Chapter 1

Introduction

'The art and science of asking questions is the source of all knowledge.'

Adolf Berle

The problem explored and analysed in this study involves the perceptions and expectations verses the reality of clinical practice of four (4) new graduate nurses. Socialisation of new graduate nurses into the wider nursing social group is also explored.

Context of the problem

Contemporary literature would suggest there has been a great deal written regarding the Australian nurse education experience since its transition from hospital based education to Australian universities (Burton & Burton 1982; Kersten & Johnson 1992; Hamel 1990 pp. 59-90; Kramer 1985 pp. 891-892). There is little available Australian data, to depict how the actual experiences of newly graduated registered nurses, compares with their expectations and perceptions of working as a registered nurse during the first year of clinical practice. The process of socialisation of new graduate nurses with senior registered nurses and the wider nursing group is analysed. This study demonstrates how the first year of clinical practice influences the career paths of new graduate nurses.

Statement of the problem

The world wide nursing shortage has prompted inquiry into the satisfaction of nurses in the workplace (NSW Nurses College of Nursing 1999). New graduate nurses appear to experience difficulty with integration and socialisation into the role of a new registered nurse and assimilation into the nursing hierarchy (Cox 2003). This research project attempts to take snapshots of 4 new graduate nurses on commencement of their initial clinical placements then again after 3 postgraduate months of experience. The final interviews were held after 6 - 8 months of experience as registered nurse clinicians.

The transfer of Australian registered nurse education to universities, as described by Madison, (1998 p.3) resulted in two clear and distinct groups of registered nurses. Prior to 1984, registered nurses received their education within the hospital setting which was largely based on "on the job learning" with intensive clinical exposure; and after 1984, a tertiary qualification in nursing with varying degrees of clinical exposure became the norm. It is clear according to Marquis, Lillibridge and Madison (1997 p.97) that post 1984, new graduates, arrive to the workplace theoretically well prepared to participate as registered nurses within the clinical environment, but with less clinical practice than their more experienced counterparts. However, it seems it is not theory but clinical preparation and competence as registered nurses that senior nurses use as the measure of the new graduate. It is the

professional differences between education, career expectations and career choices that are fundamental to the creation of tensions between the new and the experienced (NRB NSW 1997 p.97).

Statement of the research question

How do the perceptions and expectations of individual, university prepared new graduate nurses compare with the reality of practising as registered nurse clinicians in the first year of practice?

Ethics approval of the project

The project was firstly submitted to the University of New England Ethics Committee for approval to proceed with the research. Once approval was gained, the project was submitted to the Area Health Service Ethics Committee for consideration. Approval was gained to conduct the research. There were no conditions placed upon the conduct of the research with the exception that any/all variance to the proposal be offered to the committee for consideration. The research data was extrapolated from general conversation. The scope of questions was limited to those experiences that occurred at work and how those experiences affected the individual's perceptions and expectations of being a transitional nurse. The effect those experiences had upon the individual as a social being was also explored.

Assumptions and limitations

This research project is limited to the experience of 4 participants and does not offer comparison to other similar studies of the lived experiences of new graduate nurses. This project explores the assumption that the new graduate's perception of being a registered nurse differs from the reality of the first year of clinical practice as a registered nurse. A further assumption is made that the difference between perception and reality will impact upon the professional outcomes of the participants. The question is then asked 'how do new graduate nurses further develop clinical skills and what effect does that context and experience have upon their perceptions and expectations of being a registered nurse?'

The project is relevant. The last two decades have produced a large body of academic writings, findings, and recommendations relating to the experiences of new graduate nurses (Stevenson, Doorley, Modderman & Landau 1995: Kramer 1974 pp. 75-93; 1996; Hinshaw, Smeltzer & Attwood 1987; Meissmer, Abelleira & Erb 1995). Previous research confirms the importance of early, positive clinical experience, but does not appear to have resulted in a change in the behaviours of more senior nurses towards their junior colleagues. The transition from student to clinician appears to continue to offer reality shock (Kramer 1974 p.9) for new graduate nurses. It seems the clinical environment does not reflect expectations. It would appear that which is learned and developed in the classroom can be philosophically and

in practically diametrically opposed to the reality of actual clinical practice (Jasper 1996). It is timely to explore this issue in Australia. The dichotomy between the expectations of new graduate nurses and 'the real world' continues to affect the nursing profession; in a time of worldwide workforce shortages (Dreyfus & Dreyfus 1980 pp.15-45). This project compares what was expected by each of the participants in their roles as registered nurses with what actually happened in the first 8 months of clinical practice.

Rationale for the study:

The researcher as a senior nurse manager of a tertiary, Sydney metropolitan hospital, on frequent occasions, observed open, hostile dissatisfaction from registered nurses when new graduates are allocated to their clinical areas. The chronic dissatisfaction associated with new graduate nurses appeared to be related to the assumption that new graduate nurses cause additional workload burdens for more senior nurses (House 1975; Luker 1984). Many of the complaints about new graduates from senior nurses, relate to poor time management skills, slow work practices, and perceived inadequate clinical knowledge and skill, which paradoxically, are all issues that are reasonably to be expected in early career nurses.

Study objective:

The object of this study was to explore, compare and contrast the individual expectations and experiences of four randomly selected new university

prepared graduate nurses with their actual clinical postgraduate experience as registered nurses. The project also explores the subsequent effect of those early experiences upon attitudes towards nursing as a profession, perceptions of the workplace and future nursing career directions.

Chapter 2

Literature Review

We think too small, like a frog at the bottom of the well. He thinks the sky is only as big as the top of the well. If he surfaced, he would have an entirely different view".

Mao Se Tung

University education of new graduate nurses in Australia has generated a large body of research over the past two (2) decades. The transition of new graduate nurses from the university classroom to the clinical environment continues to be problematic. There is a commonly held view that new graduate nurses are well prepared academically to function as registered nurses and are well supported clinically via facilitated mentorship programs during the first year in the workplace. This research project will demonstrate that this view may not be the case and that high levels of stress, feelings of inadequacy, social isolation and professional disillusionment, impact upon the personal and professional lives of new graduate nurses. To understand the issues that are described as relevant to neophyte nurses, it is important to understand how the practice of nursing has evolved, what changes have occurred as a result of the transfer of nurse education to universities and what generational influences are likely to impact upon the nursing profession in the new millennia.

Historical perspectives of nursing

Nursing, the practise of caring for the health and wellbeing of others has existed through time. Care of the physically infirm has historically been

provided by women within the family or social group. In the early Christian era, deaconesses and other nominated groups of women were charged with the responsibility of care of the sick. There was no expectation or requirement for education, rather, those experiences, drawn from marriage and from the bearing of children, was considered to be sufficient. The middle ages saw the evolution of military and religious groups within monasteries and secular orders, from which members served in both religious and nursing activities. These groups were associated with the Roman Catholic Church and that influence affected their ministrations and the provision of services to the ill (Oermann 1991 pp. 2-3).

Florence Nightingale was the matriarch of modern nursing, born and named for her birthplace in Italy on May 12, 1820. Florence, the daughter of well-educated, affluent parents, was rigorously tutored by her eccentric father in mathematics, languages, religion and philosophy. It was these teaching which would later, greatly influence the rest of her life and the evolution of nursing. Keighley (1999) described Nightingale's religious view of caring for the sick in 1837, Nightingale at 17 years of age reported she had heard God's voice and described a 'calling' to undertake nursing practice. It was however after Florence turned 31 years of age, that this opportunity presented itself. Florence undertook nursing training at Kaiserwerth Germany, a Protestant religious community with a hospital facility. Florence completed her 'training' after just three (3) months, subsequent to which she

was declared by her educators to be trained as a nurse (Pfettscher, De Graff, Tomey, Mossman & Sledodnik 1994 pp. 69-70).

Nightingale (1859 pp 24-25) vigorously objected to the Victorian view of female indolence and marriage and envisioned nursing as a respectable, scientific livelihood for women. It was a life-long commitment to her feminist views (Halliday and Parker 1997) that caused Florence to dissociate from her family and go on to train and develop the discipline of professional nursing practice. The arguments put forth by Nightingale, were, over a century later, contemplated by Waring, (1988 pp. 96-104) who associated the powerlessness of women with roles assigned by the social institution of religion as attributable to the universal enslavement of women. During the swearing of the marriage bonding pledge, women promised obedience to their husbands, to maintain the family home and bear and raise the offspring resulting from the relationship. Black (2004 p.37) stated Nightingale is reported to have said 'being obedient is a good quality for horses and dogs, but not for nurses'. Engles (1940 p. 82) associated the affairs of the home with powerlessness for women and an impediment to their contribution to the affairs of the state. Nightingale rejected the implication (Ehrenreigh & English 1973 pp. 34-36) that nursing equates to wifely submission to doctors and maternalistic 'caring' of patients. She fervently believed, women must be scientific and appropriate in their nursing practice and that a conscious choice must be made to pursue a career in nursing, and not turn to it by

default. Nightingale has been described as visionary and insightful in her recognition of the need for cleanliness of air and body. Halliday and Parker (1997 p.6) stated Florence Nightingale is reported to have said 'a nurse must never hurry, for the noise of swishing crinoline and silk will do patients more harm than will any medicine'. Conceivably, the prophetic Nightingale, visioned today's nursing workforces disparity between standards of care that are acceptable to professional, harried clinical nurses and that which are achievable within the current world wide nurse shortage (Wickett, McCutcheon & Long 2003).

The nursing workforce; multigenerational implications for nursing

Today, 150 years after Nightingale, where is nursing? It is acknowledged the nursing workforce is aging. However generational changes in nursing are not limited to the retiring end of the nursing workforce. Generation X and Generation Y are described as representative of the entry point of the next generation to the profession of nursing. The current nursing workforce has four (4) generations of nurses working together. Hill's (2004) description of the generations included: *Veterans,* born (1921-1940) as war time witnesses, this is the generation that is described as the conservative, cautious, disciplined, hierarchy observing generation, who were mostly raised in one income families where the father was the sole breadwinner (McNeese-Smith & rook 2003). *Baby Boomers* (1941-1960) were encouraged to develop their own individuality. Most grew up in a flourishing

economy. The assassination of John F. Kennedy and the inception of the Vietnam War were two (2) defining moments for this generation. Baby Boomers are described as materialistic and are said to have traditional work values and ethics (McNeese-Smith et al 2003). *Generation X* (1961-1981) is described as the sceptical generation who embrace technology as the norm and who are distrusting of organisational ability to provide job security (Hill 2004). It is the ultra independent Generation X that is impacting on nurse workforce recruitment and retention. Wider consideration is offered to this generation later within this chapter. The youngest generation employed within nursing are described by Hill (2004) as *Generation Y,* born (1982 - present) who have embraced learning and expressiveness with parents who have been heavily involved in their upbringing and who chaperone or coach extracurricular activities. The participants of this study are all from Generation X. The generational focus of discussion for this research project will be applied to the senior nursing workforce - the Veterans (1921 - 1940) and the Baby Boomers 1(941-1960) and the junior nursing workforce - Generation X, which is the generation representative of all of the participants of this study.

The aging nurse population

Developed countries including Australia, the United States of America, the United Kingdom and Canada have an aging nurse population that is increasingly required to care for elderly people (Buchan 2002). It was also

stated nursing shortages are often depicted as solely a problem for nursing, when in his view, nursing shortages are a health system problem that erodes health system effectiveness and require health system solutions. Recent statistics from the Australian Institute of Health and Welfare Nursing Labour Force (1995) indicate Australia has approximately 268,000 registered and enrolled nurses. It is estimated of those nurses working in the healthcare system, 171,775 (64%) were (RN's) and 48,890 (36%) were (EN's); with the remainder either not working or working in non-nursing fields (Williams, Chaboyer & Patterson 2000).

Nursing, with its aging population and current worldwide staff shortages has prompted considerable debate into the education and integration of new graduate nurses into the workplace (Horsburgh 1989; Buckenham 1994 pp. 29-34; Benner Tanner & Chesla 1996 pp. 48-57). Buchan (2002), a professor of social science and health care stated developed countries around the world are all experiencing significant nursing shortages with predictions of worsening statistics for the future. Taunton, Boule, Woods, Hansen and Bott (1997) concurred the USA will have an all time deficit of 90,000 nurses by 2005. Buerhaus, Staiger and Auerbach (2000) confirmed the average age of working RN's increased by 4.5 years between 1983-1998. In Australia, the average age of RN's is 41.6 years (Australian Institute of Health and Welfare 2001; Duffield & O'Brien-Pallas 2002; Janiszewski Goodin 2003). They hypothesised that over the next decade, this trend will

lead to further aging of the RN workforce with the average age of RN's forecast to be 45.4 years with more than 50% expected to be older than 50 years. Within 2 decades it is estimated the average age of working RN's will be between ages 50-69 years.

Duffield, Aitken, O'Brien-Pallus and Wise (2004) stated nurses are actively recruited by other industries because of the organisational skills and capabilities they have gained in the profession. Long term studies in the United Kingdom have indicated increasing numbers of nurses plan to move out of nursing work and that a significant number are unsure of their long term plans (Australian Institute of Health and Welfare 1998). Duffield et al (2004 p.239) stated 'jobs for life may become less common as future generations choose to have more than one career during their working life.' Duffield and Frank's (2002) pilot study of the positive reasons why nurses leave the workforce found some nurses believed their undergraduate nursing qualification provided the foundation on which other careers could be forged. Jones (1996) and Williams (1997) stated the propensity for nurses to migrate to other professions might become more significant to Australia as the requirement for tertiary qualifications for employment increases.

Generation X

'Every few hundred years in Western history there occurs a sharp transformation. Within a few short decades, society rearranges itself - its worldview; its basic values; its social and

political structure; its arts; its key institutions. Fifty years later there is a new world. And the people born then cannot imagine the world in which their grandparents lived and into which their own parents were born. We are currently living through just such a transformation.'
Peter Drucker

An attempt has been made within this literature review to offer a synopsis of the characteristics and idiosyncrasies that are described as typical of Generation X. It should be remembered however, that caution should be exercised when making assumptions about this most interesting generation.

Generation X, according to Kupperschmidt, an American Associate Professor in nursing education (1998 p.40), is best described as the generation that was 'left by the Baby Boomers, living in families affected by divorce, being babysat by the television in a world of soaring national debt and downsizing, with diminished education standards and expensive higher education.' Howe and Strauss (1993 p.14) stated ' ... one might say that Generation X was left with the Simpsons, not the Cleavers, in Roseanne's living room rather than on Andy's front porch in Mayberry.' This is the generation that was coined the *latch key kids* because in many families, both parents worked outside the home (Hill 2004). The witness of their parents enduring long hours of work, fraught with stress has influenced this generation to seek balance between their work lives and their social lives. This is the sceptical generation who embrace technology and who as described by Dunn-Cane, Gonzales and Stewart (1999 p.932) are more likely to regard organisations as 'places to grow in, as opposed to places in

which to grow old.'

Generation Xer's according to Kupperschmidt (1998) exhibit a *need* for independence and consider themselves to be equal participants in any discussions. She stated this generation possesses work values and ethics that are vastly different from previous generations in terms of expectations of the workplace with emphasis on individual needs and wants in terms of preferred area and hours of work, with career security being more important than job security and organizational commitment. Generation X according to Joel (2002 p.13) is a generation that is '... receptive to flexible work schedules, home based work arrangements, project and episodic assignments and usually, their employment terms are not negotiable' (Swearingen 2004 p.56). Generation X would appear to appoint little value to face-to-face interaction as necessary to efficiency, probably due to their level of expertise and natural electronic abilities (Dunn-Cane et al 1999). Important for this research, the Casey, Fink, Krugman and Propst study (2004) of the graduate nurse experience, acknowledged a 55% - 61% attrition rate for new graduate nurses within the first year of clinical practice; with a further 33% changing jobs within the first 2 postgraduate years. The findings of this study attributed role overload and interpersonal strain as highly significant to the attrition of Generation X new graduate nurses. Interestingly, Santos, Carroll, Cox and Teasley's (2003) study of Baby Boomer registered nurses attributed stress related to the physical

environment and responsibility as influential as to whether they continued to practise as a nurse. It seems these 2 generations are vastly different from one and other.

Swearingen (2004 p.63) stated '... this generation of nurse promises to have the most impact upon nursing leadership as we know it.' It seems Generation X have expectations of the workplace that differ from past generations of new graduate nurses. McNeese-Smith and Crook (2003) stated this generation of younger nurses have values and attitudes towards work and career that are markedly different from their Baby Boomer predecessors; valuing '... career security rather than job security and organisational commitment'. Employment in clinical area of choice with part time hours of their choosing are conditions new graduates appear to expect from the workplace. The literature warns the fundamental differences expressed by this generation will ultimately force nurse workforce planners to be reactive to the workplace expectations of Generation X nurses. McNeese-Smith et al (2003 p.262) stated values are critical to what motivates and rewards nurses. Nurse workforce planners of the future will need to consider the dissonance of values within its multigenerational workforce to reduce disengagement, frustration and costly turnover. New graduates are not the immediate solution to the current nursing shortage; but they do represent the future for nursing.

Nursing education

It is twenty (20) years since nursing education was transferred from hospital-based programs to tertiary institutions. Historically, the acquisition of knowledge for nurses to perform their duties was referred to as *training* and was exemplified by instruction, discipline and the process of taught proficiency i.e. '*learning on the job*.' Du Toit (1995 p.165) said hospital based nurse training resulted in '... service for education ... not education for service'. Williams, Chaboyer and Patterson (2000) confirmed the first university program offered to Australian nurses commenced in 1967, as a combined nursing/arts degree and was offered by the University of New England. The final transition of nursing education to universities did not occur until 1984, when, with the consent of the Federal government, all nursing programs were made available only through the tertiary sector (Wood 1990).

Callaghan and Field (1991) described the transition of new graduate nurses from university to the clinical setting as typically problematic, resulting in high absenteeism and attrition rates from the profession. It was expected the nursing education restructure that took place in the late 1980's would 'professionalise' nursing (Eagleson 2001; Mascord 1992) by upgrading seemingly inadequate hospital-based qualifications to university degree standing and promote a more committed nursing workforce (Mascord 1992). Hempstead (1992) stated nurses are prisoners of their past which is steeped

in tradition, hierarchy and controlled environments. Oermann (1991 p.234) confirmed the task oriented training of nurses resulted in a static work environment, which promulgated a subservient working discipline that rendered nurses subservient to doctors.

Education, refers to the process of knowledge acquisition and the development of appropriate, reactive, cognitive, social and professional skills, autonomy and standards (Reilly & Oerman 1985 p.54). To imply nurses who were trained in the pre-university era are not skilled, effective, reasoning professionals is incorrect. However insufficient value has historically been attached to the promulgation of nurse driven, scientific knowledge acquisition. The task orientation of nursing preceded the value of scientific inquiry and support for nurses, to elevate themselves out from under the direction of doctors and evolve into a discrete, autonomous profession.

Nursing care requires a sound connection between education and practice. Today, universities focus nurse education on the acquisition of theory; abdicating responsibility for the consolidation of nursing practice to senior clinical nurses after new graduates are employed as registered nurses. It is at this stage, new graduates experience the phenomena known as the 'theory/practice gap,' (Benner 1984 pp. 36-46) a source of stress and anxiety for this group of nurses. Avali, Cooke and Crowe (1997 p.477) stated new graduates '... often feel vulnerable, and insecure in their professional role,

particularly when displaying clinical skills and competence.' According to Lee (1996), clinical practice is a significant component of nurse education; facilitating development of critical thinking and analysis skills, competence in psychomotor, communication and time management skills by increasing self confidence and performance as a registered nurse (Grealish & Carroll 1998).

Lofmark and Wikblad (2001) reported similar findings in their student nurse stu facilitating and obstructing factors in the development of clinical practice. They categ four (4) facilitating and three (3) obstructing categories to the development of clinical ski student nurses. The facilitating categories were: responsibility and independence, prac tasks and receiving feedback, collaboration and supervision, overview and control obstructing factors were: poor student-mentor relationships, failure of organisatio realistically and consistently offer support and supervision of new graduates, an influence of individual shortcomings of students. It is from these findings that the value supervisor or mentor is realised in the acquisition of clinical skills for neophytes.

Central to the problem of clinical skill acquisition for new graduate nurses seems to be role ambiguity (Chang & Hancock 2003); where the role of the student nurse has shifted from *doer* of clinical practice to *observer* of clinical practice. Cotterill (1999 p.29) stated 'during the three (3) undergraduate years, nursing students, in a supernumerary capacity, seem to be reluctant to undertake any nursing tasks. The role of the observer is taken literally and observation alone will not promote self confidence for new graduate nurses.'

She went on to say that political and academic emphasis would be best refocused towards seeking balance between the 'on the job' apprenticeship style learning of years past, with a more theoretical, scientific approach to nursing.

The theory/practice gap is a *consequence* of university education for *postgraduate* registered nurses and is associated with neophyte attrition from the nursing workforce (Larson 1987; Callaghan & Field 1991). New graduates according to MacNeil and Weisz (1987) have more conflicts with co-workers than do established nurses. Conflict between (and not limited to) nurses is described as horizontal violence or *friendly fire* and is a major source of stress and anxiety for new graduate nurses; culminating in psychological symptomatology such as self-doubt, depression, sleep disorders and burnout (Foxall Zimmerman Standley & Bene 1990). Oermann (1994) stated future nursing practice will become more complex and specialised. It is therefore imperative to not only prepare students theoretically, but also to promote clinical skill experience and acquisition in preparation for the required independence and understanding of responsibility appropriate to the challenges of working as a registered nurse practising in a technologically advanced, demanding clinical environment.

The NSW New Graduate Nurse Recruitment Consortium.

Prior to 1993, the recruitment of new graduate nurses was undertaken by

individual health services. This uncoordinated approach was exemplified by recruitment difficulties, confusion and increased costs. The NSW New Graduate Recruitment Consortium is a recruitment body which represented sixteen (16) of NSW's seventeen (17) health services (In 2004, this Consortium and NSW Health have been reorganised). Each year in NSW 1,800 to 2,000 nursing students from 21 nursing campuses seek employment in public and private hospitals that offer new graduate support programs. There are placements across 100 hospitals, community health facilities and specialty clinical programs across NSW. Over 1,200 new graduate positions are offered through the Consortium's recruitment process. The supposed role of the consortium is to identify, and optimise employment opportunities while pooling available positions and resources. The Consortium also aims to improve the recruitment process for new graduate nurses while providing critical workforce information via its database. The benefits of the Consortium approach to recruitment of new graduate nurses are not inconsiderable. It does demonstrate a commitment to the organised recruitment of nurses into the workforce, via a statewide database while minimising the costs of recruitment for all stakeholders - graduates and employers (NSW New Graduate Recruitment Consortium 2003).

Unfortunately, the NSW New Graduate Nurse Consortium places little significance on prior clinical experience, gained by way of student

placements or undergraduate employment when considering applications for new graduate nurse positions. Nor is any consideration given to the new graduate's suitability with proposed clinical areas. The NSW New Graduate Nurse Consortium appears to have a similar propensity to the profession of nursing, in that it seems to promote the 'one size fits all' approach to job placement. Nurses who demand the *freedom* to choose their professional work environment are unlikely to be satisfied with clinical placements that do not require use of their often, well developed clinical skills gained by employment as an undergraduate during the 3 years at university. These nurses are frequently in conflict with the concept (Swearingen 2004).

Preferred area of clinical placement

Winter-Collins and McDaniel (2000) described a graduate student's comment on an article by Kramer and Schmalenberg (1991 p.53), 'There is not a shortage of nurses, but a shortage of environments nurses want to work in.' It would appear that there is a clear correlation between new graduate nurses preferred area of clinical placement, job satisfaction and the promotion of self-confidence and self esteem to practice as a nurse. (Cox 2003). Cruickshank, Mackay, Matsuno and Williams (1994) stated the experience and performance of new graduate nurses suggests the work environment is *as* significant as is nurse education in clinical skill acquisition and mastery. Heslop, McIntyre and Ives (2001) stated a source of disappointment for new graduate nurses is the limited access to their

preferred area of practice. It was further stated that areas with chronic low staffing levels such as aged care are least popular career choices. This finding was extensively documented in Happell's study (1999). The majority of new graduate nurses according to Mozingo, Thomas and Brooks (1995) recognise themselves to be fledgling nurses who are ready to learn clinical practice. They recognise themselves to be unprepared for the clinical environment. Choice of clinical placement assists the new graduate in 'settling in' to the workplace. Third year student nurses' expectations and self-reported preparedness for the graduate year within the Heslop et al (2001) study, indicated *locality* as being the most important factor influencing the first graduate year. Luker, Carlisle and Riley (1996) recognised the relationship between low clinical proficiency and self-confidence and self esteem as a nurse clinician.

The current nursing shortage encourages placement of new graduates to areas with staffing deficits, rather than attempting to align the nurse with the clinical area of preference. Muldoon and Kremer (1995 p.547; 549) acknowledged not all issues associated with new graduate nurses can be attributed to their university training, they, along with Medcof and Wegener (1992 p. 420), acknowledged there are significant hurdles awaiting new graduates entering the clinical workplace. They suggest economic stringencies should not influence the decisions of nurse administrators when considering nurses' occupational preferences when allocating staff. They

went on to say that '... optimal *worker-work* matching would improve job satisfaction and positively influence absenteeism rates and attrition; issues, which historically have been problematic to nursing and continue to cause serious staffing dilemmas.' Theories of job satisfaction, emphasise the significance of 'goodness of fit' (Hackman & Oldham 1980 pp. 76-90; Cavanaugh 1992) where individuals are well matched to the jobs because it is rewarding and satisfying to do so. Fanelli (1998) suggests internships such as the new graduate program, should be encouraged, as they offer additional learning, development and socialisation time for new graduates. Sinclair (1987) and Bircumshaw and Chapman (1988) stated there is an increasing tendency for new generation nurses to migrate to clinical areas of their choice and take control of their own nursing practice, workload and hours of work. It was also said that nurses actively seek out areas of employment where there is more autonomy and consequent job satisfaction.

It seems the desire to qualify as a nurse is not always founded on the desire to provide care to patients. The literature would suggest nursing is perceived as an 'easy' qualification to gain and is attractive to those who see nursing as a ready platform from which to launch alternative careers. Williams (1997) stated a significant number of people are using nurse training as a foundation course to follow another career, which is a waste of resources and a loss to nursing. Duffield, Aitken, O'Brien-Pallus and Wise (2004) stated nurses are highly sought after by other industries because of their

skills and capabilities. Jones (1996) and Williams (1997) concurred new graduate nurses use their undergraduate qualifications to move on to other careers. It was also stated that it might be that universities are more concerned with filling nursing degree vacancies than they are in ensuring nursing students follow on to nursing careers (Williams 1997).

New graduates seem to be defenceless against the staffing demands of health services; as evidenced when new graduates are randomly assigned to clinical areas according to vacancy factors and rarely or coincidentally according to nominated clinical preference. Allocation of new graduate nurses to clinical areas with staffing deficits is a flawed practice, which predisposes new graduates to be put into clinical situations, which are not only beyond their interest but their current capacity (Brighid 1996). In the United Kingdom it has been stated there has been a 16 percent rise in the number of nurses from Greater Glasgow, Argyll and Clyde seeking counselling, citing 'insecurity and uncertainty about their posts due to reorganisation (Anonymous 1998). While nursing education differs between the United Kingdom and Australia, it seems insecurity about clinical area of placement is a common stressor for new graduate nurses.

Kupperschmidt (1998) contended failure to place new graduates within clinical areas of preference promotes conflict between work values and attitudes that are associated with age and generation, which may result in

varying levels of organisational commitment. The participants of this study are all from Generation X, which as described by Strauss and Howe (1990 pp. 26-28) refers to the generation born between 1961 and 1981. According to the literature, (Heiman 2001; Smith 2000; Mills & Blaesing 2000) Generation Xer's demonstrate values and attitudes towards career and work that differ from past generations. It seems Generation X nurses expect to be placed in an area of clinical preference with hours of work (predominately part time) that are acceptable to them. They demonstrate a willingness to change jobs frequently to achieve the hours and conditions of work that facilitate a lifestyle of their choosing. Job satisfaction is important to new graduate nurses because of the relationship it shares with attrition (Kramer & Schmalenberg 1991; Fisher, Hinson & Deets 1994; Gardner 1992; Gorrell & Langbach 1994; Irvine & Evans 1995). Winter-Collins et al (2000) affirmed job satisfaction is paramount in the settling in phase for new graduates, by boosting self confidence and the sense of 'fitting in' (Brighid 1996 p.1). The preferred context of work (preferred clinical area) is linked with skills development, expertise and identity as a nurse (Meleis 1975; Benner, Tanner & Chesla 1996 pp. 63-77; Gerrish 2000).

Reality shock

A phenomenon whereby new employees find themselves in a work environment that does not reflect their expectations, nor does it equate with their training or preparedness to do the job (Kramer 1974 pp 80 - 102). Reality shock was later described by Lambert and Lambert (2001 p.162) as

role stress, which "may be viewed as the consequence of disparity between an individual's perception of the characteristics of a specific role and what is actually being achieved by the individual currently performing the specific role."

Economic rationalism during the 1980's and 1990's had a significant affect upon health care (Cowin 2003). Bed closures, downsizing and an increasing reliance on a casual workforce (Creegan, Duffield, & Forrester 2003) are all factors, which have impacted upon nursing practice and nurse retention in Australia. The Australian nursing workforce is ageing, with a mean age of 40 and above (Brownson & Harriman 2001; Coffee-Love 2001). Scarcity of resources has put nurses in the unenviable position of 'doing more with less' (Ulmer 2001 p.100) Patients with multiple, complex, chronic and acute conditions (Heller & Nichols 2001) are sicker today than they were previously (Curtin & Simpson 2000). Today, these patients are nursed in busy, general wards with staff ratios of 1:8 – 1:10. Until the last decade, complex patients such as these would have been cared for in Intensive Care or High Dependency Units with 1:1 or 1:2 staff ratios. These changes have impacted upon new graduate nurses entering the workforce as the complexity of patient care is ever increasing.

Contemporary literature would suggest that there has been an inundation of Australian academic writings regarding the Australian graduate nurse

transitional experience from university to the clinical environment (Benner 1984 pp. 70-86; Buckenham 1994 pp. 68-79; Gerrish 2000; Chang & Hancock 2003). However, little Australian qualitative data exists which depicts how the individual 'coal face' experiences of these nurses compares with their expectations and perceptions of *being* a registered nurse. It seems there has been a paradigm shift in the experience of reality shock for nurses. However, today, there exists an extreme difference in the experience of reality shock for new graduates from when it was first described by Kramer (1974). Prior to the transition of nurse education to universities, it was *student nurses* who experienced reality shock as their experience of the clinical environment expanded with their evolving level of responsibility. Today it is *postgraduate* nurses who are experience extreme reality shock as they enter the clinical environment as professionally, legally accountable registered nurses who have in reality, yet to experience the reality of the role registered nurse. There seems to be little research or acknowledgement of this important phenomena, which was significant to all of the participants of this study.

Lo Biondo Wood and Haber (1998, p. 52) stated it is appropriate to focus research to facilitate learning and to map the meaning of the lived experience through intensive dialogue, with individuals who are living the experience. There is evidence in the literature (Cavanagh 1992; Hewison & Wildman 1996) to suggest the transitional experience of graduate nurses

into the clinical environment is reflected in job satisfaction levels and is central to the decision to continue to practice as a nurse. Contemporary literature over the past 2 decades suggests the transitional experience of new graduates (Kramer 1974 pp.38-44; Cohen 1981 pp.104-112; Jasper 1996; Reutter, Filed, Campbell & Day 1997) from student to registered nurse involves internalisation and survival of the shock of working in an unexpected environment. Reality shock was first recognised and described by Kramer (1974 pp. 80-102) who identified issues pertaining to mentorship, the theory practice gap, horizontal violence and bullying, poor socialisation to the wider nursing group and the effects of shiftwork and fatigue as contributory to transitional difficulties for new graduate nurses who is leaving the classroom for the real world of nursing. These issues have similarly been identified in the literature as significant to new graduate nurse retention.

The day to day workplace experiences of new graduate nurses promotes the development of individual, professional opinions and values. It is equally true to say this research confirms that significant individual experiences impact upon the new graduate's wider social existence. It is these formative experiences that serve to map how the nurse forms opinions and reacts to the profession of nursing. Coopersmith (1967 p.50) exemplified this point when it was said, 'experience of success leads to expectations of success and that aspirations mirror these expectations.' Conversely, negative experiences contribute significantly to worsening staff shortages in nursing.

There is conflict between new graduate nurses and senior nurses. It seems generational idiosyncrasies, differing work values and ethics and senior nurses who appoint little value to academia or new graduates, if their clinical skills are insufficiently developed to *do the job*. These are issues contributory to disarray, disunity and 'reality shock' (Kramer 1974 p.100), for postgraduate transitional nurses.

Mentorship

Veiled promises

The issues related to the transition of nurses from undergraduate to postgraduate status are acknowledged. The stress associated with the transition process is well documented in the literature (Kramer 1974 pp. 34-68; Larson 1987; Callaghan & Field 1991; Gardner 1992; Oermann & Moffitt-Wolf 1997; Oermann & Garvin 2002) and is attributed to increased absenteeism rates, poor job satisfaction and higher attrition rates. In recognition of these issues, new graduate nurses enter the workforce expecting to work in a supernumerary capacity that is complemented by supervision and mentorship by more senior nurses. According to Bain (1996), Runciman, Dewar and Goulbourn (1998) and Gerrish (2000) the critical international nurse shortage has seen the promise of mentorship for new graduates watered down to a recommendation - not a requirement; increasing the probability that day to day staffing levels will dictate the new

graduate nurse work unsupervised and take responsibility for a full patient load. The act of being thrown in at the deep end, impacts upon the coping abilities and experiences for the new graduate nurse with role overload being the end result (Chang & Hancock 2003).

A further challenge for new graduates is to experience the resentment and frustration of senior nurse clinicians who frequently view the role of mentor as an 'add on' to their already high workload. Stevenson, Doorley, Moddeman and Landau (1995) stated senior nurses frequently report the increase in workload as a disadvantage to training new graduates. The failure of senior nurses to provide willing mentorship for new graduates is according to Hamel (1990 pp. 38-40) caused by a lack of understanding and empathy for their less experienced co-workers. The expectation for RN's to function as appointed mentors is not necessarily based on prior education, or training to perform the role (Hamel 1990 pp. 29-34). Rather the decision is often loosely based upon whoever is rostered on duty at the time.

Thomas (1999) stated new graduate nurses have high regard for the skills of experienced clinicians and welcome the opportunity to benefit from their expertise. Conversely it seems, experienced clinicians often respond negatively to new graduates by failing to provide effective and willing mentorship in the initial transition period within the clinical environment. According to Hamel (1990 pp. 50-55) senior nurses frequently abdicate

responsibility for nurturing, supervising and educating new graduates; viewing this responsibility as incumbent to the role of academics and nurse educators (Upton 1999). Capricious mentorship promotes feelings of hostility, feelings of worthlessness, and poor social integration for new graduate nurses into the wider nursing social group. Hamilton, Murray, Lindhom and Myers (1989) stated mentorship for new graduate nurses facilitates the journey of transition from theoretical learning to clinical nursing practice.

The literature strongly links effective mentorship to increased job satisfaction and improved leadership behaviours. Owens, Turjanica, Scanion, Sandhusen, Williamson, Hebert and Facteau (2001) affirm high levels of anxiety are for new graduates associated with performance and fitting in with the nursing social group. This type of anxiety is common among new graduate nurses. This phenomena adds clear emphasis to the wisdom of sound mentoring practices within health care facilities, to support the new graduate nurse during the initial 'settling in' period. Mentoring defines and clarifies the role of the new graduate nurse and dispels role confusion and role ambiguity which, as described by Brief, Aldag, Van Snell, and Melone (1979 pp. 100-113) serves to further promote the successful integration of new graduate nurses into the clinical setting. These strategies aim to forge partnerships between senior and transitional nurses; in an attempt to support, mentor and retain new graduates as one of health care's valuable

resources. It was also said partnerships must also be encouraged, to enhance congruence between curricula and contemporary clinical practice.

Theory/practice gap

The real world

The development of nursing theory and research-based practice is fundamental to professional autonomous nursing practice. Theory and practice according to Upton (1999) are inextricably linked to each other. The evolution of nursing as a science and the development of nursing theory have created conflict between theorists and clinical nurses. It is the gap between theory and the reality of practice that is the basis for this conflict. The concept of the theory/practice gap has been documented extensively in the literature, (Kramer 1974 pp. 74-87; Hinshaw Smeltzer & Attwood 1987; Monzingo Thomas & Brooks 1995; Upton 1999; Winter-Collins & McDaniel 2000; Heslop McIntyre & Ives 2001) but remains a major stumbling block for new graduate nurses who, as neophyte clinicians (Hamel 1990 pp. 86-99) attempt to apply theory to practice.

Benner (2000) stated experiential learning in clinical practice is expensive because new clinicians arrive to the workplace with limited theoretical knowledge and clinical ability, which Allmark (1995) and Upton (1999) described as an academic/hospital dichotomy. Nursing, as a practical art derives clinical skill and competence from experiential learning. 'Hands on'

clinical experience promotes clinical skill and wisdom that is cumulative and collective. Cruickshank, Mackay, Matsuno and Williams (1994) stated the *work environment* is as significant as is educational preparation of new graduate nurses.

Transitional clinical experiences according to Chang et al (2003) are frequently associated with high levels of anxiety for new graduate nurses, declaring themselves to be inadequately prepared to perform in the role of clinician. There also is overt fear appointed to the prospect of litigation, with subsequent loss of professional registration, due to errors made because of inadequate clinical knowledge and ability (Chang et al 2003). Glass, McKnight and Valmarsdottir (1993) stated lack of support, lack of role control and overt job demands, inflict high levels of stress upon new graduate nurses; who, because of lack of a resources, are put in the precarious position of attending procedures for which they hold no level of competence. Brighid (1996) stated new graduates have a prevailing fear of being put in charge of the ward and being responsible for delegating to other staff such as enrolled nurses. Chang et al (2003) stated labile staffing levels comprised of staff with varying levels of clinical expertise compound the difficulties experienced by new graduate nurses, as often it is a junior nurse whose responsibility it is to mentor the new graduate.

Charnley (1999) stated the clinical environment is far removed from the

idealism of the classroom that does not allow students to develop skills such as time management and workload prioritisation skills. Ferguson and Jinks (1994) stated the physical separation of nurse educators from the clinical area and clinical nurses is problematic. Upton (1999) alternatively stated it is the failure of students to link the equally relevant theories of educationalists with practitioners that is at the heart of the theory-practice divide (Reed & Procter 1993 pp. 101-154).

Holland (1999) stated new graduate nurses find the volume of work daunting and feel pressured to complete all assigned tasks for their shift lest they appear *inadequate* to the next shift coming on duty. Hamel (1990) depicted the transition from student to clinician as being fear laden, with fear of failure, fear of making mistakes and fear of responsibility, as typical responses of neophytes. Gerrish (2000 p.475) associated 'the fear of the act and the consequences of making errors' as anxiety inducing for transitional nurses. Malloch and Laeger (1997) stated a cooperative effort to address and breakdown the traditional barriers that are known to exist between education and clinical practice is required. Upton (1999) confirmed students need to think logically by linking relevant theory to clinical practice. It is the partnership between education and practice opportunities that is required to address reality shock (Kramer, 1985) and the theory practice gap for new graduates.

According to Holland (1999) nursing is a confused profession. She described fragmentation of nursing roles and responsibilities with redistribution of skills and knowledge to others. Brighid (1996) stated experienced clinicians frequently complain that new graduate nurses are lacking in credibility as nurses because they lack clinical expertise when they first enter the workforce. Footit (1999) stated new graduates arrive with the *theory* of practice and a willingness to seek practical application of those theories. However, Speedling, Ahmadi, Kuhn-Weissman (1981) and Kramer (1985 pp. 891-902), stated poor clinical exposure and lack of practice opportunities during the undergraduate period of their development erodes self confidence for new graduates to apply theory to practice. These realities impact upon what is philosophically desirable and what is actually achievable. Significant to this research, Brighid (1996) confirmed the social environment into which the new graduate enters the workforce is of great significance to the acquisition of clinical skills.

Holland (1999 p.231) stated '... the idea that the student is *not* a nurse, but *learning* to become a nurse is often forgotten and that ... learning is believed to take place while caring, however the students carry all the responsibilities associated with patient care.' The development of clinical judgement is a significant source of stress for new graduate nurses who possess theoretical knowledge of nursing practice, but have little clinical experience on which to base sound judgements. Benner (1984 pp. 58-63) exemplified this point

when it was said experimental learning cannot be expressed by models, theories or conjecture to depict how a situation will be in actuality. The theory/practice gap continues to be contributory to the disharmony evident between experienced and new graduate nurses.

University education expounds self-evaluation as a reasonable tool of self assessment. Brighid (1996 p.1066) asked 'How do new graduate nurses evaluate their performance with application of perfectionism or undue criticism?' It is a given that without instructional strategies and realistic opportunities for growth and development, new graduate nurses could succumb to the influence of system pressures and self imposed unrealistic performance evaluations. In support of this statement Carper (1978) stated solutions to issues within nursing may be guided by theory, but only if the theory is *embedded in practice*.

The theory / practice gap fuels the fear of failure for new graduate nurses by eroding self-esteem. Brighid (1996 p.1068) warned 'preconceived notions of inadequacy might be self-fulfilling.' Recognition of the importance of self confidence and self-esteem may be the most important elements in the successful transition from student to practitioner for the new graduate. Self-esteem theory is complicated. Randle (2003) accepted self esteem as a predictor of personal and professional behaviour and that humans as complex beings, have many *selves* i.e. a person can attribute differing levels

of self esteem to different situations according to how confident they feel about themselves in that situation.

Herdman (2001 p.6) asserts the theory practice gap is a result of the 'illusion of progress in nursing; with the implication progress, equates to improvement.' Chapman (1998 p.460) asked whether 'nurse education is better than it was and if it is, *better for whom?*' Her main concern related to the elevation and professionalisation of nursing qualifications by structural change in nursing education standards; which by default, have weakened the clinical skill and knowledge base of patient care environments by the release of new graduates who are unprepared to function independently as registered nurses.

Crowley (1999) stated the shortfalls in clinical practice for newly graduated nurses cannot be attributed to education alone. The situation seems to be exacerbated by experienced clinical staff, laden with unrealistic expectations of new graduate nurses (Oechsel & Landry 1987; Resler 1988; Brown 1999) who, because of heavy workloads and staff shortages are too busy to effectively mentor new graduate nurses; frequently abdicating their mentoring, caring role. New graduates are ill equipped to work independently in the clinical environment primarily due to academic developments being wasted because of the failure to clarify and offer support in the acquisition of clinical experience. Brighid (1996) stated new graduates are caught in a war

between academics and the real world.

Socialisation as a nurse

The old girls club

Cohen (1981 p.234) defined professional socialisation as 'the complex process by which a person acquires the knowledge, skills and sense of occupational identity, that are characteristic of a member of that profession'. Socialisation involves internalisation of the values and norms of the group into the person's own behaviour and self-conceptualisation; by surrender of the societal and media stereotypes prevalent in our culture and adoption of those held by that profession. The paradox of nursing socialisation and culture for Australian new graduate nurses has according to Du Troit (1995) occurred with the transfer of nursing education to the tertiary sector where the role models for nursing students are nursing faculty members whose priorities and behaviours are often in stark contrast with the experienced clinicians of the acute clinical setting.

In 1943, Maslow (1943 pp. 10-14) proposed a model of the hierarchy of needs. This model demonstrated the importance appointed to satisfying needs low on the scale before the needs higher in the hierarchy become important. The hierarchy of needs is important to the socialisation of new graduate nurses who according to Ootim (1998) concentrate on improving their cognitive abilities, but fail to recognise the importance high self esteem plays in successful acquisition of clinical skills. Coopersmith (1967)

interpreted self-esteem as the level of faith a person appoints to their own abilities in terms of being capable and being successful and being worthy. Rosenberg (1979 p.86) offered support to this statement by saying, 'high self-esteem promotes feelings of being good enough, being worthy and that respect for self is offered for the person that is.'

Fagerberg (2004) identified the work environment as important to the development of registered nurse skills, expertise and *identity* a nurse (Meleis 1975; Benner Tanner & Chesla 1996 pp. 50-86; Gerrish 2000). Holland (1999 p.231) stated 'examination of nurses and their world from a cultural viewpoint continues to be a virtually unexplored territory.' This opinion was confirmed in the literature (Street 1992 pp.11-23; Holland 1993; Suominen Kovasin & Ketola 1997). Holland (1993) stated an important part of nursing culture is the established arrangement for socialisation of new members. White and Ewan (1991 p. 189) stated the process of becoming a nurse is a social one and as such should be differentiated from 'the academic process of earning a degree or qualification'. They stated professional socialisation is a process whereby an individual learns the culture of nursing; that combination of symbols and customs that make nursing distinctive. Upton (1999) stated the physical separation of nurse teachers from clinical environments and other nurses has frequently been highlighted as problematic not only with separation of theory and practice, but also by lack of preparatory socialisation of nurse students as nurses.

Buckenham (1994 p. 1067) stated nurses frequently experience stress, despair and disillusionment in their first graduate year because of inappropriate peer supervision and support. Randle (2003) stated social comparison is central to developing and maintaining professional self esteem for new graduate nurses, in order to enhance acceptance in the eyes of senior colleagues. It is perilous to patients and nurses alike to try to 'bluff your way through' rather than admit a lack of knowledge and risk diminished respect by senior colleagues. Rogers (1991 p.78) in support of this statement proposed that 'self esteem is based on live experiences and self perception and is reflected in the attitudes of others.

Szasz (1982 pp.79-123) stated uniforms are useful for individual nurse self identification, and that the wearing of uniform is associated with the hierarchy of power for health care professionals. Smith (1990 p.34) stated uniforms '... certify legitimacy, suppress individuality and create a totem.' It is through the process of socialisation that nurses learn the cultural rules of the area. Lofmark and Wikblad (2001) in support of this statement, concurred with the findings of the May and Veitch (1998) study that identified various strategies such as fitting in and learning the rules (Melia 1987 pp.10-40; Nolan 1998) are necessary for new graduates to improve their acceptability to the wider nursing social group, overcome barriers and obstacles and improve their level of job satisfaction. Glaser and Strauss (1971 pp.140-159) view socialisation as a journey or passage, whereby group status is

acquired. French anthropologist Arnold Van Gennep (1960 p.11) identified three (3) stages of what he defined as the *rites of passage,* consisting of the rites of separation, the rites of transition and the rites of incorporation into the wider social group.

Many factors may impact upon the time taken for new graduates to be accepted into the nursing team. The literature confirms lack of autonomy, peer identification and recognition of positive performance and feedback as frustrating to new graduates (Prout 1989). Socialisation to the wider nursing social group is a process that occurs over a period of time. Kramer's (1974 pp. 189-210) graduate resocialisation model was described in four (4) parts. Part one (1) is skill and routine mastery. Part two (2) is social integration. Part three (3) is moral outrage and Part four (4) is conflict resolution.

Rites of passage

The first stage of socialisation according to Turner (1982 p.24) involves detachment by the neophyte from previous social statuses. The second or transitional stage was described by Van Gennep (1960 p.11) as 'social limbo' when the neophyte is neither in one state or another. He stated it is within this stage that social order is defined and reinforced. The third stage is that of incorporation, where neophytes are returned to a new social status or social position within the social group (Holland 1999). La Fontaine (1985 p.17) stated socialisation equates with initiation for new members of a social

group, by definition of acceptable boundaries, with '... traditional knowledge, understanding and experience to ensure *correct performance*.' Holland (1999) asserts knowledge is synonymous with power; crucial to development of the behaviours required to undertake new roles within the wider social group. The rites of passage for new graduate nurses according to Prout (1989 p.357) includes '... testing feats of endurance in tasks which exaggeratedly simulate the components and challenges of their imminent role identity.' Survival of the rites of passage or *tribal rites* of the social group, guarantees progression for the new graduate into the third phase of nursing social development; described by (Holland 1999) as the appointment of an elevated social status and incorporation into the wider nursing social group.

Learning to be a nurse

Prior to the transfer of nursing education to universities, nursing students worked in an 'apprenticeship' system of training (Holland 1999) where students earned a wage and learned on the job practical skills which according to Jacka and Lewin (1987 p. 29) come second to the needs of the organisation. Holland (1999 p.235) stated this type of situational learning is learning by 'doing and being with an expert'. Nursing students today spend the majority of their learning hours within university classrooms; gaining clinical experience during workplace deployments primarily through observation, not by application of actual 'hands on' nursing care (Cotterill

1999). Nursing students according to Charnley (1999) frequently cannot maximise the opportunity to gain experience, as clinical areas are often short staffed and under resourced. The clinical experience of the student then becomes prescriptive and task oriented, usually reverting to basic nursing skills such as attending to patient hygiene and recording vital signs. The act of reverting to task allocation is as described by Simpson (1979 pp.34-50) a clear indication of the hierarchy of ability and skill the experienced nurse appoints to the new graduate. Clinical placements are often too brief for students (Charnley 1999) to gain confidence by doing the procedure.

Melia (1987 pp.48-59) and Wilson and Startup (1991), identified lack of opportunity for professional socialisation of new graduate nurses into the wider nursing social group, as contributory to the experienced clinician's negative perceptions of transitional nurses. Rapid progression through brief clinical placements has been identified as inadequate in both exposure and integration opportunities to the social rules governing the organisation of work practices and nursing social norms. The social climate into which the new graduate enters is according to Brighid (1996) of great significance. McNeese-Smith et al (2003) stated events occurring outside of personal values creates a dissonance between the inner and outer world that is stressful and exhausting. Hipwell Tyler and Wilson (1989 p.65) stated the social climate of the new graduate's work environment is the 'most potent instigator of the *drop out* syndrome.' Koerner (1996) stated the mission of

nurse managers is to recognise areas of conflict for nurses and reduce dissonance to prevent disengagement, frustration and costly turnover.

The area of clinical placement for new graduate nurses is significant to the establishment of a comfort zone, which allows nurses to perform nursing care that is familiar and from which a level of confidence is established. Charnley (1999) stated new graduates who returned to wards on which they had previously worked as a student, experienced significantly less role anxiety than their counterparts who are entering an untried clinical area. Luker Carlisle and Riley (1996 pp. 142-148) recognised the relationship between low levels of clinical proficiency and low self-confidence and self-esteem as a registered nurse. Role stress according to Lambert and Lambert (2001) is the consequence of disparity between an individual's perception of the characteristics of a specific role and what is actually being achieved by the individual currently performing the specific role.

The pressure to meet the expectations of the wider nursing group may be problematic for new graduates. Brighid (1996) stated conflict with new graduates is closely connected to the preconceived notions of new graduate nurses held by more senior nurses. The benefit of altruistic activities to nurses and patients was described by Smith (1992 pp. 38-77) as practice that is embedded in emotion and the concept of caring. Phillips (1996 p. 141) described the work of nurses as 'emotional labour.' James (1992) and Smith

(1992) concurred 'there seems to be a link between giving emotional labour, occupying the lowest status and having the fewest skills, while more senior nurses are able to withdraw their emotional labour.

The acquisition of a tertiary qualification to practise as a registered nurse is, as described by White and Ewan (1991 p.126) a mark that the student is competent in the skills and practices applicable to nursing. Brighid (1996) however stated learning to behave as a nurse by creating a professional identity, is rooted in social interaction theories. The literature contends (Mead 1962 p.96; Habermas 1990 pp. 47-54) identity is socially bestowed, socially sustained and socially transformed. Denzin (1978 p.72) stated ' we live out our every day in a complex web of recognitions and non recognitions'. Socialising the new graduate into the nursing social group is facilitated by interaction with and by observation of more experienced colleagues in nursing functions and professional interactions. Windsor (1997) describes this process as acquisition and role modelling of behaviours which allows the transitional nurse to act like a nurse and concluded that professional socialisation involves three stages which encompasses the evolution of transitional nurses from student, to the expanded registered nurse role, to final independence as a clinician. Interestingly, both Goddard (1957 pp.108-112) and Simpson (1979 pp.41-48) whose writings were separated by almost 2 decades identified the same pattern of skills hierarchy associated with the 3 year journey of student

nurses in the achievement of formal nursing qualifications.

In light of this argument, it would seem that high self-esteem for new graduate nurses is pivotal to the successful acquisition of professional clinical standards and judgements. A conundrum exists. Does the acquisition of sound clinical skills promote self-esteem and acceptance into the wider nursing social group? Alternatively, does high self-esteem provide the courage for new graduates to gain clinical proficiency and acceptance as a sound clinician? Denzin (1978 pp. 58-79) stated human experience is constructed around individual experiences, which have been influential and interpreted as important events; with further focus upon what is deemed important and what is not. This statement fits with this research as it seems the early experiences of the new graduates either positive or negative impact significantly on their early formative postgraduate experience. This point was supported by Brighid (1991 p.869) who conducted a final year undergraduate study which confirmed undergraduates felt powerless when first taking up clinical positions and that fitting in is achieved by going along with the wider group. In support of this statement, Meissner, Abelleria and Erb (1986 p.52) described 'insidious cannibalism' within nursing departments as reflective of the socialisation process and is directly attributable to changes in the behaviours of new graduates. Windsor (1987) confirmed this point when it was said that professional socialisation and behaviour change occurs when new graduates felt they were part of the profession. The sense

of belonging in turn improved how they felt about their clinical experiences. It can be then concluded that high self-esteem is inextricably linked to the process of successful socialisation as a nurse. Once accepted as part of the established nursing culture, nurses then seem to have the confidence and support to improve their clinical skills and knowledge. Alternatively, insidious cannibalism of new graduate nurses by senior nurses is recognised as being directly attributable to the adoption of adapted behaviour; whereby the new graduate assumes mannerisms and behaviours of the wider nursing social group in the attempt to be accepted into the established nursing culture. It seems the emulation of group behaviours, values and norms is a survival strategy for new grads.

Horizontal violence and bullying

Friendly fire

Hegney, Plank and Parker (2003) stated bullying, horizontal violence, aggression and harassment are descriptors for what constitutes workplace violence. Nurse education has been offered exclusively within universities for the past 20 years (NSW Nurses Registration Board 1997). Yet new graduate nurses continue to arrive to the clinical environment endowed with fear of senior nurses (McKenna, Smith, Poole & Coverdale 2003). In this 20 years of education, new graduates remain ready targets for more senior nurses.

The Queensland government report (2002) of horizontal violence in the

workplace interpreted workplace harassment as repeated behaviour, other than behaviour that is sexual harassment, that targets single or groups of individuals with the actions and intent to offend, intimidate and threaten. Adams (1997 p.89) stated workplace hostility, bullying and horizontal violence are synonymous with the '... persistent, demeaning downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self esteem.'

The literature seems to indicate that horizontal violence or bullying within the workplace largely is represented as psychological harassment (Duffy 1995; Farrell 1997; Hockley 1999; McKenna Smith Poole & Coverdale 2003). Hockley (1999) stated verbal, emotional and psychological abuse are the most common types of abuse in nursing, with physical abuse being very rare, but occasionally occurring between patients and nurses, between doctors and nurses and between nurses themselves. Harassment of nurses reportedly involves threatening, verbally abusive behaviour, overt criticism and exclusion (McMillian 1995; Farrell 1997). The psychological distress associated with these behaviours has clear consequences for nursing, with nurses leaving the profession rather than continue to tolerate the abuse (Wheeler 1998; Turnbull 1995). The literature suggests abusive behaviour towards new graduate nurses is commonplace, with significant psychological stress the consequence for this group of nurses (McMillian, 1995: McCall 1996). The literature also suggests horizontal violence is so commonplace in

nursing, that it is accepted as a norm (sic). In support of this statement, Hockley (1999) and Kingman (2001) concurred, nurses consider violence to be part of the job and are accepting of it as a normal aspect of nursing work. McKenna et al (2003) stated it is a paradox that the hub of nursing is purported to revolve around the concept of care and caring, while the literature (Cox 1987; Duffy 1995; Farrell 1997, 2001; Taylor 2001) reveals horizontal violence against its own members is a significant issue for the nursing profession. New graduate nurses are particularly susceptible to horizontal violence within the workplace. Wickett McCutcheon and Long (2003) stated Australian society is experiencing an increase in behavioural problems such as aggression and violence, reflected in the rising admission rates of such individuals into acute care hospitals. Coupled with the aging population, this phenomena is resulting in significant pressure on acute care facilities and nurses. Bullying is not confined to the clinical areas of nursing practise, rather is evident along all levels of the nursing hierarchy (Wickett et al 2003).

McKenna, Smith, Poole and Coverdale (2003) have stated new graduate nurses, because of professional and social status, are ready targets for bullying and harassment by more senior nurses. It is apparent from the literature (Aiken, Clarke, Sloane, Sochalski, Busse & Clarke 2001; Bush & Gilliland 1995a, 1995b; Cox 1987; Duldt 1981) that hostility towards new graduate nurses is well documented. Rahim and Bonoma (1979) stated

intragroup conflict is significantly increased in heterogeneous groups. Psychological harassment and intimidation (McMillian 1995; Farrell 1997; 1999; Thomas & Droppleman 1997) are forms of horizontally violent behaviours that promote job turnover and departure from the nursing profession (Wheeler 1998). This type of conflict (Madison 1998, p.3) occurs when differing professional workplace expectations exist and when the 'honeymoon phase' of socialisation is over. Sovie (1992) in recognition of varying levels of experience and skill stated teams are the new imperative in health care and are essential to an organisation's efficiency and effectiveness. Yet teamwork is continually undermined by warring team members.

The literature confirms the expectation of hostility impedes the integration of new graduate nurses into the workplace (Melia 1987 pp.93-108; Wilson & Startup 1991; Buckenham 1994 pp.55-86). It seems it is common for new graduates to experience fear and anxiety and *expect* to be targeted by other more senior registered nurses. Leifer (1995); Pearson, Baker, Walsh and Fitzgerald (2001) and Aiken et al (2001) described the morale of registered nurses as being at its lowest point in history, resulting in stressed, dissatisfied senior nurses being unable or unwilling mentor new graduates properly. The lack of supervision retards clinical skill acquisition for new graduate nurses, causing a vicious cycle of hostility between these two groups.

Clinical workload pressures appear to prematurely position new graduate nurses into situations that are beyond their current clinical abilities (Lambert & Lambert 2001). New graduate nurses arrive to the clinical environment not as independent clinicians, but rather as inexperienced, dependant registered nurses who require mentoring and supervision – all of which is seen to be excessive, time consuming and frustrating to the existing registered nurse labour force (Hamel 1990 pp. 44-76). Nelson and Fells (1989) and McCloskey and McCain (1987), stated senior nursing management, many of whom have little experience or knowledge of undergraduate nursing education, hold prejudicial views of new graduate nurses. Roberts (1983) stated it is this group of nurses that display controlling, coercive and inflexible behaviours typical of leaders in an oppressed group. Taylor (2001) stated workplace bullying goes largely unreported and filters down through workplaces by staff who seek acceptance and promotion.

The nursing profession according to Freshwater (2000) continues to be seen as typically subordinate and powerless in the healthcare system. Roberts (1983) associated stereotypical attributes such as 'caring' as a nurse as inferior to attributes such as 'scientific', which are typically associated with doctors. The difference in perception of the two professions continues to relegate nursing in a subordinate position to doctors. Freire (1972 p. 38) described how oppressed groups emulate the behaviours of their oppressors because of distortion of their own perceptions. Hockley (1999) stated

violence among nurses has long been acknowledged and is based on the fact that women, while generally not physically violent, have a propensity towards horizontal violence, employing mannerisms and behaviours that are intended to marginalise and demean. These behaviours are entrenched in nursing. It seems, If you are a nurse, and most certainly if you are a new graduate nurse, then these behaviours are part of the job and horizontal violence in nursing, is a given.

Randle (2003) described the negative impact of bullying of new graduate nurses as psychologically damaging to self-esteem in both the personal and professional sense of self worth. Southard (1995 p.264) stated nurses '... eat their own young.' Parobek (1998 p.139) quoted the writings of the late Jo Ann Ashley stating 'nursing has not gained the power and freedom to practice as professionals and that nurses as members of an oppressed group often turn against each other and perpetuate the cycle of self-hatred.' Giordano (1997 p.17) stated 'nurses often do not manage their anger effectively and '... the most lethal manifestations of anger within nursing is denegation of colleagues by horizontal violence, which is characterised by back biting, fault finding and name calling.' She also stated '... in times of uncertainty and fear, nurses put their wagons in a circle, but start firing upon each other!' Siddall (1998 p.20) confirmed anger in the workplace by nurses is represented as 'ward rage' and is a symptom of powerless nurses who vent their frustrations on each other. Horizontal violence towards new

graduate nurses is directly attributable to oppression of nursing as a profession (Roberts 1983) and that nurse's attack each other to vent anger and professional frustration. Horizontal violence in nursing is not a new phenomena, but a tragic legacy of past unresolved anger and hostility which according to Street, (1992 p.42) suggests nurses in Australia are accepting of "work place terrorism" and only pay lip service to their frustrations. In support of this statement Reeve (2000) said nurses want to retain the status quo by conveying an image of group futility that continues to infiltrate all levels of the profession.

Moore (1970, pp.89-122) described 'deformational professionelle' as any distortion of character resulting from participation in the world of work. Horizontal violence occurs within nursing as a result of lack of autonomy and control over the nursing profession (Roberts 1983). However, horizontal violence is not a phenomenon exclusively found in nursing. Sofield & Salmond (2003) stated oppressed group behaviour has been defined as any group that are subordinate to more powerful groups in society (Roberts 1996).

Wheeler (1998) confirmed new graduate nurses are fearful of the negative behaviours of more senior nurses. McKenna et al (2003) described covert conflict towards new graduates as commonplace; attributed to low professional and social group status rendering them as ready targets for

psychological harassment. Issues such as being undervalued (being treated like a student), being assigned too much responsibility with too little support readily undermines confidence and prompt symptoms of psychological distress. Rayner (2002 p.134) describes '... belittling, professional humiliation and failure to acknowledge good work as typical attributes of bullying.' The consequences of horizontal violence for nurses are serious. According to Antai-Otong (2001) physical and psychological manifestations such as hypertension, diabetes, coronary artery disease as well as depression, panic disorders and symptoms equivalent to post traumatic stress disorder are attributable to high stress work environments. This statement was validated by Borril (1998 pp.10-14) who stated stress in the workplace occurs across all professions. However, when Cooper and Baglioni (1998) reviewed over 100 occupations making comparison with a stress rating scale, nursing was shown to offer significant stress to its members, rating as the most stressful occupation of any of the service industries. Siddall (1998 p.20) confirmed statistics on sick leave, stress and suicide for nurses clearly demonstrates the negative effect 'the caring profession' can have on the health and welfare of nurses.

Shiftwork and fatigue

Larks and owls

Health care facilities are required to offer 24-hour care for patients. For nurses, this means working differing hours to cover all blocks of work hours

called shifts. Shiftwork is described as a roster, with allocated time frames on a regular basis. The effect of shift work on new graduates is significant and can be described as an element of reality shock (Holland 1999). The concept of shift work, while *discussed* with new graduates during the three (3) year period of university study, cannot be offered any true reality. There is a great deal of literature available regarding shiftwork and its effects upon workers (Alward 1988; Czeisler, Johnson, Duffy, Brown, Ronda & Kronauer 1990; Alward & Monk 1994; Humm 1997). There is however little empirical evidence specific to new graduate nurses of what impact shift work has on their initial transition into the work place. A comprehensive literature search failed to locate any Australian university evidence confirming planned curricula to improve new graduates' understanding of shiftwork.

Humm (2000) stated humans as a diurnal species are alert during the light of day but need to sleep as the levels of light diminish. Harrington (1978 p.20) stated only 10% of staff stated they enjoyed working at night, whereas 20 - 30% found working during the night time hours as torturous. The desire to be awake and the need for sleep is governed by an inner endogenous body clock or circadian clock. According to Campbell and Murphy (1998) all human physiological and behavioural rhythms are controlled by circadian rhythms which are generated by (Skene 2003) a master pace maker within the brain. Outputs of melatonin, core body temperature and the sleep/wake cycle are all controlled by circadian rhythms. The level of available light

dictates whether the brain interprets day or night and whether a wake cycle or sleep cycle is generated. The effect of working at night was equated by Skeen (2003) as comparable to transmeridian travel. Dingley (1996 p.1250) similarly described 'shift lag' as comparable in its effects to jet lag. Working shiftwork has clear consequences for all nurses, but particularly, for the sleep/wake patterns of uninitiated new graduate nurses who are simultaneously trying to acquire clinical skills.

Sleep deprivation and fatigue are the most immediate consequences of altered circadian rhythms (Humm 1997). Unlike travel across time lines, shift work does not provide resynchronisation by social and environmental cues as the nursing hours of work are continually changing throughout the 24 hour period. Fatigue according to Mullaney Kripke and Fleck (1983) manifests itself with coping difficulties, decreased ability to make decisions and in extreme cases paranoid behaviour. Stickgold, James and Hobson (2000) stated sleep deprivation significantly affects normal consolidation of the learning process, which seems to erode the new graduate nurses' ability to gain and master new clinical skills. Stickgold et al (2000) stated sleep deprivation significantly impacts upon the normal learning process, which renders new graduates vulnerable to low levels of self-esteem and self-confidence.

In the Gillespie and Curzio (1996) study of the effects of different shift

lengths, it was found that 80% of the participants identified tiredness as a problem when working 8 hour shifts - which is the shift length of the majority of the shifts in nursing. The Barton, Smith, Totterdell, Spelten and Folkard's (1983) study of shift length for 1082 nurses, demonstrated those who were rostered to relatively fixed hours of work, experienced the fewest problems, with the least amount of life disruption. Johnson (1999 pp.80-99) stated rotational shift workers experience greater difficulties in individual time management than those who work regular shift hours. Wilson (2002) stated for many nurses the responsibilities of home frequently take precedence over sleep, which further exacerbates levels of fatigue and irritability. Johnson (1999 p.34) stated shift workers experience significantly higher work-family conflict than day workers and demonstrated significantly less favourable work attitudes, presumed to be the result of chronic fatigue.

Wilson (2002) stated shift workers often experience feelings of isolation and social deprivation. Humm (1996 p.23) found in his study of personality and night duty tolerance 'If night work is making a person ill, whether it be a physiological inability to cope, or because it is a social/domestic stressor then they should not be working nights.' It was further hypothesised by Humm (1997) that not all nurses who work shiftwork are actually biologically and psychologically suited to working shiftwork. The Locus of Control theory as described by Smith and Iskra-Golec (2003) has an extensive research application and was responsible for the evolution of the Shiftwork Locus of

Control (SHLOC) which presents a clear relationship between 'sleep quality, fatigue, alertness, interference with family and social life, psychological well being and perceived stress.' It was suggested, that individuals who may be susceptible to the negative effects of shiftwork, be monitored in terms of worker health (Wheeler 1998).

Heslop et al (2001) described shiftwork as a possible problem area for new graduate nurses. McNeese-Smith and Crook (2003) stated values or what is important to the individual are used to judge situations, make decisions and shape consciousness. Super (1970 pp. 28-44; 1995 pp. 54-61) stated values sought in work (intrinsic values) and satisfaction may be concomitant to work (extrinsic values). Heslop et al (2001) concurred with this statement when she said new graduates as mostly confident that shiftwork will not interfere with their social lives, while being aware that undertaking shiftwork probably will not be easy.

Tasker and Hirshkowitz (2003) placed great emphasis on increased occupational risks in sleep-deprived states due to lowered reaction times. Mitter Dement and Dinges (2000 pp. 580-588) cited environmental disasters as Three Mile Island, Chernobyl and Bhopal as evidence of fatigue related incidents. Fatigue according to Dingley (1996) occurs at the lowest level of the circadian rhythm. Johnson and Pollard (1991 pp. 84-90) suggest tiredness and stress may be attributable to higher rates of errors for nurses.

Circadian rhythm dysfunction is responsible for both physical and physiological symptomatology. Fossey (1990) and Hawkins (1992) stated eating patterns are disrupted by irregular sleep. Humm (1997) stated a number of medical illness appear to have a rhythmical basis. Such illnesses include angina and myocardial infarction (Mittler & Kripke 1986), asthma (Lemmer & Labreque 1987) and gastrointestinal disturbances (Waterhouse, Folkard & Minors 1992 pp.111-122). Psychological sequelae have been documented as directly attributable consequences of shift work ranging from mood change (Boivin, Czeisler, Dijk, Duffy, Folkard, Minors, Totter dell & Waterhourse 1997) to minor irritability, (Kripke 1981 p.13) to severe depression to full blown psychosis (Humm 1997). Wilson (2002) stated rotational shift workers experience a significantly higher incidence of fatigue, nervousness and inadequate sleep.

Johnson (1999 pp.80-99) found rotational shift workers experienced significantly greater work-family conflict than staff that work regular hours. Women who enter the workforce as new graduate nurses are often forced to seek balance between the responsibilities of work and the responsibilities of home, children and family. Dingley (1996) stated all evidence to date demonstrates that in spite of women entering the workforce, their responsibilities in relation to home and family have not decreased. Female new graduates therefore must grapple with a workplace that frequently does not reflect their expectations, while juggling feelings of anxiety, separation

and guilt about being a good mother while trying not to feel selfish about pursing a career. Grossman (1997 p.604) stated women unlike men tend to be accepting of the '*nurturant imperative'* believing the needs of others come before their own with guilt infiltrating the woman's thoughts, behaviours and beliefs. It was also stated that this phenomena is pervasive in its perpetuation and exacerbation of inner conflict. Taskar and Hirschowitz (2003) stated child care and household management responsibilities, often prevent compliance with good sleep hygiene and ideal circadian schedule. Further, it was stated the role of the shift worker as a spouse can be highly disrupted with a longitudinal study demonstrating a 57% increased risk of divorce.

Conclusion

The literature review has examined the key issues relevant to the participants of this study, who were transitional new graduate nurses entering the workplace. It should be remembered that the participant group of this study included just 4 participants and although the issues raised in the literature are relevant to this group, it is necessary to remember a larger participant group may have produced different or more conclusive results.

Nurse education today seems to promote the acquisition of theory at the expense of practice. The literature review identifies that on entry to the workplace, new graduates do not have the practical knowledge and

expertise necessary to function autonomously as registered nurses. This phenomenon has been labelled the theory/practice gap and has been a source of academic inquiry for thirty (30) years. The theory/practice gap continues to be a significant obstacle for new graduates.

Reality shock is a phenomenon where the place of work in no way resembles the preparations or expectations of the workplace. It seems reality shock is *more* significant today for university educated nurses than when nurse education was conducted in the 'real world' environment of hospitals. The defining difference for today's new graduates is that they experience reality shock as *postgraduate nurses.* Reality shock promotes anxiety and stress for neophytes and continues to serve as a significant factor in attrition of new graduates from the profession on nursing.

There are four (4) generations of nurses working in the healthcare environment. The generations have differing values and attitudes towards what is important in nursing. Generation X, the ultra independent generation have firm views about what is acceptable to them as nurses. The demand for hours of work within areas of clinical preference are impacting upon the retention of these new graduate nurses who, it seems, 'live to work not work to live'. This trend is predicted to exacerbate staffing challenges for nurse planners of the future, as critical staff shortages are forecast to worsen in areas that are less favoured by Generation X such as Aged Care.

Socialisation of new graduates to the wider nursing group remains problematic. Today, the process of socialisation is perhaps more problematic than ever, as new graduates during their three (3) years of undergraduate education have been socialised as *students* not as nurses. Senior nurses frequently express resentment and frustration when required to mentor and supervise new graduates who are not independent in their clinical practice. New graduates face a double edged sword in the workplace. Clinical proficiency is demanded by more senior nurses who, because of staff shortages, abdicate responsibility to new graduates by placing them in clinical situations that are beyond their current level of knowledge and practice. The literature identifies stress caused by overt workplace expectations of new graduates, erodes self confidence, self esteem and consequently impedes the acquisition of practical skills knowledge and mastery.

Successful negotiation of the 'rites of passage' and espousal of behaviours to 'act like a nurse' seem pivotal in acceptance of the new graduate into the wider nursing social group. Failure to adopt the values and attitudes of more senior nurses promotes isolation and 'social limbo' for neophytes. The literature suggests the perceived powerlessness of nurses as an oppressed group, is contributory to how its members respond to its next generation. Nursing is often violent towards its membership, with bullying behaviours

being fairly common in the clinical setting. New graduates are particularly vulnerable targets for horizontal violence by other nurses. This behaviour is a paradox for the caring profession.

The worldwide nursing shortage with its aging population demands strategies that will promote improvement in recruitment and retention of nurses. New graduate nurses today are a product of their university education. It has been estimated new graduates will require a work environment that is supported by willing mentors for an estimated twelve (12) months, the time it has been estimated it takes to master most clinical skills. The large corpus of research pertaining to transitional nurses appears to have little effect upon either organisational integration strategies for new graduates or the behaviours of their senior registered nurse co-workers. New graduates today demand to work in clinical areas of choice, preferably not full time, with hours that are of their choosing. These demands will need to be considered in the future, if nurses are to be retained in the workplace.

Chapter 3

Methodology:

"In theory, there is no difference between theory and practice. But, in practice, there is."

Jan L.A. van de Snepscheut

A qualitative methodology using descriptive, longitudinal critical ethnography

was applied to this study. This is to say that the research tells a story over a period of time and makes comparison of the expectations and experiences of four Australian new graduate nurses with the reality of the clinical environment. Contemporary nursing research, according to Rose and Parker, (1994) has challenged the natural science paradigm as being too limiting to fully describe, forecast and represent the nature of nursing. In support of this statement, Meleis (1992) acknowledged nursing is a human science that encourages research into the lived experience of individuals to attempt to understand its meanings and values. Lo Biondo, Wood and Haber (1998 p.52) stated it is appropriate to focus research so as to facilitate learning and to map the meaning of the lived experience through intensive dialogue with individuals who are living the experience.

The decision to conduct qualitative research was made based on the researcher's need to understand the experiences of seemingly, marginalised, new graduate nurses. Ethnographic research according to Roberts and Taylor (1999 p.112) is research derived from anthropology which seeks to describe a '...portrait of people.' To achieve an understanding of culture, practices and rituals, it is necessary for the researcher to observe the participants in their own environment. Experience of day to day interactions provides insight for the researcher into how different cultural groups exist. This type of research promotes observation, description and documentation of the 'life activities' of cultures and

subcultures. Ethnographic research was an appropriate research methodology for this study, as it was important to identify and understand the effect workplace experiences had upon the new graduates' perceptions and expectations of the role of a registered nurse. Roberts and Taylor (1999) in support of qualitative inquiry stated qualitative research involves discovery of the changing nature of knowledge, which is relevant to the people, time, place and conditions at that moment in the human experience, suggesting the interpretation of the subjective human experience is significant to the social experience of the individual.

Qualitative research

During the seventeenth century empiricism reigned supreme. It was from these beginnings that conceived objectivity arose, in which the physical world was seen, touched and measured. Munhall and Oiler-Boyd (1993 pp. 54-55) stated the known positivistic, scientific community, was drawn from the physical material world and could *always* be associated with validation, significance and the premise of confidence. According to Minichiello, Aroni, Timewell and Alexander (1996 pp.10-24), during the 1960's-1970's digression from known and accepted scientific enquiry occurred. Polkinghorne (1983 p.10) cited the beginning of the post positivistic perspective, articulated by acceptance that '... different language systems reflect different perceptions with the same reality; with humans who are whole beings with ideas of purposive and intentional activity which offer

explanation of human activity by knowledge as opposed to truth as an expression of interpretation.'

The ultimate goal of any type of research according to Dane, (1990 pp.5-7) is to formulate questions and to extract answers. It is not possible to ask all questions and gain all answers from one form of enquiry. Limits must be set and specificity of the research question must be defined. It is the definition of exploration, description, prediction, explanation and action that will provide the nexus between which questions should be asked and which answers should be sought. It was primarily because of the need to better understand human behaviour through the lived experiences of others that qualitative research emerged as a valuable tool of social science.

Minichiello et al (1996 p.10) stated quantitative research 'assumes a fixed or measured reality;' depicting information which is a consistent, reliable, and an accurate generalisation of sample findings to the population of study as a whole. Quantitative research is descriptive of human experience, but it can not account for the rationale of why those experiences have occurred; with assumptions being made about why different people react and interpret different social experiences. Streubert, Rinaldi and Carpenter (1995 p.10) stated qualitative research promotes an understanding of life's multiple realities by description and development of social world, explanatory models and theories. Morse and Field (1996 p.2) offered clarity to this statement

when it was said the emphasis of qualitative research is based upon the *construction* of social models and theories, whereas, the emphasis of quantitative research is on the *testing* of theory. Qualitative research has a dramatically different role in the gathering of information generated within its processes. Essentially, stated Allen (1985) qualitative research offers a willingness to attempt to understand and offer appreciation for i*ndividual* lived human experiences, as apposed to the depiction of positivist enquiry, where *control* is the constitutive interest within the field of study for entire populations. A further distinction between quantitative and qualitative research methodologies is the expectation of what information will be gained from the people participating in the study. In quantitative research, the people participating within the group are referred to as subjects. This role according to Minichiello et al (1996 p.11) is to provide information about preconceived questions. There is little scope for individuality or demonstration of self experience. Alternatively, in qualitative research, the people who participate in the study are referred to as participants or informants.

Qualitative research, is conceptually different from quantitative research, in that it encourages and appreciates the individual experience, rather than relying upon the testing of a hypothesis based on known information extracted from a defined population. Olesen (1994 p.165) stated qualitative research methods depart from the empiricist view of objectivity. It was stated the field of qualitative enquiry potentially revolves around subjective data,

requiring care to ensure objectivity in the methods of data collection and data interpretation. Qualitative research data according to Minichiello et al (1996 p.11) is gained by recording the experience of the participant, most commonly by way of unstructured interviews, or by participant observation. The data from these sources is categorized (then subcategorised) into common themes or threads of shared life experiences. The data is transcribed and expressed in the language of the participants. The data and subsequent analysis describes the participant's experience to the point whereby those who have not had the experience, will gain a clear understanding of what that experience was like for the participants.

Recent literature demonstrates the differing views of the academic and scientific communities regarding choice of research methodology. Strauss (1987 p.13) said positively minded, methodologically reflective scientists disregard information that can be interpreted as soft, individual or subjective, in favour of 'real data' generated as representative of a whole sample group. Polit and Hungler (1989 p. 21) in contrast, stated quantitative methodologies fail to capture the complexity of human behaviour. It was conceded however, the major complexity confronting researchers using qualitative research methodologies is the idiosyncrasies of the central topic of investigation - humans. Streubert, Rinaldi and Carpenter (1995, p.10) stated 'qualitative researchers ... personified a radical difference in their approach and view of the world by the belief in the existence of multiple world realities; offering

commitment to identification of an approach to understanding the phenomenon studied with respect to the participants point of view, by conducting inquiry in such a way that does not disturb the natural context of the phenomena of interest.'

A well documented criticism, which is often viewed as a limitation of qualitative research is that of personal bias. Minichiello et al (1996 pp. 167-188) described several potential ways in which bias enters the quantitative research field of study. Firstly, there is the issue of sample size. Qualitative research sample sizes are usually small as the researcher is usually required to be directly involved with each participant. The qualitative research process is time consuming and constitutes complex social interactions. Dunn, Norton, Stewart, Tudiver and Bass (1994 p. 117) described participant interviews as a limitation of qualitative research, as the findings are not representative of the wider population. They go on to say that qualitative researchers use theoretical sampling which, when associated with the notion of data saturation, does not involve large sample sizes. The researcher recognises the potential for personal bias to infiltrate the findings of this study. The effects of previous encounters of workplace horizontal violence and witness of open harassment of new graduate nurses was fundamental to undertaking this research because of the need to understand more of this phenomenon.

The effects of time and space dimensions of social reality impact upon the quality of the data being sought by the researcher. The site from which an interview is undertaken may affect the participant's degree of comfort and willingness to openly offer information. Minichiello et al (1994 pp.167-188) described the participation time involved in interview recording as a potential deterrent to the participants' willingness to contribute to the interview. Researcher bias has also been identified as a potential effect that may limit the degree of success achieved in what information the participant thinks the researcher is seeking. Dunn et al (1994 pp. 117-118) were critical of quantitative research stating it is usually retrospective to previous studies, using large, representative, easily accessible samples, resulting in 'thin' data which is reflective of the perspective of the researcher, not the participants. The relationship between the participant and the researcher can also be a source of influence upon the data derived from interviews. This is to say the participant can perceive the researcher has a specific point of view and in turn will offer responses that he/she considers consistent with that perception (Minichiello et al 1994 pp.167-189).

It is acknowledged that limitations exist for both qualitative and quantitative research methodologies regarding adequacy and credibility of data. Olesen (1994, p.166) stated when working in areas involving gender, qualitative research is particularly vulnerable to the positivist's criticisms regarding credibility. It is therefore important to offer clear segregation of data to depict

distinctly male and female responses. Morse and Field (1996 pp.2-5) stated issues of rigour have been applied to qualitative research as it was the positivist's view that there exists a lack of control with validity and reliability of the findings. In contrast to quantitative research, there is non acceptance of the concept of single tangible reality. Rather qualitative research acknowledges the existence of multiple realities.

The methodological differences identified between quantitative and qualitative research, are representative of the difference in outlook and view of the world held by the scientific community. Quantitative research methodologies are achieved by the use of statistical tests and hypothesis testing, represented numerically and applied to whole populations. Qualitative research is most frequently acquired by participant observation and interviews with acceptance of the existence of multiple realities, represented as rich information. On the other hand, quantitative data is viewed as 'scientific' and is broadly generalisable to world populations, whereas qualitative research is reflective of the individual, lived, human experience. The arguments for and against each methodology hinge upon how the data is gathered and how it is interpreted. If depth of data is desired, qualitative methodologies are most often used. For breadth of data, quantitative methodologies are most often employed. Both types of research are valuable and equal in contribution to our understanding of the social world.

The framework of the interviews

A significant literature search was undertaken to identify those issues that have been described as relevant to new graduate nurses during their first year of clinical practice. It was important that this study was not limited to the findings within contemporary literature regarding new graduate nurses. Roberts (1988 p.30) warned of the inherent dangers of ignoring the human interpretation of social interactions, as the data could become retarded by overt comparison and matching of the responses of one participant to another. The interviews were deliberately conversational, designed to capture the experience of each individual's integration experience into the clinical arena, not as an undergraduate, but as a qualified registered nurse. A longitudinal study design was developed to facilitate this research project and answer the research question.

The participants agreed at the commencement of the study, that audio taped interviews would be conducted on their first arrival to the health service. Subsequent interviews were held after three (3) months of postgraduate experience, followed up with an interview between six (6) months and eight (8) months after commencement of employment as registered nurses. Provision was made for the possibility of a final interview at twelve (12) months post employment, or until data saturation was achieved. LoBiondo-Wood and Haber (1998 p.218) described data saturation as that point in the

research when the information becomes repetitive with no new ground or concepts arising from the data. It was suggested that participants keep a diary or journal of significant events to be discussed at the ensuing interview. It was important that the interviews be conversational with the same open-ended questions being offered to all four (4) participants. The interview questions were very generally constructed around the recollections of the participants. The interviews were conversational; the participants were encouraged to use their own words. There has been no attempt to cleanse the data or improve upon any grammatical errors. The data was gathered into micro themes, then grouped into macro themes of commonality. The decision to ask general, open-ended questions was supported by Polit and Hungler (1985 p.1985) who described open-ended questions as softer and less direct with the offer of more privacy, to enable the participant to respond comfortably, or reject the question as not relevant to them. Participant interviewing is an effective method of capturing individual reaction, emotion and response to events occurring within the field of inquiry. The audio taped interviews were later transcribed into text by the researcher. Minichello et al (1996 p.65) described the unstructured interview as similar to everyday conversation, which is guided through areas of interest. In this case, the interview guide was the recollections and conversations of the participants.

The selection of participants

The study was undertaken in a tertiary referral hospital in Sydney. For

reasons of employee confidentiality and health service policy, the researcher was not permitted access to the demographic information of newly appointed graduate registered nurses. The researcher provided contact details to enable willing participants to offer unsolicited consent and participate in the research . Each of the participants had been employed via the NSW New Graduate Nurse Recruitment Consortium. A total of 31 new graduate nurses were expected to commence employment on 31st January 2000. The invitations to participate in the research, overview of the project and consent forms were sealed with return postage paid envelopes. The invitations were randomly distributed by the Employee Services Department to the new graduate inductees. The envelopes were addressed accordingly and issued via Australia Post. Four (4) responses with signed consent forms indicating a willingness to participate in the study were returned. These four responses constitute the study group of this research.

Overview of the study setting

The interviews were scheduled in advance, at a time that was convenient to the participants. The researcher encouraged the participants to cancel and reschedule interviews should the agreed time be no longer suitable to them. The researcher by mutual agreement conducted the interviews at the homes of the participants. Calnan (1988) in support of Callery and Luker (1996) stated sensitive qualitative research conducted with participants in their own homes increases satisfaction for the participants, as the privacy of a

comfortable environment encourages reflection and the confidence to use their own words. Participant interviews capture qualitative data such as job satisfaction, which, because of the limited scope of questionnaires is often under represented in quantitative studies. The decision to conduct the interviews from the homes of the participants was based on the need to ensure privacy and anonymity for all involved in the research. Foucault (1988 p.126) emphasised the role of the researcher as the receiver of often time's confessional information. It was important during the course of the interviews to generate a feeling of safety, security and trust for the participants, as it is ultimately the researcher who solicits and passes judgement on the confession.

Ethical considerations

Pseudonyms for the participants were used as recommended by Hockley (2000 p.8) to protect the anonymity of the participants and ensure data confidentiality was maintained. It was relevant to this study to limit the focus of the interview questions to the participant offering the information, with limited interjection from the interviewer. It was important to limit the interview findings to the individual participant and not be tempted to generalise that experience across the spectrum of the study as representative of the contemporary nursing profession.

A further ethical consideration was the power relationship, which existed

between the researcher and the participants. The researcher as a senior nurse manager frequently had the opportunity to speak with and indeed indirectly 'supervise' the participants when they were on duty. The potential for influence based on the power relationship was discussed prior to the initial interview. It was agreed that all conversations regarding the research would be conducted face to face at an agreed venue. It was important to both the researcher and the participants that anonymity was guaranteed for all. It was also agreed, that any information extrapolated from the interviews be treated confidentially within the research and would not be referred back to the health service or addressed as issues for new graduate nurses. The researcher encouraged the participants to refer all of their workplace issues and conflicts to their local managers. A trust relationship was established between the researcher and the participants to ensure that regardless of the sensitivity of the data, anonymity was guaranteed for the participants.

Griffith (1991 pp. 1-6) described the principle of beneficence – that is "above all, do no harm". In this research project, it was particularly important to guarantee anonymity and the right of withdrawal from the study. These parameters were understood and accepted by the participants and the researcher. Johnstone (1991 p.57) in support of this protectionist approach to the participants stated 'as research in nursing by nurses becomes more prevalent and more complex, so too do questions of moral responsibility in research.' Failure to consider the inevitable effect of personal values and

interpretation of participant responses to questions can, as described by Harding (1987 pp. 167-169); Hall and Stevens (1991) and Rosser (1989) increase the risk and potential for a number of undesirable moral consequences such as marginalisation of important research questions, biased collection and interpretation of data and unethical data collection.

The participants

Alexis: Is a 21-year-old woman who is not married and has no dependants. There are no other nurses in Alexis' immediate family. Alexis lives at home with her parents and wanted to be a nurse for '... the people side of things.' She has previously worked in a nursing home as an assistant in nursing, during her second and third year of university enrolment.

Winnona: Is a 42 year old married woman with five children ranging from eleven to twenty-five years of age. There are no other nurses in her family. Winnona lives with her family and has always wanted to be a nurse for '... the caring side of things and because of an interest in the human body and how it works.' She has previously worked for six years in a nursing home as an Assistant in Nursing.

Tenielle: Is a 34 year old married woman who has a five year old son and a fourteen year old daughter. Her mother was an enrolled nurse '... back when they could do more'. She also has a cousin who is a registered nurse.

Tenielle lives with her family and has always wanted to be a nurse because she 'loves people, being with people and helping people.' She was an enrolled nurse prior to studying at university to become a registered nurse.

Evette: Is a 34-year-old woman who is married and who has three children whose age's range from seven to thirteen. There are no other nurses in her family. She is proud to be the first *professional* in her family. She regards herself as '... the alien in the family' because she is the first to hold an academic qualification. Evette had previously worked as an enrolled nurse in theatres prior to commencing her nursing degree. She wanted to become a registered nurse because '... you can do a little bit more for patients ... and you get to use the ole grey matter a bit.'

Summary

The thesis now continues with Chapters 4, 5 & 6, chronologically describing those experiences which occurred following commencement of employment in the Sydney metropolitan hospital, during the first year of clinical experience. Chapter 7 represents the data analysis and conclusions of the project. Implications and future directions are discussed in the final chapter.