyte's First Experience In Obtaining Report

Experienced nurses give and take report with ease. For the neophyte, obtaining and giving report was difficult, cumbersome and often stressful. The change of shift report on unit A was taped by some shifts and given verbally by others, while unit B relied on tape recorded reports only.

On unit B obtaining report from the night shift proved to be a difficult task for neophyte D. While listening to the taped recorded report neophyte D rapidly wrote down every bit of information given on her patient by the night nurse. The neophyte's ability to synthesize and discriminate relevant information was obviously limited. After report the neophyte approached Mary with panic in her voice and she said, "what am going to do when I have 5 patients? I won't have enough space to write." Mary responded by saying "don't worry hon, you will get better at this." Mary was not willing to take the time and help the neophyte but obviously viewed this as an insignificant obstacle for the neophyte to learn. Thus, it was up to the neophyte to master the skill of taking report through a trial and error process.

The stress experienced by the neophytes while receiving report not only was related to taking down all information correctly, but it was also difficult for the neophytes to formulate a realistic picture of the patient from the information provided by seasoned nurses. Neophyte C summarized her feelings as follows, "Sometimes at the change of shift when I hear all the things that are wrong with the patient I get very scared. I always go and check it out right away to make sure I can handle the problem." Neophyte D said:

I listen to report and they (previous shift) tell me all the tubes a patient has. The other day I had a patient who had a Groshong catheter, a colostomy and I.V.s. I was afraid to go in the room to see what I

would find. I was glad when the shift was over and it was not as bad as I had anticipated.

These experiences clarify that writing down information during report gives the neophyte limited information and forms an incomplete picture of the patient. Clinical experience adds a dimension to the information that allows the nurse to formulate a closer look at the total person.

Sharing Of Different Values Nurse To Nurse

Change of shift report given by the day shift to the evening shift is often given by a senior R.N. who has been in the profession for many years. When giving report the day nurse would speak so fast the neophyte would have had difficulty writing down all pertinent information. On both units the cultural climate of the day shift is characterized by experienced nurses having an attitude of superiority.

On unit A I observed Susan, a veteran day shift nurse, give report to neophyte A and her preceptor Ann. The manner in which she shared the information was casual and almost unconcerned. She was leaning against the side of a chair and infrequently glanced at her information sheet and a paper towel she had scribbled some notes on. I could sense Ann's frustration with the report she was receiving as the nurse omitted the patient's room numbers and only reported the patients' blood pressures and temperatures. When Ann asked her directly, "what were the patient's vital signs," she responded in a disinterested manner, "I guess they were within normal limits." Ann's facial expression was filled with frustration, while neophyte A stood silently listening

and observing. As Susan continued her report she stated that a patient's PaO₂ (partial pressure of oxygen) was 59 mm Hg (millimeters of mercury) and the physician had told her not to worry about it. Ann persisted by asking, "did he (physician) order any oxygen?" Susan, pulled up her shoulders and laughingly said, "I guess not." Despite Ann's encounter with Susan's report, role modeling for the neophyte nonetheless was demonstrated by Ann. By observing this encounter the neophyte learned that each nurse places different emphasis on what is important in nursing practice and despite this, there is basic information such as complete vital signs that must be given in report. Through Ann's persistence the neophyte also learned how to obtain information in a non threatening manner. Despite Susan's de-emphasis on the patient's need for oxygen, Ann successfully communicated to the neophyte that Susan's lack of follow through was unacceptable and would require further exploration with the physician.

On another occasion I was observing Ann with neophyte A obtaining report when the following conversation occurred, "The patient in room 652 came back from surgery in the early afternoon. She has voided twice, both times on the bedpan. I did not get her up to the bathroom." Ann looked very surprised that the patient had not gotten up and asked, "why not, is she weak or something?" The nurse grimaced and replied, "no, I was not about to get her up at 3:30 (it was time for her to be off duty). I don't even think she had to go (urinate) the second time, she just wanted to get some

attention." (said with a defensive posture) It is the standard on unit A for post operative patients to be ambulated to the bathroom and Ann re-emphasized this to the neophyte. These examples illustrate how each nurse possesses different values and standards regarding to patient care. For the neophyte this was often difficult to understand. Through the preceptor's role modeling and expertise the neophytes were taught the standards on each unit. In addition the preceptors were instrumental in teaching the neophytes how to interact in a professional manner with nurses sharing different values. Through experience and continued clinical exposure, the neophytes will learn to balance their values with those of their colleagues and the institution.

Shift Report: A Time To De-Brief

Change of shift report usually lasts thirty minutes. However, shift report often exceeded an half-hour because of the nurses need to discuss situations that occurred on the unit that were problematic. Report time often served as a "debriefing" period for the nurse giving report and was a time for ventilating uncomfortable feelings. It was also a time when the compassionate side of the nurse became evident. During one observation the following discussion occurred between an experienced nurse, a neophyte, and her preceptor. "The doctor removed the staples and pushed really hard against the incision site (of the patient). The patient was in a lot of pain but he continued to push and all this red junk came out. I think he should have given her

something for pain." Her tone of voice and body language demonstrated her discomfort with the poor treatment the patient had received. While this nurse was obviously disappointed in the physician for not prescribing any pain medication for the procedure, she was also disappointed in herself for not suggesting this for her patient. By not doing so she was not fulfilling her role as patient advocate.

A seasoned nurse shared her feelings about a patient and his family on another occasion:

This patient in 640 is 82, has terminal Ca, (cancer) and has had bladder surgery. His wife does not want any treatment and she is very reluctant to take him home. She feels that she can't take care of him (at home) but, she also does not want him to go to a nursing home. I feel sorry for her.

There was a silence and the evening shift nurses did not respond. The seasoned nurse continued, "He has been N.P.O. (nothing by mouth) because he can't swallow, but it is not as if he is starving, he is getting plenty of fluids (I.V.). I feel sorry for the wife of this man."

Neophytes listening to the experiences and feelings of seasoned nurses are likely to incorporate aspects of the caring dimension. During report time experienced nurses have the opportunity to communicate what is valued on the unit. If the experienced nurse serves as a role model for the neophyte, the chance of the neophyte incorporating aspects of the values and beliefs communicated is likely.

Learning Through Trial And Error How To Give Report

Giving report to the oncoming shift is a skill that requires practice and is a ritual in nursing that lacks structure and specific guidelines. Neophytes learn the skill of giving report by listening to experienced nurses and imitating their techniques, as minimal guidance and support is offered by the preceptors. I observed the following interaction between Ann and neophyte B in a conference room. While Ann was reviewing the nursing kardex she casually mentioned to the neophyte what information should be reported to the next shift. She only stressed that it was very important to give a "complete report". Neophyte B said, "I am so nervous doing this (giving report). It has been so long since I have taped a report." Ann just smiled and did not respond. Neophyte B began giving report but had to stop the tape recorder many times, seemingly at a loss for words and forgetting what she had reported. While the neophyte was talking Ann frequently interrupted her asking, "did you give them (the next shift) the last set of vital signs" making sure this information was reported and, "you don't have to say how many milligrams of Demerol you gave to the patient" stressing the irrelevance of this information. These points could have been emphasized with neophyte B before she began her report rather than interrupting her when she was trying to concentrate on giving report.

For the neophytes, participating in the ritual of giving and receiving report gave them the chance to learn the unwritten rules, norms, and values placed on nursing

practice through role modeling of their preceptors. Experienced staff nurses used intershift report to imprint their professional expectations, standards, values, and beliefs upon the neophyte. It was a time when institutional standards for nursing practice were conveyed both directly and indirectly. As a participant in the ritual of report the neophytes were rarely valued as team members with something to contribute. Instead, they were judged on their ability to give report in an organized, thorough manner. Knowledge alone was not enough but rather successful mastery of giving report was important. As a result, the neophytes were often frustrated with the subculture in which they were seeking inclusion. It was evident that it would take time for the neophyte to understand and accept the cultural norms and values before successful integration into the subculture was possible.

Role Taking Through Socialization

As illustrated by Schein (1968) organizational socialization is a process of learning the ropes, of being taught what is important. Throughout the new graduate experience preceptors demonstrated nursing skills in various different ways. Each preceptor emphasized aspects of the nursing role which would lead to the neophyte's ultimate success. During the socialization process two underlying assumptions held by the preceptors became evident. First, the preceptors assumed that neophytes entering the hospital setting had minimal knowledge of nursing practice. The preceptors did not value the neophyte's knowledge of nursing

theory but placed a high priority on their ability to perform nursing skills. Secondly, the preceptors assumed it was their role to teach the neophyte the "right way of doing things". This "right" way often turned out to be the preceptor's way. There was no tolerance for creativity or any encouragement for the neophyte to independently problem solve. In addition there was no collaboration between the neophytes and their preceptors.

Data to substantiate the perception that graduate nurses have minimal knowledge when entering nursing practice are plentiful. On one occasion the charge nurse was making the assignments for the night nurses when she shared the following, "These new grads now-a-days sure don't know what they are doing. They have no business being on the P.M. shift. They all should start out on the night shift. The P.M. shift is just too hectic." Another preceptor discussed her views regarding this issue and emphasized that schools of nursing are responsible for the neophyte's lack of clinical skill, "Why is it that the schools are not keeping up with the technology. They (the neophytes) have the most problems with I.V.s. Sometimes they don't know what they are doing. It seems that they have to learn everything over when they start to practice nursing." One incident previously cited is also illustrative of this issue. "The last new grad (neophyte) I worked with had difficulty giving an intramuscular injection. She was so nervous that her hands were shaking. What do you guys teach these people in school?"

The presumption by the preceptors that neophytes enter nursing practice with questionable skill levels often hindered the neophyte's socialization and learning process. The neophytes felt insecure in their practice often sensing the scrutiny of the staff nurses and lack of collaboration with their preceptors. These findings were validated in a series of interviews with the neophytes. When asked, "Do you get a sense that your preceptor thinks you are knowledgeable?" Neophyte C responded angrily:

I think Ann thinks I don't have any skill because she has gotten very angry and impatient with me if I take too long. One time I thought she was going to hit me but then the patient said that she hoped that I would be back the next day and that softened the blow a little bit. Many times Ann has said to me I'll show you how to do something (skills) because I want you to learn it right. I just did it her way but I know that I am going to do it my way when I am on my own... I will only ask her (Ann) if I don't have any other choice... I think we spent too much time on skills that I already knew. Too much time on I.V. piggy backs and not enough time on other equipment. They promised us an orientation and it was going to be one full day of I.V. equipment and we never had that.

Neophyte A responded in a similar fashion with the following remarks, "If she thinks I'm knowledgeable she never lets me know. She has told me that I'm slow but I'm getting much better. I never felt that Ann was collaborative

in any way. She will never ask me 'what do you think', seemingly never testing my decision-making." Neophyte B's response projected her feelings of ambivalence to whether her preceptor perceived her as knowledgeable, "I have mixed feelings about that. Sometimes she will give you an easy assignment and she checks up on everything you do. At other times she gives you a complex assignment and lets you stumble."

Neophyte D's facial expression and tone of voice indicated her frustration with the lack of feedback provided by her preceptor:

I never have gotten any feedback from my preceptor. She just tells me what to do. We don't discuss what needs to be done. I often have a different preceptor every time. Every new preceptor explains things differently. I'll try to do it their way but (with a different preceptor) that makes it difficult each time.

In an attempt to understand if this perception was unique to the facility under study or existed in other new graduate programs, I interviewed a group of neophytes at another hospital. Some of the neophytes felt their preceptors indicated they were not competent to practice nursing and consequently would do everything for the neophyte. Displaying a facial expression of disbelief one neophyte at the other facility said, "When I would go to her (the preceptor to verify something) she would grab things out of my hand, and she wouldn't even watch to see if I was going to do it right." Another neophyte shared how her

preceptor insisted that she do things her way:

You don't need to cover the patient, just do it like this. (leaving the patient exposed) It is quicker this way but it made me more nervous. I tried to do it the way I was taught in school. She (the preceptor) said no, no, no... I was so confused.

Other neophytes felt they could collaborate with their preceptors. Some of the neophytes in this facility felt a willingness by their preceptor to allow the neophyte to practice nursing in a manner that was comfortable for the neophyte rather than the preceptor.

With my preceptor I tell her what I know. Yes I know how to do this, no I don't know how to do that...In school we learned the basic principles and a general way of doing things. When you come into the program (the new graduate program) they show you their way. Each one of them (the preceptors) has said well this is the way I do it. You know, and you have to find what feels good for you.

While the interview data in this facility did not clearly support the perceptions of the neophytes under study the reader must consider that these interviews occurred without field observations. Additionally the interviews took place in the beginning of the new graduate program when it was evident the neophytes still in the "honeymoon phase" of their professional nursing practice (Kramer, 1974). As Kramer (1974) illustrates it is difficult for the neophyte to see the reality of the work world during this period of

their socialization.

For the neophytes there were very few role models. Often they would seek professional advice from other neophytes rather than from their preceptors or an experienced nurse. This was due largely because of the neophytes felt intimidated by their preceptors. Because the neophyte sensed that their preceptors felt they were incompetent, it was difficult for the neophytes to admit they did not know a particular nursing skill. The following example illustrates the neophytes relying on one another for clinical and emotional support. Neophyte C was looking for neophyte B and found her in the clean utility room. I heard neophyte B say to neophyte C, "Just hang in there, it will get better." Neophyte C looked stressed but asked neophyte B, "How do I put this bedpan in the toilet so the patient could use it." Neophyte B eagerly explained, "So you lift up the toilet seat, put the bedpan on the toilet and put the toilet seat down. That's how you do it." Neophyte C said "it feels like day one in nursing school."

On another occasion neophyte B related the following incident:

Yesterday I had a post-op patient on a Patient Controlled Analgesia (P.C.A.) machine. Programming the machine makes me very nervous. I programmed the machine yesterday and checked it with neophyte A and we are both new to this unit. I walked into the patient's room and the syringe was empty. He was a big man and we had to bolus him (with a narcotic) several times and his

dose needed to be readjusted frequently. But it scared me that the syringe was empty. We thought we had overdosed him.

Experienced nurses valued competent, skill oriented practitioners upon entry into practice. For the neophyte this was difficult since without repeated and consistent practice of a skill competency can not be achieved. I felt saddened that experienced nurses judged the neophytes incompetent simply because they lacked experience. The neophytes fear of collaborating with the preceptor potentially could lead to errors in clinical practice and for the neophytes perpetuated a negative enculturation process.

Transmitting Cultural Values Through Nursing Routines And Rituals

Counting narcotics is a nursing routine that occurs at the beginning of each shift. An on-coming and an off-going nurse count all the narcotics on each medication cart. It is essential that the narcotic count is accurate. If a narcotic is missing it is the responsibility of the off-going nurse to find the nurse who did not sign out for the medication. If there is a discrepancy in the count it is reported to the shift supervisor.

For the neophyte counting narcotics is not a skill emphasized in nursing school. Experienced nurses take counting narcotics for granted. When they count, they do so very rapidly. For the novice finding the medication in the drawer and counting the number of narcotics left in the

package takes time. Imprinted with the responsibility that the count is done correctly, neophytes experienced anxiety and uncertainties associated with this procedure. On her first day neophyte D was assigned to count the narcotics with an experienced night nurse. Her preceptor and neophyte E were watching the procedure. The night nurse's voice was impatient and she hurriedly called out each narcotic while glancing anxiously between the flow sheet and the neophyte after each count. Neophyte D tried to find each narcotic in the drawer and carefully picked up each box, cautiously counting the number of narcotics. The procedure was carried out very slowly by the neophyte and it was obvious the night nurse was very impatient.

On unit A I observed the following encounter in which an experienced nurse tried to teach the neophyte important aspects about counting narcotics. Sue a L.V.N. approached neophyte B and said, "Let's count the narcotics." The neophyte did not answer but moved towards the narcotic drawer seemingly accepting the challenge. Sue called off the narcotic and neophyte B responded with the number of narcotics in the box. At one time the neophyte said that she had a "full box". Sue responded with, "what do you mean when you say a full box" (said authoritatively). Neophyte B glanced at Sue and hesitantly said, "ten". Since the neophyte had never counted narcotics she did not realize that when counting each box you must repeat the exact number in the box.

Because of the responsibility associated with counting

narcotics and the inconvenience of having to count at the end of your shift, nurses frequently were reluctant to participate in this task. One evening on unit B an experienced nurse was standing by the medication cart and quite loudly made a statement, not addressing any one in particular, "who is going to count the narcotics with me on this cart." Neophyte D was standing next to the cart but did not respond to the question. A registry nurse let out a deep sigh and her facial expressions indicated she was irritated that no one offered to count the narcotics and said, "I guess I'll do it on this cart also." The neophyte raised her eyebrows while she glanced at me indicating she realized the registry nurse was upset. I never had the feeling the neophyte did not want to do this procedure, she just did not realize that it needed to be done. At this stage in her orientation the neophyte had not incorporated this as part of her nursing responsibilities.

At times a drug discrepancy can occur. Sue an experienced L.V.N. was counting narcotics with the night nurse. All narcotics counted out correctly except for one opium and belladonna (B. & O.) suppository was missing. Sue raised her voice so she could be heard loud and clear over the persistent noise level on the unit and asked, "did anybody give a B. & O. suppository and didn't sign for it?" One nurse answered and said that she had not given one, while the other nurses treated the question with silence. Sue returned to finish her own work. The night charge nurse did not appreciate that the problem had not been solved by

the evening shift and in an harsh, angry voice said to Sue, "you better find out who gave that (suppository) before you leave." Sue did not acknowledge her request and continued with her work. The tension on the unit was obvious. The night charge nurse continued with the issue and asked, "where is Ellen the evening charge nurse." Ellen responded by asking everyone again who had taken a B. & O. suppository and not signed out for it on the flow sheet. Sue said, "all the commotion over a suppository is so stupid." Neophyte B was observing the situation and said, "I am glad I did not take one out without charting it," while neophyte C nodded her head in agreeance. Through this incident the neophytes began to understand the importance of charting the narcotic on the flow sheet when taken from the drawer. It was obvious to the neophytes there was very little tolerance by seasoned nurses if documentation of the medication was omitted.

Through these experiences the neophytes began learning the importance and responsibility associated with giving and counting narcotics. Because the staff nurses were often reluctant to count narcotics, towards the end of the neophytes' orientation they often were responsible for performing this duty. Counting narcotics was often traumatic for the neophyte because of the seasoned nurses' intolerance for the neophytes lack of experience.

CHAPTER VIII

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to understand the influence of the nursing subculture on the professional socialization of neophytes. This chapter presents a summary of the significant findings regarding the neophytes' socialization process and will include my perceptions of the nursing subculture's influence on professional socialization.

Summary And Conclusions

The new graduate program was designed to assist the neophyte in the transition to professional nursing. Through seminars, individual conferences with a college faculty member to discuss their progress, and clinical experience the neophytes began to understand the responsibility and challenges associated with professional nursing practice. Under the guidance of their preceptor, the neophytes began their journey into the staff nursing subculture.

The ideal role of educator, socializer, and role model was rarely displayed by the preceptors to the neophytes. Instead the preceptors provided the neophytes with an orientation to the institution. There is a significant difference between precepting and orienting. Preceptorship involves teaching, educating, and mentoring neophytes. Orienting new employees involves sharing the institutional

policies, procedures, and routines.

It was evident to me that the hospital organization did not value the preceptor role. Often times the preceptor was responsible for precepting the neophyte, managing a patient assignment, and assuming charge nurse duties. This was an impossible task for the best of preceptors.

Integration into nursing practice was not always a positive experience for the neophytes. The preceptors lacked the knowledge and expertise necessary to facilitate a positive socialization process for the neophytes. Sharing the philosophy of the institution, its values, and beliefs was difficult for the preceptors as many of them were not consciously aware of the institution's values. In an attempt to manage the precepting difficulties, the hospital offered a formal preceptorship class but it was implemented several weeks into the program.

Acceptance of the neophytes into the nursing subculture was dependent on their ability to demonstrate competency and proficiency in patient care. Demonstrating this competency level for the neophytes was extremely difficult, as it would be for any novice entering practice. Only through intense exposure to patient care and experience would the neophytes become proficient practitioners.

In the beginning the preceptors viewed their roles as directing task completion rather than teaching the neophytes how to care for multiple patients or master difficult tasks. The neophytes did not need to be told when to take vital signs, or when to take a temperature, but needed to learn

decision making, time management, and competency in nursing practice. There was no teaching plan developed to meet the neophyte's individual learning needs and for this reason the program often lacked structure and continuity.

Despite minimal guidance from the preceptors, the neophytes eventually began caring for multiple patients. Even though the neophytes still required their preceptors' expertise, the intimidation they experienced made them reluctant to ask for help. Instead they began relying on one another for advice and developed their own subculture within the nursing culture itself.

The preceptors had difficulty socializing the neophytes. The neophytes began to understand the norms, rules, and rituals through a trial and error process. The preceptor often viewed the socializer role as an opportunity to tell the neophyte how the "real world" of nursing operated. It was as though the preceptor felt threatened by the neophyte's recent nursing knowledge and her role was to de-emphasize this knowledge and emphasize skill competency and efficiency as a valued attribute of the work world. Many times the neophytes unexpectedly stumbled onto unwritten expectations and found that aspects of their performance were unacceptable to experienced staff nurses. Integrating into a culture with diverse expectations which vary from nurse to nurse was both challenging and frustrating for the neophytes.

Despite few role models available for the neophytes, role taking did occur. The neophytes learned task oriented

nursing care. Patient interaction and the caring aspects of nursing were not emphasized nor role modeled. For the neophytes this was very difficult, as they entered the work world valuing effective patient interactions and a holistic approach to patient care.

The Transition Period

Anxiety was paramount for the neophytes entering the new graduate program with very little clinical experience. Surrounded by an unfamiliar setting, fearful of how to manage caring for multiple patients, and not knowing anyone in the institution contributed to the neophytes uneasy feelings. While most of the neophytes viewed this opportunity as a challenge, they were still very fearful.

Everyday I was afraid, especially my first week. I questioned myself. I really didn't feel I was able to do this. (patient care) There's always some fear back there...I try not to let people know that I'm afraid. I think the first night I'm alone I'm going to be scared. Neophyte A commented, "I get afraid when I get very busy. Sometimes I am afraid I won't get done and I am much too late getting out of here. When I get very busy I feel I need to be more careful." Neophyte B remarked:

Yes I am scared. But I know that I should not tell them (the preceptor and nursing staff). If they know you are scared they will think you can't handle the situation. That could go against you, you know. So you pretend you're doing fine.

As Andrews (1987) and Myrick (1988) have illustrated,

lack of organizational skills, and the fear of making mistakes characterize the neophytes entry into nursing practice. The development of proficient organizational skills for the neophytes under study was a process, not an event. Having cared for one to two patients in nursing school made the organization of five to seven patients stressful and difficult. Neophyte D summarized her feelings as follows:

At first I was sort of overwhelmed, the equipment, the acuity of the patient. But now that I've been here for awhile I have adapted to the situation. Sometimes when new patients come with new diseases I'm not familiar with I feel uncomfortable.

Neophyte C states, "it's real scary to have so many patients. I don't think it is safe to have six patients. Four (patients) would be better."

As Kramer (1974) illustrated, it is through task accomplishment that neophytes build their professional self-esteem. Nursing tasks include not only direct patient care but also the ability to complete the patients' documentation. Many of the neophytes spent countless hours on the next shift completing their work. Organizing their patient care to be completed in a timely manner was extremely difficult. The neophytes' inability to complete their work within their shift created feelings of inadequacy and disappointment. "Sometimes I can't give the care I would like to give. Sometimes I get down" (on myself). Neophyte C conveyed her frustrations as follows:

I often will tell the patient I wish I could do that for you right now. I just have time to get your temperature right now. I know you are thirsty, but I have a patient who is going to surgery... I can't be in two places at once. The patient isn't going to die, but I'm sure if the surgery schedule gets off I would get in a lot of trouble.

In an attempt to minimize the amount of overtime the neophytes were experiencing, some of them began experimenting with various methods of organizing their nursing care. For example, one neophyte came into the hospital 30 minutes early to check her I.V.'s. "You almost have to get there early to check your I.V.'s. I've been trying to do that because it takes me awhile." Neophyte A's attempt at improving her organization meant she had to forgo helping other nurses in an effort to complete her own work.

You also find that some nurses talk about how swamped they are. If you try to help them, they get out on time and you don't. So I decided that I just have to focus on my work and get my work done as well as I can and stay away from the desk. If you are at the desk people ask you to help them. If you're not there then they will ask somebody closer. It's a good trick.

For other neophytes time management was a process of understanding the difference between safe patient care and quality patient care. Valuing psychosocial interventions with their patients was an aspect of their nursing care the neophytes found difficult to part with. To become "efficient

practitioners," the neophyte had to keep the psychosocial aspects of their nursing care to a minimum. "In school I could always talk to my patients. I like to talk to them but now I don't have time to do that. The acuity on the floor is very high." For the neophytes this was in direct contrast to what they valued both personally and professionally. As stated in a previous example neophyte C said,

I'm just not fast enough. The elderly take so much time. They want to talk but I don't have the time. I also don't know how to be rude. If I ask them a question they give you all this information and I just don't have the time to listen to them. This makes me feel terrible.

While another neophyte said, "When I first started, all I cared about was doing things. I felt task oriented rather than nursing oriented. I felt even worse than I felt in nursing school. I didn't even have time to get to know anybody" (patients and staff). For many nurses getting to know their patients makes nursing worthwhile. Neophyte A shared the following, "Sometimes the patients just need to be talked to, and a lot of times there isn't time. It's hard for them (administration) to realize what you've been doing for eight hours especially when you spend time talking to your patients." Another neophyte commented:

I like to spend time and talk a little bit with them (patients) and I knew I couldn't do that. It is really hard to tell somebody that you have to go when their trying to tell you something important, or they just

want to talk because they're lonely. It's hard to break away.

From an organizational perspective, mastering time management skills was imperative and ingrained into the neophyte from the beginning. "After about two weeks they started pushing us to get out on time. I've gotten yelled at. I don't have much overtime. Here, it's get out on time. Budget, budget, budget. Not so much how are the nurses." Neophyte B shared her feelings through the following statement, "No overtime. That's the big thing right now. It's get in, get out, and no overtime. It has been a real major thing." While it was evident to the neophytes that efficiency was valued by the organization, meeting these expectations was difficult. Consequently some of the neophytes would clock out on time and stay to complete their work without being paid. "I signed out at 11:30 p.m. Even before I would take maybe a half hour, (of overtime) especially if I had a busy night. If I felt that my work load wasn't hard I should have been done on time." Neophyte A concludes:

Overtime, I don't expect to get out on time. I never do. It's more than just me. I have to cut down...There is no more overtime. If you have overtime then you have to write it on a special board above the time clock and you have to have it signed by the charge nurse. I think that's a good guilt producing mechanism. So far I haven't used it because even if I get out at 12:30 a.m. or 1:00 a.m. I don't take overtime, which probably

isn't right.

For some neophytes the transition to professional practice was characterized by fear. The thought of being totally responsible for patient care created apprehension. "I'm still real nervous before I come to work. I don't know if it is the patient, the shift, or what." Neophyte C added, "When you're in school you are not totally responsible. The primary nurse is, and you lean on your instructor. I did not feel as responsible for my patients as I do now." Neophyte D concisely states her feelings about the overwhelming responsibility. "When you were in school you could goof off and no one would know. Now it is a different story. Now you are responsible for these patients."

Throughout the new graduate program minimal support was provided to the neophytes. The attitude on both units conveyed the neophytes would have to prove themselves to be accepted into the culture. Proving yourself is one thing, however in an atmosphere which was unsupportive was disheartening for the neophyte.

They (the day shift) spend more time critiquing your nursing care than listening to your report. Everything is like well why did you do that, well I wouldn't have done that. These are old time nurses. It must have something to do with them practicing for a long time. Perhaps they are experiencing 'burnout' to some extent and this is their way of sort of feeling more control and powerful.

Neophyte E states, "In the beginning I was given a lot of

total care patients. Six people at night. You're just running around and around." Neophyte A explains, "I think I had to prove myself especially to the charge nurse. When I came with a problem she would ask me this and that and I'd let her know those things." Neophyte D felt the staff's irritation when too many questions were asked. "This new girl that just came in, she was asking too many questions. It works both ways. It would be nice if I asked more questions and it would be nice if the staff were more receptive to questions."

As neophyte B put it, "nursing is not a team approach at all!"

Minimal feedback was provided by the preceptors regarding the neophyte's performance.

I felt like I was falling through the cracks, like no one was telling me if I did something wrong or right, or whatever...I don't know, I felt like there was no follow-through. I would like to know about it (a problem) so I won't do it the next time. I feel like there is no one that's over me to be able to tell me when I've done something wrong or right.

Neophyte C related the following:

I don't get much feedback. She (the preceptor) never says much and her facial expression are difficult to read. What I do when I don't get any verbal approval I start to interpret facial expressions, hers are difficult to read.

Confronting A Variety Of Value Differences

Marlene Kramer's 1974 qualitative study illustrated that neophytes will experience conflict between school and work values because the norms, values, and behavioral expectations between school and work differ drastically. The extent to which the subcultures of school and work differ directly affects the degree of difficulty the neophyte has moving from one subculture to the next.

Neophytes entering the nursing subculture experienced immense value conflicts. From the beginning of the new graduate program the preceptors established an atmosphere which supported the unfreezing of school bred values. This unfreezing period was often camouflaged as an opportunity to "help" the neophytes by showing them ways to accomplish their tasks more efficiently. Additionally the preceptors insinuated the neophytes values were often insignificant with statements like, "you don't need to do that" or "in the real world we do it this way." This created insecurity in the neophytes who were desperately attempting to hold on to something meaningful and familiar. Neophyte E shared the following in one of the weekly seminars:

My preceptor said, I know what you were taught in school but we are going to show you some shortcuts. I thought at the time you can tell me all you want but I am going to do it the way I was taught in school. My patient's safety comes first.

One neophyte was told that aspects of her charting were irrelevant and unnecessary. "I was charting the quality of

my patient's heart sounds when I was told this was not pertinent information to chart. Perhaps the staff nurses don't know the difference in heart sounds and were threatened that a new nurse does. I'm not about to compromise my professional values."

The reality of the nursing subculture came as a surprise for some of the neophytes. Benner (1988) states there is an ideological separation between physicians and nurses with physicians providing the cure and nurses providing the care. Without both however there can be no recovery. The ideology that nurses and physicians work collaboratively became unreality. For the neophytes this was extremely disappointing.

In school I thought nurses were like part of a team, the doctor being there and you're helping the doctor and curing the patient. But what I have experienced is that it's really more like the doctors' arena. You're really just there to clean the patient and filling the orders. I work nights but from what I've seen it's like I'm just there to do what is ordered and to follow the rules. That's what I've experienced.

Because the neophytes lacked experience in clinical practice, it was difficult for them to prioritize their nursing care. In addition they lacked the organizational skills necessary to afford them opportunities to spend time with their patients. Consequently, the neophytes often felt guilty and inadequate about the care they could provide. One neophyte summarized her feelings in the following

discussion:

The things you have to do in those 8 hours. You can't be there for that one patient in order to make him feel really comfortable. So you feel like a failure in a way, because you're not doing really what's best for that patient. There's no way of doing those things because you have other patients to take care of. You just have 8 hours to do everything...I think afterwards, after awhile, there's a feeling that you don't care...You're a nurse. You're suppose to be caring and helping these people cure themselves, helping them feel better.

Another neophyte shared her feelings regarding her inability to complete all of her nursing care:

When you have one or two patients in school you have the luxury of doing everything, even plucking the nose hairs on your patient. You know, you pamper them...I've already had days where it's like pits and crotches. That's all you wash and you don't worry about the rest because those were not the essentials. Those were not the important things that day.

As Drew (1986) points out when there is an imbalance of authority and power such as with the preceptor and neophyte relationship, the person who is dependent is vulnerable to the emotional message of the other. With the preceptor in a powerful and authoritative role, and the neophyte as a novice caregiver in a dependent role, at times the neophytes would interpret their preceptors behavior negatively. As a

result the neophytes often felt excluded from the unit. Neophyte B states, "I feel like an outsider looking in. I try to break the ice but it doesn't always work. I don't know who I can trust at this time...I know what it's like to be in the trenches." Social acceptance was very important to some of the neophytes. For some neophytes it took time to be accepted and for others it did not occur during the observation period. Neophyte D stated:

I think the staff work well together. Sometime I feel a part of the unit and sometimes I don't. They often talk about something I don't know anything about, like potluck they have had or parties. I often feel closer to the registry nurses than to the nurses on the unit. But I don't have too much time to think about it.

Neophyte A shared the following in a interview: "In the beginning I didn't feel a part of the unit. I felt like a stranger. But the other night I went out after work with the girls on the unit. So I am beginning to feel part of the unit." For others, social acceptance did not take precedence as surviving the challenge of patient care was top priority. Neophyte E summarizes her feeling about being a part of the unit in the following, "Sometime I feel part of the unit but I've been too busy to worry about it. I do know that no one gives you any positive feedback on how you're doing or if you are doing good."

Reflections

This study has given me an opportunity to observe the nursing profession through a different lens. Examining the

nursing subculture and its influence on the professional socialization was both rewarding and compelling. The rewards came as I began to understand the neophytes' perceptions of the subculture. The importance of nursing education to emphasize effective independent problem solving, to encourage students to interface directly with staff nurses, and to focus on the reality of nursing's world will only help bridge the gap that exists between new and experienced nurses.

During the initial observation period I was very uncomfortable with the role of the field researcher. It would have been much easier to be a practicing nurse than an observer. Many times I would have liked to help the nurses, while at other times I would have liked to disappear and not be noticed. The restraint necessary for my role as observer created frustration. With time however and experience in the field observer role, I began to feel more comfortable. As my comfort level increased so did my awareness of the environment I was observing.

Observing on unit B was much easier as this unit had so many temporary staff no one was concerned with what I was doing. Additionally, the elderly, confused, debilitated patient population was not capable of asking what I was doing. On unit A it was quite different. The nursing staff were very threatened by my presence and I was often referred to as a "spy". In the beginning I was constantly reiterating my purpose in an attempt to reassure the staff. They often felt I was there to observe them practice nursing, rather

than observing the process of socialization for the neophytes.

There were aspects of the nursing subculture that disappointed me. I was hoping for an environment that was supportive and interested in the neophytes' knowledge. What I found, however, was an environment that, not only did not respect the neophytes' knowledge, but went to great length to degrade the neophytes' capabilities. Rather than valuing and capitalizing on the neophytes' latest nursing knowledge, the staff nurses emphasized efficient, task oriented nursing. The staff equated the ability to perform nursing tasks, with competency in nursing practice.

The nursing subculture valued mechanistic, task oriented nursing care. Minimal emphasis was placed on the caring, humanistic aspects of nursing. Instead, efficiency in nursing skills and the ability to document these mechanistic procedures was the entire focus on both units. Valuing effective communications with patients was not a priority to the nursing staff. An atmosphere of "high tech (technology) and high touch" gave way to "high tech and no touch".

The culture on both units thrived on perpetuating the negative aspects of nursing. Their energy was focused on the long, stressful hours spent caring for patients. Many of the nurses seemed to be experiencing "professional burnout". For the neophytes entering an environment in which nurses did not feel positive about nursing, the stress was compounded. Not only did the neophytes have to integrate into a new

culture, master the art and science of nursing, but now they were faced with wondering if they would experience the same feelings in their professional future.

Towards the end of my observation period hospital administration initiated 12-hour shifts for the nursing staff. The nursing staff were scheduled to work six 12-hour shifts in a two week period. The nurses were divided into two teams. When one group was working the other was off. Many nurses enjoyed working 12-hour shifts as it provided them with more time off. The impact on the culture was significant however. Working 12-hour shifts only provided the nurses with an opportunity to work with one group of staff. They virtually never saw some of their co-workers. Consequently two different cultures emerged within the larger cultural context. Each group had their own norms, values, and rituals some of which overlapped within the larger culture, some of which did not. This made the integration into the nursing subculture difficult for the neophytes who were working eight hour shifts during their preceptorship.

To summarize, entry was the most difficult phase of this research study. Having to manage my own conflicts associated with the field observer role, and trying to manage the insecurities this role created in the staff, was both challenging and frustrating. Looking at a slice of the nursing subculture was like opening "pandora's box". I liked some of what I saw and was extremely disappointed with other aspects. While it is true that no profession is perfect,

nursing must meet their professional challenges with introspection, a willingness to grow, develop, and change those aspects of their culture that do not foster a professional development.

Recommendations

Integration of neophytes into the nursing subculture is both challenging and difficult. It is however extremely important that neophytes become socialized into this culture both for their professional success, and the success of the organization. It is only through successful socialization that an individual believes in, and makes a commitment to the organization. For these reasons the following is a list of recommendations to the institution under study for improving and enhancing the professional socialization of neophytes in the future.

1. Organizational reexamination of its mission statement, goals, and cultural climate with a concerted effort at revitalizing the cultural environment. Quality patient care is at core of the nursing profession. Treating nurses with dignity and respecting his/her professional knowledge is a component that must be present in a culture that demands nursing care excellence. I observed an health care environment on unit A and B that was characterized by nurses frequently not having the time they needed to provide quality patient care. Nurses and neophytes on both units often expressed the feeling that management at the facility was not truly interested in them as individuals but only in their ability to perform their nursing duties efficiently.

In order for the institution to nurture and maintain neophytes, I strongly recommend they examine means to promote a culture in which nurses have control of their own practice, have opportunities to provide input to the organization, and are recognized for the contributions they make. Job satisfaction will improve and quality patient care will be the outcome.

2. Provide a formal preceptor class. This class should be offered to all prospective preceptors prior to the new graduate program. Identification and discussion of the three roles of a preceptor must be presented. The course should be designed for as much participation from the preceptors as possible. Exercises discussing the differences between school and work values, differences in the roles of educator, socializer, and role model should also be presented. In addition teaching-learning principles and evaluation techniques must be incorporated.

3. Develop a self-assessment of learning needs tool to be completed by the neophytes which will assist in directing their learning needs.

4. Ongoing evaluations of the neophytes' learning needs by the preceptors with identification of the neophytes' strengths, weakness, and goals for the coming period.

5. Careful selection of the preceptors by management with the goal of attempting to "match" personalities for optimal success.

6. A comprehensive recognition program especially for unit B due to the difficulties associated with working with

chronically ill, debilitated, terminal patients.

7. Monetary and/or a recognition program for those nurses selected to precept.

8. Establishment of a mentoring program that would allow the neophyte access to the guidance and support needed during the first year of the neophyte's employment.

Recommendations For Future Research

The strength of this study lies in the fact that various aspects of the professional socialization of neophytes was studied from the neophytes' perspective. Through thick descriptions of the neophytes' experiences and perceptions, an aspect of their socialization into the subculture of nursing was documented. The essential strength of this investigation was its contribution to our understanding of professional socialization. This study enables researchers and practitioners to examine the values, attitudes, and beliefs of the nursing subculture and its impact on neophytes integrating into the culture. An added strength is the method by which the research data was gathered. By using the qualitative methodology the reader is afforded the luxury of understanding how real experiences take place and the meaning individuals attach to these experiences.

Perhaps the most significant limitation in this study is that the researcher was unable to observe the cultures on both units for long periods of time. In the spirit of a true field researcher it would have been optimal to observe the culture for longer than six months. Because professional

socialization did not fully occur within the research time period, observations over the course of one year would have been helpful in contributing to our full understanding of the process.

Another limitation of this investigation stems from my own background and experience with the nursing subculture. My previous experiences ultimately may have prompted me to see those aspects of the culture which were familiar to me. It may be argued that a researcher seeking to uncover specific concepts looks for those aspects. However, rather than entering the research study with an a priori assumption about the culture, I attempted through the use of in-depth descriptions, to focus on the neophytes' perceptions of the nursing subculture.

With the strengths and weaknesses of this study apparent, there are several areas for future research. Investigating the influence of women's socialization on professional nursing socialization would enhance our understanding of the socialization process for nurses. As Gilligan (1982) points out, women's developmental stages of identity and intimacy seemed to be fused. Thus, when the novice nurse seeks entry into the nursing subculture, in an effort to belong and build relationships in that subculture she may be willing to compromise her professional identity. Studying this aspect and its relationship to professional socialization would enhance our understanding of what socialization for women is all about.

Methodologically, future researchers could build upon

this work through participant observation for extended periods of time on one unit. This would facilitate a deeper understanding of the culture rather than have one unit's observations influence the other. Studying a culture for at least one year would be beneficial, as not all of the neophytes under study integrated and became part of the culture within the six months of observations.

Additionally future research could focus on the neophytes as preceptors. It would be interesting to note how they would integrate and socialize other neophytes. Would their experiences guide and direct the manner in which they socialize future neophytes?

Finally, does educational preparation of the preceptors influence the manner in which they socialize the neophytes? Graduates with a baccalaureate degree in nursing are said to have more professional orientations than do diploma or associate degree nurses. If this is true it would be interesting to note in future research how professional orientation influences the socialization process.

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