

2010

A phenomenographic study exploring nursing education and practice

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A phenomenographic study exploring nursing education and practice

by

Greta M. Degen

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Education (Educational Leadership)

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Ames, Iowa

2010

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DEDICATION

*There's an elephant in the room.
 It is large and squatting, so it is hard to get around it.
 Yet we squeeze by with, "how are you?" and "I'm fine"
 And a thousand other forms of trivial chatter.
 We talk about the weather.
 We talk about work.
 We talk about everything else – except the elephant in the room.
 There's an elephant in the room.
 We all know it is there.
 We are thinking about the elephant as we talk together.
 It is constantly on our minds.
 For, you see, it is a very big elephant.
 It has hurt us all.
 But we do not talk about the elephant in the room...*
 (Excerpt from Terry Kettering's (2008) "Elephant in the Room")

Last year a nursing friend who was also a faculty member stood up at a largely attended nursing function and stated to a highly powerful politician in attendance, "There is no difference between two and four year nurses." As I looked around the room, I was struck by the silence from all the attendees. She had touched on a nerve that none of us would agree on nor feel empowered to debate. The nursing profession is suffering under the disjointed effects of different educational programs to prepare nurses for practice, but we don't have enough evidence to convince ourselves to unify our educational preparation. Although we should be seeking answers together for the good of the profession instead of taking these debates personally, two and four year faculty members are hesitant to antagonize one another in discussions to define standards of preparation for nurses. Nursing has its own "elephant in the room"—that of differentiated education to prepare nurses for practice. This differentiation thwarts the ability of nurses to speak in a unified voice during a time of critical health reform. This dissertation study is dedicated to nurses like me who are still searching for answers regarding how to educate the nurses of tomorrow.

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ABSTRACT

The purpose of this study was to illuminate the qualitatively different ways in which three nurses with an associate degree (ADN) and three nurses with a baccalaureate degree (BSN) experience, conceptualize, perceive, and understand their own nursing practice within the context of their educational background. Using a phenomenographic methodology for qualitative inquiry and data analysis, findings of this study revealed two main differences between the nursing practice of newly graduated ADNs and BSNs: (1) ADNs focused on their (a) education as the means and their practice as the end result, over which (b) the nurse has no ultimate control (external locus of control); whereas (2) BSNs focused on their (a) education and practice as an ongoing process, and how (b) the nurse him/herself is in control of his/her own learning processes and practice (internal locus of control).

CHAPTER 1. INTRODUCTION

Introduction and Problem

In 1949, nursing educational choices were diversified from a three-year degree (hospital diploma programs) and a four-year degree (baccalaureate degree) to include a two-year degree (associate degree) based upon research by Dr. Montag of Columbia University (Anderson, 1999). In an attempt to increase the amount of nurses in the workforce and, thus, decrease the nursing shortage at that time, Montag (1951) theorized that the functions of nursing were on a continuum of three: from simple (assisting) to intermediate (technical) to complex (professional). Her proposal was to give simple functions, which are based upon common knowledge and on the job training, to nurses' aides who were already beginning to be hired in the workforce; and to split the other functions of nursing into intermediate (technical) and complex (professional) functions. The addition of a "nurses technician" (p. 9) was suggested, to focus only on the technical skills of nursing which require lesser skills and some judgment, as compared to the professional nurses' functions that require expert skills and expert judgment. Professional nurses, Montag (1951) proposed, would continue to be prepared in universities and colleges, while only two years were required for preparing the nurse technician for technical functions.

Although the two-year "technical" nurse was clearly intended to be a different kind of nurse than the four-year "professional" nurse, this practice differentiation has not occurred as Montag had envisioned. Today, the two-year preparation for nursing is considered an equivalent alternative to four-year education in nursing by the employers who hire nurses. In the first decade of 21st century, nurses from all educational backgrounds continue to take the

same licensure examination, and are hired equally by employers and at the same beginning salary level (Kidder & Cornelius, 2006).

There are numerous public perceptions about nurses that are influenced negatively by this multilevel-educational entry into nursing practice, such as the status and appeal of nursing, the public's overall perceptions of the practice of nursing, and nursing's acceptance as a profession rather than an occupation or vocation (Kidder & Cornelius, 2006; Rabetoy, 2005). Nursing has long been chastised for its failure to come together and speak out about patient care (Buresh & Gordon, 2000) but, perhaps, nurses cannot come to a table if they are split into factions depending on educational level. For those in nursing today, and especially for nursing faculty, the differences in the educational levels of nurses are, perhaps, one of the greatest barriers to connecting and working with other nurses. "Lack of unity has caused RNs to lack autonomy and authority to influence their future" (Kidder & Cornelius, 2006, p. 19).

One way that employers have dealt with the multilevel entry into nursing practice, is through "differentiated practice models" (Harkness, Miller & Hill, 1992, p. 26). These models seek to clarify expectations that are consistent with the expected competencies of graduates from different kinds of educational programs. However, since the 1980s, researchers have failed to identify what competencies are integral to educational background, and the literature has begun to suggest that the "differences between associate degree and baccalaureate degree programs may not greatly affect nurses' ability to perform basic nursing tasks" (Karp, Jacobs, Hughes, 2002, p. 38). Examples of a two and four year course of study in nursing programs in the Midwest are included in Appendix A and B, and are discussed in the literature review and data analysis.

Community colleges offering associate degrees in nursing have grown exponentially with the help of governmental influence and funding, and numbers of their nursing graduates are increasing rapidly. More than half of the practicing nurses in the United States now have an associate's degree (Health Resources Services Administration, 2005). Although there have been ongoing discussions about how to differentiate the practice of two and four year nurses, the literature, research, and the public eye have turned almost exclusively to discuss the looming nursing shortage as well as potential ways to accelerate the education of more nurses. According to the Joint Commission on Accreditation of Healthcare Organizations (2005), there are 126,000 nursing positions currently unfilled in hospitals across the country, with an accelerated amount of baby boomers aging and living longer, which will produce an even greater demand for nurses. The same organization estimated that, by 2020, approximately 400,000 fewer nurses will be available to provide care than will be needed (p. 5). A growing shortage of registered nurses threatens patient safety and health care quality.

State licensing boards for nurses have been situated perennially under state governmental control (Anderson, 1999). According to the Iowa Nurses Association Legislative Connection (2007), 100% of nurse licensure fees paid to the state treasurer and added to the General Fund were not appropriated back to the Iowa Board of Nursing until 2008 (in comparison, at least 100% of the Board of Medicine's licensure fees have always been appropriated). To what extent and how ethical it is to have governmental monies controlling the regulation of a profession and profiting from a percentage of the nursing licensure fees is a debate that would require too much influence to tackle as a doctoral student. Nevertheless, it is important to the extent that it be recognized that government has now placed itself as a stakeholder in both developing the two-year programs for nursing

(through governmental funding for students of community colleges and use of licensure fees for budgetary matters other than nursing) as well as the current practice of funding the licensure of all nurses equally, regardless of education or preparation.

Although the associate degree in nursing was never intended to be an equivalent alternative to the more professional baccalaureate degree in nursing (Montag, 1951), the government has bought into and sanctioned this practice. Such governmental influence may impair the power and motivation of nursing boards and the nursing community to investigate the differences in education and the resulting practice of nursing. It falls to researchers, then, to produce the impetus for ongoing discussions about nursing education and practice.

Purpose

The purpose of this study was to illuminate the qualitatively different ways in which associate degree (ADN) and baccalaureate degree (BSN) nurses experience, conceptualize, perceive, and understand their own nursing practice within the context of their educational background. The nature of phenomenographic methodology is to find differences. This research provides a deeper understanding of the differences between associate and baccalaureate degree nurses in their experience of practice as nurses caring for patients. The research contributes to the body of knowledge focused on the need to unify nursing educational requirements through differentiation of practice or licensure. This body of knowledge is commonly known in nursing literature as the “entry into practice or ‘differentiation of practice’ ” debate.

Interviews were conducted with nurses who have associate and baccalaureate degrees to understand the meaning respondents constructed regarding how they experience and

practice nursing. The practice of nursing is the phenomenon that was examined for connections between nurses and their educational backgrounds. The interviews enabled the researcher to view the world as it appeared to the respondents, and to develop a perspective of the differences in meaning according to the respondents' educational backgrounds. Seeking to find differences in respondents' perceptions (called "conceptions") is described as qualitative phenomenographic research (Merton, 1981). The interviews are examined for "qualitatively different categories of meaning" (Stromberg, 1997, p. 37). The current research sought to clarify and focus on patterns of differences identified in the interviews.

Research Questions

The purpose of this research was to examine the practice and perceptions of recently graduated nurses with associate (ADN) and baccalaureate degrees (BSN) to examine differences. Examining these differences within the lens of phenomenographic inquiry, the focus of the interviews was to discover patterns of thought and behavior related to the respondents' educational background as they explored their conceptions of the education and practice of nursing. Interviews from the two groups of respondents (ADNs and BSNs) were first explored to determine within group similarities which were subsequently compared and contrasted between groups. Themes emerging from these comparisons were examined to provide answers to the following research questions:

1. What are the differences between ADNs and BSNs as related to the meaning and values they place upon education and practice?
2. What are the differences between ADNs and BSNs as they relate and interact with persons during their education and practice?

Significance of the Study

A review of the most current nursing literature revealed that the connection between educational level and the practice of nurses was studied by Aiken (2003). Aiken examined the patient mortality rates in a hospital and found that a 10% increase in the "...proportion of nurses holding a bachelor's degree (versus a two or three year degree) was associated with a 5% decrease in the likelihood of patients dying within 30 days of admission with an odds ratio, 95% confidence interval" (p. 1,620). Aiken pushed for greater emphasis in national nurse workforce planning on policies to alter the educational composition of the future nurse workforce toward a greater proportion with baccalaureate or higher education (p. 1,623). Aiken's study stands out clearly from others of this nature because, until now, expertise in nursing was measured not by educational level, but by years of experience or by levels of critical thinking skills (Benner, 1984). Benner described the four stages of knowledge acquisition from novice to expert and posited a theory explaining how nurses, through time and critical thinking skills, can progress from one level to the next. Benner's research did not study the correlations between level of education and the level of expertise of a nurse.

Although the literature review did not reveal many differences there may be between nurses with different educational levels, some conclusions can be drawn from Aiken's study. First, the Aiken (2003) study established that differences between educational levels do exist in practice, but no significance was found for years of experience among the same nurses in the current study. This stands in stark contrast to any assumptions about how nurses from all educational levels can improve their practice purely by experience (Benner, 1984). The current research sought to add to the body of knowledge about how educational backgrounds

can affect the practice of nursing. It was the goal of this study to add to the discussions about quality of nursing practice.

Theoretical Framework

This study was conducted through the lens of the nursing theory of Human Becoming by Parse (1981, 1987, 1992, 1998). Parse's new worldview added to Roger's (1984) earlier works to bring the paradigm of nursing into a qualitative, philosophical school of thought regarding health care. Early major nursing theory tended to describe and theorize about nursing as a bio-psycho-social-spiritual discipline, interacting and adapting to an environment in an effort to maintain equilibrium and achieve the goals of patients. Nursing was viewed by theorists – and nursing, itself – as an extension of medical, quantitative science, whereas Parse saw the possibilities for nursing to emerge on a qualitative, philosophical level, with roots in the human (as opposed to the natural) sciences. Parse introduced a new theory of nursing as an alternative to the past nursing theories that were posited in the natural, quantitative and medical approach to nursing; she initiated another worldview of nursing as the simultaneity paradigm which views man as “a unitary being in continuous mutual interrelationship with the environment” (1987, p. 136). Parse's theory integrates the philosophies of Heidegger, Sartre, and Merleau-Ponty to make assumptions about humans and health. These assumptions about health are inherent to the current study and are further discussed in this section.

The basic concepts of Parse's theory are: intentionality, human subjectivity, coconstitution, coexistence, and situated freedom. Although each of the concepts is explicated in great detail in Parse's theory, for the purpose of the current study, the most

important aspect is that each of the basic concepts can be synthesized. The process of synthesis is the main tenet of Parse's theory—that the basic concepts are combined to create something new and different. For nursing, it means that what patients (or “humans” as Parse later began using the term in her theories) try to achieve together with their health care providers and nurses for their health is new and different in every case—to be determined together with the patients. This new process is opposed to the medical and quantitative view of diagnosis and treatment of patients towards a specific, medical goal. Although several nursing theorists have begun to discuss the emerging, holistic view of nursing, none have broached the philosophical and phenomenological nature of Parse's theory.

Parse (1987) identified three main principles of nursing that bring the aforementioned concepts together: meaning, rhythmicity, and cotranscendence. These principles will be explicated in greater detail as follows. Although there are many other tenets of Parse's theory, discussion of these main principles help to illuminate the rationale for the current study: Using Parse's definitions and assumptions about each principle, the three principles are discussed in depth in this chapter. The principles are applied in data analysis and revelation of the findings of this study.

1. Principle of Meaning: Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging (Parse, 1992).

Parse related the concepts of imaging, valuing and languaging, showing that lived experiences drive all meaning that humans attach to reality. The meanings that humans reveal can be through languaging (speaking and movement), valuing (the process of living one's beliefs) or imaging (explicit or tacit knowledge). Cocreating involves humans' participating with one another and their environment in the act of developing meanings.

The impact of this principle upon the current study is that nurses show how they structure meaning through their use of language, their lived beliefs, and their knowledge. Parse (1992) defined nursing as a scientific discipline, the practice of which is a performing art. How nurses cocreate reality with patients in the health care system is something tangible and can be identified through interviews and observations of these nurses. It was inferred in this study that two and four year degree nurses will most likely use this principle in different ways, attributed to their educational lived experiences, and that these differences will emerge. The research sought to illuminate the differences between two and four year degree nurses by conducting interviews in which nurses display their use of the principle of languaging, valuing and imaging to describe their own nursing practice. Stories that participants shared in their interviews were analyzed for language, values and images they chose as important enough to share.

2. Principle of Rhythmicity: Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting, while connecting-separating (Parse, 1981).

Parse interrelated the concepts of revealing-concealing, enabling-limiting and connecting-separating in life. This principle considers the manner in which humans live in a paradox of these concepts, while simultaneously developing their own patterns of living in the universe. The concepts seem to be opposites of one another but, according to Parse, they are two sides of the same rhythm and are simultaneous: creating relationships allows people to both reveal and also conceal parts of themselves; decision-making both enables and limits an individual; and existing in our world allows us to both connect and move apart from others. According to Parse, in nursing, we must move within these paradoxes, in our own lives and in that of our patients, in our attempt to exist with others to help them recognize

their own harmony and patterns of being. Parse stated that our goal is not to balance the paradoxes in which we live or see in others, but to help humans see new possibilities. As nurses, when we discuss the meaning of situations with patients and their families, the meaning of those situations changes both for them and for us.

To recognize and coexist within these paradoxes in our own and others' lives, means to bring a large amount of innovation and creativity to a situation (Parse, 1981). A nurse must be able to think beyond the normal boundaries of the health care system, which focuses on balance and goal-oriented treatment, to allow the patient and oneself to develop individually.

According to Stewart (1929):

The real essence of nursing, as of any fine art, lies not in the mechanical details of execution, nor yet in the dexterity of the performer, but in the creative imagination, the sensitive spirit, and the intelligent understanding lying back of these techniques...all our elaborate scientific equipment will not save us if the intellectual and spiritual elements in our art are subordinated to the mechanical, and if the means come to be regarded as more important than ends. (p. 1)

This creativity is feasible in a nurse, but only when that nurse has been given opportunities to experience and value such creativity. The current researcher's premise is that a two-year nursing degree—which, by nature of its short-term goal of achieving the licensure exam—provides less time to promote creativity or value of such in nurses. Instead, two-year degree nurses are given the shortest time to digest explicit knowledge to be able to regurgitate it for the licensure exam. To what extent does a liberal arts degree, whether by nature of the extension of time allowed to study nursing, or by the liberal arts curriculum content, serve to enhance a nurse's perception of creativity and value in self and environment? For the purposes of this study, are there differences in the way in which two and four year degree nurses think creatively about and use the interrelationship of these concepts in their nursing

practice? In this study, observation data were analyzed to determine the nurses' perceptions of valuing creativity in their own practice.

3. Principle of Cotranscendence: Cotranscending with the possibles is powering unique ways of originating in the process of transforming (Parse, 1987).

Parse stated that the way we move beyond the actual meaning of the moments we encounter to that which is "possible" (p. 167) defines how well we can change or increase our own diversity in nursing. By being with patients and helping them discover their possibilities, both the nurse and the patient and others can transcend the actual moment to embrace change and new ways of thinking about the situation. To power unique ways of originating is how nurses interact with each person they encounter to enhance the process of transforming, or moving beyond the situation at hand to embrace the possibilities.

Parse's (1987) third principle illuminates how nurses interact with situations and patients. Parse stated that the authority, responsibility and consequences of decisions are given to the patient. Nurses must help empower new ways of looking at health issues within the patients and families they encounter, not by placing values or goals, but by listening, and being willing to facilitate change in themselves and others about new, emerging possibilities. Diverse challenges in the education of nurses widen their horizons which, in turn, empowers them to encounter patients in new ways. In terms of the current research, interviews and observations with nurses illuminated the differences in the ways in which two and four year nurses approached and dealt with patients and families and health care situations. Different nursing practices and different ways of valuing these encounters and change were evident between the two and four year nurses.

Differences were found using the three principles of Parse (1992) in talking to and observing nurses in their practice. Therefore, these principles can be applied to the current study. Parse believed that the "...knowledge and beliefs (of a nurse) are there in the way the nurse approaches the person, the way the nurse talks and listens to the person, what the nurse is most concerned about and how the nurse moves with the flow of the person" (p. 147). Parse's theory focused on illuminating meaning and moving beyond the person/family to changing health patterns. The client, along with the nurse, determines the activities for changing health patterns, and nurses provide the "...true presence to promote health can the quality of life" (1987, p. 169). Although the traditional role of nurse as counselor, leader, caregiver, and advocate is not congruent with Parse's theory, the roles of teaching as illuminating meaning and acting as a change agent are quite important in her principles.

Based on this theoretical framework, differences in the importance placed on teaching and acting as change agents were found during data analysis. Themes emerged by using this theoretical framework to view the perspectives, language, values, and statements from participants during interviews and observations with two and four year nurses about their practice. Two overarching differences in how two and four year nurses perceive their nursing education and practice are discussed in this study. In addition, new possibilities and conclusions frame the discussion of this study which may enhance the way we study, educate, value, and practice nursing.

Limitations

This study was conducted to find new ways to explore differences between ADN's and BSN's. This study was limited to six new graduates (within six to twelve months), from

four different schools of nursing, who were working in obstetrics in four different hospitals in the Midwest. Nevertheless, it is possible that some of these findings are applicable to the practice of other ADN and BSN nurses.

Delimitations

This study was delimited to nurses with two and four year educational backgrounds practicing in obstetrics in main hospitals in the Midwest, within twelve months of their graduation. Nevertheless, it could provide useful information to all nursing educators and employers of nurses in the United States in similar contexts.

Researcher's Positionality

I have been teaching at a small liberal arts college for eight years. Recruited from the field of obstetrics and community health, my teaching passion lies in the explication and discovery of the social responsibility of nurses to their own profession; how nurses attain professionhood in health care. I teach a professionalism class to both incoming sophomores and outgoing seniors, as well as many other courses, including those offered to associate degree nurses who return to receive a baccalaureate degree. Our college developed a curriculum that focuses on developing nursing students' social responsibility to society (among other things). I am encouraged daily to apply teaching pedagogies to enhance their investment in their profession, such as joining a professional nursing association and using this as a clinical site to explore how nursing can impact policies in society.

My teaching philosophy is to encourage, support and motivate students as we discover new issues that impact the nursing profession and society together. Being a co-discoverer with my students means that I learn daily from my students as they learn from me,

and that the sum of what we can accomplish together is much more than we could each accomplish individually. Together with my students, each class is a new adventure and we discuss issues as they pertain to our profession, and to our society to find common grounds of resolution.

As the researcher was the primary instrument used in this study, potential personal bias must be noted. As a previous labor and delivery nurse, I am familiar with different nursing practices and skills used in the labor and delivery and postpartum (obstetrics) units of Midwestern hospitals. Observations and descriptions of obstetrics' practice by respondents enabled me to examine data within a familiar context. I was also able to examine data for what was present as well as what was missing in obstetrics nursing practice. Newer graduates (within twelve months of graduation) were selected as respondents, so that their obstetrics' practice was not influenced by any previous experience. However, they may have had differing experiences as student nurses in clinical rotations at these hospitals that influenced their practice, spending extended or limited amounts of time in obstetrics due to the nature of the school rotation schedule, using obstetrics as an internship setting, personally knowing other nurses practicing in the same obstetrics unit, etc. These are unknown factors. As a nursing faculty member, I know many students and graduates. All but two of the respondents were graduates from different schools of nursing and I had never encountered them prior to the study; the two other respondents were familiar with me, but I had not instructed them in any nursing courses and our relationship was not close.

In order to minimize bias, I maintained focus throughout the interview questions and in all interactions with the respondents. The respondents were asked to reflect solely upon their own practice and their education in nursing. Disclosure and willingness to share might

decrease from respondents just by knowing that the researcher is from a four-year education or teaches at a four-year college, so disconfirming evidence was sought on the topic as the interviews unfolded. Differences/themes/connections between the educational background and nursing practice were a focus only for analysis of the findings, not of the interview and interview questions itself (Ashworth & Lucas, 2000). The questions asked were not about differences between their education and practice; rather, they enabled the respondents to describe their own practice and develop their own meaning in answers. Themes of difference emerged based upon the research questions, as the respondents shared their conceptions of their practice of nursing. As they emerged, I sought to minimize bias by focusing on modes of experience and patterns of thought of the respondents.

Definitions

The following terms were defined for use in this study:

Associate Degree nurses: Those who study at two-year institutions. Generally, these students license themselves as Licensed Practical (one-year) nurses after the first year of study and as Registered Nurses after the second year of study. Typically, these courses of study are found exclusively within hospital centered or community colleges (Committee on Nursing Education, 1965).

Baccalaureate Degree nurses: Those who study typically in liberal arts colleges and universities for four years before they are licensed as Registered Nurses. There are also completion degrees in baccalaureate degree programs offered to two-year graduates who seek to complete their four-year degree after licensure as Registered Nurse at two years (Committee on Nursing Education, 1965).

Conceptions: The perceptions of reality that a respondent has about a phenomenon of interest, in this case, the practice of nursing (Marton, 1984; Richardson, 1999).

Licensure of nurses: A state-regulated online testing of graduates from an accredited nursing program. Results are given in terms of pass or fail, with a 95 % confidence rate to meet the national standards as decided by computerized adaptive testing and set by the National Council of State Boards of Nursing. License renewals occur every three years upon completion and submission of proof of 36 hours of continuing education (National Council of State Boards of Nursing, 2009).

Phenomenography: The approach and methodology of research that seeks to discover and classify categories of differences in respondents' conceptions (Richardson, 1999).

Practice of nursing: Refers to any nursing skills, interventions, critical thinking and judgments that take place by a Registered Nurse while working for an employer. In terms of this research, employers are exclusively hospitals in the Midwest.

Organization of the Study

In this study, nurses from a two- and a four-year degree nursing program were interviewed about their practice of nursing. Using a phenomenographical approach, respondents' answers were categorized and compared for differences. Chapter 1 describes the basic outline for the proposed study. A more detailed literature review in Chapter 2 situates the necessity for this research within current nursing literature and experience. Chapter 3 describes epistemology and theoretical perspectives, methodology, methods, and data analysis in detail. Chapters 4 reports the findings, and Chapter 5 contains a detailed discussion and summary of this study.

CHAPTER 2. LITERATURE REVIEW

Introduction

This review of literature seeks to clarify where nursing stands currently regarding the issues pertaining to this study—the educational processes and outcomes of the nursing degree. A wide range of literature on the practice of nursing, historical trends in nursing practice, the curriculum of both two and four year nursing programs, the licensure exam, and employers' preferences for hiring nurses was reviewed to clarify the focus of two and four year degree nursing education, as well as identify trends in nursing pertaining to the differentiated practice issue. Research about differentiated practice pertaining to the education of nurses seems to be a topic that had been put aside since the 1960s but has recently emerged. The reason for the current resurgence of this research seems to be the looming nursing shortage, which brings with it quantitative issues regarding the number nurses America is losing and how many new nurses can be educated rapidly. Few researchers seem to recognize the importance of quality of nurses; this should also be a consideration in the search for the answer to the nursing shortage. The following literature review reflects on current trends in nursing that may affect or be affected by this study, including the continued need for nurses, various themes in nursing education, and entry level to nursing practice.

The Continued Need for Educating Quality Nurses

There are currently hundreds of thousands of nurses in the working world, comprising one of the largest existing bodies of professional women and men. They function in a vast array of settings, so varied, so constantly expanding that it seems almost to defy limitation. Nurses are involved in that vital field of human effort concerned with health care. In addition, the complex mechanism of the modern hospital cannot function without an organized body

of nurses. The need for nurses is as great today as it was in the past. (Donahue, 2004, p. 3)

Nursing still plays a vital and relevant role in the health care system today. Thus, the education of good nurses is a vital aspect of health care in today's society. The challenges in today's health care can be huge and overpowering; therefore, the quality of nursing education must be increased and enhanced to meet these challenges as a necessary part of reforming our health care system.

Nursing must (today) again move in the direction in which values of individual human dignity, quality caring, and humanitarian concerns are emphasized, even while being forced to cut costs...the nurse must be the conduit of care, keeping the focus on humane patient care while seamlessly weaving the science of nursing with the art of nursing. (Donahue, 2004, p. 8)

The current study seeks to emphasize the need for quality nursing care. Hess (1996) stated: "...just as the number of nurses must be adequate to meet demand, the profession's commitment to ensure the competence (quality) of its members also must be demonstrated" (p. 294).

Themes in nursing education

Themes which have followed the development of nurses throughout American history are: politics, power, gender, economics, and technology (Donahue, 2004; Anderson, 1999). Nursing education has readjusted and redesigned its structure and curriculum to meet these new challenges throughout time. One issue still remains as much debated today as it was in the past—the base of education for a nurse. The issue of whether nursing is a profession and, as such, needs to be built upon a liberal arts education is an issue that is still discussed at length in nursing today. The idea of building the profession by using "liberal arts degrees ...as a basis for excellence in nursing" (Donahue, 2004, p. 12) has always appealed to nurse

educators, and was even embraced by the professional nursing association in the 1965 (The American Nurses Association), but has never been enforced. Instead, in 1951, a landmark study by Montag (1951) proposed the two year nursing degree (“education of nurse technicians”) in response to a looming nursing shortage. “In times of shortage, there is usually a call to reduce educational requirements and to change licensing and accreditation standards” (Donley & Flaherty, 2008, p. 2). At that time, it was perceived that the two-year degree would provide for an “assisting” nursing role for the four-year nurse. Instead, the challenges for receiving accreditation and licensure approval for the new two-year degree was so great that, when the approval was given for the two-year degree:

...differentiation between and among those prepared in different kinds of programs through the development of different licensing mechanisms was not attempted. Therefore, even today, one licensing exam, now called the NCLEX, is used to test all students irrespective of whether they have been educated in hospital, community college, or senior college and university programs. (Anderson, 1999, p. 56)

Many nurses feel that this practice must not continue. Shapiro (2002) purported that most justifications for continuing to maintain current standards (two and four year nursing education) follow one of two lines of thought. The first maintains that change is unnecessary because bachelor’s degree nurses do the same work that associate degree nurses do. “While it’s true that both may perform the same work in hospitals, bachelor of science nursing graduates know more...the second argument holds that raising the academic bar will close off an avenue to those who lack the opportunity or means to pursue a BSN...until now we’ve kept RN education accessible and affordable-to the detriment of both our profession and our patients” (p. 11).

Shapiro (2002) maintained that it is possible to discuss the value of the BSN without devaluing the contributions of the associate and diploma degree nurses. “No one would deny that they are skilled and committed professionals, but we must prepare nurses for the future, which promises to pose more rather than fewer challenges”(p. 11). The need for the current study exists within the nursing arena today more than ever. It is important to continue raising the question regarding the quality of nursing education.

Practice differentiation or entry level to practice

There are two ways to look at resolving the issues of different paths in nursing education. One is to embrace the currently very popular two-year degree, but to differentiate those who practice with two-year degrees from those who obtain four-year degrees by nature of licensure, compensation, and role. Another way to resolve this issue would be for nursing to agree on a minimal entry level to practice for all nurses. The literature reviewed next pertains to research that others have conducted on these two issues. Although none of these authors reached any earth-shattering decisions about how to resolve the issue, the research helps to highlight the importance of congruency among nurses on nursing education. “We are entering the 21st century without consensus on the appropriate system for conveying nursing knowledge” (Hess, 1996, p. 291).

One recent, landmark study stands out for current nursing practice on the differences between two and four year degree nursing practice. Aiken (2003) published a study that revisited the differentiation of practice in nursing. Aiken researched patient mortality rates in a hospital and found that a 10% increase in the “...proportion of nurses holding a bachelor’s degree (versus a two or three year degree) was associated with a 5% decrease in the

likelihood of patients dying within 30 days of admission with an odds ratio, 95% confidence interval” (p. 1620). Aiken used her study to push for greater emphasis in national nurse workforce planning on policies to alter the educational composition of the future nurse workforce toward a greater proportion with baccalaureate or higher education (p. 1623).

The National Advisory Council on Nurse Education and Practice (NACNEP), policy advisors to Congress and the U.S. Secretary for Health and Human Services on nursing issues, has urged that at least two-thirds of the nurse workforce hold baccalaureate or higher degrees in nursing by 2010. Currently, only 43 percent of nurses hold degrees at the baccalaureate level and above. (American Association of Colleges of Nursing, 2005, p. 1)

The current study adds to the discussion on whether more baccalaureate nurses should be educated.

Aiken’s (2003) study stands out clearly from others. Until recently, expertise in nursing was measured not by educational level, but by years of experience or levels of critical thinking skills (Benner, 1984). Benner conducted a study to determine how nurses progressed from the beginning role of novice to that of an expert. She decided that acquisition of knowledge was the basis of this progress. Benner described the four stages of knowledge acquisition from novice to expert. Her theory revolved around how nurses, through time and critical thinking skills, can progress from one level to the next highest. A great nurse, she theorized, is not based on the educational background, but on progress through levels of knowledge acquisition. She chose not to determine any correlations between the level of education and the level of expertise of a nurse.

Although the literature review did not reveal what kind of differences there may be between nurses with different educational levels, some conclusions can be drawn from the Aiken study. First, the Aiken (2003) study established that significant differences do exist, in

this case in patient mortality rates (within similar hospitals and similar units of care); and, when controlling for nurses' years of experience, no significance was found. This stands in stark contrast to any assumptions about how nurses from all different educational levels can improve their practice purely by experience (Benner, 1984). The importance of Aiken's study is also that it is put into terms (patient mortality rates) that can be easily understood and used by hospital administrators and executives. Although the purpose of the current study was to add to the discussion about how nurses practice differently, the audience for my research was the nurses, themselves. I hope to add to the body of knowledge about how educational backgrounds can affect the practice of nursing so that nurses can have more evidence to impact changes in our educational system.

Other authors have been interested in the extent to which nursing practice, nursing education, and years of experience vary across the health care setting. A meta-analysis by Kovner and Schore (1998) concluded that there was "...no consistent or systematic association between type and amount of previous nursing experience and current nursing practice" (p. 99). Kovner and Schore did conclude, however, that there is "evidence of a consistent and systematic association between baccalaureate preparation and level of registered nurse practice" (p. 99). Their recommendations centered around using more baccalaureate-prepared nurses in positions associated with more complex practice and greater responsibility that requires better problem-solving, decision-making and leadership.

Kovner and Schore's (1998) analysis is important to the current study in two ways: first, during interviews I expected to find the baccalaureate nurses describing their practices with greater emphasis on the three areas these authors discovered (problem-solving, decision-making and leadership); and secondly, if baccalaureate degree nurses emerge as different in

practice than two-year nurses, the recommendations from Kovner and Schore's report might still apply today. Perhaps we do need to differentiate among nurses' educational backgrounds by placing four-year nurses into higher, more complex positions.

Other studies disagree with Kovner and Schore's (1998) findings about the strength of leadership abilities and decision-making in baccalaureate degree nurses. Rose (1988) and Johnson (1988) suggested that nurses with different educational degrees do have different levels of nursing skills, but that the differences in decision-making and leadership abilities—characteristics on which baccalaureate programs are perceived to focus—are less striking. Primm (1987) found that diploma nurses (three year degrees) were better prepared for entry level hospital work than are nurses with associate or baccalaureate degrees.

One report from the community colleges seems to imply that there is no differentiation in nursing practice according to nursing education. In their report for the American Association of Community Colleges, Karp, Jacobs, and Hughes (2002) noted "...there is little research comparing ADN (two year) and BSN (four year) programs, particularly in regard to differences in ...clinical experiences" (p. 19). On this basis, they concluded that, since employers hire two year degree nurses to the same positions as four year degree nurses, associate degree programs were responding by enhancing their programs, until "clinically, the two types (of nursing preparation) were probably equal" (p. 21). Although they did report that nurse educators interviewed agreed that the baccalaureate programs emphasize the liberal arts and management skills to a greater degree, these nurse educators failed to quantify the difference, and the authors focused on nurse administrator statements that, "...if you are a patient, you wouldn't...notice the difference between the two types of nurses" (p. 21).

Two important things stand out in the report by Karp et al. (2002): (1) the community colleges emphasize and only give importance to quantifiable differences in nursing practice and choose to ignore suggested qualitative differences in nursing care; and (2) their reports about how the two programs are equal all stem from nurse administrators and nurse educators of two year programs, which makes this report seem very weak and biased. Although the entire report seems to provide less than a holistic view of both nurse educational programs, the authors do conclude by emphasizing the importance of future research such as the current research, “does the way theory and practice are taught in nursing programs have an effect on subsequent job performance...and whether the degree to which ADN (two year) and BSN (four year) students study the liberal arts and sciences affect nursing practice?” (Karp et al., 2002, p. 25). In this sense, the current research can be viewed as important for both two and four year nursing programs.

If nursing leaders and educators do not finally come together and recognize the necessity of agreement upon an entry level to practice or, at the least, recognize differentiation in nursing practice, nursing might find itself disempowered in its ability to make its own decisions about education. In California, an initiative by the Association of California Nurse Leaders (Barter & McFarland, 2001) has been developed to require the baccalaureate in nursing as the “...credential for entry into practice as a registered nurse by the year 2010 in the state of California” (p. 3). The Association of California Nurse Leaders decided upon the baccalaureate degree as basis for nursing due to the continuing challenges in health care and society today. Barter and McFarland (2001) also found that the Veteran’s Administration had already changed the qualifications for registered nurses. The Veteran’s

Administration revised their standards to include the minimal requirement of the baccalaureate degree for employment at their institutes of health.

These are not nursing decisions; rather, they are decisions made by other entities about nursing educational preparation. Meyer (1997) called for the American Nurses Association (the professional association for nurses), together with the accrediting agencies for nursing programs, the National Leagues for Nurses and the American Association of Colleges of Nursing to "...take the initiative for clearly identifying the different levels of nursing practice based on education and role expectations" (p. 1). This would allow nurses to make decisions for nurses. With this in mind, the audience for the current research outcomes will be nurses. It is my hope that adding to the discussions about this issue will eventually bring about change from within our own profession.

Curriculum in programs of nursing

The curricular content of associate and baccalaureate degree programs are discussed in the following sections. Information is divided into the three distinct influences on curriculum content: the licensure test (NCLEX), the accreditation agencies and competencies of nurses from each program.

Licensure test (NCLEX)

"Nursing schools originally based their curricula on the job analysis of nursing duties" (Smith, 2005, p. 34). Today, the NCLEX as licensure exam for all nurses is also based mainly on job analysis (Smith, 2002). Job analyses were always meant to be a consideration for what nurses are taught in nursing school (Guinee, 1966), but not as a guide for what the curriculum needs to be (Smith, 2005). The nursing profession and nursing

educators should be in charge of developing their own curriculum to enhance the quality of nursing practice, and the emphasis of nursing school should be quality of patient care, not passing of the NCLEX licensure exam (Smith).

Table 2.1 shows there is no statistically significant difference between the pass rates of BSNs and ADNs on the NCLEX exam.

The fact that passing rates for the NCLEX, the national licensing examination for registered nurses, are essentially the same for all three types of graduates is not proof that there are no differences among graduates. The NCLEX is a multiple-choice test that measures the minimum technical competency for safe entry into basic nursing practice. Passing rates should be high across all programs preparing new nurses. This exam does not test for differences between graduates of different entry-level programs. The NCLEX is only one indicator of competency, and it does not measure performance over time or test for all of the knowledge and skills developed through a BSN program. (American Association of Colleges of Nursing, 2005)

Accreditation

In addition to institutional accreditation through the state Board of Nursing, ADN programs are professionally accredited through the National League of Nursing's accrediting body, National League for Nursing Accrediting Commission (NLNAC), and BSN programs are professionally accredited through the American Association for Colleges of Nursing's accrediting body, Commission on Collegiate Nursing (CCNE).

Accreditation is a nongovernmental process conducted by representatives of postsecondary institutions and professional groups. As conducted in the United States, accreditation focuses on the quality of institutions of higher and professional education and on the quality of educational programs within institutions. Two forms of accreditation are recognized: one is institutional accreditation (Board of Nursing) and the other is professional or specialized accreditation. Institutional accreditation (through the Board of Nursing) concerns itself with the quality and integrity of the total institution, assessing

Table 2.1. National pass rates in the NCLEX (2009)

RN	Jan-Mar 2009		Apr-Jun 2009		Jul-Sep 2009		Oct-Dec 2009		Year to Date Total	
Type of Candidate	#	%	#	%	#	%	#	%	#	%
First Time, US Educated										
<i>Diploma</i>	933	91.10%	721	92.09%	1,582	90.96%	441	87.07%	3,677	90.75%
<i>Baccalaureate Degree</i>	11,876	88.98%	13,581	92.44%	22,488	87.76%	4,296	86.01%	52,241	89.49%
<i>Associate Degree</i>	18,226	87.33%	21,131	89.69%	32,318	81.08%	6,990	81.39%	78,665	87.61%
<i>Invalid or Special Program Codes</i>	26	84.62%	37	86.49%	37	81.08%	25	80.00%	125	83.20%
Total First Time, US Educated	31,061	88.07%	35,470	90.79%	56,425	88.20%	11,752	83.29%	134,708	88.42%
Repeat, US Educated	5,441	50.36%	6,386	54.68%	7,533	58.64%	7,294	58.17%	26,654	55.87%
First Time, Internationally Educated	5,775	42.06%	5,576	42.70%	5,061	41.02%	5,023	43.42%	21,435	42.30%
Repeat, Internationally Educated	4,614	25.21%	5,132	24.67%	4,741	24.57%	4,700	24.26%	19,187	24.67%
All Candidates	46,891	71.84%	52,564	74.85%	73,760	77.85%	28,769	60.31%	201,984	73.18%

Source: National Council of the State Boards of Nursing, 10/19/09.

the achievement of the institution in meeting its own stated mission, goals, and expected outcomes. Professional or specialized accreditation is concerned with programs of study in professional or occupational fields. Professional accrediting agencies assess the extent to which programs achieve their stated mission, goals, and expected outcomes. In addition, consideration of the program's mission, goals, and expected outcomes is of importance to the accrediting agency in determining the quality of the program and the educational preparation of members of the profession or occupation. (Commission on Collegiate Nursing Education, 2009)

Although slightly different in scope, comparison of accreditation standards for both programs reveals that both programs must show strong rigor in developing classroom and clinical experiences. Maintaining accreditation status involves regular visits by the accrediting agency and well-kept records and commitment to continuous change to improve the learning outcomes of the nursing students.

Both of the accrediting bodies have weighed in on the topic of differentiated practice. The American Association of Colleges of Nursing (2005) is in support of the baccalaureate degree as minimal entry into education:

Nurses with Bachelor of Science in Nursing (BSN) degrees are well-prepared to meet the demands placed on today's nurse. BSN nurses are prized for their skills in critical thinking, leadership, case management, and health promotion, and for their ability to practice across a variety of inpatient and outpatient settings. Nurse executives, federal agencies, the military, leading nursing organizations, health care foundations, magnet hospitals, and minority nurse advocacy groups all recognize the unique value that baccalaureate-prepared nurses bring to the practice setting. (p. 1)

The National League for Nursing (2009) takes a different approach to the differences in nursing and advocates for more pathways for ADN's to complete their degrees before going to a minimal entry into practice policy, "A critical goal for the future must be to sidestep the old argument of baccalaureate entry and move to options, such as RN to BSN or RN to MSN, that are not based on entry but as opportunities for lifelong learning and

progression for those who enter the nursing profession through diploma and associate degree programs” (p. 1).

Competencies

The state administrative code allows for the institutional accreditation of both associate and baccalaureate degree nursing programs. Additional content in research and community health nursing is a requirement for an ADN in Iowa to complete his/her baccalaureate degree (Iowa Administrative Code, Chapter 2, p. 2). This suggests that these are the only curricular content that differ from that of a BSN program, although the sample programs of nursing in Appendices A and B reveal additional content area for BSNs to be in leadership, community health, research, and liberal arts.

The most current research on the competencies of new graduate nurses from both programs shows no differences. In 2008, the Nursing Executive Center published the results of surveys done with over 100 nursing leaders, employers of nurses, nurse administrators and nurse faculty members from both associate and baccalaureate degree programs. “Regardless of institution type, predominant degree program, geographic region, and admissions policy, nursing schools are placing a remarkably similar weight on the 36 competencies across their respective curricula” (Nursing Executive Center, 2008, p. 42). The statistics of this survey also reported that there was no clear linear relationship ($p=.015$) between enhancing new graduate nurse preparation by increasing curricular emphasis on those competencies where new graduate nurses are most dramatically underperforming, but there was a relationship between lack of emphasis of certain competencies in nursing schools and skills deficit. The authors theorized that the reason for these statistics was that most competencies are best

learned in clinical and not in the classroom; therefore, added emphasis on any competency in the classroom alone would not bring about necessary changes to the performance of the new graduates. The study by the Nurse Executive Center (2008) is applicable to the current research, because it suggests that quantifying differences according to educational background will not bring any new discussions to the table. My study concentrates on how ADN and BSNs differ in perceptions of nursing education and practice and how this affects their practice.

Paradigms of Nursing Practice

Given the results of this literature review, it would be relatively easy to analyze the results of the interviews in the current study based upon skill sets and level of functionality in participants (competencies) after they graduate from different levels of schools of nursing. The difficulty in using a competency-based version to evaluate nursing practice is that it only depicts outcomes focused in a quantitative manner, not on the qualitative process involved in nursing practice. The qualitative process involving the way nurses perceive, think about, and actually practice cannot easily be measured by what they do (i.e., skills sets or technical skills). The results of this study are only effective when viewed within the paradigm of what perceptions nurses of different backgrounds have about their own quality of practice.

Many different nursing theories exist that try to examine the qualitative process of being a nurse and, after a thorough examination of over 27 different nursing originated theories, the results of the current research are based on the works of a more contemporary nursing theorist, Rosemarie Parse, who created a theory about the paradigm of nursing, striving to explain the different ways nurses think, do, act, feel and value their nursing

experiences. Parse first published her new theory for nursing in 1982. This contemporary theory has continued evolving (1987, 1992, 1998) as the theorist has further explained and redefined nursing in our contemporary society. Using Parse's (1982) nursing theory to help frame nurses' perceptions seems much more intuitive than using a business-related tool for the purposes of this phenomenographic study. Parse's work can be used to analyze the data to answer the two research questions guiding this study:

1. What are the differences between ADN's and BSN's as related to the meaning and values they place upon education and practice?
2. What are the differences between ADN's and BSN's as they relate and interact with persons during their education and practice?

Comparing the similarities between nurses of the same educational background based upon a nursing theory, and then contrasting these between nurses of different backgrounds seems the most likely way to find answers to the elusive question of how nurses perceive their own practice and what this has to do with their educational background. Parse's (1982) theory helps delineate a nursing worldview that fits well with the application of knowledge and competencies necessary in today's world.

Summary

There is a paucity of research on the differences between the outcomes of nursing educational programs. A great need exists, especially at this time of impending nursing shortage, to reopen and revisit this theme. Nursing is faced with the challenges of increasingly complex health care with a decreasing number of practicing nurses to deal with these new challenges. At the same time, minimal educational standards for nurses are still the

same as they were when revised 75 years ago. It is time for a change to increase the quality of nurses everywhere. The current research adds to the basis of discussions in this area, providing nurse educators and employers of nurses with new insights about nursing practice and educational preparation.

CHAPTER 3. METHODOLOGY

Phenomenography as a Methodology

The approach to the differences between the phenomenon of the practice of nurses, given their educational background, can be best conceptualized through qualitative research that is phenomenographic in methodology. Qualitative research emphasizes that "...meaning is socially constructed by individuals in interaction with their world" (Merriam, 2002, p. 3), and phenomenography focuses on qualitatively different ways of experiencing aspects of the world (Friberg, Dahlberg, Petersson, & Ohlen, 1998, p. 37). Not to be confused with phenomenology, phenomenography focuses on the differences rather than the similarities of respondents' perceptions. Categories of description are the key features resulting from analysis of data in phenomenography, which serve to identify and describe the variation of experience and represent the qualitatively different ways in which phenomena are understood (Bowden, 2000). In this study, the categories of description are used to identify and describe the variation of experience in nursing practice between two and four year nurses.

Framing the study

Phenomenography was first developed by Marton (1981). Marton wanted to know if he could identify the difference in participants' perceptions of practical experiences, according to the way in which they were taught concepts in school. Marton's first study took place with math students. He studied whether different methods of explaining and teaching math-related concepts correlated to different understandings of practical applied math in students. Marton found a significant difference in the way in which students understood or "perceived" math according to the manner in which they were taught the principles of math.

Later research themes for phenomenographical studies have been related to issues of learning in education, and in nursing to patients' experiences in health care and differences in conceptions of health care providers given a common problem (Martensson, 1997; Stromberg, 1997). Researchers use phenomenography to experience the phenomenon simultaneously with the respondents, and focus on the respondent's understanding of a certain aspect of reality, then identify the variations in the meanings. Through dialogue, stories, and observations, I experienced the perception of the practice of nursing with associate degree nurses and baccalaureate degree nurses. The aspect of reality in this study was the emergence of any patterns in how the respondents' educational background impacted their perception of the practice of nursing.

Conceptions

“Conceptions are the object of the study in phenomenography and assumptions are made about the nature of their development” (Ramritu, & Barnard, 2001, p. 7). Conception refers to a “specific aspect of people's ways of experiencing or making sense of their world” (Sandberg, 1994, p. 47). Respondents' perceptions or conceptions can be used interchangeably for the purposes of this study. Applied to this research, conceptions of practice refer to how a two or four year nursing graduate experiences and understands his/her nursing practice.

Distinguishing phenomenography from phenomenology

The theory of thought based in phenomenography is to find and systematize forms of thought in terms of which people interpret aspects of reality (Merton, 1981). One of the biggest themes of this kind of research is the positivist quest for generalization more than the

development of hermeneutical understanding (Webb, 1997). This distinguishes phenomenography from phenomenology. The researcher is not searching to study what is in the reality of the world (phenomenology), but what is in people's conception of the world (phenomenography) and to then categorize these conceptions. This perspective enables the researcher to look for patterns of behavior in which the differences in the practice of nursing are emphasized.

Although the position of phenomenography in terms of values and interests, especially with regard to theories of knowledge such as critical theory, remains largely unexplored, Webb (1997) stated that a researcher can intentionally look for modes of experience and forms of thought without placing value. The focus of my interviews is to explore what patterns of thought and behavior are consistent in associate degree respondents and the extent these are different than those of the baccalaureate degree respondents as each explores his/her conceptions of the practice of nursing.

Phenomenography and learning

Phenomenography has its roots in studies about learning. A study by Marton and Saljo (1976) asked first year university students to read an article and answer questions on it. Answers showed different levels of understanding and analysis revealed how students described the task, which paved a way to new thoughts about approaches to learning. Marton (1981) later termed this kind of research as phenomenographical in nature and approach. The goal of this kind of research is to map out ways in which variations in student learning could be used to understand learning. These variations were later conceptualized in Marton and Booth's (1997) research of a theory of learning called the variation theory. The variations

were important, because teachers could use the variations of conceptions as examples in teaching; students who were learning an issue were given examples of variations in the way people might conceive of the issue and allowed to make judgments on how to place values on these variations. This process seemed to enhance the learning that took place.

Criticisms of phenomenography

Entwistle (1997) summarized criticisms and past problems of phenomenographic research. The major criticism he found in past studies was that of the subjectivity of interpretation in these studies. He cautioned researchers using this methodology to:

1. pose questions in a way which allows the respondents to account for their actions within their own frame of reference, rather than one imposed by the researcher. It is better to move in the questioning from actions to experience, and from concrete to abstract;
2. present categories of description with sufficient extracts to delimit the meaning of the category fully, and also to show, where appropriate, the contextual relationships which exist ... a description isolated from the interview extracts cannot be fully understood by the reader;
3. take great care in establishing the categories in ways which most fairly reflect the responses made... (keeping) the possibility of gender differences in identifying categories in mind; and
4. explore the relationships between (the categories of description)... and analysis of the meaning of each category in relation to every other one. (p. 132-133)

This caution regarding subjectivity of interpretation has direct implications for the results section of the current study. Thick, rich description is used to describe the respondents, their answers, and the resulting categories. Relationships between and among categories are explored in the discussion section of this dissertation, and a precise detailed account with excerpts providing contextual understandings is given on how these categories were developed and the meaning attributed to each one. Larger excerpts of narratives are used in

order to allow transparency for the context in which they have been used and to enhance overall data analysis for the purposes of this study.

Phenomenography and teaching

Marton's (1981) study has been used to look not only at student learning, but teacher's conceptions. Carlsson, Fulop and Marton (2001) used phenomenography to investigate student teachers' conceptions of literary understanding. Their research took place in two separate studies in two separate countries. The student teachers' conceptions were categorized into understanding as a linear process, understanding as a vertical process, understanding as a process of discernment and understanding through variation. It is noteworthy that there were similarities in the variations of understanding between the different cultures; that is, the same categories could be applied to both cultures although there were also several distinct differences between cultures mentioned. This shows the relevance of phenomenographic research across cultures and across country boundaries.

In the current research, I found similarities between all two year nurses and between all four year nurses, even across different hospitals and different schools of nursing. I was able to find categories that emerged pertaining to the educational background and preparation of the nurse, regardless of the environment where the nursing practice took place. For the sake of relevance, I limited my study to hospital nurses with equivalent positions in equivalent areas of patient care.

Themes and categories of differences

Saljo (1997) determined that many of the assumptions in phenomenography recognize the fundamental role of discourse analysis, conversation analysis, discursive

psychology, social constructionism, and linguistic anthropology. Many authors reviewed for this literature search used these and more to determine basic variations, or themes of different conceptions, which were then categorized into overarching “categories of difference” in their phenomenographic studies (Atkinson & Heritage, 1987; Bruner, 1990, Goodwin & Durante, 1992; Parameshwar, 2005; Shotter, 1993).

In terms of the current study, it means that interviews and observation provide rich sources of information to determine basic themes of different conceptions of nursing practice. Whether or not different conceptions emerge, the phenomenon of differences or of no differences are valid findings for the purposes of this study. In this study differences did emerge and these themes are organized into two “overarching categories of difference” and discussed in the findings section. Not only what the respondents say and do must be scrutinized by the researcher, but also how they interact with others and their attitude and choice of language must be scrutinized carefully in order to look for variations.

Phenomenography and the workplace

In addition to its applicability in educational research, phenomenography has spread to be used in workplace learning. Paloniemi (2006) used this methodology to examine employees’ conceptions of the meaning of experience in job-competence. She found that employees valued the workplace as the most important learning environment. Experience in relation to the amount of time was a source of competence and self-confidence. At first glance, this study would seem to contradict the nature of the current research. However, it must be noted that the experience was described in terms of “tacit knowledge” (p. 447), which included other kinds of competencies not learned in formal education, such as

managing social interaction and communication. In the current research it becomes increasingly difficult to examine nurses' conceptions of their practice as applied to their educational background if they have been out of school for very long; therefore, the criteria for respondents to not be out of school for more than one year seemed to be a good fit.

Phemenography and nursing

During the past several years phenomenography has been discovered as an applicable methodology for nursing research. Most often, the studies were about nurses' perceptions of themselves. Brammer (2006) used a phenomenographical approach to understand the variation in experience and understanding of student nurses with registered nurse buddies. Other authors have used this methodology to describe ways that nurses look at their job satisfaction (Lindberg, 2007), nurses' perceptions of quality assurance (Lundqvist & Axelsson, 2007), nurses' clinical experiences of the inverse bed position on a neurointensive care unit (Dahl, Nyberg, & Gustafsson, 2003), and nurses' understanding of their role in student learning (Brammer, 2006).

Therefore, the use of phenomenography as an approach to discover nurses' perceptions/ cognitions of their own practice is logical in approach. When planning for the current study, an email to the founder of phenomenography, Francis Marton, resulted in following comments about the applicability of this inquiry for the purposes of investigating differences between educational preparations for nurses: "Although your idea is a perfectly reasonable and highly creative idea, nobody has so far embarked upon the path envisaged, to my knowledge" (Francis Marton, personal communication, October 13, 2007).

Some nursing researchers have focused more on how phenomenography can be used in nursing. Friberg, Dahlberg, Petersson, and Ohlen (2000) examined why the complexity of nursing cannot always be described in interviews and observations. Their conclusion is pertinent to the current study, since they found that "...knowledge about the significance of context for the informants' answers or the research dialogue between the researcher and informant is important" (p. 42). For my research, it was important to find areas of nursing practice in which I am most familiar, so I could visualize the deep contextual possibilities that interview questions and answers can provide. My area of expertise is in obstetrical nursing, so I located newer nurses in these units. Barnard, McCosker and Gerber (1999) also found that phenomenography has potential for health care research and "emphasizes collective meaning" (p. 213).

The closest phenomenographical and nursing study to the current research was a study by Baker (1996). Baker applied several different methodologies in nursing research about nurses' clinical decision-making and concluded that phenomenography can be used well in nursing research if the outcome is to describe the differences in perceptions. The current study describes the differences in perceptions, or cognitions, of nurses about their own practice. Baker conducted her study to examine the way graduate nurses perceive the development of their practice. She found that the nature of clinical decision-making ability and the factors that influence learning for nurses should be an important focus for future nursing research. The current research also had some implications about clinical decision making and learning emerge during the interviews. I discovered new meanings about how the educational experience affects the perceptions about nursing practice.

Theoretical Perspective

The following premises are an integrate part of phenomenographical research. Constitutional framework, conceptions and knowledge, as defined in this study, help set apart the main differences between phenomenology and phenomenography, and present the rationale for the methods used in data analysis. In this paradigm, the emphasis is on the differences in knowledge and conceptions. Theorists in this perspective believe that differences in knowledge and perceptions of reality can be related back to differences in learning and curriculum.

Epistemology

Marton (1986) contended that the basic theoretical premise of phenomenography does not coincide with either that of constructivism (that knowledge is constructed by individuals within their own reality) nor that of positivism (that knowledge mirrors reality). He coined the term “constitutional framework” for his paradigm. “While the constructivist paradigm puts the emphasis on the individual’s acts, the constitutional framework (phenomenography) is primarily interested in how various aspects of the world are seen by different individuals” (p. 45). “Phenomenography was not developed on the basis of phenomenological philosophy...there are fundamental similarities between phenomenography and phenomenology” (Swensson, 1997, p. 164).

While phenomenology studies seem to come closest to the theoretical basis of phenomenography, the difference is that phenomenographers are most interested in the relationship between knowledge and perceptions of reality while phenomenology seeks to explain the perceptions of reality of the respondents. The basic premise for the current study

is that knowledge and perceptions of reality are related and that, while perceptions in reality are unique to the person and can be qualitatively analyzed such as in phenomenology, the differing perceptions and experiences reported by respondents can be related back to the knowledge and learning that took place in either a two or four year education.

Knowledge

Swensson (1997) noted that, in phenomenography "...knowledge is based upon thinking...conceptions (perceptions of reality) are dependent both on human activity and the world or reality external to any individual.... Knowledge and conceptions (perceptions of reality) are relational" (p. 165). In terms of the current study, this means that, although respondents reported differing experiences (in different hospitals with different patients), there were similarities in categories of analysis between nurses with a two year degree and those with a four year degree. This approach differs from positivist assumptions about observations as facts and knowledge as deductive thinking based upon facts (Merton, 1986). It also differs from constructivist assumptions about knowledge as rational or mental constructions within a rational system (Merton, 1986). A phenomenographic view of knowledge is that it is created through thinking about external reality (Swensson, 1997).

Conceptions

Conceptions are the central concept and phenomenon in understanding the nature of knowledge in phenomenographic research (Swensson, 1997). In terms of the current study, conceptions are what participants perceive as their own nursing practice or their perceptions of reality of their nursing practice as described previously in this chapter. According to Richardson (1999) "...today most cognitive theorists assume that conceptions are constructed

by learners precisely in order to make sense of the context and the curriculum” (p. 65). Based upon the differing context and curriculum involved in educating two and four year nurses, it can be assumed that nurse respondents from differing educational backgrounds will have differing conceptions or perceptions of their nursing practice. Marton (1994) maintained that the aim of phenomenography is to classify people’s conceptions in the same way a botanist would classify new species of plants. In this context, it can be expected that the respondents’ cognitions of their nursing practice can be classified into different categories that will mirror their nursing education.

Research Methods

The following sections detail the participants, and interviews and observations conducted for the purposes of this research.

Participants and sampling

Three interviews and one observation were planned with three associate degree nurses and three baccalaureate degree nurses. According to Esterberg (2002), research participants should be chosen for the special qualities they bring to the study. For the purposes of this study, research participants needed to be both those educated in two and four year degree nursing programs, and at similar times in their careers (i.e., time after graduation from a nursing program). It was decided to select participants within the first six months to a year of their graduation from nursing school so that their practice was still influenced by how they were educated. The participants also needed to be practicing in a similar area of nursing, so that the stories and responses they bring can be analyzed for differences. Participants can also come from different employers for maximum variation in the data collected (Merriam,

2002). This purposeful sampling technique (Seidman, 2006) of nurses with two different educational backgrounds, within 12 months of graduation, from different hospitals and from similar areas in nursing (obstetrics) should enable the researcher to gain as much maximum variation as possible in participants for the purposes of the study and its methodology.

Access to the respondents was gained through nursing managers or administrators of similar departments (labor, delivery, postpartum units) at hospitals in the Midwest. After Institutional Review Board (IRB) approval was granted by each institution, managers/administrators identified nurses who had been practicing less than 12 months, with both two and four year degrees, and who were not currently involved in further education towards another degree. Initial contact by the nurse managers/administrators was made with six different nurses, and these nurses were willing to participate in this study, so contact information was forwarded to the researcher for follow-up. The sites of practice were all hospital settings.

Interviews

Three separate, one-hour interviews were held with each respondent, with the potential to extend the time if necessary in order to obtain redundancy of information (Lincoln & Guba, 1985). According to Seidman (2006) the series of three interviews allows the interviewer to “explore the meaning of the experience” (p. 17). The first interview concentrates on the “context of the experience”, the second on the “reconstruction of the details of the experience within the context in which it appears”, and the third “encourages the participants to reflect on the meaning their experience holds for them” (Seidman, p. 17).

An observation of each respondent in her/his nursing practice was conducted, and field notes of these observations were written, analyzed and triangulated (Merriam, 2002) with the data obtained through interviews to enhance meaning. Interviews were audio-taped and transcribed, and all notes, memos, transcriptions, and audio-tapes were coded and kept locked to be destroyed at the end of the study, no later than December 30, 2010.

“Open-ended questions” (Esterberg, 2002, p. 98) were used to guide the interviews (e.g., “Tell me about your education? What meaning does your practice of nursing have for you? How do you believe that your education has impacted your practice?”). The interview guide is included in Appendix C. Clarification was sought during and after each interview by continual “member checks” (Merriam, 2002, p. 26): After each interview, I summarized my comments and asked the respondent if she/he was able to recognize her/his experience from my words.

Observations

Observations were performed after the interviews were conducted with each respondent. I accompanied each nurse in her/his daily practice arenas for at least one hour or until I was able to identify data saturation. According to Emerson, Fretz and Shaw (1995), conducting field research such as observations involves “...enter(ing) into a social setting and get(ting) to know the people involved in it...participat(ing) in the daily routines of this setting, develop(ing) ongoing relations with the people in it, and observ(ing) all the while what is going on” (p. 1). Adler and Adler (1987) further delineated that there are various ways in which a researcher may elect to participate in observations. I assumed a “peripheral role” (Adler & Adler, 1987, p. 36) status as researcher, to the extent that I sought an insider’s

perspective on the nurses, activities, and structures of my participants' world through firsthand experience, but did not interact directly with patients as a nurse (i.e., I refrained from participating in most nursing activities myself as an observer).

Due to the fact that I have extensive firsthand experience in labor and delivery and postpartum, I am able to understand the nuances of nursing activities in this area, and my observations were used to look for confirming or disconfirming evidence from the interviews previously conducted or for new information to include in the next interview session. Adler and Adler (1987) detailed the membership experience for researchers conducting observations in this manner. They stated that first the participants must explicitly understand the nature of the observations, there must be a relationship formed between them and the researcher, and that role demands must be delineated during observations. For the purposes of this study, this meant that I first established informed consent through a formal contract with participants, then conducted formal interviews with the participants, followed by observations. Discussing possible role demands prior to observations included discussing with the participant and with his/her nursing supervisor what possible roles I might be asked to assume during the observations. If asked to help on the floor, I identified myself as a non-participant observer during all observations. Discussing this before the observations took place helped to ensure that the participants were comfortable with my presence and could go about their daily nursing routines unhindered.

Following recommendations by Emerson, Fretz, and Shaw (1995), I took field notes during observations, jotting down important events and thoughts as they occurred. These field notes "provided the primary means for deeper appreciation of how (I) came to grasp and interpret the actions and concerns of others" (p. 13) during observations. Due to the stressful

and confidential nature of labor and delivery floors, visible recording of field notes might be considered “inappropriate or out of place” (p. 25). Therefore, I took every opportunity to step away or to take breaks in order to catch up on writing field notes, so this did not distract patients or my participants. Field notes provided additional data and/or confirming/disconfirming evidence to support the interview data and are considered and discussed in the data analysis.

Data Analysis

Phenomenography has not been applied to this kind of nursing research enough to establish a systematic step-by-step approach to data analysis. Following the steps for generic qualitative data analysis (Creswell, 2003), all data were transcribed after interviews and observations were conducted. A first reading of the data provided a general sense of the information and its overall meaning in relationship to the research questions.

Open coding was used to identify patterns, themes, and categories in the data (Esterberg, 2002). Different conceptions of nursing practice as expressed by nurses of different educational backgrounds was a focus only for analysis of the findings, not for any interviews conducted in this phenomenography. “(Phenomenography) necessitates...setting aside initially the objective of producing categories of description and presuppositions about the precise thing being studied...questions posed should not be based on the researcher presumptions about the phenomenon, but should emerge out of the interest to make clear the (respondent’s) experience” (Ashworth & Lucas, 2000, pp. 299-300). A copy of the research questions is provided in Appendix C.

According to Brammer (2006), phenomenographic research necessitates a decision trail for the reader to follow the steps taken during data collection, analysis, and development of categories of description. The data provided many themes, but only those that repeated themselves several times in different manners were chosen to be included in the results. Decisions made by the researcher about themes are thoroughly described in the study to provide a detailed decision trail. The themes are then examined for any patterns or overlapping between them.

I allowed the meaning of the nursing practice to evolve only from the observations of and the interviews with the respondents. Interviews were conducted with participants until data saturation was accomplished. A systematic analysis of data according to emerging patterns and respondents' experiences is reflected in the findings. Each of Parse's principles was used to examine the interviews and observations of the two groups of participants and themes of differences emerged and were discussed using excerpts of the data. Table 3.1 illustrates how Parse's principles and the research and interview questions were applied to the data gathered and analyzed for meaning.

Validity

Merriam (2002) recommended that qualitative researchers use triangulation, member checks, and peer review to ensure validity and reliability. It was possible for me to use these methods to allow the respondent to develop his/her own meaning and connections. Triangulation took place through observations of the participants in their work environment, and member checks with participants ensured that my interpretations reflected the information in the interviews. Seeking counterexamples of evidence (Richardson, 1999) as

Table 3.1. Parse's principles applied to the data analysis

Principle	Description	Data used to analyze findings	Data used from	Research question
1.	Analysis of Meaning	Stories about education & practice	Interviews	1
	Analysis of Linguaging	Language used in descriptions in stories	Interviews	1
	Analysis of Imaging	Subjects and context of stories	Interviews	1
	Analysis of Valuing	Assumed values behind stories	Interviews	1
2.	Analysis of Rythmicity (creativity in clinical situations)	Observations of practice	Observations	1, 2
3.	Analysis of Cotranscendence (interactions with people)	Reported and observed interactions with peers and patients	Interviews & observations	2

Source: Theoretical Framework (Parse, 1982).

the interviews proceeded helped to keep me focused on the data, as I attempted to find ways to disconfirm each result I found through literature, further interviews, or observations. Peer review from colleagues and the dissertation committee helped ensure the strength of the research and validated my interpretations.

Marton (1986, 1992), the founder of phenomenography research, felt that phenomenographic analysis could be done without using bias, in the same way a botanist classifies new plants. Webb (1997) added that a phenomenographic researcher can intentionally look for modes of experience and forms of thought without placing value. However, later researchers such as Richardson (1999), wrote in a review of the concepts of phenomenographic research that this analysis necessitated a "...reflexive approach that takes into account the social relationship between researchers and their informants and the constructed nature of the research interview" (p. 70) and encouraged researchers to "transcend their preconceptions by seeking out counterexamples and validating their interpretations through peer debriefing" (p. 70). I used peer debriefing for this study, as well seeking disconfirming evidence or counterexamples as the interviews proceeded.

Maximum variation (Merriam, 2002) was reached quickly, due to hiring constraints in the Midwestern hospitals. To protect participants' identities, these hospital locations are not revealed in this study. Out of eight possible participants meeting criteria, six were selected; the two remaining were unavailable due to personal issues at that time. Outreach to other hospitals revealed that there are truly few newly graduate nurses hired in obstetrics at larger hospitals. Further attempts to expand to larger hospitals in outer Midwestern areas to reach more participants meeting criteria were futile at the time. Saturation of the data discussed during data analysis revealed that even these six participants demonstrated similarities among and differences between categories for the purpose of this study.

Goodness and Trustworthiness

Lincoln (1995) discussed reliability for qualitative studies. Instead of replication possibilities, the most important question for qualitative research should be whether the results are consistent with the data collected. Coding of the data enabled the conceptions to emerge. Describing how these conceptions emerged, and giving thick, rich descriptions illuminated the connections found between the interviews and the outcomes of the study. Comparisons between and among the respondents were carefully considered and subjected to numerous peer reviews before being included in the outcomes. Trustworthiness of this study was established by including an audit trail (Lincoln & Guba, 1981) such that another researcher can follow the path of the decisions I made during the research through the data to determine whether the conclusions are reasonable. Merriam (2002) suggested that a study must also show "goodness" (p. 30) and be conducted in an ethical manner. Although I could examine in advance all the ethical dilemmas which I might encounter, I provided detailed

discussions about my assumptions as I encountered situations by using critical self-reflection in order to show any biases that might have affected the study as it proceeds.

According to Seidman (2006), qualitative research can be an "...emerging design in which the number of participants in a study is not established ahead of time" (p. 55). The two main criteria for knowing how to set number of participants is whether there are enough qualified respondents available and when the information heard in the interviews becomes repetitive, a "saturation of information" (Seidman, 2006, p. 55). The initial plan for interviewing in this research study was set at three participants from the two year and three participants from the four year educational levels, from differing hospitals in the Midwest, but the design was flexible until the criteria of sufficiency and saturation were reached. The number of qualified respondents available were only six (due to a hiring freeze in major Midwestern institutions in the past two years), with two other possible respondents identified who were not able to participate for other reasons, so there were no further respondents possible.

Participants

For confidentiality and ease of comparison, associate degree nurse participants have been identified with pseudonyms beginning with the letter A: Amy, Alice and Allie. BSNs were assigned pseudonyms beginning with the letter B: Becky, Brandi and Betty. Their stories follow.

Amy

Amy is a Caucasian woman, who is 25-30 years old. She was originally pursuing a degree in another discipline in another city and had to quit her education there and move

away for personal reasons. As she was waiting to go back to school in the new location, the births of her children made her aware of just how very wonderful nursing could be. *“It was the babies that did it to me...obstetric nurses have the coolest job ever...I just thought there wasn’t any better honor than that and I wanted to begin nursing.”* According to Amy, when it came time to pick a nursing program, she didn’t spend much time looking around at different degrees or colleges, but just put herself down on the waiting list for one specific Midwestern community college. *“Then I heard of another two year degree program without a waiting list and I applied and got in right away.”* As she rotated through various clinicals during school, she came to love many different kinds of nursing, not just obstetrics. *“I can’t believe that nursing is so under-appreciated...we are the lifeline for the patient and I never understood that before I went to school.”* After graduation, 11 months prior to our conversation, Amy first found a job in a different area of nursing until there was an obstetrics opening in the same hospital. *“I think OB is the ultimate place for me to be every day because I can go in and shape what they (moms) are doing and how they are feeling. I can encourage and see results and know that I have done a good job.”* Currently, Amy has almost completed three months of orientation on the obstetrics floor and will soon be working on her own without a preceptor. She anticipates completing her baccalaureate degree sometime in the near future, with her long-range goals of completing a master’s degree in midwifery.

Alice

Alice is a Caucasian woman between 20-25 years old. *“When I was in high school, I was a Certified Nursing Assistant because I wanted a good job.”* She originally had planned

to become a real estate agent, until her guidance counselor told her there “...*was no money to make in that area, so I should become a nurse...so after I graduated, I wanted get the cheapest loans possible.... I lived at home with my parents and went to college close by.*”

The choice of colleges for her was made according to cheapest nursing program and proximity to her parents’ house. “*I worked at the hospital the whole time I went through nursing school, so I knew a lot more...about computers and I was the one who helped my classmates and even teachers figure things out*”. Part of the time, Alice worked as a certified nursing assistant for the obstetrics floor and part of the time she spent on the telemetry floor. “*After looking at how people worked on the telemetry floor and comparing it to nursing on the obstetrics floor, I decided it would be so much better here (obstetrics)...I fell in love with taking care of babies and moms and people who aren’t sick all the time.*” Alice graduated five months ago and found employment immediately after gaining licensure on the obstetrics floor of the same local hospital she had worked at while being a certified nursing assistant. She has just completed three months of orientation at the hospital and is almost ready to graduate to working without a preceptor. Although she has no specific goals about going back to school some day, she stated: “I think I will but just not right now.”

Allie

Allie is a 30-35 year old Caucasian woman with a previous degree from another state. After practicing in a different job, she had several babies and experienced some difficulties with one of the births. “*I was in the hospital for (so long) and that was when I decided that I wanted to try nursing. After she was born (my baby) I went back to school.*” Family ties to a local associate degree nursing program was the reason she chose the school from which she

graduated: *“I didn’t really look at any other programs.”* Graduating 11 months ago from her program, she stated that she first went into practice in acute care until she had an opportunity to visit the obstetrics floor during her orientation and that hooked her. *“I knew going into it (nursing school) that I was probably leaning towards obstetrics, then when I did my preceptorship there later, that is when I decided that...I fell in love with that (area).”* She has been working for the past four months on obstetrics and has completed the orientation period and practices without oversight now, although she still has a preceptor assigned to her. Alice stated she really wanted to go back to school for her baccalaureate degree, but has no plans after that. *“I just think that (BSN) is an important thing. There is so much more I have to learn. I don’t think that I’ll ever stop (learning) because it (nursing) changes every day.”*

Becky

Becky is a Caucasian woman, between 20-25 years old. She experienced a hospital for the first time during a relative’s accident when she was still in high school. *“I was in the emergency room department and a light bulb just went off. I didn’t know anything about nursing, but I knew right then that I was going to be a nurse.”* She talked to several people who knew her and they all thought it was the perfect job for her. Finances were the main reason for the nursing school and the program she chose to attend right after high school, although she stated it had to be a four year program. *“My favorite clinical was obstetrics...I knew I wanted to (go into) women’s health, I just didn’t know what area.”* After a senior preceptorship in obstetrics, she decided to look for a job in that area *“...then I had a really difficult time finding a job. I searched for a good 3-4 months with no prospects at all...on a whim I applied here and got the job within a couple weeks.”* Becky graduated four months

ago and has been working on the obstetrics floor now for one full month, and has almost completed orientation. She plans to go back to school at some time in the future, but is not sure when.

Brandi

Brandi is a Caucasian woman between 20-25 years of age. She first attended another school locally for a different degree. She transferred to nursing because *“I knew this (current program) wasn’t something I wanted to do, I didn’t go to my classes and I didn’t get good grades. Then I transferred, got accepted into a nursing program and worked my tail off and graduated with my baccalaureate in nursing.”* She didn’t pick a four year over a two year degree; she didn’t even know there was a difference until she had actually transferred. *“Then I thought, well.... I really do want to continue with my education and I know I want to at least get my masters, so why don’t I just go for it (BSN) and get it out of the way. So I decided to get my baccalaureate.”* During school, Brandi developed a passion for obstetrics nursing during her clinical rotation. *“I didn’t know whether I wanted emergency room or intensive care unit or obstetrics...until I had my internship with (obstetrics instructor) and I realized this was something I was good at and so that is what I strived for.”* Brandi began working on another floor when she graduated 11 months ago, until there were jobs available in obstetrics. *“(Obstetrics) was a passion of mine and I put in for it (application) and got it (job).”* She has been practicing there for more than one month and is close to completion of her orientation. She plans to work for a while before thinking about going back to school.

Betty

Betty is a Caucasian woman, between 20-25 years old. She wanted to become a nurse because she liked caring for people. *“I looked at (two year nursing degrees) but I felt like I would just basically get my skills and be done. I wanted to have a more well rounded education,”* so she chose a four year degree local nursing program to attend. *“I originally had a very broad spectrum of what I wanted to do because I like all kinds of people...then I did my obstetrics rotation (clinical) and (thought) this is totally it...I just had so much fun and that is when I knew that this (obstetrics) is what I want to do...I think that this is where I will always be.”* After doing an internship in obstetrics during school at a local hospital, the manager came to know her and told her of a job opening up right after graduation. She graduated nine months ago and has been working in obstetrics ever since that time.

The participants' stories reveal that each pool of participants, both the associate and baccalaureate degrees, have a variety of ages and reasons for going into nursing and obstetrics, and time since graduation. Table 3.2 provides an overview of all the participants for ease of reference. It should be noted that all associate and baccalaureate degree nurses interviewed in this study worked at different hospitals. In addition, two of the three associate degree nurses and two of the three baccalaureate degree nurses had graduated from the same nursing school. However, in each case, they graduated at different times and were not members of each other's classes. Two of each participant group (associate and baccalaureate) had graduated almost a year ago whereas one in each group was a newer graduate. Participants' ages ranged from 20-35 years, with some participants mentioning having children while the others did not (this was not part of the interview questions). Overall, participants worked at four different Midwestern hospitals and graduated from four different

Table 3.2. Demographics of the participants

Participant	Age (yrs)*	Educational degree	Type of workplace	Months since graduation
Amy	25-30	Associate	Metropolitan Acute Care not for profit hospital (#1)	11 mo
Alice	20-25	Associate	Regional Referral Center not for profit hospital (#2)	5 mo
Allie	30-35	Associate	Metropolitan Acute Care not for profit hospital (#3)	11 mo
Becky	20-25	Baccalaureate	Metropolitan Acute Care not for profit hospital (#1)	4 mo
Brandi	20-25	Baccalaureate	Metropolitan Acute Care not for profit hospital (#3)	11 mo
Betty	25-30	Baccalaureate	Regional Medical Center private (#4)	9 mo

* Age categories selected by participants.

programs of nursing. Compared to the locality of this study and the availability of nursing schools in the same area, this is widest range of variability that I could have hoped for as a researcher.

Summary

Using phenomenography to discover the differences in meaning that nurses place on their own practice, given their educational backgrounds, is a logical way to approach the research questions. Although it is a newer methodology, nurses and education experts have successfully used phenomenography in learning and health care situations. Implications from their studies were used to guide the current research. Grounded in my experience as a nurse and a desire to know how nurses' education affects their practice, this research has merit and adds necessary information to the body of knowledge about nursing education and practice.

CHAPTER 4. FINDINGS

Introduction

The purpose of this study was to examine the practice and perceptions of newly graduated nurses from associate degrees (“ADN”) and newly graduated nurses from baccalaureate degrees (“BSN”) to examine the differences. Two research questions guided this study:

1. What are the differences between ADNs and BSNs as related to the meaning and values they place upon education and practice?
2. What are the differences between ADNs and BSNs as they relate and interact with persons during their education and practice?

Examining these differences within the lens of phenomenographic inquiry and Parse’s theoretical framework, the focus of the interviews was to explore patterns of thought, language, values, and behavior and the meaning of these related to the respondent’s educational background as the participant explored his/her conceptions of the education and practice of nursing. An analysis of the interviews and observations identified four themes of differences in participants’ interviews about education and practice of nursing: (1) Conception of Self as Coparticipating in Experience with Patient vs. Focus on Self as Doing For or To the Patient; (2) Conceptions of Big Picture vs. Task Orientation; (3) Conceptions of Self in Control vs. Preceptor and Policies in Control; and (4) Conception of Inclusion and Omission of Patient Interaction During Practice. These themes were then organized into two overarching categories of differences that interrelated participants’ education and practice and answered the research questions: (a) Education as a Means to an End or as an Ongoing

Process; and (b) Internal versus External Locus of Control. The following section discusses the results and findings of the study.

Thematic Findings

Category of difference: Education as a means to an end or as an ongoing process

One of the two overarching categories of difference in this study is that ADN's viewed their education as a means to the end result of nursing practice, whereas BSN's viewed education as an ongoing process. The two conceptions (themes) discussed in the next section lend insight into this category of difference. First, Parse's Principle One and Two are applied to the data, and emerging conceptions are discussed using supporting evidence from interviews and observations. Then, similarities among and differences between each group of participants are discussed. Discussions of the two overarching categories of difference are discussed in Chapter 5.

Principle of Meaning, Linguaging, Imaging, Valuing (Parse, 1982): Conceptions of Focus on Self as Coparticipating in Experience with Patient vs. Focus on Self as Doing For or To the Patient

The impact of Parse's (1982) principle upon this study is that nurses show how they structure meaning through their use of language, their lived beliefs and their knowledge. The assumption is made that the educational background of a nurse might influence the way they use or chose to use language to illustrate the meaning and values shown in their practice. All nurses should be able to reflect upon and dialogue about the way they view their own education, practice and how the two fit together, but the choices in narratives and language and values they chose to illustrate might be different, depending on how they were educated to value and reflect upon their own practice. Three abstract questions were asked during the

interviews: “tell me a story from your education,” “tell me a story about your practice,” and “tell me a story about how your education impacts your practice,” These questions enabled the participants to select any number of illustrative narratives to emphasize their perceptions of their practice and education. The choices in stories, as well as the manner in which these stories were told, the language used, and the values highlighted within the stories were analyzed for similarities among participants from the same educational background, and then contrasted from group to group to see if any overall differences emerged. The emphasis here is not placed on telling the stories of how nurses perceive their own practice related to educational background, but how participant nurses in each group were similar to each other and how this was different than the other group.

BSN Participants: Conception of Self as Coparticipating in Experience with Patient

This particular group of participants, each interviewed alone with the same interview questions, had some similarities in both the language and the stories they chose to illustrate their time spent as a nursing student. When asked to reflect on educational background, all primarily focused on clinical rotations during school and one of the most difficult situations they had had to face, including the big picture for both the nurse and the patient.

Becky: The first time I had someone with a fetal demise (baby dies before or directly after birth) really stood out for me....It made me so sad....There was something about just being with somebody and standing by them during such a hard time....The things I did were making sure the pastor was there if they (parents) wanted...picked out the clothes for the baby to wear...things that made the experience more tolerable (for the parents).

Brandi: I remember doing a pamphlet during school that I wasto teach to this girl (patient who was giving up baby for adoption)....I started going down it (pamphlet) and ... she wasn't clicking....I just put my stuff down and said, my sister gave up her baby for adoption when she was 14. And she kind of stopped and looked at me....I told her it was the hardest thing and...took courage and faith to take a chance....That was something she could relate to

and ...listen more...and just her looking at me and saying thank you, thank you, thank you for recognizing that and thank you for sharing and caring....just that fact that (I) sharedpart of (my) personal story...this made (me) more of a person to her, more of a somebody she could relate to.

Betty: During my medical surgical rotation, I was caring for an elderly lady and shedidn't make it to the bathroom. She was very humiliated by that....and I went in and helped her and she was so humbled by that experience....that I was able to help her...and get (her) cleaned up and not look down on her because she wasn't able to care for herself....(it was important) to take each patient as their own individual person and not try to stereotype people together.

As evidenced by their stories, all three BSN participants reflected on more than just a step-by-step playback of what they did for or to a patient during clinical; they added nuances about how the patient felt and how this made them as nurses feel and they were able to draw lessons learned from each story. Each story was told clearly from start to finish, ending with a statement about what the participant had learned for future reference from that situation. All three participants seemed eager and ready to tell stories that not only illustrated their own experience, but also the perspectives of the patients. These stories were told with no hesitation by the participants and they were similar in that they all had untold variables that were affecting the patient medically, but focused instead on what emotionally was influencing each patient. The overarching theme of the way in which the BSN participants viewed their education was how education allowed them to emotionally, as well as physically, participate in caring for patients. Their reflections and stories were not focused on what they had learned, as much as how they applied what they had learned in their education.

When asked for a second story in the interviews, the BSNs seemed to focus in on scenarios that not only highlighted their practice, but also the patients' perceptions of what was going on. *"I had a patient come in at 9 centimeters and ... delivering (baby) 15 minutes*

later....good outcomes....you can see in the mom's eyes that it was worth it and they would do it again"(Becky). This was illustrated in Brandi's choice of a story as well when she described having a friend deliver a baby with her and how she was able to function as a professional and as a personal friend at the same time, using higher level clinical skills as well as working with her friend on an emotional level. Her friend ended up telling her, "not only are you an awesome nurse, but you are an awesome friend". Betty chose to describe a patient who had lost her fiancé two days after finding out she was pregnant and the joy it gave her to help this mother deliver a baby and reflect along with the mother how blessed she was to have this baby to remind her of her fiancé. Again, the focus here was emotional health balanced with the physical health of the patient, with a small interjection of how all these participants found that their skills, when coupled together with emotional, mental and social aspects of their practice, made a difference in the lives of patients. When asked for a third story about how their education affected their practice, BSNs illustrated once again how they were coparticipants in patients' situations:

Becky: I had a patient who had a cesarean section. She needed a few different medications.... I just sat down and told her step by step what I was doing and why I was doing it. I can't point to one class where I learned that because I think it was stressed in all of them.

Brandi: Working with people from different cultures was stressed during school....(I had a patient) it was a woman of a different culture....the husband was concerned because sheneeded a cesarean. In his country, the women go under general anesthetic, which would put them to sleep but it is a higher risk. He didn't know that and wanted it explained to him why (we do this differently here). Normally that is the job of the anesthesiologist. The anesthesiologist went in and basically said, this is America and if you don't like it, you can go back to your own country....I (told the doctor) he needed to review with the patient what is going on andI can't believe you would talk to anyone like that, regardless of their religion or race....It was so unprofessional (of the doctor)....so I was able to stick up for myself and my patient.

Betty: Last Thursday I took care of a quadriplegic for the first time. She had just delivered the night before and she was very demanding as far as needing everything done for her, even though her family was in there....There were points of time when I really wished I could just go in and do my skills and be done, but I couldn't do that. I felt like everything that had been engrained into me meant that I needed to stay in there, and I felt like I needed to be in there for this patient and do everything I could for her....I felt like I made a difference that day and that what I learned in school as far as basically going the extra mile in taking care of her, came to the forefront with that patient.

These three stories illuminate the difference that the BSN education made for these participants. Their ability to tell the stories that hold meaning for both themselves and their patients was clearly part of who they were as a nurse and their professional values. All three BSN participants had no difficulty launching into stories whenever asked, no matter how abstract the question seemed and these stories all revolved around how they and the patient dealt with situations they encountered together, dealing with all aspect of the patient's health: emotional, physical, mental and spiritual.

The common use of language can be examined within the BSN participant group, also. Using Parse's principle of languaging, it can be assumed that the thoughts and language generated by the stories told reflects the BSN concrete educational and cultural reality. There were similar uses of language between the BSN participants: "*making the situation more tolerable, sticking up for, going the extra mile, making a difference, take each person as their own individual,*" indicating a sense of power found in a moment of action; the initiative that a nurse can use to help patients. Likewise, the verbs used to indicate an action were not about doing something to or for a client; much more, they indicate a coparticipation in the event by both nurse and patient. This further illustrates Parse's (1982) first principle of cocreating meaning with the patient.

ADN Participants: Conception of Self as Doing For or Doing to a Patient

All three ADN prepared participants chose scenarios from a nursing school incident to describe when asked about a story from educational background. Their focus was on self and the outcomes of a situation.

Amy: We were in lab....and were trying to put in a (tube) in a dummy. We were all standing around the bed watching the nurse do it. I looked over at my friend and she kind of looked white, I asked, is she having a seizure? Then her eyes rolled back in her head and she just hit the floor. I don't think she could handle sticking someone with those needles... so we were all standing around her; she had to live that one down for a long time....the other (story) the same thing happened but with a real patient. And instructor was helping her put the (tube) down for the first time and saying, he's going to gag but that's OK. You just keep going. So ... he gagged and he threw up and ... then she threw up on the floor next to him.

Alice: One day at school...like the biggest day that I did something and messed up ... we were doing our mental health clinical this past winter. Our teachers always told us not to tell anybody your name, full name, where you live, or anything. We went in just for 5 minutes to meet the mental health patients on the unit that we were going to be on for the next 8 weeks or whatever. We sat down with them and right away... everybody was nervous because nobody had ever been with these people... and somebody asked me where I lived and I just flat out told him without thinking about it. My teacher was like, what are you doing? And I was like, Oh my god, I forgot. So that is a funny story.

Allie: During my 5th semester, I got really sick. I got a strep infection that settled in my pancreas and I ended up being a diabetic. I spent a week in the intensive care unit and my instructors were so kind about that.... As far as patient care, I got really attached to one of my patients in my 4th semester and that patient ended up dying. That was really hard. We were there for weeks, through the full semester there. That was really, really difficult to care for someone every week and then check on them and have them pass. That was hard.

All three of these stories focused on the ADN within their education; what they were thinking and doing. No mention was made of what the patients or other people in the story were feeling. The stories were told precisely, with some reflective emphasis on how hard this

situation was for the participant when they were a nursing student. The similarity between all participants seemed to be that they regarded their education as something linear they struggled through and had completed, but no applied learning was evident from any stories about clinical. Their choice of stories about learning lacks reflection on how their school knowledge was applied to patient care in nursing school.

It wasn't until the second interviews with stories about their practice, that the ADN participants mentioned both the nurse and the patient's perspective of their practice, although they still were not indicating that they felt any sense of participation in what their patients were experiencing. Amy was describing a delivery that went very quickly and how she had to think on her feet:

...we grabbed a doctor in the hallway. It was meaningful because ... she (the mother) was freaking out and we (told) her it was going to be OK....It reminded me that this can go fast; you don't always have time to do all of your special stuff that you want to do, but you have a very important job to do....It was overwhelming.

Alice had a harder time thinking of a story, as seemed to be common among the ADN participants who generally needed more urging and more time to think of stories when questioned:

...oh my gosh, I have no idea (what to talk about).....I had one patient a couple months ago who was a friend of mine from my hometown...she was high strung....and her baby was choking...I grabbed the baby and she began crying.... I spent three hours telling her and reassuring her she could do this.

Allie also had a story to tell about her work and showed some recognition of the difficulties patients were experiencing:

I had a 24 week old fetal demise...that was a really good opportunity to love on that family and just to care for them. I think it was probably one of my best days personally in nursing because I felt like I accomplished what I needed to do as a nurse....it was hard for them....and maybe it was just a little easier.

The ADN participants needed more urging and coaxing to understand how to answer interview questions that asked for stories and often they forgot to include the patient's perspectives in their narratives. Their stories reflected the work they did and how they felt about it, with little to no emphasis on what the patients were feeling. The third story they told about how their education impacted their practice suggested that they viewed education as a closed process, the foundation upon which they now practiced:

(I) was in CCU (critical care unit). We really had to pull things together and the nurses up there would quiz you....I just had to pull it (the knowledge) all together.... When I could look at a situation on my own and say, this is this way and.... I had that knowledge and I was able to apply it and help figure out what was going on with the patient...that was most important to me. (Amy)

I had a teacher in obstetrics in school and she would tell us, we were doing education (teaching patients) and we were upset because we don't know what we are doing so how can we educate them? She always told us to fake it until we make it, honey because they are looking to you for guidance. I try to always sound confident even when I'm not, she helped me realize how important my knowledge is to someone when I'm telling them something important. (Alice)

One of my favorite patients....had complications...ended up dying on our floor. She was with us for months and months and her family didn't come see her. She was depressed.... We did an Easter egg hunt for her in her room and colored Easter eggs and hung pictures up. She was ... sad....she was lonely....I realized that...her body we can patch but the fact that her family didn't come and see her and all of the other stuff is so much bigger. (Allie)

These stories suggest that ADNs think of their education as a means to practice and that their practice focuses on doing something for or to a patient. With the exception of one story told by Allie, the ADNs never chose to discuss the difficulties their patients face every day; they focused on self as the actor of the story. Use of language was also evaluated in the ADN interviews to illuminate similarities in thinking found within the ADN participant group: “*how important my knowledge is, I was able to apply it (knowledge), I spent three*

hours reassuring her she could do this, just sitting with her, love on that family, care for them,” indicating a sense of being in possession of something important such as knowledge.

The verbs used by the ADN group: care for, love on, sit with, reassure her, apply it, illustrated their conception of doing for or to a patient as a result of learning something in their education.

Parse's (1982) Principle of Meaning, Linguaging, Imaging and Valuing: Differences in Conceptions Between BSNs and ADNs

Parse's first principle about how meanings can be shown through speaking and movement, the process of living one's beliefs and how explicit or tacit knowledge is shared can be found in the stories that the participants told. Not only their choice of stories, but also their language and ability to use words to describe the quality of their work gives insights into the values placed on nursing by each group of participants. When asked about education stories, only the BSN participant group was able to find meaning for both nursing and the patient in what they studied in school. They all described somewhat similar situations, in which their focus was on being there for the patient, not what technical skills they were able to complete in each situation. This is similar to what Parse (1982) described with cocreating, meaning that humans participate with each other and their environment in developing meanings. The BSN participants were able to show this cocreation of meaning as they reflected upon what the patients thought about their nursing practice and how they helped the patients get through difficult situations, even though they were just nursing students at the time. It is interesting to note that the words, stories, and values chosen by the BSN group to highlight stories from their education in the first story told seemed to focus on education as a key component in the process of becoming a nurse. The ADN participants, however, didn't

seem to feel that the education was more than just a means to the end result of becoming a nurse; this was evidenced by the stories they chose to tell which highlighted only themselves and their own learning.

As the questions about practice were introduced, themes from both participant groups began to describe the patient as the focus of their nursing practice. ADN participants, as well as the BSN participants, described stories in which the patient focused care was detailed and highlighted and they all reflected on what they had done that filled a more emotional or mental need of the patient. It seems that the values placed on nursing practice by both groups of participants were equally focused on patient centered care. There are a lot of limitations to the conclusions that can be drawn from this, since every nurse experiences the concept of “patient centered care” in hospital orientation. This is the main point of many of the hospitals’ orientation sessions for new employees when orienting to any hospital based care unit. It remains an unknown conclusion whether the value placed on patient focused care came about from both participant groups’ education or from the employer’s orientation sessions. It can be concluded, however, that the BSNs from this study found more meaning in patient centered care during their education than those with ADN background. They all described being there for the patient emotionally, rather than what was going on with their own nursing student practice. The BSNs also focused on how they were interacting or coparticipating in events with the patients, while the ADNs reflected on what they were doing for or to the patients that held meaning.

The differences in use of language between the two groups can be identified: the BSN group seemed to feel a sense of empowerment in acting on their knowledge highlighting depictions of the ongoing process of applying learning in their practice; the ADN group

claimed that same empowerment in possession of knowledge which suggested they defined learning as something they had already completed. ADN stories illustrated that they use their knowledge to do for or to patients, instead of coparticipating in the experience, as the BSN stories suggested. Use of language showed values that can be interrelated to how both groups of participants related their education to their practice.

Dealing with abstract questions when asked for narratives was also similarly easy for the BSN participants and harder for the ADN participants. At one point, Amy stated between interviews, *“This is so hard. I just don’t feel that I’m giving you anything of any value in these interviews.... Can you tell me what the others are doing and if I’m doing it right?”* This consistently seemed to be a point of anxiety the ADN participants voiced throughout the interviews and the observation; whether what they answered or showed of their practice was of any value. It is similarly interesting that at no point in time, whether during an interview or when chatting about it later, did any of the BSN participants ever ask or show any anxiety about what was asked of them, what was observed, or whether their answers were helping the research study. This phenomenon adds to the values principle by Parse (1982) in which she described the process of living one’s beliefs as inherent to a nurse’s practice. The assumption can be made that the ADN participants in this study questioned any value placed on their lived experiences, while the BSN participants anticipated that their lived experiences would produce results worth exploring.

Parse’s (1982) Principle of Creativity: Conceptions of Big Picture vs. Task Orientation

The impact of this principle upon this study is that nurses show how they structure meaning through their ability to help patients realize their own harmony and patterns of being/existing, ultimately assisting patients to see new possibilities. This occurs not through

nursing technical skills completed as tasks during a workday, but in being creative and sensitive to the needs of patients, both physically and spiritually (Parse, 1982). The assumption is made that the educational background of a nurse might influence the way they perceive their own creativity and value in self and environment. Observations were used to determine the extent to which all participants used creativity and valued this use in interactions with their patients.

BSN Participants: Conception of Big Picture

Situations encountered during observations in the obstetrical units of three different hospitals in the Midwest illuminated the practices of three different BSNs. All three participants with BSN background were in various stages of their orientation to the unit (orientation is defined as the first six to twelve weeks on the unit or until deemed ready to practice on their own by the preceptor); two were orienting to the labor and delivery side, and one had just completed orientation to the postpartum side. After completion of three interviews with each participant, a time was set up for observation. Observations were carefully planned so I could be with BSN participants as they interacted in some way with their patients, at least for one hour, but with the preemption that this could be extended, should there be opportunities to view participants in different stages of their practice. All BSN participants had nurse preceptors who were helping them orient to their unit, but were allowed to engage in nursing responsibilities and were individually assigned patients as their skills and knowledge advanced. Following are extracts and discussions of the three BSN observations which pertain to Parse's (1982) principle of creativity.

During the observations, all of the BSNs encountered situations when they were overwhelmed with performing tasks to complete their workday and still needed to be creative

and sensitive to their patients' needs. Their creativity in anticipating and dealing with patients' needs was never halted by the need to perform or to learn a technical skill. As demonstrated in the three excerpts below, these BSNs showed extreme vision and understanding of the big picture of patient health, instead of focusing on the smallness of technical tasks in their work:

Becky was working with a young teen mother when I arrived.... She was in discussion with a preceptor and discussing the placement of an internal monitor to show baby's heart rate. This is a skill usually only done by nurses after one year's experience, and requires certification, so it was not surprising that Becky couldn't do this placement alone. She watched intently as her preceptor completed the task, never releasing control of the environment nor her focus on the patient. At the same time, Becky was talking the patient through the effects of having an epidural as pain management during labor (which had just been placed), and constantly moving around the room, efficiently ensuring that all monitors and medications were in their place.... Becky eluded a self-confidence which the family was using as an excuse to withdraw from actual support of the young patient; immediately noticing this, Becky took extra care to involve the family in her encouragement, taking hold of a family member's hands and demonstrating how to stroke the patient's back so it would be more comforting. She kept encouraging them to be with their teenager and emphasized their importance in the birthing room as support; turning lights off to allow the patient to rest and speaking in a low voice to role-model supportive environment as she got ready to leave them all alone to rest for awhile. (Excerpt of Observation Notes, Becky, 2009).

During the later delivery phase, Brandi moved around the room, engaging in conversation and teaching about this phase of the delivery with the family and patient. Although her preceptor was present in the room to help, Brandi never looked to her for instructions, and instead focused on urging the patient when to push, interjecting things she thought the father of the baby would like to see or know such as looking at the hair of the baby's head, or taking the blood pressure cuff off as it got in the way of the patient's pushing efforts. As issues came up that Brandi needed instructions on, such as how to chart on the monitor strip, or when to call the physician, she initiated questions about what to do, already conceptualizing the need to chart, just not having clarity on where and how. (Excerpt of Observation Notes, Brandi, 2009)

Betty had a lot to do that day....she never stopped smiling and speaking in a low voice to keep mothers and babies as undisturbed as possible, while doing

physical checks, and teaching on all the aspects of care each patient needed. Her third patient was a younger mother with lots of questions and she took her time, pulling up a chair so as not to stand over the mother in bed while discussing, getting her face parallel to that of the patient, and explaining each point she was making while holding the newborn and pointing out things on the baby's body. She included rationale for each teaching point, her obvious goal was to empower the mother of the baby to care for their own baby and she utilized every opportunity to get her patients to touch their own babies. She spent a very short time charting on each patient as she moved from room to room, stating that she would take time to complete the charting when her shift was over and she didn't have to take time away from her patients to do so....The seventh patient was having a rough day and complained of a sore throat; Betty took the time to walk her through all the different ways to sooth a sore throat....(she ordered) a lemon from the cafeteria to add to her patient's tea with honey to sooth her throat. As she returned to the patient's room with the lemon, the situation took a new twist and the patient, upon finding that Betty was prepared to go to extraordinary lengths to take her complaints seriously, suddenly began discussion about a newborn issue she had obviously been concerned about. (Excerpt from Observation Notes, Betty, 2009)

In these excerpts, it is easy to see that the BSNs focused on the patient's needs, and not on doing technical skills or the tasks to complete their daily work and charting. In Becky and Betty's cases, going the extra mile for their patient led to unanticipated results that they had to be sensitive to and address immediately, despite other work waiting for them. Becky immediately noticed that her care of the patient had somehow interfered with the family's connection and took steps to alleviate this, while Betty ordered a lemon and found a way into a patient's confidence by being so sensitive to her needs. Brandi was able to help a father connect with his unborn baby while simultaneously learning new skills and incorporating them into her maintained control over the calming environment for the patient. Newer graduate nurses tend to concentrate on learning skills to enhance their practice and their attention is most often focused exclusively on these skills and not on the big picture for the

patient (Benner, 1994) and, yet, these BSNs were able to incorporate learning as a normal process without losing sight of the big picture for their patient.

Also similar was each participant's focus on the emotional, mental and spiritual health as well as the physical assessment of their patients. To an extreme, each participant encountered patient situations which, without subtle intervention by the nurse, could easily have had a different outcome; from providing lemons for a sore throat and opening new avenues for trust, to the removal of a blood pressure cuff or involvement of a father in the birth of his baby or to the inclusion of the family of a young teenager in soothing the patient, all participants intuitively were able to comprehend how important these small things were to the big picture of taking care of the patient. Creatively opening new possibilities for families or patients to interact gave them new opportunities in the birthing and bonding processes that would have otherwise not have been possible.

ADN Participants: Conception of Task Orientation

Three observations, all set up for approximately one hour, with the potential of time extensions should they be necessary for data saturation, were conducted at three different hospitals in the Midwest. Each participant observed had already completed a set of three interviews with me. Several attempts had to be made before each ADN participant had been observed for a full hour of patient care, so these observations were made over several different periods of time. Observations were examined with excerpts as follow for creativity according to Parse's (1982) principle of rhythmicity.

All the nurses from this participant group were on orientation, although two out of the three had almost completed their orientation fully. Several observations of their practice showed their focus on technical skills, sometimes to the exclusion of patients' other needs.

Excerpts of the following situations highlight how this group of participants often missed opportunities to creatively address patients' issues, instead focusing on technical skills and tasks.

After hooking the patient up to a blood pressure cuff and fetal monitor, Amy was preoccupied with the paperwork and kept her head down while asking questions, seated next to the patient in bed and the computer in front of her. She was charting and asking questions, using humor to make small conversation with the couple. As the patient was going through this process, several times she or her husband stopped to ask a pertinent question about how things might progress for them should they be in labor already. Amy never answered their burning question about whether they could film the birthing event, focusing instead on completion of the paperwork or computer charting. As they pressed the question yet again, Amy looked up from her work and asked them to repeat the question, after which she replied that many couples do this. The sharp pain that was the cause of this patient's trip to the institute was revisited, with questions about the exact nature of the pain: sharp, constant, intensity, duration, etc. As Amy completed the paperwork, the patient asked several questions about what this pain could potentially mean for the baby. Anxiously waiting for an answer, the couple was intent on listening to whatever the nurse had to say, but she stated that she didn't know and they would have to ask the physician when they saw him. (Excerpt of Observation Notes, Amy, 2009)

Alice was off of orientation and working with a laboring couple, during the pushing phase. When different phases of the pushing occurred, she was so preoccupied with her charting and getting the room ready for the physician and the birth of the baby, she missed the opportunity several times to make the process more comfortable and understandable for the patient and her spouse:

....she (Alice) was told that her patient had suddenly gotten dizzy....as a nurse I (researcher) implicitly understood that this dizziness sometimes accompanies as woman getting fully dilated and progressing to the pushing phase of labor and also the sudden blood pressure changes associated with this which necessitates putting the patient's head of the bed down a little, but no teaching or rationale was offered by Alice, who simply stated she needed to check the patient. After the check....the sudden urgency and eagerness by the couple to discuss excitedly that this was almost over and to determine how much longer it would be until they met their baby was lost on Alice, who was

frantically attempting to get all the furniture in the room moved so the delivery table could be set up....the understated atmosphere of the room changed while (Alice) was stressing about the position of the bed and lamp, etc. The couple,, picking up on her stress, stopped their discussion while the husband helped Alice move the chair out of the way to the side of the bed.
(Excerpt of Observation Notes, Alice, 2009)

A similar pattern happened with Allie as with the other two ADN's during observation. In this situation, Allie was so intent on drawing up medication for the birth of the baby, getting the baby warmer ready to receive the new infant, that she was not able to continue giving support and encouragement to the patient and her family. Allie's preceptor had to step in and help with the big picture, while Allie was only able to focus on one technical skill after another...opportunities for bonding and connecting the patient with her newborn baby were later lost as Allie concentrated on immediately whisking the baby over to the warmer to undergo a physical assessment.

The observations of the three participants with ADN backgrounds showed many similarities both in how situations occurred and also in what did not occur. The first similarity was the task-oriented focus of the ADN's practice. All ADN's seemed to concentrate on achieving the tasks or responsibilities set out for them by the preceptor. Their work did not seem to be self-driven and motivated, rather a checklist that they needed to complete. These tasks were usually physical in nature and the majority of them observed did not include more than the physical well-being of the patients (omitting attention to the spiritual, emotional and mental wellbeing). For example, while attending to the charting, the Amy seemed oblivious to the emotional needs the patient was stating in her questions. Even when fulfilling tasks independently of their preceptor, there was very rarely any sense of creativity on the ADN's part: no indication that they could sense how their reaction and

motivation to help the patient with needs other than the physical tasks at hand could change or help to structure other possible patient outcomes. The lack of value these participants placed on their own use of creativity, as well as the lack of creativity actually used during the observations to help patients come to new outcomes was evident in this group of participants.

Parse's (1982) Principle of Rhythmicity: Differences in Conceptions Between BSNs and ADNs

Although we know that new nurses tend to concentrate more on the physical aspects of a job than expert and more experienced nurses (Benner, 1984), the ADNs and BSNs were all within the first months of learning a new job and within the first twelve months of graduation from nursing school. Therefore, the contrasts between the way they view and conduct their job cannot all be explained by gaining expertise in the area; there must be something additional that BSN nurses bring to their nursing practice that allows them to see multiple possibilities for each situation they experience. The vision, or creativity expressed by the BSN participants in their interviews and observations and the glaring contrast to the ADN participants left no doubt that there are differences, at least among these participating new graduates. The opportunities presented themselves in each observation for the ADNs to take a course of action, which had the potential to change the patient's perceived situation, but their omission of actions which would impact the patients on mental, spiritual or emotional levels, led to an environment that lacked the depth and connection I observed in the BSN participants' situations. Although all of the ADNs mentioned in their interviews that they wanted to help patients on both physical, as well as spiritual, mental and emotional levels, they were not able to sustain that premise when confronted with the reality of the job's demanding responsibilities.

Category of difference: Locus of control as internal or external

The second of the two overarching categories of difference in this study is that ADN's viewed the locus of control over their practice as external, while BSN's viewed the locus of control to be internal. The two conceptions (themes) discussed in the next section lend insight into this category of difference. First, Parse's Principle One and Two are applied to the data, and emerging conceptions are discussed using supporting evidence from interviews and observations. Then, similarities among and differences between each group of participants are discussed. Discussions of the two overarching categories of difference are discussed in Chapter 5.

Parse's (1982) Principle of Creativity: Conceptions of Self in Control vs. Preceptor and Policies in Control

Parse's (1982) principle of creativity can also be used to analyze the data for answers to the second research question in this study: what differences are there between ADN's and BSN's as they relate to and interact with others? Parse discussed that this principle is not just applicable to finding new ways to be creative in dealing with others, but also to the paradoxes found in interactions. In the connection of humans to one another and to the universe, they are "enabled and limited by the infinite numbers of opportunities and restrictions inherent in all choosing" (Parse, 1998, p. 30). The lived paradox of being a newly graduated nurse fits this description: by graduating, and becoming a nurse, the graduate now has attained a high status in the public's eye, but the same newly graduated nurse is still experiencing knowledge assimilation to the new unit, new skills, and new peers while simultaneously having to appear competent. How each newly graduated nurse chooses to deal with this paradox is unique to each person. In this study, observations of ADN's and

BSNs are analyzed to see how they deal with the paradox of being a nurse, yet having to learn new skills and prove themselves as if they were still in school. Nurses show how they structure meaning through their ability to balance the paradox of being knowledgeable and yet seeking new information. The assumption is made that the educational background of a nurse might influence the way they perceive and deal with this paradox.

Observing Becky's interactions with her preceptor and the physician, it became clear that she was in control at all times of her environment and her own learning:

Everything all ready for the birth, Becky stepped out of the room, conferred with the anesthesiologist and physician, asking leading questions, such as "do you want me to call you when she is complete, do you want pitocin after the birth?". These were asked directly, using eye contact with all stakeholders in the conversation, and in anticipation of needs to direct what kinds of things she asked about. At no time was there the feeling that she was not in control of her patient's progress, and the anesthesiologist and physician treated her with respect and directed answers to her, despite the fact they knew and saw her preceptor standing to her right...(Excerpt from Observation Notes, Becky, 2009)

Likewise, Brandi's clinical observation illustrated many times how she was able to multitask, managing the patient and the environment. One such incident was while her patient was pushing:

Situating herself close to the mother's face and staring her in the eyes as she encouraged the mother verbally to push hard and not come up for air yet, Brandi glanced over at the monitor at the bedside to check on fetal heart tones, then nodded at the support person, and adjusted the blood pressure cuff on the mother's arm, all the while talking steadily and softly to the mother, counting down the time until the mother could rest between pushes. After several pushes, BSN 2 felt the mother's tummy, and could obviously feel the relaxation of the tummy muscles, so she helped the mother back to lie down in bed, feeding her more ice chips and supporting the father's arm as he wiped the mother's forehead with a washcloth. Turning towards me, Brandi introduced me to the family at the appropriate time and continued to give both the patient and the unborn baby her attention.... As the nursing preceptor came in the room to check with Brandi about progress, she mentioned calling the physician to give an update, which Brandi immediately took on as her own

task with no further questions or hesitation. Dialing the phone, one could hear her speaking authoritatively into the phone, giving information about the stage and anticipated progress of the patient. It was noticeable that Brandi did not ask for guidance to talk to the physician, which is understood by all nurses in practice to be one of the most difficult issues: what kinds of information and how this is verbalized to each separate physician is a matter of personal choice of the physician and normally an inherent part of orientation between preceptor and mentee: that was not the case here. Clapping her phone closed, she turned to the mother of the baby, stating that the physician was in house and soon would come in for the delivery, and began moving furniture around the room in anticipation of the delivery phase.... (Exerpt of Observation Notes, Brandi, 2009)

Following her preceptor's instructions never took away Brandi's control over the environment, rather the task was accomplished and the unspoken understanding was that this was merely a task that Brandi hadn't had experience with, but that she still maintained the lead nurse role in the birth process for this patient; the preceptor was merely an additional body in the room. Preceptor, family, patient and physician deferred to Brandi when discussing the progress of this birth.

Betty showed almost complete autonomy during my observations with her, also, in fact, she only checked in with her preceptor once during my entire visit with her. She controlled and regulated her own pace, allowing the needs of the patients to set the flow of her work as she prioritized according to patient needs.

BSN Participants: Conception of Self Control

The most interesting similarity between all three BSN participants is the continued and maintained control of the environment in which they are working. Although each of the participants was with a preceptor, in various stages of learning autonomous practice, all three maintained control over their own learning and their patients' situations and did not release this control, even when getting directions for practice from other sources. Conversation

between the participants and their preceptor or other health care workers occurred under the tenet of peer advice or consultation. This indicated the high level of value each participant placed on their own practice and their own ability to use that practice to the betterment of the patients.

ADN Participants: Conception of Preceptor and Policies in Control

The ADNs never seemed to be in control of their practice environment, whether alone in the room with the patient, or together with their preceptor. Either the ADNs hurried out of the room to confer with their preceptor, or their preceptor was present with them, setting the tone and the stage for everything that occurred in that environment. One such observation was of Amy as she was asked to admit a couple to see if they were in labor. Although the couple was anxious to learn about the sharp pain that had brought them to the labor floor, wondering whether this was labor or something dangerous for baby, Amy continued her admission questions, concentrating on getting her task completed, only pausing to answer, “*You’ll have to ask the physician.*” She stepped out the room constantly to check in with her preceptor about her progress and to ensure she was doing things correctly. Later, a telephone call to the physician was made after she received exact verbal instructions from her preceptor on what to say and how to report about the couple she had admitted. Interactions she had with the patient and her preceptor and even her physician suggested that she was following policies and guidelines to the letter, but somehow not incorporating her own learning into her practice. My observation notes stated: “*...it was as if she stopped being a nurse sometimes in order to revert to being a student and asking for guidance on each step.*”

The same similarities emerged with the other ADNs. Alice and Allie visibly deferred to both the physicians and their preceptor when they entered the room. Alice was caring for

her patient in labor and had just checked her dialation, but when the physician came in immediately afterwards and wanted to check for dialation, she never mentioned she had just completed this and that the patient was fully dialated. Instead, she waited to see if the physician's assessment was comparable to her own before beginning to discuss. Any time Alice or Allie's preceptors entered the room, they deferred control of the environment and patient care to her.

The ADN's observations all contained aspects of care that, had they taken control of the environment and the patient care, opportunities to interact differently with peers, preceptors and physicians would have emerged. It was evident that most of their tasks were completed according to instructions given previously by their preceptor or by knowing what institutional policy demanded that they do in each situation. Reaching beyond those policies or instructions by the preceptors could have reshaped their relationships with others, but they remained very task oriented. Although it was good care, it was not under their own control. It was also noted that each of these participants took the opportunity before or during my observations to comment on their lack of technical skills leading to their angst that they were somehow not able to contribute as well to my observations as someone else. Their lack of self confidence in their own practice struck me again as an outstanding similarity between this group of participants.

Parse's (1982) Principle of Creativity: Differences in Conceptions Between ADN's and BSN's

ADNs perceived themselves not to be in control of the environment or of their patient care or own learning. Instead, they looked to other health care practitioners for guidance when they entered the room, or they were so busy ensuring they were adhering to policy and procedure in different situations that some opportunities for creative interactions with

patients were missed during observations. It was as if the need to learn new skills again reverted them back to being students, instead of being able to be both a learner and a nurse simultaneously. This lack of control to stimulate changes in and to control their own work environment stood out in contrast to the BSN coexistence with each patient within the situation at hand. During this study, all of the BSNs were able to be both a learner and a nurse at the same time, never losing control or focus on their patient care when learning new skills, and not forgetting that they were in control of their own learning.

Parse's (1982) Principle of Interaction: Conceptions of Inclusion and Omission of Patient Interaction During Practice

Parse (1982) stated that the way we move beyond the actual meaning of the moments we encounter to that which is “possible” (p. 167) defines how well we can change or increase our own diversity in nursing. By being with patients and helping them discover their possibilities, both the nurse and the patient and others can transcend the actual moment to embrace change and new ways of thinking about the situation. To power unique ways of originating is how nurses interact with each person they encounter to enhance the process of transforming, or moving beyond the situation at hand to embrace the possibilities.

Parse's (1987) third principle illuminates how nurses interact with situations and patients.

Parse stated that the authority, responsibility and consequences of decisions are given to the patient. Nurses must help empower new ways of looking at health issues within the patients and families they encounter, not by placing values or goals, but by listening, and being willing to facilitate change in themselves and others about new, emerging possibilities. In terms of this research, interviews and observations with nurses detailed above have already illuminated the similarities and differences in the ways in which two and four year nurses

approached and dealt with patients and families and health care situations. It might seem redundant, therefore, to revisit this data and analyze interactions of these participants. After thorough analysis of the data; however, the differences between what participants said in their interviews and what they actually practiced when observed became obvious as a conceptual difference that could be interrelated to their background education.

Parse's (1982) third principle about interaction with patients is discussed and analyzed with the data. Differences between how the participants say they practice and observations of their actual practice are highlighted. Although all of the participants were well able to define how they interacted with their patients and focused on their patients' needs, only one group actually was observed doing this to fullest extent. The following section uses Parse's (1982) third principle to compare participants' description of their interactions with people with the actual observed interactions. Similarities between each participant group are highlighted, and then used to contrast the groups according to educational background.

BSN Participants: Conception of Inclusion of Patient Interaction During Practice

In their interviews, BSNs were able to verbalize what their practice entailed and reflected on their own strengths and weaknesses. These were similar in nature, dealing with the psychosocial aspects of interactions with patients with less focus on the technical skills of learning to become an obstetrical nurse. All participants seemed to view the technical skills of nursing as something that would be learned over a period of orientation time on the floor, not as determinants of their own level of expertise in nursing practice. They all were also able to look beyond their lack of having time to learn all the necessary technical skills to focusing on the essence of their practice as meeting the emotional needs of patients.

Observations triangulated this interview data and showed that all BSN participants did, indeed, interact with patients on many different levels. Following are excerpts of interviews with BSN participants highlighting their practice and their own evaluation of their strengths and weaknesses in practice, followed by discussions about the triangulated data from the observations of interactions with patients.

Becky described her practice as:

providing a calming presence for people... (I) always explain things (to patients) and that does make a big difference... I think for the most part, I look at the big picture as far as these are my priorities....but I tend to be a little scatter-brained in the real high stress situations....afterwards when I go look at the chart I notice that I didn't write this thing (that happened) andhave to try to connect all the pieces at the end...

Detailed previously in this data analysis chapter, observations of this participant showed her commitment to the big picture and empowerment with her patients. As Becky was walking her patient through the steps of an epidural while encouraging the patient's family to help participate in patient care and massage, she was empowering the family to be there for her patient, while explaining step by step procedures in the effort to help the patient. Sensing the family's reluctance to provide sustained support for her patient, Becky emphasized the need for them to be present, creatively finding ways for them to interact with the patient and to enhance the situation at hand. Her interactions with her patient, as well as her preceptor and other health care professionals showed her self-confidence and understanding of the big picture of the birth process and her role in this situation. Although, as observed, Becky needed to ask another nurse to place an internal monitor (technical skills), this was never the source of her self control or self esteem in her practice or in her interview about her practice.

Brandi described her practice as:

there isn't anything that is not important with my job.I think I bond with my patients well....that can really make a difference in somebody's delivery...You need to be able to bond with the patients and assess their needs....social or physical....how well they are going to do....being able to judge that, being able to recognize signs that they might have trouble.....You have to connect on all levels and (you) have to be there – you have to watch baby, the mom, the monitors, the medications that you have to give- it's everything....I'm really good with (all the skills) getting up to the point of delivery....I'm excellent with taking over on baby (once it's delivered), but I forget Mom (the patient) is there. I forget (to do the skills) all at the same time I'm supposed to do stuff on the baby. I know that I will get it....it will just take time...and finding out what works with me. Being in orientation, you are with multiple people as your preceptor and everyone does things differently....you have to adjust your style for that person (preceptor) so you can't find your own style until you are on your own.

As detailed previously, observations of Brandi's practice were similar to what she described.

Brandi was multi-tasking the technical skills of helping a patient push while simultaneously dealing with the patient's anxiety by staying close by and looking in her eyes as she softly talked her through each pushing phase. She was able to connect with her patient and the patient's family and to develop her own style of interaction with the patient, while also working with her preceptor and the other health care professionals. She maintained control over her own learning as pertained to technical skills, as well as the patient's situation, and this control was evident during the whole observation period.

Betty, when asked what was important about her job, what her strengths and weaknesses were, stated

being there in a time of need, when a parent is in distress over what is going on with their baby or if the baby is needing to be monitored for some reason....the most important thing is being right there by their side, letting them know what is going on, giving them everything in layman's terms so that they can understand what the next step is....I think I bring a smile to my staff and my patients....I think (my weakness) is me truly believing that I am doing everything that I should be....a lot of that is technical skills just in situations where I'm not sure what's going on right now, or I don't think I know what is going on.

Observations detailed Betty pulling up a chair to sit close by the patient while describing and showing details about the baby and its care. This situation showed the value placed on creating a nurturing presence by the nurse and her focus on interaction with patients on all levels. Taking her time with each patient, she left each one with the impression that, not only was she not in a hurry, they each were special to her care. Going the extra mile to find ways to help and comfort her patients, even to the extent of ordering honey from the cafeteria, showed her investment and valuing of other peoples' needs.

BSN participants all not only discussed their interactions with patients as important to their practice, but observations showed the extraordinary value they placed on this aspect of their practice. These three participants all described their weaknesses in terms of technical skills, but not in terms of learning these skills, rather in the application of these skills during highly stressful multitasking situations. Becky needed to ask another nurse to place an internal monitor, yet this was not viewed as a weakness of her practice, instead she highlighted the highly stressful situations and learning to better multitask with technical skills inside these situations as what she needed to learn to do better. Brandi and Betty added to this discussion as they described their needs in terms of "*learning what works for my own style*" (Brandi) and "*learning what is normal (in which situation)*" (Betty). Never do any of these participants connect not knowing a technical skill as a weakness, rather, they described their own weakness in not being able to apply several technical skills within nursing situations and they also reflected quite clearly that they all anticipated this would cease to be a problem as soon as they'd had more experiences in this area. Thus, the application of the skills to the

situation, rather than the skills, themselves, were viewed by the BSN participants as outstanding items to learn.

ADN Participants: Conception of Omission in Patient Interactions During Practice

All of the ADN participants also described their practice as focusing on being with the patient, similar to the BSN participants. They used terms such as “*make people feel comfortable*” (Amy), “*bonding with people*” (Alice) and “*people skills*” (Allie) as their strengths in practice. Similar to the BSN participants, the concept of being present with the patients seemed to be integral to their understanding of good nursing practice. Following are excerpts of their answers about what is important in their practice, as well as where their own strengths and weaknesses lie, triangulated with observations of the same in these participants as they interacted with their patients:

It is wonderful to be there on somebody's best or worst day....the most important thing to me is making sure that I am thorough and that I am always watching...making sure that I catch if something is going wrong or going downhill before it happens....and the second most important thing- the most fulfilling thing to me anyway- is the part where I get to connect with the patient and make it a good time for them and make it a happy time for them or whatever they wanted it to be...I'm able to make people feel comfortable....they can be freaking out and in pain and I can look at them and talk to them...that is what I do best, comforting and calming people down when they are freaking out.... (but) being able to identify something that a twenty year veteran (in obstetrics) knows is difficult for me....that is my weakness, not having those twenty years (of experience) to back me up.”
(Amy)

Observations of Amy were previously described in this chapter. Although she had discussed her practice strength as “*making people feel comfortable*,” the observation showed that she missed several interaction opportunities to make her patient feel comfortable. The inadequate attention to the anxiety of her patient turned a routine admission into something more stressful for her patient. She seemed more content to follow a procedure or policy by doing

her skills necessary, and never investigated each interaction with patients as an opportunity to help them find possible outcomes or empowerment. Her attention was on the skills she needed to get done, under the orders of the preceptor and she never seemed to quite be in control of her own interactions with patients.

Alice described being caring and compassionate as well as having a knowledge base:

I think it is important for me to be knowledgeable....being caring and compassionate for people is just as important....I can bond really well with people...building rapport and making people trust me so we can work together....(but) because I am so new I get nervous and get panicked when I'm doing a delivery and get caught up in what's going on and not paying attention to what else is going on (big picture).

Observations were detailed previously of Alice's practice. Although she had stated that she put emphasis on "bonding" with her patients, she showed a lack of bonding as she seemed to get stressed over the impending birth of the baby and missed the opportunity to explain to the patient what was occurring with the birth process, as well as not encouraging the patient to use different positions for pushing in attempts to ease the pain of birth. Rushing around the room changed the environment from positive and hopeful to a kind of anxious waiting that Alice could have easily dispelled with some conversation about what she was doing and what was occurring to the patient. Her inattention to the emotional needs of the patient and the patient's family turned a hopeful situation into a somewhat fearful event:

Taking care of the patients' spirits and hearts is one of the most important (aspects of the job) to me....I'm going to make sure that their hearts are nurtured a little bit and I will love on them (patients)...just spending time getting to know them and their families, asking about their grandchildren...tell them that they are going to be OK, that we are going to get through this, that I am not going to leave them...my people skills are....my strong suit....(but) procedures (skills) and policies is a brand new area (for me). (Allie)

As observed and detailed previously, Allie failed to show that she spends much time interacting with her patients. Although Allie described the emphasis of her practice as “people skills”, there was little to none of this occurring during the observation time spent with her. Although she addressed her patients as “honey” and “sugar” which might be the kind of “*loving on my patients*” she described in her interviews, she was given every opportunity to connect with her patient and family in the room during the birth process. Instead, she allowed the preceptor to take charge of the situation, responding to orders instead of thinking ahead and using her people skills with the patient to ensure that the patient was encouraged to continue pushing. Allie showed good attention to the technical skills of delivery and newborn assessment, but missed the opportunity afterwards to continue the bonding between baby and parents by leaving the baby snuggled in the newborn warmer instead of back with its parents. Once again, inattention to the emotional needs of the patient changed the situation.

Observations of the ADN participants showed a lack of connection between what they claimed was important in their practice, and their actual practice, itself. All of them were observed to miss several opportunities to answer questions and to interact with patients, which could have made the patient less anxious; instead, they could be found focusing on their technical skills. Triangulating the words ADN participants used about their practice with their actual practice settings showed a clear lack of connection between what they said they did and what they actually did. It is interesting to note that all participants in this group knew to describe their practice in ideal terms, such as “*being with, making people comfortable, etc.*” but did not actually know how to create situations that would enhance this aspect during their nursing practice. Again, the aspect of “cotranscending the possible” with

patients clearly is an important concept of nursing practice which all participants were able to describe, but in this case, the ADN participants seemed to miss opportunities to actually use this principle in their own practice. The missed opportunities for “cotranscending” (Parse, 1982) with their patients were many, even though ADNs’ practice itself was not technically unsafe at any time.

Parse’s (1982) Principle of Interaction with Patients: Differences in Conceptions Between ADNs and BSNs

Using Parse’s (1982) third principle to evaluate the participants’ interactions with patients necessitated using both what the participants said about their practice and what they actually did in their practice when being observed. From the triangulation of these data as previously detailed, one can conclude that both groups of participants knew and placed value on interacting with patients in order to create new possibilities in their health. All participants used terms to describe the strengths of their practice in terms of what Parse (1982) would call “cotranscending the possible” or ways of interacting with the patient that allows the patient to come to new understandings about the situations they encounter. The difference in how this cotranscending occurs in different groups was found not in the description of the participants’ nursing practice, but in what actually transpired during their practice. The BSN participants clearly understood both verbally and during their practice the value of interaction with the patient, while the ADN participants could name the value of cotranscendence, but seemed to miss many opportunities to interact in new ways with their patients. Observations showed many lost possible moments of interaction between ADN participants and their patients; these interactions, although not life threatening in any manner, could have led to new ways of connecting with the patients and new understandings that simply did not take

place. The main difference for the ADN participants was the omitted act of cotranscendence, but not of the value of this within nursing practice.

The weakness in their practice as described by the ADN participants were, “*not being able to identify something a twenty year veteran (in obstetrics) could*” (Amy), “*not seeing the big picture*” (Alice), and “*being new to some procedures and skills*” (Allie). With the exception of Allie, both other participants seemed to recognize that there was more to nursing practice than just the technical skills. Recognizing the aspects of nursing situations as complex and contextual, Amy and Alice verbalized their need for this added understanding to enhance their practice. Allie still seemed focused on the acquisition of new technical skills necessary to enhance her practice. The importance of naming their own weaknesses in practice becomes evident when comparing the two groups of participants: all participants seemed to understand the need for applying their technical skills according to the context of the complex nursing situations they encountered, but were at varying stages of being able to complete this. The ADN participants were lamenting their lack of understanding of the contextual influences within their practice situations, while the BSN participants already voiced their understanding of the contextual influences and were wanting more complex situations in order to validate their understanding of how to apply technical skills within those situations to make their practice complete. Working backwards, it may be concluded that most of the ADNs first worked at developing confidence in technical skills, but they are beginning to acknowledge that there should be more to a nursing practice than just using skills; whereas the BSN participants have bypassed this isolated focus on technical skills in favor of contextual application of these skills.

Summary

This chapter examined the practice and perceptions of ADNs and BSNs for differences. The following research questions guided the analysis:

1. What are the differences between ADNs and BSNs as related to the meaning and values they place upon education and practice?
2. What are the differences between ADNs and BSNs as they relate and interact with persons during their education and practice?

Four differences in conceptions (themes) emerged:

1. Conception of Self as Coparticipating in Experience with Patient vs. Focus on Self as Doing For or To the Patient;
2. Conceptions of Big Picture vs. Task Orientation;
3. Conceptions of Self in Control vs. Preceptor and Policies in Control; and
4. Conception of Inclusion and Omission of Patient Interaction During Practice.

These differences were organized into two overarching categories of difference: ADNs focused on their (1) education as the means and their practice as the end result, over which (2) the nurse has no ultimate control (external locus of control). BSNs focused on their (1) education and practice as an ongoing process and how (2) the nurse him/herself is in control of his/her own learning processes and practice (internal locus of control). These categories of differences are discussed and related to previous research in Chapter 5.

CHAPTER 5. DISCUSSION

This chapter considers the implications of the differences (the key component in phenomenography) found between associate degree nurses and baccalaureate degree nurses regarding the way they perceive their education and practice. The chapter is organized to first provide a discussion of the findings (two categories of differences) and an overall summary of the study. Next, a final discussion on the ethical considerations of this study follows. The chapter concludes with a discussion of implications and recommendations for nursing education and practice.

First Category of Difference: Education and Practice as a Result or a Process

It can be concluded from the data coding and analysis of the data above that the ADN participants perceived their education and practice differently than the BSNs in this study. Discussion with the ADN participants revealed that they perceived their education and practice as an isolated and completed result of acquiring knowledge and taking the licensure test.

(Classes) were extremely hard....we were expected to know all of the disease process...all of this...everything, how it works, medications...everything....it was just a scramble, who can study the most....who can make it through....I ended up doing it and doing fine, but it took a lot of work. (Amy)

This stands in sharp contrast to the BSN who reported:

What sticks out most in my mind (about my education) is the amount of compassion and the individualized....quality education....I didn't really know (sometimes) why I was taking (classes), honestly I didn't get it until my last year and then everything tied in together. And I was like, oh my gosh, this is what I'm doing. Because of that, I have been able to hold myself in whether it may be a patient interaction or physician nurse interaction or even just nurse to nurse interaction I've been able to hold myself and my career more...in a

professional manner....so it helped mature me as a human being and as a worker, employee and member of the workforce. (Brandi)

These excerpts represent the overall attitude by each participant group towards their education as noted in interviews; both placed value on the education, but the ADNs seemed to believe it was over and completed (a result) while the BSNs discussed the ongoing nature of how what they learned is ongoing and reflected in their practice (ongoing process). The BSNs described what they learned in education as a process still inherent in their practice, whereas the ADNs chose words and reflections that seemed to indicate that education consisted of learning difficult facts, earning the right to take the licensure test and this was completed when they received their registered nurse license.

Differences in participant stories

Differences can also be found in the stories these participants picked to reveal during interviews. Stories of ADNs focused on self and hard work, whereas stories of BSNs focused on perspectives from their own and their patients' viewpoints. ADNs' stories about their colleagues who fainted at the sight of body fluids, and forgetting to keep their own last name private for the sake of confidentiality and safety during clinical, to getting sick during clinical and how nice the teachers were to let the student make up her homework, all highlighted the importance placed on themselves getting through the ordeals of education. When asked the same questions, however, BSN participants chose to highlight stories from their education about a patient who lost a baby and how that affected both student and patient and family, or how a student learned to figure out the strength of personal stories when shared with a patient in order to help gain trust. These stories showed the application of knowledge which

suggested education was an ongoing process, not the acquisition of knowledge which suggests education was a completed task.

The process of learning in nursing education

Benner et al. (2010) described nursing education as “fragmented” (p. 78). They added that all too often nursing education separates acquisition of knowledge in the sciences, social sciences and humanities in the classroom from experiential learning in clinical situations. Their claim is that learning facts in nursing education does not automatically translate into how the student uses the information to care for patients and this seems to be illustrated by the differences between the perceptions of education from participants receiving ADN education and those receiving BSN education. In a work about professional knowledge and competence, Eraut (1994) also pointed out the differences between the processes of thinking during education, “...the kind of deliberative process that professional practice demands cannot be developed solely through mastery of procedural or abstract information” (p. 112). It seems that, in this study, BSN participants were able to understand that their education was a process which enhances their practice, and not a completed result of hard study of facts such as the interviews with the ADNs would suggest.

Although a multitude of literature already exists which expounds the importance of the application of knowledge as compared to the acquisition of knowledge, by far the newest and most radical piece of nursing literature on this aspect of education has been done by Benner, Sutphen, Leonard, and Day (2010). Benner and her coauthors surveyed 1,648 members of the National Student Nurses Association, studied the student perspectives on the practice-education gap, and then examined teaching and learning in the classroom and skills

labs and during clinical settings. They discussed that the central goal of nursing education is to develop an attuned, response-based practice and capacity to quickly recognize the nature of whole situations in terms of most pressing and least pressing concerns. “Experiential learning” (p. 43) is vital to the students’ learning process, but “does not happen in just any condition with just any person or on every occasion. Participation in experiential learning requires openness and readiness to improve practice over time, along with clinical reasoning” (p. 43). Case studies about master teachers and how they teach gave way in this work to discussions about how the separation between being a student and then a nurse is not a passing score on the licensure exam, but the judgment that the person is prepared to practice and feels a civic responsibility to their own profession. “It’s what they learn after they know it all that counts” (p. 98). The authors concluded that learning nursing with a sense of salience and situated use of knowledge is more important than any other aspect in nursing education and that students report the necessity for real world situations to develop their clinical imagination. This highlights the differences between the ADN and BSN participant groups that were found in this study: the perception of the ADNs that knowledge is something to acquire, and once acquired, is complete. This is not the same way the BSNs viewed knowledge. The BSN programs or the BSN students, themselves, understood the sense of salience and situated knowledge and the importance of application of their knowledge as an ongoing process.

Technical skills in nursing education

In addition, during data analysis, when ADNs and BSNs discussed their weakness in practice areas, the ADNs wanted to learn and master more technical skills, but the BSNs

stated the ongoing need for more contextual learning. Two of the ADN participants felt that they still needed to learn additional skill sets in order to practice better (without discussion of the situations encountered in practice which was at least mentioned but not further defined by the third ADN participant), but the BSN participants, with no exceptions, focused on continuing education in how to apply their knowledge and this kind of experiential learning. Again, this illuminates the BSNs' understanding of how their education not only impacted their practice during school, but how education is an ongoing process to be used to enhance their practice, without isolating the skills learned from the situations and the patients they encounter.

The subject of technical nursing skills became an important factor in the results for this study. Observations and conversations with the ADN participants showed their preoccupation on nursing skills as inherently vital to their practice. Although these participants verbally gave credence to the other aspects of patient care, observations showed that their skills were the focus of everything they did. Whereas BSN observations showed the inclusion of care for emotional and mental needs of patients, observations of ADN practice illuminated that their actual nursing practice did not include many aspects of anything beyond the emphasis on what skills needed to be completed and in what order for which clinical situation. Sometimes, as described previously, patients' emotional needs were ignored in order to complete nursing skills by ADN participants. Although Benner (1984) theorized that all nurses, when first practicing, place more emphasis on their nursing technical skills than on the big picture of emotional and mental needs for the patients and develop expertise in using the whole picture throughout time, both ADN and BSN participants were equally new to their practice areas in this study, so time in practice was not a variable in this study that should have made as much difference as it did here.

Karp, Johnson, and Hughes (2002) believed that nurse practice is predicted on the ability of nurses to apply discrete tasks and skills, think critically, exhibit professional judgment, and function in a highly complex work environment, activities which are difficult to measure. Proponents of baccalaureate education believe that only four year nurses have the ability to demonstrate all of those requirements, and that the two year nurses concentrate solely on the technical skills of nursing, while opponents state that there is little evidence to support this theory. Giger and Davidhizar (1990) surveyed nursing students' answers to practice licensure questions and found that "the students from associate degrees were found to be most concerned with technical skills and content driven nursing tasks, ...as opposed to the baccalaureate students who were more knowledgeable in their use and implementation of the nursing process and their ability to evaluate the effects of nursing interventions" (p. 41). Another study by Sanford, Genrich, and Nowotny (1992) compared the ability of baccalaureate and associate degree nurses to think critically when identifying patient problems. They found no difference in competence between the baccalaureate and the associate's degree nurses. In this study, the ADN's demonstrated that their focus was on technical skills, while BSN participants showed more attention to the care of the patient on physical, mental and emotional levels.

Coparticipation in nursing education and practice

Likewise, stories from the interviews about their practice illuminated the differences in ADN and BSN perceptions about their education and practice. While ADN's used the active forms of verbs to depict how they do skills to or for patients, BSN's used descriptions that showed the sharing of purpose with the patient, such as being with or present with

patients and how this influenced both patient, family, and nurse. The ADNs all chose to describe how their actions of “doing for” a patient helped a patient in the physical sense, while BSNs focused on the changes that they made in patients’ lives by working with them (not on them) on physical, mental and emotional levels. The BSN group focused more on coparticipation of the nurse with the patient to come to better health choices. This is consistent with Parse’s (1998) vision of nursing as a coparticipation with the patient.

Although Parse’s theory was discussed in detail in both the literature review and this chapter, and her theories were applied to the data analysis and coding sections, it is important to note that she is not alone in predicting the necessary paradigm shift in nursing practice. Many other contemporary authors view the emerging patterns of health and nursing as shifting to a coparticipation of both nurse and patient: Ferguson (1980) discussed health as a view of the whole person with an emphasis on human values and caring; Dossey (1982) detailed health as human connectedness; while Serge King (1981) and Mann (1997) also described health as a shifting paradigm in which patient choice and values are as important as the physical attributes of disease in nursing. In essence, nursing is changing to a focus on all needs of the patients and nurses must be sensitive to care of the whole person, not just the physical ailments of a patient; education of a nurse must, therefore, teach the importance of this aspect of nursing. Although both ADN and BSN participants were able to verbalize holistic care as being integrated into their practice, only the BSNs actually practiced with this focus. This seems to indicate that, although both ADN and BSN programs emphasize the need for holistic care in their education, only those BSN participants were able to apply this in their practice.

Differences in ADN and BSN curriculum content

Both the ADN and BSN program curriculum content are included in the appendices and were discussed previously in the literature review. Although not a central focus of this study, an overall review was done to ascertain if there were any obvious differences (besides time) between the programs that might explain the differences in perceptions found between the two groups of participants. Peers from different local nursing programs were also consulted about whether they taught differently to an ADN or a BSN student and what those differences might be. A review of the programs and discussions with peers showed the differences between the amount of classes that time allowed BSN versus ADN students to take and the nature and depth of these courses, but not in the quality of teaching. Whereas both ADN and BSN students are given clinically focused classes during the last part of their program, i.e. obstetrics, pediatrics, gerontology, mental health, etc., BSN students have had the time to first take separately focused science classes delineating anatomy and physiology, pathophysiology, nutrition, and microbiology as separate sciences before encountering these issues in clinical situations and the ADN students have most of these sciences integrated into their clinical course work (when encountering obstetrics classes, they discuss the normalities and abnormalities as applied to the birthing process, etc.). In addition, ADN students are mainly given clinical courses using institutionalized health care situations, and do not usually get much experience in community health (parish nursing, school nursing, etc.).

Leadership and research are also areas that receive additional coursework in the BSN program, but are not addressed separately in the ADN program. This is supported by data from a study by Candela and Bowles (2008) in which 352 nurses surveyed stated that they were not sufficiently prepared in leadership content. Nurses in this study also reported needs

that were not sufficiently addressed in their educational programs to be: pharmacology content, more clinical hours, and more team based learning. Of those surveyed, “associate degree graduates were slightly more satisfied with their educational preparation than baccalaureate graduates, although the results were not statistically significant ($p=.067$)” (p. 269).

Another difference between programs is that ADN programs are accredited by the National League for Nursing (NLN) whereas BSN programs can be accredited by either the NLN or the Commission on Collegiate Nursing Education (CCNE) (Smith, 2005). All of these program differences do not sufficiently describe the differences found in the perceptions of the nurses interviewed in this study, and a complete new study comparing each correlating course and the teaching that takes place from each program to see where and how differences may be found would have to be conducted to focus on this aspect of practice differentiation. It can only be concluded, for the purposes of this study, that something in the educational program, whether it is quantity of additional time and coursework or the quality of the courses, might have made a difference in the perceptions of participants. This conclusion of the study is that there are, indeed, differences in the perceptions between ADNs and BSNs pertaining to their education and practice, but not what the origins of these differences might be.

When ADNs were asked what school consisted of, their answers included descriptions of constant testing as a sort of screening process to weed out those students who could study and test their way through classes, “*who can study and make it through....we probably graduated with half of the people we started with....you had to have a C to pass in each class....we had straight lectures and then clinical...you had to do a technical skill in the*

lab and then in the field during clinical to get pass,” but BSNs remembered slightly different things about their education, besides the hard studying and clinical experiences: *“(I remember that one teacher) would buy us little Welch’s fruit snacksgetting rewarded for your good...thoughts and answers....it was neat because it (teaching) was individualized....I realized (school) was just a building full of people just like me....I had a lot of good professors.”* The focus by ADN students on testing is not surprising, given the reality of nursing licensure. “The ... common denominator for the different programs of study is the licensure exam (NCLEX) (Kidder & Cornelius, 2006, p. 18). All graduates from all nursing programs have to take the NCLEX. Nationally, there is no significant difference in total scores on the NCLEX test between ADN and BSN students as shown in Table 2.1, although the BSN pass rate overall is slightly higher at 89.49% compared to the ADN pass rate of 87.61%. Since two years gives students less time to prepare than four years for the same test, it does seem reasonable that the ADN students would remember their days in school as constant testing, and BSNs had more memories of experiences and individual teachers.

Second Category of Difference: Perceptions of Locus of Control as External or Internal

The second overall finding of this study was very unexpected. Immediately within the first two observations, differences in how the respondents practiced within their environment were noticed, but these had less to do with skills practiced than with the attitudes of the nurses towards their own practice in learning new skills and in practicing what they had already learned. These differences influenced not only their own practice, but also the attitudes of all coworkers and patients around them. The first BSN participant was constantly

learning new skills and routines during the time I observed her, but never was her control of the environment or the process questioned by self or others. In fact, the physicians, the nurses and the patient all referred to her decisions in care, even during the time she was very openly asking questions about procedures and skills. She was able to make connections between the new things she actively learned and the situation at hand, contextually making comments that showed her understanding of how the new skills fit into the bigger picture. Observing the first ADN participant a week later showed the opposite to be true; never did the ADN gain control of her practice environment or total trust in her decision making from self or others, even though she was actually further in the orientation process than the BSN participant had been. She questioned her own ability, seemed fearful to make mistakes, and allowed the preceptor to make the majority of patient care decisions. These two first observations were similar enough that I had expected the expertise of the ADN to outweigh the expertise of the BSN, but the opposite was true. Both respondents were learning while they were practicing, but the ADN herself seemed to feel that she could not take control of the patient's situation since she was still learning new skills and routines. She evidenced no self esteem or confidence about her own learning in the same way that the BSN had done and all coworkers responded to this lack of self confidence by taking control of the nursing situations she was in. Further observations showed this was a major difference during observations of all respondents of the ADN and the BSN group. Although it was not immediately clear how to categorize this phenomenon, peer consultations with several teachers prompted a review of the literature about locus of control.

History of locus of control

Locus of control has been a concept in psychological studies since the early 1970s. Psychologists such as B. F. Skinner (1971) wrote about the way we view ourselves and how this influences how others perceive us. Experiments further examined the effects of perceived control by exploring the aspects of fear and anxiety of the unknown on human subjects during psychological testing (Glass et al., 1969; Mower & Viek, 1948; Staub, Tursky, & Schwartz, 1971). These classical studies revealed that subjects were less fearful of an aversive stimulus when they could exercise control in terminating it. Extrapolations from these psychological experiments still affect health care today: "...initially a patient who is ill is complicated by concern lest his suffering continue indefinitely or perhaps grow worse. After a reassuring diagnosis (visit from the doctor), this concern abates....and the patient is likely to feel a lot better as a result" (Mowrer, 1950, p. 473). The extent to which control plays a part in health care for patients has long been accepted and theorized, but this study is concerned with the control as felt by the health care provider, or nurse.

Lefcourt (1967) began using the notion of internal and external control research and applications to explain behavior. The internal and external control refers to the degree to which persons expect that an outcome of their behavior is contingent on their own behavior versus the degree to which persons expect that the reinforcement or outcome is under the control of others, or is simply unpredictable. (Rotter, 1990). Lefcourt researched this notion extensively during the 1970s and suggested that persons who perceive themselves to have an internal locus of control (whether true or not) have better cognitive functioning abilities. Human learning theory and social sciences have embraced this notion over the past years, as well as education.

Achievement and locus of control

Stake (1979) studied the relationship between achievement orientation and locus of control. People with perceived internal locus of control can achieve more than those who perceive an external locus of control. Her study, however, assumed that locus of control is a characteristic of the person, not a learned construct that education can help students to assume. Applied to this study, it would seem that the ADN students had never learned to internalize the locus of control, thus not allowing them to control their own environment nor their own decisions, which impacted the manner in which these ADN students provided patient care. The missing link for this study is how educators can impact a student's perception of locus of control in order to help that student to higher achievements.

Education and locus of control

Nordstrom and Segrist (2009) researched what happens in an academic setting to influence locus of control. They stated that internal locus of control occurs when students perceive themselves as exerting control over their educational fates. These students believe they have a direct impact on their learning, grades and educational opportunities through the time and effort they put in. Those with external locus of control believed that external factors such as luck, professors, course requirements dictated what they learned and the educational outcomes they derived. Furthermore, they found that the consumer mentality approach to the educational process was influential on students; a student with this mentality assumes that they go to college to get more money instead of learning for its own sake and these students placed little to no value on pursuing additional learning. Instead, these consumer students with external locus of control mentalities, just wanted to graduate school and begin earning.

When interviews in this study were examined for related patterns, the similarities and differences began to emerge even further.

“Moving, being close to family and my mother works at the college I attend” were the reasons that the ADNs gave for attending a two year degree. Two of the ADNs also added later that they had both had babies and the *“awesome”* job the nurses had done had influenced them to want to help others have their own babies. The BSN respondents described their choice of schools with different words: *“I always knew I wanted to be a nurse, I looked at all the possible programs available for me....I began in another field and recognized that nursing was a better fit for me and “I wanted to have a more well-rounded education.”*

In this study, only the BSN respondents described the extensive amounts of time and effort they invested into picking the correct institution for themselves and how they had to examine themselves to see if they would make good nurses before attending school. In addition, BSN respondents spent a lot of time in interviews reflecting on the kinds of learning that took place in their studies, contrasted with those of the ADNs who reported the hard work and testing as a major focus. The BSNs reported and discussed having to make their own decisions about what was correct nursing practice even while in school, while the ADNs reported mainly about the need for studying in order to pass their tests in school; this phenomenon has already been thoroughly discussed in the previous analysis of data.

The results of this study suggest that the manner in which these students experienced school and learning (two versus four year nursing programs) impacted the internal or external perception of locus of control over their own education, which in turn, influenced the locus of control they perceived during practice after graduation. Exactly how these perceptions

were formulated or changed by the educational program gives way to new hypotheses for future study.

Self value and locus of control

Every ADN respondent, whether during interviews or observations, mentioned their fear that they were not contributing what was necessary for this study to be completed. *“I don’t know if you can get the information you need from watching me”* (Amy) *“you have to understand that I’m not very good at this yet and you might not be able to observe what you want”* (Alice) and *“I don’t think I’m giving you very good information, don’t you want to talk with a more experienced nurse?”* (Allie) were comments this group asked along the way. In contrast, the BSN respondents never questioned or seemed confused by what was asked or concerned about the observations of their practice even while still on orientation, nor did they verbalize any concern that their practice and interviews wouldn’t give me the information I needed. They seemed content with the explanation that their practice and interviews would help this study understand what they did and how they think, and gave me their insights accordingly. This alone does not indicate a perceived internal versus external locus of control, but coupled with the observations and interviews as recorded, leads to the second overall conclusion of this study: BSN respondents perceived themselves, their education and their practice with an internal locus of control, while ADN respondents showed patterns of perceptions of an external locus of control.

Summary of the Study

This study illuminated the qualitatively different ways in which three associate degree nurses (ADN) and three baccalaureate degree nurses (BSN) experienced, conceptualized,

perceived and understood their own nursing practice within the context of their educational background. Using phenomenography, data analysis revealed many different themes of difference between ADNs and BSNs. Findings of this study examined the two main differences found between ADNs and BSNs: (1) ADNs focused on their (a) education as the means and their practice as the result, over which (b) the nurse has no ultimate control (external locus of control), whereas (2) BSNs focused on their (a) education and practice as an ongoing process and how (b) the nurse himself/herself is in control of his/her own learning processes and practice (internal locus of control). These differences impact the potential for quality of nursing practice and have implications for nursing educators, the nursing profession, and employers of nurses. This study suggests that the educational background of a nurse, does, in fact, impact the quality of nursing practice and further potentiates phenomenography as a methodology applicable to this kind of nursing research.

Ethical Considerations

According to Merriam (2002) a “good qualitative study is one that has been conducted in an ethical manner” (p. 29). Some ethical dilemmas can emerge in the “collection of data and in the dissemination of findings” (p. 29). A detailed audit trail described in the data analysis in Chapter 4 revealed how the triangulation of data from interviews and observations, member checks and peer review were used to help validate the findings of this study. Entwistle (1997) also discussed some difficulties limited to phenomenographic inquiry that could affect the validity of the findings; these were discussed in Chapter 3 and helped to guide the interviews and data analysis. He stated that since phenomenographic inquiry posits relationships within and between categories, establishing

these relationships requires extra attention to a detailed audit trail of decisions made and how questions during interviews are posed. Although the ultimate goal was to find categories in this study, the similarities and differences between categories were not the subject of any questions specifically posed to the participants. Instead, they were asked “questions... which allowed (them) to account for their actions within their own time frame of reference, rather than one imposed by the researcher” (p. 132). This, in addition to thick, rich description added to the validity of the findings.

Merriam (2002) also stated the importance of the “researcher-participant relationship...determining how much the researcher reveals about the actual purpose of the study – how informed the consent can really be – and how much privacy and protection from harm is afforded the participants” (p. 29). All participants were given the informed consent and interview questions including an overview of the study in advance by a nurse manager without the researcher present. They had time to reflect on their participation and whether or not they had time and energy for such an undertaking. Nurse managers’ interactions with the participants were not observed, however, and it is unknown whether the participants felt any pressure to participate. In order to help minimize any such pressure from management to be included in this study, managers were informed by the researcher in advance that they would not know exactly who consented to participate or not, the only revealing factor would be if they happened to be present when observations of the participant were conducted.

Observations were conducted when possible during evening shift hours for this reason. All participants invited were so positive about being part of the study that they contacted their nurse manager on their own and let him/her know they would be helping with this study, which impacted this aspect of planned confidentiality. Participants did not seem to mind that

others knew about their participation, although they were asked not to reveal any aspect of the interviews and details to any peers. All participants were reminded that they did not need to continue in this study after each interview was finished and member checks were made, but all decided to continue their involvement. Thus, participant decisions about continuation and final inclusion in this study were made independently of nurse managers, hopefully minimizing any ethical dilemmas participants had initially felt about being involved in the study through nurse managers.

Implications of the Study

The nature of the findings in this study suggest that, although associate and baccalaureate degree nurses take the same licensure examination and work the same jobs, their perceptions of how they practice is different. This, in turn, is reflected in their practice itself. Nurses who believe that they have control over their own practice potentiate the quality of their own practice (Lefcourt & Smith-Telgedi, 1971), which should be a characteristic important to employers. Similarly, employers of nurses would be more interested in these kind of research findings if there was more evidence to provide information on the following emerging research questions: (1) Do nurses who do not perceive themselves to have any control over their nursing practice and skills tend to need a longer orientation period before they can practice without an overseeing preceptor; (2) Are patients more likely to sue nurses who do not perceive and/or show themselves to be in total control of the health care situation involving that patient; (3) How do nurses who perceive themselves to be in control of their own practice and learning environment impact the health care institution, coworkers and peers, and administration; (4) Would a similar study including

males as participants yield the same findings; and (5) Would other areas of practice besides obstetrics have similar findings?

Likewise, more research needs to be done to ascertain how nurses are educated to impact their perceptions on locus of control. Is it the extended length of time that baccalaureate nurses are expected to attend school that directly impacts how they perceive themselves to be in control of their own practice, or is it the liberal arts foundation, or is it teaching pedagogies utilized by certain educational institutes? How can associate degree nursing programs use this information to develop better and more impactful educational pedagogies for their students?

Several smaller studies (Candela & Bowles, 2008; Gob & Watt, 2003; Smith & Crawford, 2003) gave some prior evidence regarding the perceptions of nurses about their educational programs. These studies revealed that participants stated a need for more clinical experiences in working with physicians and supervising others, caring for multiple patients, and more support during the transition from student to nurse, although these results were not separated between ADN and BSN nurses. The only mention of differences between ADNs and BSNs was revealed by Candela and Bowles (2008), who found that associate degree nurses were slightly more satisfied with their educational preparation than baccalaureate graduates, even though the results were not statistically significant ($p=.067$). The aforementioned studies focused on quantitatively measurable differences (lack of content area in education), but there were no other studies found that described qualitative differences between ADNs and BSNs. Phenomenographic qualitative research about these differences is, therefore, helpful to fill the gap in this area of inquiry and gives researchers new ways of looking at these differences.

Nursing as a profession is still harmed by the differentiated educational preparation for practice, because nurses cannot come together to discuss if they do not have the same perceptions and understandings of nursing education or practice. Although many authors call for laying aside the differentiated practice issues, this debate still continues until a resolution can be found and is an unspoken barrier to nurses speaking out on issues with one voice. Research needs to provide more answers to how nurses can find common ground. Current nursing literature (Benner, 1984) seems to suggest that all nurses can come to the same and similar practice standards, however no one has explored in depth the differentiated educational backgrounds and its impacts on this theory. Using Benner's (1984) model of examining the differences between associate degree and baccalaureate degree nurse novices as they develop expertise in nursing practice could illuminate differences that might provide insightful information for nursing educators and programs for schools of nursing.

Another author on the topic of differentiated nursing practice suggested a different kind of resolution: Smith (2005) stated that it would be easiest to have the baccalaureate degree educators add distinction to the licensure exam for baccalaureate degree nurses. Specialty areas, or questions demonstrating the expertise of the baccalaureate degree nurses can be added to the national licensure test for all BSN nurses to take. This would emphasize any differences between nurses and impact the employment of nurses. It falls to nurse educators and researchers, then, to provide the impetus for this change in licensure.

More attention needs to be placed on how we educate nurses. Nurse educators need to use methods to impact internal locus of control in their students and to emphasize the need for continued learning in all nurses, teaching students early that learning never ends. Benner, Sutphen, Leonard, and Day (2010) stated that improvements in nursing education cannot

occur only through curriculum and pedagogical efforts; the profession of nursing needs to develop an active interest in how nurses are being educated and to initiate radical changes in education to impact the quality of nursing practice. In order to initiate changes, all nurses must decide whether the differences between educational backgrounds differentiates nurses or can bring them together. Benner et al. (2010) suggested that there are currently many barriers for ADNs to pursue further education as BSNs besides that of cost: articulation and transition from one degree to the other is still difficult as nursing programs are not dialoguing about how to work together. Nurses cannot continue ignoring the big division between nursing education, and nursing educators cannot concentrate together on initiating changes to impact the quality of nursing practice if they are still debating the differences in quality and quantity between BSNs and ADNs.

Recommendations for Education and Practice

The findings of this study suggest that ADNs and BSNs do, indeed, practice differently. This differentiation in practice needs to be addressed and resolved. Obviously, more research has to be done until data saturation of these differences convince the nursing profession to make a final decision. Until such final decision is reached on one educational preparation or another as minimal entry into nursing practice, the following recommendations emerge from this study to impact how nurses can work together towards a better nursing practice, given the barriers of differentiated education:

1. Solve the problem of BSN and ADN differences by initiating changes to the BSN licensure exam. This would necessitate national change to the exam which would automatically be implemented then on all state testing and include extra concepts for

- BSNs that are enhanced only in the BSN degree. This would differentiate one degree from the other in the easiest fashion, and provide a strong basis for differentiated pay from employers. With differentiated pay for degrees, nurses could accept each other's educational background and move on to address important issues in health care together;
2. Develop better ways to attract nurses from ADN programs to complete the BSN degree by improving articulation between programs and making the transition easier, thus providing more BSN prepared nurses for practice;
 3. Based on the findings of this research, ADN and BSN educators need to find ways to enhance students' perceptions of internal locus of control. Some suggestions are:
 - a. Faculty development for teaching salience in nursing (Benner et. al. 2009); and
 - b. Involve students in discussions of controlling their own environments during clinical or use reflective discussions to show students how internal locus of control can impact nursing situations they encounter; and
 4. Nursing faculty need to educate students on becoming lifelong learners, developing the student mindset of, "It's what you learn after you know it all that counts" (Benner, 2010, p. 98).

Personal Reflection

For the past eight years as a nurse educator, teaching and working with students who graduated from associate degree and baccalaureate degree programs, I have noticed differences in how the students from different educational backgrounds perceive nursing. Despite many hours spent in the library, I couldn't quite identify what those perceptual

differences were or if they had ever been previously researched. As I approached the dissertation phase of my doctoral program of study, I knew that I wanted to contribute to the nursing profession by grappling with a theme that would bring nurses together, help remedy any differences we have, and further contribute to our professionhood. As I was struggling with themes, one of my qualitative research professors sent me a link to a newer methodology that she thought I would be interested in—phenomenography. The connections were immediate: I could see how this would help me focus my research topic for my dissertation and began working on my proposal. The following is my reflection on using this methodology to discover the differences in perceptions of ADNs and BSNs.

Using and discovering a newer methodology (phenomenography) required an undertaking that was larger than originally anticipated. It was important to review all previous research done with this methodology in order to gain an understanding of the applicability and validity of this methodology to what I wanted to investigate. In addition, it was difficult to understand just exactly how this methodology could be applied to my research until I was actually engaged in the data analysis. That was when it all seemed to come together.

The initial part of data analysis was to find commonalities between participants with like educational backgrounds. It was difficult to figure out exactly what kinds of information to use to look at these commonalities, because the overall data collected was so overwhelming. Although it was tempting to look at each interview question and analyze the data gathered based upon each answer and each observation, researchers in previous phenomenographical studies had cautioned other researchers to find different ways to

identify categories, using complex and contextual information to separate categories instead of linear methods.

Introducing Parse (1982) during the data analysis as a way in which I could review the data collected helped tremendously and it was just necessary to figure out which data to use where, so I created a table defining how I looked at and examined data and which answers and observations were used to apply each of the three principles of Parse about nursing practice. In essence, I analyzed the data three times. As described previously, once looking at commonalities among the nurses with similar backgrounds; then, yet again, I had to go back to these commonalities and see if there were differences between nurses of different backgrounds on the basis of each of Parse's principles. Then, I worked at organizing the total implications of all the differences and commonalities into two overarching themes that spoke to the differences between associate degree nurses and baccalaureate degree nurses.

Working with newly graduated nurses, I had to ensure that relationships were developed, but that I maintained the role of researcher and not of mentor (which, as a nurse educator, I was tempted to do). It helped that most of my observations were at hospitals that I had never visited before and that I was able to find participants I didn't know or at least had very little previous contact with. Working with labor and delivery nurses allowed me to use my previously gained nursing knowledge to observe what was done and what was not done in their nursing practice which became an important part of my study.

Differences in the locus of control emerged from the very first observation, although it took several weeks for me to realize how to categorize these differences. I have to thank the process of peer review for helping me develop an understanding of what I was seeing. It

was immensely challenging for me to make that connection and, only by reviewing my narratives and assumptions again and again and discussing these with another faculty member, did the phrase “locus of control” get mentioned to me. Then, the lights clicked on and I knew I was on the track of something intriguing in this study. This brought up a totally new and large body of literature which I also had to review for application to my study. In short, my desk was full of books, my file cabinets are full of articles, and my mind whirled for about six months.

Not having courses at the same time as completing my dissertation was both an advantage and a disadvantage. It seemed to screen out the select few who have self initiative to continue working alone and without constant checking in with others, and it challenged my self initiative to the extent that I wondered if I would ever “get it finished.” At no time have I felt like I am exhausted with this content area, like others have reported to me, “I am so sick of my topic” or “I feel like I am just writing this for my committee and it’s not my own work.” In fact, my committee encouraged me and motivated me throughout the whole process in a positive manner and I feel that my research is unique and reflects my original intentions. Presentations to my committee during the course of the whole doctoral program became celebrations of all the work I was showing off and there was nothing fiercely “scary” about it except what my own self limiting anxiety was telling me.

I can see now how I struggled over and over again, not to try to save the world (as my major professor kept telling me), but just my little part of it. This was perhaps the toughest part; deciding on a topic and narrowing it down enough to be feasible as a dissertation/research study. I owe this to my dissertation seminar professors and peers, and to the curricular structure and placement of this seminar in the higher education program of

study to enhance my perception of how this all fits together. I had the proposal almost completely written by the time the dissertation seminar was completed, and had gained a thorough understanding of what the rest of the research would require of me in time and effort. Several of the professors helped me structure a study into a newer methodology and my major professor was instrumental in calming me down and helping me to prepare for all of my work. His faith in me monumentally moved me to complete this research time and time again. I could not have accomplished this without everyone's help and support! I count myself lucky to be in a program that embraces this kind of environment for their doctoral candidates.

I plan to continue researching this topic with other participants and adding to the basis of knowledge that I have begun here. This topic will apply to nursing education as we struggle to come together and have a voice in the new health care reform. My research adds to the discussion of how we as nurse educators can contribute to preparing the best students who, in turn, will contribute to the nursing profession as a whole.

APPENDIX A. ASN CURRICULUM PLAN (ASSOCIATE DEGREE)

ASN CURRICULUM PLAN
2007

Course #	Course	NSG Hrs	LAS Hrs	Total Hrs
SEMESTER I				
NSG 101	Introduction to Professional Nursing Concepts	5		
NSG 102	Nursing Skills I	1		
ENG 101	English Composition I		3	
Psy 101	General Psychology		3	
BIO 133	Health Science Anatomy		4	
	TOTAL	6	10	16
SEMESTER II				
NSG 131	Nursing Health Promotion Across the Life Span	5		
NSG 132	Nursing Skills II	1		
PSY 202	Developmental Psychology		3	
SOC 102	Sociology		3	
BIO 134	Health Science Physiology		4	
	TOTAL	6	10	16
SEMESTER III				
NSG 160	Nursing Care of Patients Across the Life Span I	6		
BIO 132	Health Science Microbiology		4	
BIO 302	Pathophysiology		3	
PHI 110	Critical Thinking in a Diverse World		3	
	TOTAL	6	10	16
SEMESTER IV				
NSG 200	Nursing Care of Patients Across the Life Span II	6		
PHA 202	Pharmacology		3	
NSG 280	Caring in a Diverse Health Care Environment	3		
	TOTAL	9	3	12
SEMESTER V				
NSG 200	Nursing Care of Patients Across the Life Span III	6		
NSG 231	Role Transition to Professional Practice	6		
	TOTAL	12		12
	PROGRAM TOTALS	39	33	72

APPENDIX B. BSN CURRICULUM PLAN (BACCALAUREATE DEGREE)**Sample of Courses for a Nursing Student**

Pre-Nursing (Freshman)	Courses	Credits
Ints 101	New Student Seminar	1
Biol 101	General Biology I	4
Engl 101	Freshman Composition	3
Math 111	Intermediate Algebra	3
Psych 101	General Psychology	3
Nurs 110	Nurturing Well-Being	2
	TOTAL	16

APPLY FOR ADMISSION TO THE DIVISION OF NURSING DURING YOUR SECOND SEMESTER

Second Semester	Courses	Credits
Biol 157	Introduction to Human Anatomy and Physiology	5
Engl 110 or Engl 111	Themes in Western Literature Introduction to Literature	3
Spch 101	Introduction to Speech Communication	
Soc 101	Intro to Sociology	3
	TOTAL	14

200 Level (Sophomore) First Semester	Courses	Credits
Nurs 215	Caring	3
Nurs 216	Professionalism I	3
Psych 212	Human Development	4
Chem 107	Fundamentals of Organic & Biochemistry	4
Core		3
	TOTAL	17

Second Semester	Courses	Credits
Biol 256	Microbiology	4
Nurs 230	Pathophysiology	4
Core		3
Nurs 202	Introduction to Pharmacology	3
	TOTAL	14

300 Level (Junior) First Semester	Courses	Credits
Nurs 301	Assessment of Well-Being	4
Nurs 302	Caring Responses	5
Biol 140	Nutrition	3
Core		3
	TOTAL	14

Page 2 (Sample Schedule of Courses for a Nursing Student)

Second Semester	Courses	Credits
Nurs 330	Nursing Situation (Child & Family Institution)	5
Nurs 331	Nursing Situation (Adult Institution)	5
Psych 320	Abnormal Psychology	3
Core		3
	TOTAL	16

400 Level (Senior) First Semester	Courses	Credits
Nurs 332	Nursing Situation (Child/Family Community)	5
Nurs 333	Nursing Situation/Adult Community	5
Math 241	Statistics	3
Core		3
	TOTAL	16

Second Semester	Courses	Credits
Nurs 417	Managed Care Leadership	5
Core		3
Nurs 450	Professionalism II	4
Ints 470	Capstone: Experience and Knowledge in Social Context	3
Nurse 401 (elective)	NCLES & Computers	1
	TOTAL	16

Core classes include choices in the following areas:

1. History – U.S. or World
2. History
3. Philosophy
4. Religion
5. International Diversity
6. Aesthetic Dimension

APPENDIX C. INTERVIEW GUIDE

Title of Research:

Understanding Nursing Practice: An Exploratory Study In Phenomenographic Research About the Educational Background of a Nurse

Overarching Research Question(s):

1. What are the differences between ADNs and BSNs as related to the meaning and values they place upon education and practice?
2. What are the differences between ADNs and BSNs as they relate and interact with persons during their education and practice?

Interview Questions:

1. Tell me about your background. How did you decide to get educated as a nurse? Where did you go to get your education? Tell me about your education? What stands out as memorable about it? Can you tell me any stories about your days in nursing school? What is the most important thing you learned in school about nursing? Did you decide in your education what kind of nursing you wanted to go into, how and why? Do you think you would ever go back to school to earn a further degree in nursing, which one and why?
2. Tell me about your practice as a nurse? How did you get to practice in the area you are now? Tell me about your job? What aspects of your job are important to you? What do you do really well as a nurse? What are your weaknesses? How do you view your practice of nursing any differently than any of your peers might? Tell me some stories you have about your practice? What stands out when you think of nursing in general?
3. What do you believe is the connection between how you were educated in nursing and your practice of nursing? Do you think how you practice nursing is related at all to your educational background, why? What stories can you tell me that reflect how your education influences your practice? Do you see any differences in the practice of nursing when reflecting on your background compared to other nurses?

Follow up interviews:

1. Member checks to see if data obtained is what the respondent said. Any additions that respondent might want to add. Any overview or connections that respondent might want to bring out. Observations to triangulate data obtained from interview and possible member checks on data obtained there.
2. If necessary, another member check.
3. Copy of finished report given to respondent. Thanks and closure.

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ACKNOWLEDGMENTS

A sincere thanks to...

- My children, Tara, Toran, Luca and Lamar, for learning how to make dinner on their own while I attended school, and being patient while I worked on my “book.”
- My partner, Kent, for listening, and his gracious encouragement and support.
- My Mom and Dad, for all the prayers of perseverance and Dad’s “just do it” lines.
- Skosh, Erik, Papa, for all the belief and love you show me.
- My major professor, Dr. Dan Robinson, who always puts it in perspective and keeps me on track.
- My POS committee, Drs. Larry Ebber, Robyn Cooper, Margaret Torrie, and Virginia Arthur, for celebrating my journey with me and all their comments and encouragement.
- Dr. Robyn Cooper, for finding my new methodology and helping me sort through it.
- My editor, Pat Hahn, who did her “magic”.
- Dr. Martha Driessnack, for listening and inspiring me, and for her ideas listed on the napkin.
- My nursing professors who instilled in me a passion for nursing.