

The Pennsylvania State University
The Graduate School
College of Behavioral Sciences and Education

**AN EXPLORATION OF REGISTERED NURSES' INTENTIONS TO LEAVE THE
PROFESSION: A QUALITATIVE STUDY**

A Dissertation in
Adult Education
by
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Submitted in Partial Fulfillment
of the Requirements
for the Degree of
Doctor of Education
May 2011

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ABSTRACT

The purpose of this qualitative study was to explore the perceptions of female registered nurses who have intentions to leave the profession with particular attention to the influence of gender. The theoretical framework of feminist poststructuralism informed this study, which emphasizes the role of discourse and power relations in the construction of identity. An aim of this study was to uncover the visible and invisible influences of gender as a social structure in respect to workplace experiences and career decisions in nursing. Semi-structured interviews were conducted with eleven female registered nurses who had serious intentions of leaving the nursing profession.

Five major themes emerged from the data: feelings of duty and obligation; the power distribution in the hierarchy; growing incongruity between working conditions and patient care; interpersonal communication; and shifting perspectives on work and self. The findings suggest that gender role socialization was an influence on career entry into nursing which was related in some ways to the decision to leave nursing. The participants felt unable to provide adequate nursing care, and the inability to do so was found to influence their decision to leave nursing. Additionally, the participants perceived that they were at the “bottom” of the hierarchy. They also perceived that they had few opportunities for advancement and did not have access to power structures, which contributed to a lack of voice. The decision to leave was not easy for most of the participants, partially because their identity as a nurse was closely aligned with their personal identity. Several of the participants wanted to leave nursing to find passion in their work, which speaks to a need to reconceptualize the relationship between work and individual subjectivity. Thus, this study supports the feminist poststructural notion that social structures, such as gender, do affect identity development in respect to career decisions and work experiences. Based on the

findings of this study, suggestions are offered both for further research and nursing education in an effort to potentially influence recruitment, practice, and retention in a profession that is already experiencing a shortage of workers.

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ACKNOWLEDGEMENTS

First of all, I would like to thank my parents, John and Shirley Wargo, for instilling in me the value of education and the confidence to believe in myself. I am also thankful for my sisters, Kelli, Megan, and Kayla, for being supportive and understanding throughout my doctoral journey. Each of them adds richness to my life in different ways, and I particularly appreciated Kelli's willingness to listen to my ideas and share insights and perspectives from her experiences as a registered nurse.

To all of my friends, family, and co-workers who provided me with encouraging words of support along the way, I am deeply grateful. I am particularly thankful for all of the moments when I heard the right words at the right time to encourage me to continue on this endeavor. I hope to be able to spend more time connecting with all of you in the near future.

I would like to thank the Adult Education Faculty at Penn State Harrisburg, Patricia Cranton, Daniele Flannery, Ed Taylor, and Libby Tisdell, for challenging me and for expanding my perspectives in ways I had not imagined. I have always wanted to be a teacher, and I am so grateful that I have had the opportunity to learn a variety of teaching techniques from individuals who not only are passionate about their work, but they are excellent role models as teachers and scholars.

I have had many wonderful teachers in my life, and I am especially grateful to Sally Bair and Ralph Barker, who were two of my teachers at the Pennsylvania Governor's School for Teaching when I was in high school. They both were instrumental in showing me in many kind ways how the role of the teacher can extend well beyond the classroom.

To the cohort of 2006, my life is richer from having each of you in my life. Even though there never seemed to be enough time for us to connect outside of the classroom, we supported each other along the way and we have some wonderful memories to carry with us. I am

particularly grateful for my friendship with Jodi Jarecke, particularly for the times when we worked on a class project after exercising at 5:30 am, for all the times we spent carpooling, and for all the times we spent laughing trying to decrease each other's anxiety.

I would like to also thank the eleven registered nurses who participated in this study. Without their willingness to share their experiences and perspectives, I would have been unable to complete this study. I wish all of them the best as they pursue new passions and paths for their lives.

I would like to thank my friend, April, who was very supportive during my data collection phase. She attentively listened to me as I was working to make sense of my findings and also helped to remind me of what matters the most in life.

To all of the water girls who have been part of my life for the past 9 years. During my doctoral journey when I had limited leisure time, I looked forward to seeing all of you on Saturday mornings to exercise. Each of you has been supportive of my career, my entry into motherhood, and my education. You have provided me with many words of wisdom over the years and you are all shining examples of life-long learners.

Lastly, I would like to thank my wonderful husband, Vince, for all of his support and encouragement over the past 5 years. In addition to completing this program, I started a new job, we built a new house, and we welcomed our beautiful son, Jack, into our family. I am so blessed to be able to share this life with you, and I hope that Jack, with his endless curiosity, keen sense of humor, and feelings of compassion, embarks on his own quest for knowledge.

CHAPTER ONE

INTRODUCTION AND PURPOSE

The field of adult education spans a wide area which includes issues in adult higher education classrooms, issues in training and development, and ongoing learning in workplaces. In the United States, the health care field is an enormous area of workplace practice, and registered nurses constitute a large portion of the field. Issues associated with nursing education related to clinical practice is an area that has been discussed in adult education (Aiken, Cervero, & Johnson-Bailey, 2001; Bevis, 1975; Daley, 2000; Mikulecky & Winchester, 1983; Ruth-Sahd & Tisdell, 2007). Additionally, in adult education, there are calls to explicitly examine the power and status of a particular group (Brookfield, 2005; English & Irving, 2008; Guy, 2004). In the workplace, women have been consistently marginalized, and the hidden curriculum in organizations often teaches women to assimilate to the patriarchal culture and not challenge the status quo (Bierema, 2001; Hayes & Flannery, 2000). The dominant discourses that are present in society influence structures and hierarchies within organizations (Bierema, 2001; Mojab & Gorman, 2003). Even though women constitute over half of the workforce, they do not have the same earning power as men, they hold fewer leadership positions, and they have fewer opportunities for advancement (Dubeck & Dunn, 2006). Therefore, there is a need to call attention to practices that marginalize and oppress women in the workplace.

Because nursing is a profession dominated by women, registered nurses are an ideal group to study how social structures influence career decisions, particularly in light of the current nursing shortage which has reached approximately 118,000 (American Association of Colleges of Nursing, 2009). The influence of structural barriers on career development is a relatively unexplored area (Aiken, Cervero, & Johnson-Bailey, 2001) in the fields of nursing and adult

education. However, it is an important consideration for the health care industry and the adult educators who provide nursing education given the shortage of registered nurses.

Nursing shortages in the past have been short-lived and have not significantly impacted the healthcare system, but the present pattern began in 1998 and does not have a foreseeable end in sight. In fact, it is predicted to substantially worsen over the next ten years (Allen & Aldebron, 2008; Buerhaus, Steiger, & Auerbach, 2003). According to the American Association of Colleges of Nursing (AACN, 2009), the number of vacant nursing positions is expected to grow to over 300,000 by 2020. If this prediction is accurate, the deficit of registered nurses will be three times larger than any previous deficits in the past 50 years in the United States (Buerhaus, 2008). This prediction is based on the increasing number of baby boomers that will require healthcare services and the number of registered nurses that plan to retire in the next 10 to 15 years (Schuman, 2003). In order to explore the factors impacting the nursing shortage, it is pertinent to discuss the current nursing workforce, the impact of the problem, and the strategies that have been offered to solve the crisis.

Background to the Problem

According to the U.S. Department of Labor (2008), women constitute 92.1 percent of registered nurses. On the 2004 Sample Survey of Registered Nurses, less than 11% of nurses identified themselves as non-white, Hispanic or Latino (U.S. Department of Health and Human Services, n.d.c). As can be seen, the profession of nursing has not attracted a diverse group in respect to gender or ethnicity (Milstead, 2003; NLN, 2009); therefore, the nursing workforce is not representative of the population it serves (U.S. Department of Health & Human Services, n.d.a). The average age of a nurse in the United States is 46.8 years of age (U.S. Department of Health & Human Services, n.d.c), and it is projected that by 2012, the largest group of registered

nurses will be over the age of 50 (Donelan, Buerhaus, Desroches, Dittus, & Dutwin, 2008). The largest percentage of nurses continue to be employed in hospitals (U.S. Department of Health & Human Services, n.d.c), with the majority of these positions being in direct patient care. As the average age of a registered nurse increases, new challenges will arise due to the physical nature of this type of work.

The Impact of the Nursing Shortage

Because of the complexity of nursing work, it has been difficult to estimate the impact of a lack of nursing care. However, recent studies have revealed that hospitals with lower nurse to patient ratios had a statistically significant decrease in surgical patient mortality (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). In essence, adverse patient outcomes have been directly correlated to both high nurse to patient ratios and poor work environments.

In addition to affecting patient care, the nursing shortage has financially impacted healthcare organizations. It is costly for organizations to continually recruit, hire and train new nurses. Research estimates that the cost of nurse turnover is between \$22,000 and \$64,000 per nurse (Jones, 2004). These financial estimates are based on a loss of future returns from keeping the nurse employed, short-term productivity losses, the need to pay overtime to fill vacancies, and the cost to orient and train new nurses (Jones, 2004). Furthermore, regardless of the cost to attract nurses to organizations, there are still not enough nurses to fill all of the vacancies.

Current Strategies to Solve the Nursing Shortage

Strategies to combat the nursing shortage have often focused on recruitment into the profession and on retention from organizational perspectives (Buerhaus, Steiger, & Auerbach, 2003; Schuman, 2003). Recruitment incentives have focused on increasing funding of nursing

education programs, scholarships for nursing students, advertising campaigns, and loan repayment programs (AACN, 2009). While recruitment into nursing programs has increased over the past few years, this will only be an effective strategy if nurses remain in the profession (Lavoie-Tremblay, O'Brien-Pallas, Gelinias, Desforages, & Marchionni, 2008; Loquist, 2002). Even though schools of nursing have reported increased enrollments over the past few years, it is not projected to be enough to meet the increased demand (AACN, 2009; Feldman, 2003).

Organizations have attempted retention strategies such as sign-on bonuses, flexible scheduling options, and improvements to the workplace. They have also forged relationships with schools of nursing by providing funding for education in exchange for service after graduation. Many of these strategies have been utilized during past nursing shortages with limited success (Buerhaus, 2008). Other initiatives have focused on trying to attract inactive nurses back into the workforce. However, there is little evidence that this is an effective strategy to combat the nursing shortage (McIntosh, Palumbo, & Rambur, 2006). From a historical perspective, the majority of these strategies have only led to short-term solutions to the nursing shortage; it is essential to take a deeper look at the underlying factors contributing to the lack of registered nurses, because retention and recruitment initiatives have not resulted in long-term solutions.

Factors Contributing to the Nursing Shortage

In addition to the aging of the nursing workforce, as well as the aging of the population, there are other interrelated issues contributing to the nursing shortage. First of all, there is a lack of qualified nursing faculty (Schuman, 2003). According to the AACN (2009), a 12% vacancy rate exists in nursing education positions. Additionally, thousands of qualified applicants have

been denied entry to nursing education programs over the past few years due to the shortage of qualified nursing faculty (Buerhaus et al., 2003; Buerhaus, 2009).

Secondly, job burnout and job satisfaction have been explored as possible causes of the nursing shortage. Job satisfaction is a complex phenomenon involving many facets of work, including: salary, management, co-workers, and work environment (Coomber & Barriball, 2007). Compensation, working conditions, scheduling, and lack of advancement are other reasons that have frequently been related to nursing job dissatisfaction (Chandra, 2003, Mee, 2003; Nelson, 2002). The 2004 National Sample Survey of Registered Nurses (U.S. Department of Health and Human Services, n.d.) found that nurses were less satisfied with their jobs than employed individuals in the general population, and a study of nurses in five countries revealed that the highest levels of job satisfaction were in the United States (Aiken, Clarke, et al., 2001).

Not only is it pertinent to explore job satisfaction, but the number of nurses who have intentions to leave the profession. Between 11 and 50% of registered nurses have indicated an intention to leave the profession (Borkowski, Amann, Song, & Weiss, 2007; Bowles & Candela, 2005, Lavoie-Tremblay et al., 2008; Noguerras, 2006; Whittock et al., 2002). These data indicate that there is possibly a serious problem extending beyond the current shortage, because actual job turnover is typically preceded by an intention to leave. In the decision-making process, intention to stay or leave a position is the final cognitive step (McCarthy, Tyrrell, & Lehane, 2007). The choice to leave nursing is a complex process dependent upon many factors, and the decision is usually not easy for nurses to make (Cheung, 2004). Examining research from this critical point in the decision-making process can shed light on individual perceptions and experiences at the time they occur rather than examining thought processes retrospectively. It also allows for the opportunity to develop educational strategies that may foster increased tenure

within the profession, as well as identifying issues that must be confronted in order to lessen the predicted shortage.

Research on intentions to leave the nursing profession has focused on numerous variables often in relation to job satisfaction, which is a multifaceted concept. Job satisfaction as a global component can incorporate concepts such as stress, work schedule, collegial relationships, empowerment perceptions, ability to deliver high-quality care, educational preparation, salary, and family responsibilities to determine if a relationship exists with intentions to leave the profession. Increased perceptions of job stress (Lavoie-Tremblay et al., 2008; Letvak & Buck, 2008; Shader, Broome, Broome, West, & Nash, 2001), inability to provide safe and ethical care (Cheung, 2004; Hart, 2005), work-family conflicts (Duffield, O'Brien-Pallas, & Aitken, 2004; Flinkman, Laine, Leino-Kilpi, Hasselhorn, & Salantera, 2008), lack of opportunities for professional development (Flinkman et al., 2008; Foschen, Sjogren, Josephson, & Lagerstrom, 2005), limited involvement in decision-making (Barron & West, 2005; Barron, West, & Reeves, 2007; Joshua-Amadi, 2003), and unacceptable financial compensation (Barron & West, 2005; Barron et al., 2007; Flinkman et al., 2008; Fochsen et al., 2005) have all been found to contribute to higher intentions to leave the nursing profession.

While this body of research has provided useful information about factors possibly contributing to intentions to leave the profession, the research lacks a depth of information and it fails to explain the underlying reasons that lead nurses to consider leaving the profession. The majority of the studies utilized surveys to collect data and many of the instruments were designed for groups other than nurses; these scales may not be able to adequately assess nurses because of the diversity in occupations as well as work environments (Coomber & Bariball, 2007). Only one qualitative study was found examining nurses who were in the process of

leaving the profession (Joshua-Amadi, 2003) and a related qualitative study was conducted on nurses who had already left the profession (Cheung, 2004). Both of these studies were conducted outside of United States, so there is a paucity of deep, rich knowledge on why nurses leave the profession in the United States. As can be seen, the existing research has created a foundation for exploring why nurses leave the profession, but much of what is known is not from the voices of nurses themselves.

To further explore this problem, it is also necessary to consider the composition of the current nursing workforce. As previously stated, approximately 91% of nurses are female. Surprisingly, the nursing shortage has not been extensively explored from a feminist perspective, which would place gender at the center of inquiry. Attempts have been made to compare men and women in nursing, but because of the small sample sizes of men, it is difficult to draw any conclusions about the influence of gender on intentions to leave the profession through quantitative analysis. What is known is that men tend to leave nursing at a faster rate than women (Cheung, 2004; Rambur, Palumbo, McIntosh, & Mongeon, 2003; Whittock, Edwards, McLaren, & Robinson, 2002), but there is limited knowledge about how gender may influence professional decisions. As Howell, Carter, and Schied (2002) note, women's intent to leave the workplace from a gendered nature of work has not been extensively explored in adult education. Hence, new knowledge can be generated by placing gender at the center of women's work experience as adult learners, which is consistent with a feminist orientation to research (Dubeck & Dunn, 2006). The next section will discuss the gendered nature of work and examine how gender has influenced the nursing profession.

Women, Work, and the Gendering of Professions

Over the past few decades, women have dramatically increased their presence in the workforce. In 1960, approximately 30% of women were in the paid workforce and by 2000, approximately 60% of women were in the paid workforce (Dubeck & Dunn, 2006).

Occupational opportunities for women have become more diverse and increased numbers of women are attending colleges. Today, women are present in almost every profession, although many jobs are still segregated by gender. Women are overrepresented in fields such as teaching, nursing, and clerical services, and they are underrepresented in fields such as architecture, engineering, construction, and maintenance (Dubeck & Dunn, 2006). Even though the responsibilities and job descriptions of the registered nurse have changed over the years, nursing has remained a predominantly female occupation (Evans, 2004; Leighow, 1996; Whittock et al., 2002).

The concentration of same-sex workers within a career category is referred to as occupational sex segregation (Dubeck & Dunn, 2006). The occupational segregation of nursing as a women's profession is particularly problematic considering that the population of women between 23 and 54 is expected to remain the same through 2030 while the population of those older than 65 is expected to double (Schuman, 2003). Societal constructions of masculinity and femininity in relation to work are magnified when occupations are segregated by gender. While all professions now have a female presence, some professions have remained predominantly female, which maintains dominant beliefs about the work that women do, as well as the skills they possess. Women are often assumed to possess attributes that are considered feminine, such as being nurturing, caring, and emotional (Davies, 1995; Dubeck & Dunn). When professions,

such as nursing, are occupationally segregated by gender, the direct and indirect results of gender discrimination can become magnified.

The disadvantages women experience in the workplace are vast and often hidden. In the workplace, women continue to be paid less money, have fewer opportunities for advancement, and occupy fewer top management positions (Dubeck & Dunn, 2006). Although less than 6% of nurses are men, their average salaries are greater than those of female nurses (Gladfelter, 2007; Jones & Gates, 2004; Snyder & Green, 2008), and they are more likely to hold leadership positions (Evans, 2004; Whittock et al., 2002). Even within a predominantly female profession, the gender gap is clearly visible.

The discrimination experienced by women in the workplace is a complex sociological problem without simple solutions, but it warrants further exploration of the structural components affecting women's experiences in the workplace. As stated by Dubeck and Dunn (2006), "The more we learn about women's experience and the context in which women work, the more we understand the structures and processes that influence experience and either facilitate or impede women's opportunities" (p. 3).

Healthcare institutions have traditionally been hierarchical and patriarchal with power typically exerted from the top down (Kane & Thomas, 2000). Within the healthcare environment, nurses are bound to the authority of the masculine hierarchy (David, 2000), which affects their practice in the workplace not only as nurses, but also as learners and educators of others. Gender issues that have influenced the profession include: the image of nursing, gender role socialization, gender oppression, and the domination of the medical model in healthcare. In the medical model of patient care, health problems are defined by those in power rather than by the patient, and rewards are given for outcomes that are measurable and cost-effective

(Robinson, 1985; Stuckey, 2009). Nursing models of patient care encourage a more reciprocal relationship between patients and healthcare providers, which can be threatening to the patriarchal system. The profession of nursing lends itself to the study of women in the workplace considering the context in which direct patient care occurs.

Research on gender and nursing has primarily focused on gender and career advancement (Tracey & Nicholl, 2007; Whittock, et al., 2002), as well as gender-role orientation and gender-role conflict in student nurses (Muldoon & Krema, 1995). There has been a lack of emphasis on the gendering of the nursing profession, particularly relating to gender-based political and societal issues affecting the shortage of nurses. Research on the nursing shortage has often been conducted from organizational standpoints based on financial costs of turnover and the loss of clinical expertise. Many studies have been conducted on the nursing shortage and nursing retention, but only a handful have examined the influence of gender on nursing practice and retention (Herron, 2007; Jones & Gates, 2004; Miranda, 2007, Seymour & Buscherhoff, 1991). In respect to other professions and occupational turnover, gender has been examined in the field of women's coaching (Cunningham & Sagas, 2003), but otherwise it is a relatively unexplored area of research.

Until patriarchy is recognized on a conscious level, women will continue to be unequal in the workforce. Dominant societal patriarchal beliefs will continue to prevail without critical examination of the underlying problems that contribute to the experiences of women in the workplace. The experiences of nurses in the workplace can help us to better understand how their perceptions of practice in a female dominated profession have contributed to their intentions to leave the profession, including their reasons for entering and exiting a profession that they have invested considerable time and effort.

Because nursing is a profession that is occupationally segregated by gender, the problems experienced by nurses in the workplace cannot be completely separated from the problems of women in society (Kane & Thomas, 2000). It is remiss to explore the nursing shortage without exploring the position of women within a gendered profession. Gender needs to come to the center of the issues that have contributed to the nursing shortage. Therefore, this feminist study not only seeks to explore the perceptions of registered nurses who have intentions to leave the profession, but also to examine whether the gendered nature of the work environment has influenced their decision.

Problem Statement, Purpose, and Research Questions

Nurses play a vital and essential role in the healthcare system and the nation is in the midst of a severe shortage of registered nurses, which is predicted to worsen over the next ten years. Due to complex issues, strategies designed to improve retention and recruitment into the profession have not lead to the development of long-term solutions (Buerhaus, 2008). Further complicating the deficit of nurses is the number of nurses who have intentions to leave the profession (Borkowski et al., 2007; Bowles & Candela, 2005, Lavoie-Tremblay et al., 2008; Nogueras, 2006; Whittock et al., 2002). Research investigating factors which influence decisions to leave the profession have primarily focused on job satisfaction and have resulted in various findings with few consistencies. The majority of the research has been conducted quantitatively and has not incorporated the actual experiences and perceptions of registered nurses. Additionally, nursing has historically remained a predominantly female profession and few studies have explored aspects of the nursing shortage from a gendered perspective.

Furthermore , adult educators have found that women often lack gender consciousness in relation to career experiences (Bierema, 2003; Clark et al., 1999), and Bierema (2003) has called

for more research on exploring sexist work environments in an effort to address women's career development. There has been some investigation into women's experiences in the workplace (Howell, Carter, & Schied, 2002; Mikulecky & Winchester, 1983) and nurses' experiences with continuing education (Cervero & Rottet, 1984; Cervero, Rottet, & Dimmock, 1986; Daley, 2001), but there is a lack of data-based research that truly examines the gendering of work and the gendered nature of experiences in the workplace, including the nursing workplace in either adult education or in the nursing literature, which can affect the decision to leave a profession. Thus, there is a need to utilize a feminist lens to investigate not only the reasons female registered nurses leave the profession, but also how they perceive their practice in a female dominated profession. Therefore, the purpose of this qualitative study is to explore the perceptions of female registered nurses who have intentions to leave the nursing profession with particular attention to the influence of gender in their decision-making process.

The specific research questions guiding the study are:

1. What factors have influenced a female registered nurse's intentions to leave the profession?
2. How do female registered nurses who have intentions to leave the profession perceive their practice in a female dominated profession?
3. How do female registered nurses who have intentions to leave the profession perceive the influence of gender on their practice and/or their decision to leave?

Theoretical Framework

The theoretical framework that informed this study is poststructural feminism. Poststructural frameworks have largely developed out of the work of French social philosopher, Michael Foucault. In his theoretical work, Foucault explored the relationship between power,

knowledge, and subjectivity (Weedon, 1987). As will be discussed further in chapter two, poststructuralism challenges the notion that an underlying organized system of social structures exists (English, 2006), and that structural theories (such as Marxism) alone are inadequate in explaining societal social relations; it is important to consider social structures such as race, gender, or social class. The addition of feminism to poststructuralism places gender and the gendered nature of experience as the central focus of analysis. In general, feminist research challenges gender-linked barriers with women's experiences as the focus. Feminist poststructuralism is a useful framework to explore complex social conditions that move beyond the individual (Phillips, 2001), but also do not focus solely on social structures. The current literature exploring intentions to leave the nursing profession has found that the majority of the reasons deal directly with the work environment, rather than individual factors, such as age, work experience, and organizational tenure, which undergirds the necessity to utilize a framework that not only incorporates gender, but one that encompasses underlying social structures as well.

Poststructural feminism moves beyond the psychological and structural models of feminist theory (Tisdell, 1998). Psychological models of feminism are primarily concerned with the development of female identity as gendered while structural models are concerned with how social structures such as gender, race, class, and sexual orientation impact systems of oppression and privilege. The theoretical framework of poststructural feminism is concerned with the influence of social structures on the construction of self (Tisdell, 1998). Major tenets of poststructuralism include: questioning the idea of truth, gender in relation to structures of oppression, shifting identity, and deconstruction.

In feminist poststructuralism, multiple realities exist and can be viewed from numerous positions (Cheek, 2000). Poststructuralism questions assumptions related to absolute knowledge, a single truth, foundationalism, and power (St. Pierre, 2000). Experiences are relevant to one's perspectives of reality rather than to one given absolute truth. Poststructuralism does not seek to search for meaning, but rather how discourse functions and is historically produced (St. Pierre, 2000). The intent is not to develop a singular and universal understanding of human experience, but instead to focus on factors such as gender, which affect perceptions and professional decisions. It acknowledges that reason is socially and culturally situated and is always developed from passion and desire (St. Pierre, 2000). In this way, it is a useful framework to study the perceptions of female nurses regarding their decision to leave the profession.

Additionally, feminist poststructuralism seeks to explore hierarchical social networks that marginalize and oppress, which in the present study will be the workplace. The complex social interactions that are present in society also manifest themselves into organizational structures (Bierema, 2001). The social construction of femininity and masculinity affects career choices and leads to gender stratification of job roles in the workplace (Correll, 2006). From a historical and sociocultural perspective, women have been constructed as nurturers and are more intimately connected to the care of humans (Colliere, 1986; Nast, 1994). The association of the work of nursing with feminine attributes provides insight into why nursing has remained a predominantly female profession.

The dominant structures in healthcare environments, the medical model of patient care and the hierarchical organizational model, both shape the workplace environment for nurses (Davies, 1995). These structures emphasize rational and scientific approaches, which can be considered masculine constructs. Within a masculine culture, emotions and personal judgment

are not a basis for decision-making, which can create a context that does not value the knowledge and experience nurses bring to patient care (Davies, 1995). Nurses are typically positioned within the medical discourse, which has silenced their own discourse; therefore, shaping their perceptions of their practice (David, 2000). Utilizing a feminist poststructural lens to examine structures of oppression from a profession that is occupationally segregated by gender can lend insights into how knowledge production is affected by both social structures and power relations. “Patterns of sex segregation in the health labor force are evident to the most casual observer, but understanding of the interaction between gender and other characteristics of the occupational hierarchy is less accessible” (Butter, Carpenter, Kay, & Simmons, 1994, p. 79).

In addition to providing a lens to examine how social structures can marginalize and oppress women in the workplace, feminist poststructuralism also explores how these systems have affected the development of identity, which is viewed as fluid and constantly shifting (St. Pierre, 2000; Tisdell, 1998). One’s positionality as a nurse affects perceptions and decisions, including the choice to leave one’s career. The shifting of multiple identities can occur through the sharing of experiences and contribute to the construction of voice, which has typically been absent in the literature on leaving the nursing profession. In poststructuralism, the participants may think differently about themselves as they share experiences and become aware of their own positionality within certain discourses.

The poststructural tenet of deconstruction is useful for exploring unequal power relations and disrupting the dominant discourse in an adult education environment such as in the workplace. Data analysis in this framework deconstructs social structures that are at work in an attempt to rebuild them. Through feminist analysis, power structures cannot only be analyzed and critiqued, but opened to provide the possibility for different social systems to emerge. This

framework can make the experiences of nurses in direct care-giving positions available to offer explanations of how some discourses become dominant and influence nursing practice. At the same time, spaces can be created for different discourses to develop and assist adult educators in the workplace and in nursing education to seek long-term solutions to the nursing shortage.

A poststructural feminist framework calls for looking at problems differently. In light of the current nursing shortage, there is a critical need to utilize a different lens to gain insight into the factors which influence registered nurses' intentions to leave the profession, as well as how perceptions of gender have influenced their practice in the female dominated profession. Further exploration of this framework in respect to language, power, discourse, and subjectivity will be discussed in Chapter Two.

Overview of the Methodology

Qualitative research emanates from a paradigm in which the world is viewed as socially constructed and constantly changing. Qualitative research is conducted to describe experiences and to explain how humans make sense of the world (Merriam, 2002; Merriam & Simpson, 2000). Qualitative methodologies are particularly appropriate to investigate phenomena that are not well understood or when there is a possibility that current knowledge on a topic is biased (Morse & Field, 1995). In qualitative studies, the researcher is the primary instrument of data collection, and a purposeful sample is selected to gain rich insights into the phenomenon of interest. Because the purpose of this study is to explore perceptions of female registered nurses who are considering leaving the nursing profession, as well as the influence of gender on their decision-making process, a qualitative methodology is the most appropriate choice.

Within qualitative research, there are several methodologies that can be used. For this study, a basic interpretive approach was selected. According to Merriam (2002), qualitative

researchers who employ a basic interpretive methodology are interested in (a) how people interpret their experiences, (b) how they construct their worlds, and (c) what meaning they attribute to their experiences. Additionally, phenomena were interpreted through a poststructural feminist lens to be consistent with the theoretical framework.

As will be discussed further in Chapter Three, inherent in all feminist methodologies is the central focus on gender, and there is not one type of methodology that is exclusively feminist. In general, feminist studies incorporate both interpretive and critical perspectives into the methodology (Gillis & Jackson, 2002). In order to conduct a feminist study, the researcher must explicitly disclose biases and assumptions to create a more objective analysis (Harding, 1987). Feminist research demands a high degree of reflexivity, which is an integral piece of each part of the study. Data analysis and interpretation were both filtered through the lens of poststructural feminism.

In order to find participants for the study, snowball sampling was used to seek participants who were willing to provide in-depth information about the decision to leave the profession. In addition to having intentions to leave the profession, participants needed to be female, have at least three years of experience as a registered nurse, and be employed in a patient care position. Participants also needed to have taken a step towards a new career by either engaging in a job search, acquiring new skills, or pursuing additional education. Eleven female registered nurses who met these criteria participated in the study.

The primary method of data collection was from participant interviews. Interviews were selected as the most appropriate choice to explore personal perspectives, to hear the voice of the individual nurse, and to be consistent with a feminist methodology. The interviews were semi-structured in nature, and the date, time and location was selected by the participant. Interviews

were audiorecorded and transcribed; member checks were conducted with the participants to make sure that their perceptions were accurately portrayed. Additionally, participants were invited to bring any documents to the interview, such as a diary, creative writing, professional information, or electronic communication, which was related to their choice to leave the profession.

I also kept a researcher journal to reflect on personal insights raised during data collection and analysis. Researcher journals can promote reflexivity, as well as direct data analysis (Ortlipp, 2008). Data collection and data analysis occurred simultaneously. The four cognitive processes described by Morse (1994) and the five procedures of analytic processes by Marshall and Rossman (1989) served as a guide for data analysis. Data were coded and organized into themes and categories.

Significance of the Study

This qualitative research study exploring registered nurses intentions to leave the profession has implications for adult educators in the workplace and in nursing education, as well as social policy initiative. Examining this issue with gender at the center of the nursing shortage placed a critical lens on current organizational, educational, and social practices. As the population ages and individuals with chronic health problems live longer, the demand for nurses is anticipated to significantly increase. As previously stated, nursing care has been demonstrated to decrease medical complications, decrease mortality rates, improve patient safety, and decrease the risk of errors, which are all a service to the public (Buerhaus, 2008). Nursing has failed to attract diverse groups, and the findings of this study could be valuable to social policy makers who are charged with increasing retention and recruitment of registered nurses by shedding light on why female nurses intend to leave the profession. Barron and West (2005) state “strategies to

improve nurse retention must attend to nurses' status, authority, and position in the hierarchy if they are to be successful" (p. 155). Qualitative research on nursing retention, including intentions to leave the profession, has been limited and this study adds depth to the body of literature by incorporating the voices of women in the workplace.

This study also holds significance for adult educators involved in organizational development and workplace education. Issues related to gender and power are present on a daily basis in the workplace, yet they are rarely articulated. In the workplace, women are often viewed as being less committed to their work and therefore, are less valued (Larson, 2006), which undoubtedly affects working conditions. The structure of the workplace environment affects work experiences and may lead to personal decisions about one's career choice. As stated by Bierema (2003), "Women's uncritical career development not only causes them to adapt to a masculine model, but also prevents them from addressing power differentials or claiming a career on their own terms as women" (p. 4). Without a heightened awareness of social structures that influence career decisions, it is difficult for workplace educators to prepare registered nurses for career challenges and make recommendations to improve working conditions. Undoubtedly, there is a need for workplace educators to develop a more thorough understanding of factors which influence registered nurses' intentions to leave the profession. According to Cheung (2004), the system will need to change in order to not only attract nurses to the profession, but to keep them in practice. However, radical changes in the workplace, including challenges to occupational sex segregation and gender inequality, are not easy to attain (Barron & West, 2005). Although work environments are difficult to change, adult educators can play a role in calling attention to problems of gender discrimination, which is an important component of this study.

Additionally, this study extends the theoretical framework of poststructural feminism. This framework has been used in nursing to study clinical issues (Arslanian-Engoren, 2001; Cheek, 2000; Dickson, 1990) but rarely to study nurses themselves (Traynor, 1997). Historically, there has been a gap between nursing and feminist theory. This space is the result of nursing's attachment to women's duty (instead of women's rights), beliefs that political action is unprofessional and unfeminine, and the close proximity of nursing to medicine, which aligns with positivist approaches to knowledge (Kane & Thomas, 2000). This research illustrates how poststructural feminism can be a valuable framework for studying nurses' perceptions of their work, as well as their experiences in the workplace. The existence of nursing issues related to working in a female-dominated profession has been obscured by the lack of a dialogue between academics and nurses (Group & Roberts, 2001).

Current research on intentions to leave the nursing profession has primarily used organizational and job turnover frameworks. Thus, feminist frameworks have not been extensively used to study issues related to human resource development (Bierema, Tisdell, Johnson-Bailey, & Gedro, 2002), such as intending to leave one's profession. Without calling attention to gender issues that influence practice, nurses will not be able to effectively exercise their capacity for agency to advocate for better working conditions. If nurses gain insights into how gender has impacted their positionality, they may be better able to develop a collective voice, which may lead to the development of solutions to overcome the shortage. The existing research on intentions to leave has offered few strategies related to education to keep nurses in the profession, and this work seeks to make curricular and pedagogical recommendations based on the study findings.

In addition to contributing to adult education, this study offers significance to the field of nursing education. Nurse educators have a responsibility to teach nursing students the realities of practice within an organization, as well as how structural systems influence the work environment. In order to develop solutions to the nursing shortage, there must be an effort to close the gap between nursing education and nursing service (Oulton, 2006). The field of nursing education can pose challenges to the social construction of nurses and their work, which both influence nursing practice and retention in the profession. Some of the problems contributing to the nursing shortage are the direct and indirect results of gender discrimination and biases, and this study creates a link between the two, which is important for nursing education. If nurse educators only acknowledge that problems exist without discussing the underlying systems that have contributed to them, student nurses will internalize these problems as normal and come to accept them. Pedagogical techniques which facilitate discussion of these issues need to be incorporated into nursing education.

Furthermore, this study has significance for registered nurses. Lawler (2002) discusses nursing as a woman's business and states "it is taken for granted, it is storied, it is grounded in experiential knowing, and it has been silenced in a patriarchal world" (p. 185). This research has the potential to create a discourse surrounding how social structures exert particular influences on decisions to leave one's profession in a career that is occupationally segregated by women. Understanding power relations and how voice is constructed within an organization are necessary tenets to negotiate structures of power and to gain access to decision-making and professional development, which have both been suggested to improve nursing retention (Cheung, 2004).

Finally, this study is personally significant. When I became a nurse, I did not have intentions to stay in the profession for very long. As I entered the profession, I lacked confidence in my skills, was unsure of my knowledge, and was uncertain that I had the desire to practice as a nurse. I intended to work as a nurse until I was able to obtain education in another field, but somewhere along the way I developed a passion for the profession and for the work that nurses do. In my own practice as a nurse, I have experienced the difficult nature of the work environment and the complex care that patients require. Many of the organizational expectations are incompatible with the conceptualization of what constitutes “good nursing care,” and the assigned work usually cannot be adequately accomplished in the given time frames.

As a nursing educator, issues surrounding leaving the profession have continued to intrigue me. Admission into nursing programs is extremely competitive and each year, thousands of qualified candidates are denied entry into nursing due to the lack of nursing faculty and other resources (AACN, 2009; Buerhaus et al., 2003; Schuman, 2003). Despite the high admission standards and requirements necessary to enter the profession, some nurses choose to leave the profession, which leads me to question whether educational preparation is adequate for nursing practice in today’s healthcare environment or whether the work environment itself affects the practice of nursing, thus affecting professional intentions. The findings of this research study have provided insights related to these questions.

In conclusion, this work has sought to uncover the perceptions registered nurses have of their practice in a female-dominated profession, as well as the influence of gender on intentions to leave the profession. Without critical examination of the underlying problems that contribute to the experiences of women in the workforce, dominant societal patriarchal beliefs will continue to prevail, and gender biases will continue to be passed on by both men and women unless they

are investigated and addressed (Kane & Thomas, 2000). Analyzing the social aspects of healthcare organizations and examining gender issues through a poststructural feminist lens has the potential to transform nursing practice. With current debates about the crisis in healthcare and the scarcity of nurses as a valuable resource, now is an opportune time to advocate for changes in the work environment that could prevent nurses who are dissatisfied with their work environments from leaving their profession.

Assumptions, Limitations, and Strengths

All research studies are based on certain assumptions, and have certain strengths and limitations. The assumptions guiding this study include:

1. Women's experiences in the workplace are valuable to study.
2. Knowledge, perceptions, and experiences are socially constructed.
3. The reasons women leave the profession of nursing have not been adequately studied.
4. Registered nurses will be honest and serious in sharing their intentions to leave the profession.
5. The practice of a registered nurse is influenced by gender, discourse, power, knowledge, and language.
6. The gendered nature of work and work environments are influenced by discourse, power, knowledge, and language.
7. The researcher is an active participant in the research process, as well as the data analysis, and must have an awareness of personal positionality.

This study, like any study, has some inherent limitations and strengths. The limitations include:

1. This study is dependent on voluntary participation of registered nurses' who have intentions to leave their profession. The participants may be angry and frustrated about their working conditions. Furthermore, it may be difficult to discuss leaving a profession that required rigorous education and personal commitment. They may be apprehensive and unsure of their new career interests.
2. The results of qualitative research can have limited transferability due to the small sample size, as well as the fact that experiences are socially and culturally situated.
3. The participants are limited to those who intend to leave the profession from patient care positions.

In spite of these limitations, the proposed study has many strengths, including a strong rationale and a rigorous research methodology. The use of a poststructural feminist lens to uncover structural issues which influence personal decisions is a study strength. While the study may not be generalizable to all nursing populations, the results of the study could cast new light on the dynamics of why nurses might leave the profession, which could offer implications for interventions, as well as innovative strategies to combat the nursing shortage.

Organization of the Study

The opening chapter of this research study has provided an overview. Chapter Two includes further discussion of the theoretical framework of poststructural feminism, the gendered history of American nursing, a review of literature on nursing as a female occupation, and a literature review of research on intentions to leave the nursing profession. The description of the research methodology, as well as the rationale for the study design are included in Chapter Three. Chapter Four includes introductions of each participant and the presentation of the

findings. Chapter Five contains a discussion of the findings in relation to the current body of literature and in light of a feminist poststructural framework.

Definition of Terms

Constantly shifting identity: the process of individual identity shifting with personal examination of social structures and their effect on positionality (Tisdell, 1998).

Discourse: the social, historical, and cultural structure of language (St. Pierre, 2000).

Gender: “a type of social relation that is constantly changing, created and recreated in daily interactions...through school, work, and the family” (Hayes & Flannery, 2000, p. 4). Our actions, interactions, status, knowledge, and learning are all related to gender.

Intention to leave: the cognitive process before the actual act of leaving that usually occurs as a result of multiple variables (Coomber & Barriball, 2007).

Job satisfaction: a complex phenomenon that is dependent on individual perceptions of how a job meets personal needs and values (Coomber & Barriball).

Nursing shortage: the lack of registered nurses in jobs which require one. The current shortage began in 1998 and is the result of an increased demand, decreased supply, stressful working conditions, and an aging registered nurse workforce (Buerhaus et al., 2007).

Occupational sex segregation: the unequal distribution of men or women within an occupation that contributes to a sexual division of labor and also affects benefits, status, and authority (Reskin, 2006).

Patriarchy: a societal structure in which power relations are formed in the interests of men and women’s issues are seen as subsidiary (Weedon, 1987).

Positionality: an individual’s position in relation to systems of power and privilege. It also incorporates systems which oppress.

Poststructural feminism: a theoretical framework which connects social structures such as power, privilege, and oppression to one's constantly shifting identity (Tisdell, 2001).

Practice: the performance of work as a nurse. Practice can include patient assessment, administration and monitoring of medications, collaboration with other healthcare providers, patient education, coordination of care, supervision of care, and psychosocial support.

Registered nurse: a graduate of a nursing education program who has successfully passed a national exam and possesses a license to practice nursing.

Subjectivity: the conscious and unconscious effects of sexism, classism, and racism on how individuals come to view themselves in relation to dominant discourses (Weedon, 1987).

CHAPTER TWO

LITERATURE REVIEW

The purpose of this study is to explore the perceptions of female registered nurses who have intentions to leave the nursing profession and to explore the influence of gender on intentions to leave the nursing profession. This chapter focuses on reviewing the relevant literature, and begins with a discussion of the theoretical framework of poststructural feminism (as related to nursing), which informs this study. Poststructural feminism provides a lens from which to examine the reasons nurses have intentions to leave the profession. By utilizing a gendered lens to view issues which influence nurses' decision-making process, a broader spectrum of the problems women experience in the workplace can be explored (Davies, 1995).

The second section provides an overview of nursing as a gendered profession and includes a brief history of the nursing profession in the United States; the view of nursing as a female occupation in considering its career roles; and research relating to nurses in adult education, which has been primarily associated with continuing professional education and workplace learning. The third and final section reviews the research on intentions to leave the nursing profession.

Theoretical Framework:

A Poststructural Feminist View of Nursing

Poststructural Feminism in the Context of Feminist Theory

The theoretical framework for this research study is poststructural feminism. To begin with, it is important to discuss the major philosophical assumptions of feminist theory in general before discussing the major tenets of poststructural feminism. "Feminist theoretical frameworks are fragmented, spanning perspectives variously described as liberal, Marxist, socialist, radical,

poststructural/postmodern, existential, and psychoanalytic” (Howell, Carter, & Schied, 2002, p. 113). While many differences exist between these theoretical frameworks, some of the basic roots of feminism are similar. In order to set the foundation for the development of poststructural feminism, a brief overview of feminist theory in general will first be provided. Then, the main tenets of poststructural feminism will be discussed, and a consideration of feminist issues in nursing will follow.

Feminist theory is concerned with the empowerment of women and the creation of opportunities for women. Gender is the central focus in all feminist theories and it is seen as being socialized in many ways, both conscious and unconscious. Power is a fundamental component in all feminist theories, but it is conceptualized differently depending on the theoretical orientation. Chinn and Wheeler (1985) define feminism as “a worldview that values women and that confronts systematic injustices based on gender” (p. 74).

Traditional epistemologies have often excluded women as knowers and feminists ascertain that these epistemologies have been derived from the viewpoints of men (Harding, 1987). As stated by Luke and Gore (1992), “Feminists disagree on many theoretical and political issues but they do agree on the rejection of the masculinist subject in history as foundational to all truth and knowledge” (p. 7). Many feminist philosophers would argue that scientific knowledge has mainly been created by men and with male interests in mind (Hagell, 1989). Another component of feminism is the belief that women need a comfortable and safe environment to grow in (Merriam, et al., 2007). This component of feminism has been criticized by hooks (1984) who points out that safe spaces have not been created for those in the margins.

The theoretical framework of poststructural feminism is grounded in both the psychological and structural models of feminism (Tisdell, 1998), so it is important to provide

some insights into these theoretical frameworks. Liberal feminism and psychoanalytic feminism have both created the foundation of the psychological model of feminist pedagogy (Tisdell, 1998). Psychoanalytic feminists believe that a patriarchal system is developed on a subconscious level (Merriam, et al., 2007). This model gives focus to the individual woman and is concerned with the needs of women. Individuals are seen as independent and rational (Doering, 1992). Existing social structures are seen as providing for equality to be achieved between men and women; societal changes are possible through education (Doering, 1992). Gender socialization and identity formation is believed to be the result of patriarchy, which must be confronted in order for individual changes to occur. The development of this type of feminism has greatly been influenced by the work of Carol Gilligan (1982) and Belenky, Clinchy, Goldberger, and Tarule (1986). The psychological strands of feminism focus primarily on women as individuals with little regard to structural factors of race, class, or ethnicity, which is a major critique of this work (Tisdell, 1998; Tisdell, 2001). These more psychological strands of feminist theory encourage individual empowerment to achieve emancipation. However, the emphasis on individualism may not be adequate in explaining social causes of gender inequity (Group & Roberts, 2007). Psychological strands of feminist theory put the onus for change on individual women without examining the underlying social structures which contribute to inequality.

Structural feminist theories have drawn on the work of Marx, who provided a way of analyzing class as a social structure (Tong, 2009). Marxist feminists have focused on the intersection of class and patriarchy in understanding women's oppression, while socialist and standpoint feminists have focused on the intersections of social structures of race, gender, and class (Collins, 1991; Tisdell, 1998; Tong, 2009) and where women "stand" in relation to the dominant culture. Focus is given to societal structures, such as systems of oppression and

systems of privilege, and attention is not called to individual needs. Societal structures determine how knowledge is produced, maintained, and perpetuated according to structural feminist theories. Organizations “must be seen as social constructions that arise from a masculine vision of the world and that call on masculinity for their legitimization and affirmation” (Davies, 1995, p. 44). Thus, the social structures that are present in society are also present in organizations. Structural feminist theory offers a social explanation of gender differences rather than a biological reasoning (Francis, 1999). However, the criticism of structural feminist theories is that there is a lack of attention given to an individual’s capacity to exercise some level of power outside social structures (Tisdell, 1998). As stated by Lather (1991), “Structuralism displaced the agency of the idea with the agency of the material” (p. 154). Because of this overemphasis on the need to transform social structures, there is a need to also include individual capacity for agency in feminist theory.

Major tenets of feminist poststructuralism

Poststructural feminism combines concepts from both the psychological and structural models to form its foundational base; it acknowledges the role of social structures in relation to how individuals form their identities and function in society, but it extends beyond social structures. A major assumption is that the gendered development of men and women is socially constructed. Feminist poststructuralism moves beyond gender differences and calls attention to larger issues associated with power relations and positionality or where one is “positioned” in society in regard to race, class, ethnicity, and sexual orientation. Gender is an important concept for analysis as well as examining how gender impacts experiences (Tisdell, 1998). Recognition is given to the oppression of women based on their gender in addition to other differences which are often marginalized in a patriarchal system. Shifting identity, questioning the idea of truth,

gender in relation to structures of oppression, and deconstruction are the major tenets of poststructural feminism. Each of these tenets will be further discussed and related to the study purpose.

Constantly shifting identity and multiple truths. Poststructural feminism is concerned with how identities are formed, deconstructed, and reconstructed (Hayes, 2000). Identity is seen as being constructed between the structural realms of privilege and oppression with identity being fluid and ever changing, and thus, is constantly shifting (St. Pierre, 2000; Tisdell, 1998). Individuals have multiple subjectivities, which leads one to behave differently depending on the social situation (Weedon, 1987). One's identity at work is undoubtedly influenced by the structures present in the workplace, which can impact decisions surrounding career choices. In this framework, there is a shift from the view of the static, authentic self to a flowing and socially positioned self (Lather, 1991).

The concept of one single truth and the existence of absolute knowledge are called into question in poststructuralism (St. Pierre, 2000). The notion that there is a complex and ordered system beneath everything is also questioned (English, 2006). Truth is relative to how one has constructed knowledge; there is no universal approach to knowledge development (Doering, 1992). Knowledge and reason are seen as socially and culturally constructed entities that cannot "be free from error, illusion, or the political" (St. Pierre, 2000, p. 496). Furthermore, the exclusion of certain groups from the production of knowledge creates doubt in what is seen as truth and reality (Lather, 1991). This component of the framework provides voice to experiences and dispels the myth that everyone has similar experiences in the workplace, which is particularly valuable for this study because registered nurses have been marginalized by the

dominant discourses of the medical model of healthcare and hierarchical organizational structures.

Additionally, feminist poststructuralism takes the stance that structures exist but there must be investigation into how they are developed and sustained (Ryan, 2001). Structures impact the development of self, and places where individuals meet systems of privilege and oppression contribute to knowledge construction. Poststructuralism emphasizes the need to analyze these relationships rather than simply acknowledging their existence. In this way, “we examine our own complicity in the maintenance of social injustice” (St. Pierre, 2000, p. 484). In healthcare, it is evident that the majority of registered nurses are women, but it is not well understood how gender interacts with other workplace components of the occupational hierarchy (Butter, Carpenter, Kay, & Simmons, 1994).

Furthermore, career choices and workplace job roles are affected by social constructions of masculinity and femininity (Correll, 2006). According to Davies (1995), the cultural codes of masculinity and femininity are deeply embedded within organizations and “they must be seen as social constructions that arise from a masculine vision of the world and that call on masculinity for their legitimization and affirmation” (p. 44). As individual experiences intersect with structures, knowledge is socially constructed and in close proximity to power. The position of a nurse in the workplace is usually within the medical discourse, which influences perceptions of practice (David, 2000). This framework provides an opportunity for participants to become aware of their own positionality as individual nurses and as nurses in the workplace. With this aim in mind, it is important to note that relations of power exist on many levels and require careful analysis.

Power and resistance. Power as a central tenet of poststructural feminism has been greatly influenced by the work of Foucault (1980). Power is often depicted as coming from above or as a “power over” concept, though Foucault argued that power circulates. Power is a dynamic that shifts among individuals and groups (Powers, 2001). Power does not come from a central point, rather it exists everywhere, which allows it to be produced, reproduced, shifted, and dissolved. Thus, it cannot be examined only from a hierarchical position with the assumption that it is mainly exercised by domination. Power is considered to be relational and is not always intentional or conscious. Every individual has the potential to exercise power in a variety of ways, whether overt or covert (English, 2006). To create a balance of power does not mean that each person has similar capabilities for achieving equality, but rather that he/she has a capacity for agency and accessibility to resources (Roberts & Group, 1995). However, power exists on many levels, and therefore, power and capacity for agency must be examined from several vantage points. Unequal power relationships require critical exploration; they are often perpetuated by society, and education can be a medium for identifying and developing solutions to these issues.

Power can be influenced by domination or resistance (English, 2006), and resistance can be found wherever power is found (Powers, 2001). Thus, power and resistance accompany each other and contribute to how the other is defined. According to Foucault, resistance is always possible when there is discourse (Francis, 1999). This creates a context specific tension leading to marginalization and oppression of nondominant groups. Oppressed groups develop techniques of resistance that are often passive and indirect. With this type of resistance, marginalization creates tension which can actually help to sustain the dominant discourse, rather than challenging it (Powers, 2001). Nurses themselves have often been the subject of blame in regard to their

working conditions rather than critical analysis of the underlying processes which have never produced an environment conducive to nursing care (Davies, 1995). An aim of this study is to analyze whether underlying structures of power have influenced a nurse's intentions to leave the profession. Poststructuralism "enables us to explore the meanings of difference and the possibilities for struggling against multiple oppressive formations simultaneously" (Lather, 1991, p. 156).

Areas of resistance are not always easily identifiable and a heightened sense of awareness may need to be achieved for solutions to be sought. Deviation from long held beliefs which challenge our personal value system can be difficult to comprehend and resist (Tisdell, 1998). As stated by Butler (2004), "Sometimes the very conditions for conforming to the norm are the same as the conditions for resisting it" (p. 217). However, the presence of resistance allows for the potential of change (Doering, 1992). It is possible for an individual who is not in a position of power in one discourse to reposition the self into a position of power in another discourse (Francis, 1999). If a nurse perceives a lack of power in work decisions, she may seek other employment opportunities to reposition the self. According to Weedon (1987), all actions either signify "compliance or resistance to dominant norms of what it is to be a woman" (p. 87).

Critically examining individual perceptions can help to identify where areas of resistance exist. Feminist poststructuralism searches for areas of resistance which are open for change (Dickson, 1990). Recognizing struggles and sharing difficulties relate to the concept of creating a safe space for sharing to occur; voices of women can come to the forefront with the creation of safe spaces. It is hoped that through interviewing female registered nurses regarding their intentions to leave the profession that a safe space will be created and their voices will be heard. Furthermore, not only are safe spaces created in this theoretical framework, but the existence of

empty spaces in what is believed to be known can be analyzed (St. Pierre, 2000). In the workplace, many beliefs are maintained in respect to professional attributes, the type of work performed, and career commitment, and this framework provides an opportunity to search for other areas of workplace education that need to be explored to meet the needs of women and others who have been consistently marginalized in the workplace.

Language and discourse. Also, germane to poststructural feminism are concepts of language and discourse. Humanism has attempted to create fixed definitions and unique identifiers in the language we use (St. Pierre, 2000). Poststructural feminism has attempted to problematize this notion that the world can be organized and categorized in a simple fashion, which fails to acknowledge differences within a category. This perspective advocates for the deconstruction of dominant discourses, including language, in an effort to view problems differently. Language consists of signs which are constructed of a written image and a meaning (Weedon, 1987). Signs carry a great deal of symbolization in our society and serve as a foundation in the way we communicate with each other. Signs are identified and interpreted through language which is not static (Crowe, 1998). Meanings are attributed to differences between signs; therefore, language is a social construction. Davies (1995) attributes the language of nursing to be related to its identity as “women’s work.” However, the language in healthcare is dominated by medical discourse, which often silences the discourse of nursing (David, 2000).

In a society that highly values individualism, it can be difficult to accept how society influences language, as well as beliefs and values (Dickson, 1990). The deconstruction of binary relationships such as male/female, rationality/emotion, objectivity/subjectivity is a main tenet of poststructural models (Aranda, 2006). Feminists have contended that the first term in a binary is

“male and privileged and the second term is female and disadvantaged” (St. Pierre, 2000, p. 481). Because language is inscribed by those in social power (Doering, 1992), the values of those in power are conveyed through language which then reinforces the power when it is adopted by society (Crowe, 1998). Thus, it is important to deconstruct the hidden meanings embedded in language. Poststructuralism allows binaries to be deconstructed and reinscribed for new meanings (Aranda, 2006).

The purpose of deconstruction is not to reject or eliminate structures, but to dismantle and reconfigure them differently (St. Pierre, 2000). Concepts have multiple meanings which can be reinscribed through this process. When language is not deconstructed, there is a tendency to value one binary over another placing it in a hierarchical position. If knowledge is viewed “as an effect of power” (Crowe, 1998, p. 340), then language contributes to epistemological assumptions and what is valued as truth. “Discourses are socially and culturally produced patterns of language which constitute power by constructing objects in particular ways” (Francis, 2000, p. 21). Additionally, St. Pierre and Pillow (2000), ascertain that reconstruction occurs through public discourse, and therefore, poststructuralism can be used to critically examine practical problems. The next section will briefly discuss the pedagogical implications of feminist theory in adult education.

Implications for pedagogy. The philosophical perspective of feminist theory in adult education, as it affects teaching and learning, is often referred to as feminist pedagogy, encompasses many different models and draws on a variety of philosophical underpinnings. The roots of feminist pedagogy stem from radical philosophy, critical theory, and humanistic psychology (Elias & Merriam, 2005). In many ways, feminist education has been institutionalized and therefore, it has not been accessible to numerous women.

Inherent in all versions of feminist pedagogy are five interconnected themes: (a) how knowledge is constructed, (b) voice, (c) authority, (d) identity as shifting, and (e) positionality (Tisdell, 2000). Educating from a poststructuralist standpoint involves the use of women's stories "to facilitate both women's development and structural social change for women" (Tisdell, 2000, p. 182). "Poststructuralists ask what the connection is between our feelings and emotions and how they relate to what we can rationally know about the world" (Tisdell, p. 171). To be able to think differently and ask questions not previously contemplated is a form of political intervention (Lather). The potential for humans to establish knowledge and power also creates the possibility for them to change (Dickinson, 1990). Micro-level changes of resistance can happen through research and pedagogy (Lather, 1991). Being able to see the world as relational rather than hierarchical enables us to develop epistemologies beyond ourselves (Lather).

Limitations. While there are many strengths to using a feminist poststructural framework, there are some criticisms that need to be acknowledged. Poststructuralism has been criticized for being esoteric in its language making it inaccessible and ambiguous as a philosophical framework. However, poststructuralists contend that too much clarity will negate reflection and critical analysis, which are both essential components (St. Pierre, 2000). An additional criticism relating to language deconstruction is that we must use the language we have to deconstruct, which makes it difficult to escape humanism. Also important to note is that if deconstruction is emphasized more than reconstruction, social change does not occur. Ogle and Glass (2006) suggest that poststructuralism's emphasis on discourse can overshadow lived experiences and take focus away from economic and material power relations. Furthermore, if intentions are to expose modernist assumptions rather than offer solutions (Ogle & Glass, 2006), a cycle of identifying injustices without proposing solutions is created. A final criticism that

must be acknowledged is related to the emphasis on marginalization. Because marginalized groups are highlighted in a poststructural framework, there is a potential that attention to “otherness” may have a negative connotation and individuals may be further distanced from societal constructions of the norm.

While the theoretical framework of feminist poststructuralism has some limitations, it combines the concepts of power and female experiences, which are both relevant to the nursing profession (Doering, 1992). There is tremendous value in researching “the political, historical, and gendered processes embedded in all knowledge production” (Aranda, 2006, p. 136) and a poststructural feminist lens provides the opportunity to examine the structural influences on career intentions to leave the nursing profession. The next section will further discuss the value of utilizing such an approach to study nurses.

Feminism and Nursing

This section of the literature review provides perspective on the fragmented relationship between nursing and feminism in order to further elaborate on the choice of the theoretical framework. Concepts central to both nursing and feminism are the patriarchal devaluation of caring and the importance of individuality, life, and the environment (Roberts & Group, 1995). However, there has not been substantial research in nursing utilizing a feminist lens. In an editorial on feminism and clinical nursing, Webb (2002) noted that searching CINAHL for articles related to feminism resulted in 127 articles from 1992-1996 and this number fell to 46 from 1997-2001. For the same time periods, articles on feminist research were 45 and 18 respectively; the number of educationally oriented papers further fell to 30 and 8 respectively. A recent search for feminist research in nursing journals resulted in 19 published articles between 2002 and 2009. Based on these search histories, it is evident that feminist theories have not been

widely used in nursing research or they have not been explicitly stated. Furthermore, based on this literature search, it appears that feminist research in nursing has decreased in recent years. In light of the fact that there seems to be a decreasing amount of literature in nursing that is explicitly feminist, many of the references in this chapter are not recent. However, many of the points raised by previous feminist research in nursing are still applicable to the work environment today. The intent of this section of the literature review is to shed light on reasons that gender has not typically been placed at the center of research on the nursing shortage.

While commonalities exist between nursing and feminism, differences in language have made it impossible to see the similarities (Kane & Thomas, 2000). Even though nursing is a predominantly female occupation and would seem to have a natural tendency to align with feminism, there has been a separation between the two for many reasons. Traditionally, liberal feminism was refuted by nurses because they viewed the flaws in the healthcare system as unable to provide equality and autonomy (Reverby, 1987). Also, misconceptions continue to abound that aligning with feminism will conflict with other female roles such as wife and mother (Speedy, 1997).

Secondly, within the healthcare system, the discourse of medicine wields more power than the discourse of nursing. While nursing is often touted as an art and a science, within the dominant discourse, it is the science that is emphasized. Therefore, in an attempt to improve their social position, nurses have often emulated the research practices of medicine, which have been derived from positivism and an individualistic view of health and illness (Hagell, 1989). The approach to research within this social structure has also affected the development of nursing theory, which has primarily been developed by highly educated nurses who have obtained power in patriarchal structures making many of the philosophical concepts inaccessible

to nurses working in direct care positions. “The approaches to nursing theory reflect the dominant culture rather than the lived experience of nurses at the bedside” (Wuest, 2002, p. 70). The viewpoint from which nursing research is designed may not be compatible with actual nursing practice, creating a disconnect between nurses, the research, and their work. If nurses utilize these same techniques to study themselves, they risk maintaining dominant ideologies, including organizational structures and practices which affect their professional work.

Even when a feminist analysis is used in nursing research, it is often not explicitly stated (Roberts & Group, 1995). While an emphasis on rational and scientific knowledge has helped to advance the practice of nursing in certain areas, ideas central to nursing such as health and wellness have largely been absent from the research (Cheek, 2000). Chinn and Duffy were two of the first authors to critique the emergence of nursing research from male worldviews (Chinn, 1980). Davies (1995) states that it is through nursing that medicine is able to not only “present itself as masculine/rational” (p. 61), but to also gain power and privilege.

A third aspect to consider in relation to nursing and feminism is the socialization of nurses. Nursing has historically been seen as a calling which has shaped its adversarial relationship with the capitalist values of money and power (Benner, 2007). Nurses are socialized to be “good,” obedient, and submissive which makes it difficult to raise consciousness of gender issues. Considering the caring nature of nursing, nurses are socialized to be conservative in their actions and therefore do not offer resistance to dominant discourses. Nurses take their responsibility to serve seriously and therefore, they have paid very little attention to the social issues that have impacted their practice. As stated by Butler (2004), “In the United States, the word ‘compassionate’ has been linked to ‘conservative’ (p. 223). Even though social issues for

nurses have existed for many years, the first nursing book to examine issues of women and relate them to professional issues in nursing was not published until 1982 (Andrist, 2006).

The profession of nursing can advance through aligning with models of feminism (Andrist, 2006). Feminist theory is a relatively new framework for nursing research, and it has only been applied over the past 25 years (Andrist, 2006). Feminist theory is rarely included in nursing textbooks, which contributes to the lack of connection between nursing and feminism (Kane & Thomas, 2000). Additionally, feminist histories of nursing have not traditionally been included in nursing education (Roberts & Group, 1995).

Feminist theory has relevance to many aspects of the nursing profession. The lack of inclusion of personal stories that foster philosophic and political debate obscure the need to analyze individual realities (Kane & Thomas, 2000). By considering the unique position women hold in society, the profession of nursing can be more closely examined. “The absence of an extended dialogue between women scholars in the broader academic community and women in nursing has led to difficulties in understanding nursing as a predominantly woman’s profession” (Group & Roberts, 2001, p. xiii). Gender biases will continue to be passed on by both men and women unless they are analyzed and addressed (Kane & Thomas, 2000). The social aspects of healthcare and attention to gender issues through feminism have the potential to transform nursing practice.

Based on this discussion of feminism and nursing, the theoretical framework of poststructural feminism can challenge the notion that reality can be captured as being natural rather than cultural (Crowe, 1998). This approach to research allows nurses to question structures of power which affect individual experiences and perceptions. Poststructuralism has the potential to explore the realities of nursing practice in ways that encourage careful reflection

(Cheek, 2000). It is this type of approach to research that has the potential to influence nursing practice. Applying a poststructural feminist framework to the nursing profession can increase individual capacity for agency and identify issues of power related to gender issues. Without deconstructing existing structures which have impacted the nursing profession, it is impossible to improve the retention of nurses in practice.

Historically, nurses have had difficulty in creating a collective voice despite the number of nurses in the United States. The voices of women need to be heard if the status of the nursing profession is to be elevated. Listening to the stories of women in regard to their experiences in nursing can help us to better understand the reasons nurses may choose to leave the profession. As stated by Porter (1992), “Gender remains one of the most important factors in nurses’ experience” (p. 524). Without an understanding of existing power structures and dominant discourses, it is difficult to develop strategies to keep nurses in practice. “As long as the relationship between nursing and feminism remains invisible, the gender problems in nursing that are systemic to a woman’s occupation in a male-dominated society will continue” (Kane & Thomas, 2000, p. 17). Nursing must be analyzed as an important component of women’s history; thus, essential to understanding the relationship between gender and professional intentions is an analysis of the historical roots of nursing in the United States.

Nursing as a Gendered Profession

While the responsibilities and job descriptions of the nurse have changed over the years, it has remained a predominantly female occupation (Evans, 2004; Leighow, 1996; Whittock et al., 2002). In order to understand current issues in nursing, it is important to trace the roots of nursing in the United States, because historical, political, and social contexts contribute to knowledge production (Doering, 1992) and widely accepted beliefs. In an article comparing the

nursing shortage in the late 1980's to the current nursing shortage, Gunn (2000) finds that many of the causes have remained the same. He states, the "causes stem from the gender-based history of modern-nursing and the cultural and professional based problems that nursing has had great difficulty changing" (p. 150). This section of the literature review will begin by discussing the history of the nursing profession in the United States, issues which have contributed to nursing remaining a female occupation, and the influence of gender in nursing. Next, it will consider current career roles in nursing, and follow with workplace education and adult education in the nursing profession particularly related to gender. Finally, it will conclude with a consideration of gender issues relating to the nursing shortage.

Historical issues in American nursing

Most historical accounts of American nursing begin with the influence of Florence Nightingale on the establishment of nursing education in Philadelphia during the late 1800's (O'Brien, 1987). However, a more thorough history includes accounts of religious orders and family duty (Group & Roberts, 2001; O'Brien, 1987). Catholic sisters provided care for both armies during the Revolutionary war (Group & Roberts, 2001). Their order was modeled after an order established by St. Vincent de Paul and St. Louise de Marillac in France in 1646. Nursing sisterhoods evolved and created hospitals, orphanages, and provided home care visits. These women took on challenges such as poverty and disease epidemics (Group & Roberts, 2001).

Nursing's early years in America. In early American life, women were primarily responsible for caretaking in their families, which created a blend of work and home life (Group & Roberts, 2001; O'Brien, 1987). Because of this duty, there was an assumption that all women had the ability and desire to serve in a caretaking capacity. The symbolic image of "The Lady

with the Lamp” further instilled this belief and tied nursing to a calling rather than paid work (O’Brien, 1987). Nursing was an extension of domestic life and should not require an education or special skills.

The Popular Health Movement during the 1830’s and 1840’s was led by feminist and working class women to oppose the poor medical practices of the times and expose quackery. Because practices were being questioned, many medical schools were established during this time and they closed their doors to women (Ehrenreich & English, 1973). As doctors became “educated,” they criticized the practices of independent lay practitioners. Women in midwifery roles were touted as illegitimate practitioners and were seen as competition to male physicians (Group & Roberts, 2001; O’Brien, 1987). “The only remaining occupation for women in health was nursing” (Ehrenreich & English, 1973, p. 34). Early reformers in nursing were successful in creating work for women outside of the home, but the work capitalized on the abilities and skills women were to possess.

Joseph Warrington, a Quaker physician, founded a nursing society in 1839 in order to help deliver care to lower class women during childbirth (O’Brien, 1987). He also wrote *The Nurses Guide* which was published during the same year. By establishing training courses, nurses became supervised by physicians and women who had experience in midwifery roles were touted as illegitimate practitioners (O’Brien, 1987). Women with medical experience were seen as competition to male physicians (Group & Roberts, 2001). Middle-class nurses were particularly criticized for their lack of experience and competence.

Ann Preston, one of the few women physicians at the time, founded the Woman’s Hospital of Philadelphia in 1861 (O’Brien, 1987). She wanted to train nurses from a higher social class to work under medical supervision. The emphasis on a hierarchical relationship

between the nurses and physicians was not publicly apparent, but Preston privately saw nurses as able to take on additional work, such as domestic tasks, in order to have fewer employees (O'Brien, 1987). "Even if female physicians identified themselves as feminists, the institutional power structures they learned in training would shape subsequent encounters between women as nurses and women as physicians, since all of them were initially shaped by the patriarchal culture in which they developed and were trained" (Group & Roberts, 2001, p. 90).

The mid-19th century. During the Civil War, military physicians also saw nurses as opponents and created difficult working conditions for them (Group & Roberts, 2001). Despite authoritative calls for obedience and duty, some nurses spoke out against unethical and corruptive treatment of patients (Group & Roberts, 2001). One nurse who was very influential during this time period was Clara Barton. She is well-known for developing the Red Cross and is also credited with starting military nursing (Roberts & Group, 1995). Barton was a strong supporter of women's rights and for their inclusion in the military.

Nursing schools were first established in the late 19th century (Abel, 2007). At this time, very few hospitals existed and part of the impetus for formal education was to attract a higher social class of women (Leighow, 1996). Up until this point, nursing care was a function of women's home life and women who entered nursing work to care for those without family caretakers tended to be young, single women of a low socio-economic status. Because of the difficult nature of nursing work, upper class women did not enter the profession as hoped (Ehrenreich & English, 1973). Women from the lower middle class and working class entered nursing and were taught the upper class values of the upper class nurse educators which greatly impacted their socialization (Ehrenreich & English, 1973).

Nursing schools had few financial resources and student nurses performed labor in exchange for monetary support (Andrist, 2006; Davies, 1995; Doering, 1992). Hospital based nursing programs utilized an apprenticeship model where student nurses were responsible for providing patient care and staffing units. The training was often organized by physicians, which contributed to creating a hierarchical relationship between nursing and medicine (Abel, 2007). “In fact, the power relation between (male) physicians and (female) nurses was epitomized in the notion that nurses were to be “trained” while physicians were to be educated” (Doering, 1992, p. 28).

The hospital training programs emphasized character, discipline, duty, and obedience. Attention to detail was expected and nurses were not encouraged to search for other ways to complete tasks (Doering, 1992). There was often not a charge for tuition because of the nature of the education. Nursing schools had few financial resources and student nurses performed labor in exchange for monetary support (Andrist, 2006; Davies, 1995; Doering, 1992). The average students worked 70-90 hours per week (Kalisch & Kalisch, 1986 as cited in Andrist). In addition to this workload, student nurses had to follow strict rules, including curfews and visitation policies. Nursing students were isolated from life outside of the hospital and therefore, did not have the opportunity to talk about their work outside of the institution, which led to ambiguity about their work duties and the conditions necessary to provide patient care (Colliere, 1986).

Nurses were expected to make decisions regarding service issues, such as personnel and supplies, but they were not recognized for their decision-making abilities (Ashley, 1975; Colliere, 1986). Nurses were responsible for making many hospital reforms, but they were not typically included in high level decisions. Nursing leaders were often forced to meet organizational and physician demands before meeting the needs of the students. The intrinsic

values of duty and caring did not align with the necessity to gain control over nursing. Nursing administrators were positioned under these two groups and therefore did not have direct access to hospital trustees (Group & Roberts, 2001). This structure ultimately impacted student nurses and their perception of their position in the workplace. Nurses were subordinate to the predominantly male administrators and physicians.

Feminists in the late 19th century during the American women's movement utilized the nurse/mother image as a way to obtain the right to vote and glorified the domestic work of women (Ehrenreich & English, 1973). By the beginning of the twentieth century, medical science began to evolve, physicians gained more prestige, and four year medical schools developed (Ehrenreich & English, 1973). Half of all babies at this time were still delivered by midwives, who were typically black or immigrants from the working class (Ehrenreich & English, 1973). Because midwives were not formally educated and from a lower class, they did not receive information on scientific advances concerning infection prevention for mothers and infants. Physicians used this opportunity to maintain their power by ridiculing the care provided by midwives despite a 1912 study from Johns Hopkins indicating that midwives were more knowledgeable (Ehrenreich & English, 1973). Midwifery became outlawed, and women in the lower classes who relied on their care for childbirth were often unable to afford physician care (Ehrenreich & English, 1973).

One nursing leader who did speak out about the male domination of nursing was Lavinia Dock. Dock was considered a radical feminist and she encouraged women to speak out against professional injustices, such as sexual discrimination and the right to practice as independent practitioners (Ashley, 1975). Dock saw the relationship with hospitals as particularly problematic, because nursing leaders aligned with physicians and administrators with the hopes

that they would help solve the problems in nursing, which prevented nursing from gaining independence (Ashley, 1975).

The 20th century. After World War I, mortality and morbidity rates declined, which was attributed to nursing care (Speakman, 2006). Despite the rapid development of pharmaceutical and medical advances in the 1940's, there was a shortage of nurses. Family responsibilities and marriage were the primary reasons women cited for leaving nursing during this time (Leighow, 1996). Nurses were encouraged to make contributions to society through their roles as wives and mothers, which deemphasized a commitment to the profession (Ashley, 1975).

World War II brought a tremendous demand on the nursing profession because “half of the nation’s active registered nurses volunteered for active military duty” (Speakman, 2006, p. 367). Increased technology in the 1950's and 1960's further heightened the demand for nurses. Labor force participation of women increased after World War II. Increasing salaries, on-site childcare, and part-time options made paid labor more attractive to women who had left the workforce (Leighow, 1996). However, it was difficult to return to the nursing workforce even after an absence of only a few years because of the rapid changes in healthcare (Leighow, 1996).

In the 1960's and 1970's, efforts were made by nurses to raise their salaries and status. They aligned with the feminist movement and attempted to resolve issues they believed were the result of occupational segregation and gender role socialization (Leighow, 1996). The image of the nurse changed from a “chaste” young woman to an increasingly feminine, promiscuous woman (Porter, 1992). “Inadequate salaries, lack of autonomy, and the difficulty of juggling work and family suddenly looked different, examined under a feminist lens” (Leighow, 1996, p. 82). Women were encouraged to enter more male dominated professions, such as medicine, but this encouragement solidified the status of nursing as simply “women’s work” and promoted

inferiority compared to other professions (Andrist, 2006). Additionally, attempts at change were met with resistance from nurses who did not want to separate themselves from traditional female roles such as wife and mother. Rising inflation rates and a floundering economy in the 1970's lead women, including nurses to increase their labor force participation. It was also during this time that some of nursing education moved into universities, which caused contention between nurses because of the shift from clinical service to research and theoretical development (Davies, 1995).

During the 1980's, nurses participated in strikes over issues such as pay inequity. Few nurses actually took part in these strikes and not all who did considered themselves feminists. A nursing shortage during this time gave nurses the necessary leverage to work for salary increases and improved working conditions. Nurses worked to fight injustice and take more control of their profession. However, the economic climate created barriers to accomplishing their goals. Since this time, nursing has been affected by managed care, increasing complexity of patient needs, and another nursing shortage; all of these issues have certainly created tremendous challenges for the profession.

As can be seen, many social issues and historical events laid the foundation for nursing to become a gendered profession. While many women have entered medicine, few men have entered nursing (Porter, 1992). Feminist theory, particularly a poststructural lens, is useful in analyzing the reasons behind these trends. Nurses do not often reflect on their practice nor their historical roots (Andrist, Nicholas, & Wolf, 2006). The practice of nursing has been heavily influenced by patriarchal organizations, such as healthcare institutions. "Only by understanding nursing's history can nurses break the oppressive chains of the past" (Ashley, 1975, p. 1467). Without a consciousness of the history of care-taking, "women cannot build up the identity of

their work and always desire to reproduce men's model" (Colliere, 1986, p. 108). This historical picture of the nursing profession provides insight into nursing's positionality in the workplace and underscores the need to explore the role that gender plays in the nursing profession, including the nursing shortage.

Career Role and Nursing

In the past 50 years, women have substantially increased their presence in the workforce, which has doubled since 1960 (Dubeck & Dunn, 2006). Occupational opportunities for women are more widely available and greater numbers of women are attending colleges. However, women continue to be predominant in the fields of teaching, nursing, and clerical services (Dubeck & Dunn, 2006). When professions primarily consist of one gender, it is referred to as occupational sex segregation, which contributes to dominant beliefs about the type of work and the skills the workers possess. When professions, such as nursing, are occupationally segregated by gender, dissatisfaction can occur as direct and indirect results of gender discrimination.

Research has shown that nurses are not retained because of dissatisfaction with compensation, working conditions, scheduling, and lack of advancement (Chandra, 2003). It is essential to illuminate some of the underlying issues leading to these problems, which have contributed to professional dissatisfaction and the nursing shortage. These interrelated and overlapping issues include: the image of nursing, gender role socialization, moral conflicts, gender oppression, the domination of the medical model in healthcare, and the wage gap.

Image. Gender has tremendously impacted the social view surrounding the image of nursing (Fletcher, 2007). When a profession, such as nursing, is highly segregated by gender, sexual stereotypes and assumptions abound. The image of a nurse is often depicted as a white, beautiful woman dressed in white who has the wings of an angel. The culmination of gender

beliefs and perceptions relates to the image one has of themselves as a person and as a professional. The socially and culturally constructed image of a nurse not only discourages diverse groups of women from entering the profession, but also men. Nursing is so connected to the female sex that when a man becomes a nurse, he is referred to as a “male nurse” (Davies, 1995). On the 2004 Sample Survey of Registered Nurses, less than 11% of nurses identified themselves as non-white, Hispanic or Latino and less than 6% of nurses were male (U.S. Department of Health and Human Services, n.d.c). Comparatively, the percentage of women who are physicians has increased to almost 25% (U.S. Department of Health and Human Services, n.d.b). Furthermore, the stereotypical image of a Black woman is often aggressive and unfeminine (Collins, 1991), which is not consistent with the socio-cultural image of a nurse. When viewing the stereotypical image of the nurse from a poststructural feminist lens with its emphasis on structural considerations (such as race, class, and gender) on the development of identity, it is not difficult to understand why the profession has not attracted more diversity, which has undoubtedly contributed to the shortage of nurses.

Gender role socialization. Gender beliefs about work are socially constructed before individuals make career choices and enter the workforce. Individuals associate certain characteristics and qualifications, including gender, with job roles. “It has been argued that the influence of gender role socialization combined with actual gender segregation in occupations instruct children early in life which occupations are considered appropriate for each sex” (Powers & Wojtkiewicz, 2004, p. 604).

Even when men enter the nursing profession, gender role socialization continues in respect to the type of nursing work. In a research study examining the nature of sex segregation in nursing, 16 men and 19 women were interviewed (Snyder & Green, 2008). This study did not

reveal that the proportion of men in administrative positions was higher than the proportion of women, but it was revealed that men gravitate to certain specialty areas such as intensive care units, emergency rooms, and operative rooms, which are perceived to be more masculine. Very few men in nursing were found to work in areas described as female-clustered. For women who were interviewed, gender was rarely mentioned in respect to their choice of specialty area, and men were found to be much more aware of gendered connotations associated with a specialty area.

In addition to the image of a nurse being socially and culturally constructed, the effects of gender role socialization influences the behavior of a nurse. Nurses are assumed to be a conservative, homogenous, and politically neutral group in their actions. Women as a whole are encouraged to put the needs of others above themselves. As stated by Belenky et al. (1986), “Nice girls fulfill other people’s expectations” (p. 206). Furthermore, women are socialized to place a high value on relationships and are therefore willing to make sacrifices to avoid confrontation (DeMarco, Roberts, Norris, & McCurry, 2007). “In many typical women’s jobs, graciousness, deference, and the readiness to serve are part of the work. This requires the worker to fix a smile on her face for a good part of the working day, whatever her inner state” (Kourany, Sterba, & Tong, 1992, p. 107). Nurses are socialized to appear cheerful at all times and to believe that sacrifice is necessary for the greater good of patient care.

Relating to gender role socialization is the concept of self-silencing. Self-silencing refers to individuals remaining silent over advocating for self or others (DeMarco et al., 2007). For women, self-silencing begins in childhood where girls have been found to participate less in the classroom due to fear of saying the wrong answer and becoming embarrassed (Orenstein, 2006). Perceiving a lack of voice can lead to a tolerance of poor working conditions and professional

dissatisfaction. While nurses make up the largest collective group of healthcare providers, they rarely speak out and join together as a collective force.

The socialization of women in their roles as nurses can lead to a lack of care for self, which can be emotionally exhausting contributing to burnout and professional dissatisfaction. The socialized role of women in the home continues to be a source of conflict for all women in the workforce. Women continue to be primarily responsible for household duties and childcare despite the number of hours they work per week. African American women are more likely than white women to be single heads of household (England, Garcia-Beaulieu, & Ross, 2006), which may preclude them from seeking careers in fields, such as nursing, which demand long working hours and rotating shifts. In a poststructuralist lens, a female nurse can be positioned in one discourse as fulfilling her natural caretaking role and in a different discourse be positioned as a career woman (Francis, 1999). The poststructuralist concept of shifting identities may be difficult for women in nursing because their personal image is so closely connected with their professional image due to the influence of gender role socialization.

Moral conflicts. Despite the efforts of nurse educators, theorists, and researchers to tout nursing as a thinking profession for recruitment, the reason given for entering the profession is often a desire to help and care for others (Francis, 1999; Seymour & Buscherhof, 1991). Through interactions with patients, nurses make meaningful contributions to human life, which can provide personal satisfaction. However, the context of healthcare may not be suitable for providing satisfaction for the nurse (Sumner & Townsend-Rocchiccioli, 2003). Nursing care is structured in a way that nurses are “continuously acting” and “time to think, to observe, discover, listen, understand, to make a situation comprehensible, to look for information, to acquire a wider knowledge through reading references is not included in the use of nursing time” (Colliere,

1986, p. 107). While that statement was written over 20 years ago, the work of nursing has become increasingly more task-oriented due to safety initiatives and technological advances. In the current economic climate, if ancillary care positions are eliminated, nurses in direct care positions will be responsible for additional tasks, which will take them even further away from patient care. If a nurse derives satisfaction from the emotional part of her work, and this work is unable to be accomplished, moral conflicts result for the nurse leading to inner turmoil and professional dissatisfaction.

In addition to not having the opportunity to provide the care they believe is necessary, nurses may not have the opportunity to perform the caretaking tasks that they are held accountable for by the healthcare organizations. In the current healthcare system, standards of nursing professionalism are often measured by outcomes such as low rates of pressure ulcers and nosocomial (hospital-acquired) infections. In a large study of 43,000 nurses in 5 countries, at least 40% of the participants reported spending time on tasks that did not require expertise such as housekeeping, patient transport, and meal delivery, while nursing care such as oral hygiene, skin care, teaching, and comforting were often reported as tasks that were left uncompleted (Aiken, Clarke, et al., 2001). The inability to perform these tasks can cause poor results on outcomes measurements, which are then attributed to poor nursing care. A failure to care can translate into personal failure as a nurse (Sumner & Townsend-Rocchiccioli, 2003). The personal conflicts nurses' experience when their care is deemed as inadequate can be very distressing and are related to the structural influences that impinge on the ability to provide satisfactory nursing care.

Domination of the medical model. The domination of the medical model has led to epistemological assumptions about healthcare practices, which has affected many aspects of

nursing. “The American dominative medical system consists of several levels that tend to reflect class, racial/ethnic, and gender relations in the larger society” (Baer, 2001, p. 179). The typical medical model operates on a dominator-dominated system (Colliere, 1986), which means that those in positions of power define health problems and needs based on their own beliefs rather than the beliefs of the patient (Robinson, 1985). In this system, rewards are given for cost-effectiveness and measureable outcomes (Robinson, 1985). A nursing model of healthcare is more holistic and takes into account patient beliefs. In this type of model, a relationship between a patient and a healthcare provider is encouraged to become more of a reciprocal partnership, rather than a hierarchical relationship. The changing of this dynamic is threatening to the patriarchal system.

In the education process, nurses are taught to follow a nursing model of healthcare, but the healthcare system is based on a medical model. Davies (1995) states that it is through nursing that medicine is able to not only “present itself as masculine/rational” (p. 61), but to also gain power and privilege. This domination of the medical model has led to the hegemonic beliefs in society that care of the body is less important than knowledge about the body (Cheek, 2000). Consequently, nurses have lost their independence in their role and tend to spend a majority of their time performing tasks delegated by physicians, leaving little time for the true essence of nursing care.

Because of the domination of the medical model and its discourse, nursing has internalized this discourse as “normal,” which has silenced its own discourse. According to Foucault, normalizing judgment is the process of maintaining standards to reinforce conformity (Doering, 1992). Novice nurses enter the workplace and are exposed to the work of nursing which is within the medical discourse. “Once a discourse becomes ‘normal’ and ‘natural,’ it is

difficult to think and act outside it” (St. Pierre, 2000, p. 485). Thus, nurses learn to speak the language of the medical discourse in order to rationalize the work that has been delegated to them. Viewing the domination of the medical model through a poststructural feminist lens calls for nurses to question structures of power which have affected their discourse, theoretical development, research methodologies, and ultimately their practice, which all have contributed in some way to the nursing shortage.

Gender oppression. Because nursing is a primarily female profession and nurses are situated within the medical discourse in the workplace, nurses often exhibit behaviors of oppression. In healthcare organizations, nurses are the subordinate group and physicians are still treated to be in positions of power. “If the dominant culture does not value the subordinates’ characteristics, the tendency is for the subordinates to feel hatred for themselves” (Roberts, 1983, p. 22). Experiences of oppression cause tension within an oppressed group and lead to intergroup conflict which is known as “horizontal violence.” Episodes of horizontal violence cause victimized behaviors, such as helplessness and powerlessness. Nurses see themselves as the “other” which contributes to a lack of personal or professional identity. However, the full implications of gender are often overlooked because the oppression is minimized and not attributed to gender. This lack of identity contributes to struggles for the individual, as well as the profession, resulting in professional dissatisfaction. The influence of structures on identity and oppression can be explored in a poststructural feminist framework. Additionally, there are often financial implications related to gender oppression in the workplace, which is the final issue that will be discussed.

The wage gap. Nursing has evolved from the domestic work of women, which has been unpaid work. It has also been conceptualized as a profession individuals enter to help others and

not to make money, which has led to the notion that salary is not related to the nursing shortage or nursing satisfaction. However, recent studies have indicated that salary is a source of satisfaction for nurses. Research has shown that nurses who were satisfied with pay were more likely to remain at an organization (Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002) and nurses who were paid more were found to be less likely to leave the profession (Barron & West, 2005; Barron, West, & Reeves, 2007). Salary was the most frequently cited theme for considering leaving nursing in two studies (Flinkman et al., 2008; Fochsen et al., 2005).

Women continue to make less money than men on average and occupational sex segregation further contributes to this trend. According to the Institute for Women's Policy Research (2009), the ratio of women's and men's median annual earnings was 77.8 for full-time, year-round workers in 2007, which means that women continue to be paid considerably less money than men even when other factors are adjusted. Progress in closing the gender earnings gap has slowed considerably since the early 1990s. Societal beliefs persist that women choose lower paying jobs and careers so they can have the opportunity to fulfill family and household responsibilities. There are also assumptions that women are less committed to their work and that their income is not essential for family support. Even in professions that are predominantly female, such as nursing, men are often paid higher salaries. Female registered nurses make on average 11% less than male nurses (U.S. Department of Labor, 2007). A poststructural feminist lens can lend insights into how structural systems of oppression, power, and privilege have influenced the ever-present gendered wage gap since pay has been cited as a reason for exiting the profession. The issues discussed in this section affect the practice of nursing and influence professional satisfaction; they also affect how nurses learn in the workplace.

Nursing and Workplace Learning

The majority of research relating to nursing practice in adult education is in the area of continuing professional education (CPE). In one of the earliest studies, Bevis (1975) examined the relationship between role conception of novice nurses and participation in continued learning activities. She found that the service component of role conception, which relates to a primary loyalty to the patient, was found to have the most influence on continuing education. Through examining how context of practice affects learning in the professions of nursing, social work, and law, Daley (2002) also found that nurses typically attend CPE with a focus on improving care for a particular client and that the context in which professionals practice plays a role in learning. Additionally, nurses often discuss new ideas for care with colleagues before they attempted to implement them (Daley, 2000). Nurses are unlikely to try to implement information from a CPE program if they feel they would “not have the power, money, or time to use it” (Daley, 2002, p. 84). Ultimately, organizational structure influences whether learning can actually be implemented in practice (Cervero, Rottet, & Dimmock, 1986; Daley, 2002).

Two studies have been conducted with nurses to test Cervero’s framework to explain the relationship between CPE and job performance (Cervero & Rottet, 1984; Cervero, Rottet, & Dimmock, 1986). This framework incorporates the social system as an influence on behavioral changes in practice. While the results of these studies do not provide any conclusive evidence for the success of some programs over others, it was acknowledged that the formal educational system, the informal learning system, the administrative system, and the evaluation system all interact to impact job performance (Cervero, Rottet, & Dimmock, 1986). Educational programs in healthcare are often designed to enforce policies and address problems which require systemic solutions, rather than additional education. Conflicts exist when there are differences between

the subculture of nursing and other organizational subcultures (Daley, 2000). This creates ambiguity about work roles and responsibilities. Nurses “are consistent in how they view their role, what they learn from clients, and how they value their profession” (Daley, 2000, p. 84).

The bureaucratic healthcare system structure affects clinical practice, and strategies which move beyond organizational structures must be developed in order to meet client needs.

Organizational culture, professional autonomy, and the positionality of the learner need to be taken into account in workplace education. Bevis (1975) also noted that conflicts between the bureaucratic and service components can adversely affect participation in continuing education.

Relating to the issue of involvement in CPE is participation in baccalaureate completion programs to further one’s nursing education and to possibly provide opportunities for advancement. A study on participation of Black female registered nurses in such programs found that the culture of racism and the experience of being the “other” were the most significant factors which discouraged participation (Aiken, Cervero, & Johnson-Bailey, 2001).

In addition to a focus on participation in CPE, attention has also been paid to the gap between nursing education and nursing practice. A study on the use of intuition in novice nurses discusses the importance of recognizing the diverse needs of learners in the workplace and the need to incorporate multiple ways of knowing into nursing education (Ruth-Sahd & Tisdell, 2007). In a small study investigating the relationship between job literacy strategies and job performance of student nurses, licensed practical nurses, and registered nurses, Mikulecky and Winchester (1983) found that literacy skills are not always transferred to the workplace. They proposed that there is a need to create learning activities to simulate work activities. Both of these studies suggest that improvements should be made to nursing education and workplace education to better prepare nurses for practice.

This body of work on nurses and workplace learning does provide insights into the ways nurses utilize information in practice. It also highlights the role of structural components on learning initiatives. However, it does not create a relationship between nursing practice, workplace learning, and career intentions. Factors associated with participation in adult education have been extensively studied, but structural influences on particular careers are not well understood (Aiken, Cervero, & Johnson-Bailey, 2001). The shortage of registered nurses has profound implications for the healthcare system, and it is imperative that insights into these relationships are explored.

Gender and the Nursing Shortage

Issues surrounding nursing shortages have been an area of interest in nursing research for the past few decades. Despite the fact that nursing is a profession that is occupationally segregated by women, the influence of gender in relation to nursing shortages has rarely been studied. However, a few studies have explored this relationship to some degree. Seymour and Buscherhof (1991) analyzed factors of dissatisfaction which had influenced career course in nursing, Jones and Gates (2004) examined gender-based wage differentials in respect to implications for the nursing shortage, Miranda (2007) explored how male nurses' negotiated masculinity in a predominantly female profession in an effort to improve recruitment and retention in the nursing profession, and Herron (2007) examined the perceptions of nurse educators on gender, practice, and policy in respect to the nursing faculty shortage through a critical feminist lens. All of these studies were conducted during an existing nursing shortage.

Seymour and Buscherhof (1991) invited open-ended responses on career influences as part of a large survey study on attitudes, choices, and achievements in nursing. Out of the 252 participants who wrote responses, 67 mentioned gender role issues, such as sexism, ageism, and

female socialization, as factors which contributed to dissatisfaction with nursing. Even though gender role issues were commonly mentioned in respect to dissatisfaction, they were not cited as reasons for wanting to leave the profession. Additionally, the association of nursing with “women’s work” and the power of the medical profession were both mentioned as contributing to inadequate financial compensation. Also relating to remuneration, Jones and Gates (2004) attempted to present gendered-wage differentials in relation to the context of nursing, healthcare, and society; the study revealed that male nurses are paid premium wages in nursing compared to female nurses. This differential was able to be partially explained by educational level, years of experience, and geographic location, but a considerable portion of the wage differential was unable to be explained. While this study did not conclude that this difference is the result of gender discrimination, it was suggested that nursing wages for all nurses must increase to improve the nursing shortage.

Issues surrounding gender were both central to the dissertations of Miranda (2007) and Herron (2007). Gender was the basis for exploring the socialization and professionalization of men working in nursing (Miranda). The male participants in this qualitative study perceived their work assignments, work experiences, and work expectations to be influenced by gender role socialization. Similarly, the nursing faculty in Herron’s qualitative study perceived gender role orientation to be an influence on career choice and practice. While some of the participants acknowledged that gender can influence experiences in higher education, the majority of the participants portrayed their institutions as gender neutral. All participants attributed the femaleness of the profession as being a component of the nursing shortage.

As can be seen, there has been relatively little work done which explicitly attempts to make a connection between the gendering of the nursing profession and the current nursing

shortage. Even though this body of work is small, it has been instrumental in laying the foundation for this study. The dissertation by Herron (2007) was particularly significant in helping to develop the purpose of this study. While it is difficult to draw any major conclusions from these research studies, it is evident that structural barriers do exist for women in the workplace and nurses do perceive these factors to have an influence on the shortage of nurses. It is not known whether these factors contribute to nurses' intentions to leave the profession, which is part of the purpose of this study. Thus, the final section of this literature review examines in general the research that has been done to date that relates directly to nurses' intentions to leave the profession.

Research on Nurses' Intentions to Leave Nursing

This final section of the literature review will explore the influences on career turnover intentions in the nursing profession. This review seeks to provide insight into the reasons that nurses consider leaving the profession of nursing, which is projected to have devastating effects on the healthcare system. One way to examine reasons nurses leave the profession is to review research on intentions to leave, because actual job turnover is typically preceded by an intention to leave. Studying behavioral intentions is grounded in the work of Fishbein and Azjen's theory of reasoned action. Their work proposes that behavior can be predicted by behavioral intentions, including individual and societal factors (Becker & Gibson, 1998). Behavioral intentions are additionally influenced by components such as job satisfaction and organizational commitment (Irvine & Evans, 1995). In the decision-making process, intention to stay or leave a position is considered to be the final cognitive step (McCarthy, Tyrrell, & Lehane, 2007). The choice to leave nursing is a complex process dependent upon many factors; the decision is usually not easy for nurses to make (Cheung, 2004). Examining research from this critical point in the decision-

making process can shed light on individual perceptions and experiences at the time they occur rather than examining the process retrospectively.

A better understanding of intention may lead to the possibility that changes can be implemented to prevent actual turnover (Chan & Morrison, 2000). In their review of the literature, McCarthy et al. (2007) found that “intent to stay and intent to leave were the single most important predictors of actual turnover behavior” (p. 252). Furthermore, even if behavioral intentions do not result in a nurse leaving the profession, it is important to attempt to understand reasons that nurses, who are primarily women, desire to work in a different profession.

Overview of Research Studies and Participants

Literature examining nurses’ intent to leave was identified from the following databases: Academic Search Premier, CINAHL, Ovid On-Line, ERIC, and Proquest. Key words included: “intent to leave and nurs*”. This search yielded 77 results. The search was further limited to publication dates from 1996 to 2009 in order to focus on current rationale for leaving nursing. The current nursing shortage began in 1998 and previous research on intent to leave may not be applicable to the nurses of today due to the rapid changes in the healthcare environment. Research articles specifically relating to factors that impact a nurse’s intent to leave the profession was included for review. Articles only examining intention to leave a particular place of employment or job turnover intentions were not included. This review was not restricted to nurses in direct care-giving positions, because nurses work in a variety of settings. The shortage of registered nurses is not only a national problem, but also an international crisis with shortages existing in Germany, the Netherlands, Switzerland, and many African countries, including Ghana, Zimbabwe, Malawi, and Uganda (Oulton, 2006). Thus, it is important to not only review literature from the United States, but also to examine research from other countries

to gain insights into issues surrounding the nursing shortage. Using these criteria, thirty research studies and one literature review were examined. The majority of the research studies were quantitative with surveys being the primary source of data collection and only two studies were qualitative in nature; both of these studies were conducted outside of the United States. Most of the studies surveyed nurses who were currently working. Four studies included nurses who had either left the profession or were in the process of leaving; these studies were all conducted outside of the United States.

The literature revealed varying rates of intentions to leave the profession. Bowles and Candela (2005) found that 1 in 5 nurses plans to leave the profession within 5 years. In a study of 147 Finnish nurses under the age of 30, 26% of the participants indicated that they frequently considered leaving and only 24% never considered leaving the profession. Forty-six percent of a sample of 284 Florida nurses indicated that they were considering leaving the profession (Borkowski, Amann, Song, & Weiss, 2007). Furthermore, over 12% of 1,000 Canadian nurses under the age of 24 indicated intentions to leave the nursing profession (Lavoie-Tremblay, et al., 2008). While it may be the case that many individuals contemplate leaving their profession, these rates of intention are particularly problematic in a field where a shortage currently exists and it is necessary to analyze the findings from these studies.

Based on the literature reviewed, the most salient factor contributing to intentions to leave the profession was job satisfaction, which was researched from many angles. Job satisfaction is a complex concept illustrated by the multiple variables that have been studied in relation to it (Coomber & Barriball, 2005). Some of the studies measured job satisfaction as a global component and other studies were interested in determining factors which influenced job

satisfaction. In any case, many of the factors associated with intentions to leave the nursing profession relate to job satisfaction.

In addition to job satisfaction, the following factors were found to be most significant in contributing to intentions to leave: educational level, gender, moral conflicts, work/family life, job stress and job strain, workplace violence, empowerment, and the work environment itself. To relate to a poststructural feminist framework, these factors were divided into two categories: individual factors and organizational/structural factors.

Individual Factors Contributing to Leaving the Nursing Profession

Individual factors refer to personal characteristics and behaviors while organizational/structural factors refer to components that directly concern the work environment. Each factor will be briefly defined followed by a review of the relevant literature.

Educational level. Educational level for entry into nursing practice has been a debated topic for many years and it has been studied as a factor in the research on intention to leave the profession. Entry into the nursing profession can be gained by attending a hospital-based diploma program, an associate degree program, or a baccalaureate degree program. Nine research studies and one meta-analysis utilized self-reported demographic data to examine whether differences existed between educational level, job satisfaction, and intent to leave. This research has yielded mixed results. Three studies found no statistically significant differences between entry level of education and intent to stay (Barron & West, 2005; Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002; Lynn & Redman, 2005). Six research studies and one meta-analysis found varying results in respect to educational level and intent to stay or leave (Borkowski, Amann, Song, & Weiss, 2007; Coomber & Barriball, 2007; Duffield, O'Brien-

Pallas, & Aitken, 2004; Ingersoll et al. 2002; Lu, Lin, Wu, Hsieh, & Chang, 2002; Nogueras, 2006; Scott, Engelke, & Swanson, 2008).

A study conducted in Taiwan on over 2,000 nurses found educational level to be negatively correlated to job satisfaction and positively correlated to intent to leave the organization, but unrelated to professional commitment (Lu et al., 2002). A study of new graduates in North Carolina indicated that associate degree nurses were significantly more satisfied with nursing as a career than baccalaureate nurses (Scott et al., 2008). Career satisfaction was found to share a statistically significant relationship with intent to leave the profession in this study; nurses who were not satisfied with nursing as a career were more likely to have an intent to leave within three years. Research conducted in Australia surveyed 150 registered nurses who were currently not working in nursing to investigate the reasons they became a nurse and their reasons for leaving (Duffield et al., 2004). The researchers found that nurses who had higher initial qualifications had a shorter tenure in the profession, but those who sought further education after entry into practice had a longer tenure (Duffield et al.).

In a research study examining nursing job satisfaction and commitment to the work setting, Ingersoll et al. (2002) surveyed a random sample of 1,800 nurses in New York. They found that nurses with master's degrees were more satisfied than nurses with a baccalaureate degree and nurses prepared with less than a baccalaureate degree. Additionally, master's prepared nurses were less likely to intend to leave the profession within five years. A study of Florida nurses also found that nurses with master's degrees were less likely to have intentions to leave (Borkowski et al., 2007). Furthermore, a study of occupational commitment, education, and experience as predictors of intent to leave nursing found that nurses with graduate degrees had greater commitment to the nursing profession than nurses with undergraduate or diploma

degrees (Nogueras, 2006). This research suggests that nurses who pursue higher levels of education within their field after entry into practice are satisfied with their career choice and are making a career investment by seeking additional education. Higher educational attainment can provide career mobility and more diverse work opportunities. Scott et al. (2008) suggest that nurses who have a baccalaureate degree upon entry into practice may not be as tolerant of poor working conditions which might explain their higher intentions to leave.

The literature review by Coomber and Barriball (2007) also found inconsistencies in the research regarding the relationship between educational attainment and intent to leave nursing. The data examined may be specific to the samples studied and it is possible that nursing education programs in other countries were undergoing changes, which may have prompted the research to be conducted. One conclusion that can be drawn from this research is that nurses who attain at least a master's degree are unlikely to leave the profession. More research needs to be conducted in this area to determine how entry level preparation affects intentions to leave.

Gender. The differences between men and women in regard to intention to leave the profession is difficult to ascertain due to the small number of men in nursing and the small number of them included in the research samples. However, it is important to discuss the findings in relation to gender. The probability of a male leaving nursing was predicted to be 7% higher than for a female in a sample of almost 3,000 London nurses (Barron, West, & Reeves, 2007). Men represented approximately 10% of the participants in this study. A study examining nursing employment history over a 10 year period found that men were more likely than women to have left nursing for another occupation (Barron & West, 2005). Borkowski et al. (2007) found that men were more likely to leave, but the finding was not statistically significant. From these studies, it is difficult to draw any strong conclusions, but the research does seem to indicate

the possibility that men leave nursing at a higher rate than women and further research in this area is certainly warranted.

Moral Conflicts. To date, the literature has not placed much emphasis on issues of morality as reasons that nurses leave the profession. As part of this review, one qualitative study (Cheung, 2004) and one quantitative study (Hart, 2005) demonstrated evidence of ethical conflicts in relationship to intent to leave. Personal conflicts transpire when nurses are unable to see the value in their work or they compromise their values in the work setting. These occurrences can cause nurses to become distressed when they believe their values have been violated. Cheung (2004) conducted 29 semi-structured interviews on nurses who had left nursing in Australia. Through the interviews, it was revealed that some nurses left nursing because of value image violations. The idea of value image was part of the theoretical framework for this study and it can be described as the values, standards, or principles that are important to a person (Cheung, 2004). When nurses were unable to deliver the quality of care they believed patients required and do not receive recognition for the work that they did, their value image was violated. In this study, the nurses who left because of value image violations were typically over the age of 30 with over 10 years of nursing experience. Nursing was a career choice for them, which made the value image violation a traumatic and emotional event (Cheung, 2004).

Hart (2005) investigated the effects of hospital ethical climate on professional turnover intentions of registered nurses. “Ethical climate is defined as the organizational conditions and practices that affect the way difficult patient care problems, with ethical implications, are discussed and decided” (Hart, 2005, p. 174). While ethical climate is an

environmental/structural construct, intrapersonal conflicts arise when ethical dilemmas in the workplace compromise personal values, which affect the individual.

This was the first study to examine this relationship and the researcher hypothesized that job dissatisfaction and turnover may result if nurses perceive patient care to be compromised. In this cross-sectional survey study, the participants were 463 registered nurses working in hospitals in Missouri. The researchers found evidence supporting the fact that ethical climate is a significant determinant of a registered nurse's intention to stay in a position and in the profession. Nurses who reported a more ethical climate were more likely to intend to stay in their current position. These results display evidence that nurses are concerned about the quality of patient care and when they are unable to provide a safe environment, ethical conflicts result which contributes to intention to leave.

Despite the limited amount of research in this area, this work has provided valuable insights into personal events and perceptions that may result in intentions to leave the profession. The intrapersonal conflicts that arise when ethical dilemmas in the workplace compromise personal values can have detrimental effects for the individual. Nurses may question their multiple positionalities as a result of these occurrences, which undoubtedly affects their life outside of the workplace.

Work-family conflicts. Finding a balance between work life and home life can be challenging for many people and it is further complicated for nurses who often have to rotate shifts and work nontraditional days and hours. Five studies in this review included conflicts between work life and home life as factors contributing to intentions to leave (Duffield et al. 2004; Flinkman, Laine, Leino-Kilpi, Hasselhorn, & Salantera, 2008; Foschen, Sjogren, Josephson, & Lagerstrom, 2005; Lu et al., 2002; Lynn & Redman, 2005). Work life/home life

issues such as childcare, rotating shifts, and long work hours were found to be associated with a shorter tenure in nursing (Duffield et al. 2004), and work-family conflicts were associated with a strong intention to leave (Flinkman et al., 2008).

Nurses with families who were dependent on their income were less likely to intend to leave nursing (Lynn & Redman, 2005). Nurses who were married and had children over the age of three had lower turnover intentions (Lu et al., 2002). Work schedule and childcare conflicts were not found to be related to intention to leave by Foschen et al. (2005). However, it was noted that Swedish hospitals have adapted work hours over the past decade to make them more compatible with home life and childcare needs. While it is difficult to draw any conclusions regarding work/family conflicts, family life does seem to be a pertinent factor in making decisions about employment intentions in the nursing profession. Decisions regarding family life and work life can lead to increased levels of stress, which has consequences for the individual, their family, and their workplace.

Job stress and job strain. Stress is a response to an event which can be positive or negative depending on individual perception. Ineffective coping skills can lead to a chronic state of stress, which can cause emotional exhaustion leading to burnout (Schwab, 1996). Shader et al. (2001) defined job stress as the amount of stress that nurses perceive in relationship to their work environment and job. This occurrence undoubtedly has an effect on turnover intentions. Three studies (Lavoie-Tremblay et al., 2008; Letvak & Buck, 2008; Shader et al., 2001) and one literature review (Coomber & Barriball, 2007) included the role of stress on intent to leave.

In a study of 241 nurses in a southeastern university hospital, researchers conducted a survey to examine the relationship between stress, age, cohesion, work satisfaction, work schedule, and turnover (Shader et al., 2001). The Job Stress Scale, which is a 22 item Likert

scale instrument, was used to measure perceived stress. Over half of the nurses in this study were under the age of 35 and one-fourth had only practiced nursing for two to three years. This study found these statistically significant relationships: (a) increased job stress is correlated to lower levels of group cohesion and lower levels of job satisfaction, which both contributed to increased turnover intentions, (b) a stable work schedule resulted in less work related stress, and (c) job stress was a particularly significant predictor of turnover intentions in the 20-30 year age group.

In a study of work productivity, job stress was the most frequently cited reason for the 15% of respondents who intended to leave (Letvak & Buck, 2008).

Also correlated to perceptions of job stress is job strain. Job strain relates to psychosocial work constraints and includes decision latitude. Lavoie-Tremblay et al. (2008) found that new nurses under the age of 24 who intended to leave the profession perceived increased job strain. These findings do provide support that job stress and job strain impact decisions to leave the profession. Even though an individual's appraisal of an event or anticipated task determines the level of stress, factors in the work environment contribute to perceptions of stress.

Organizational Factors Contributing to Leaving the Nursing Profession

There were also organizational and structural factors contributing to why nurses intend to leave the profession. Some of these include: workplace violence, feelings of empowerment, and issues directly related to the work environment. Each of these factors will be discussed in relation to the relevant literature.

Workplace violence. Workplace violence is verbal, emotional, or physical abuse encountered in the work environment. There is not a universal definition of workplace violence but incidents in healthcare tend to be nonfatal in nature (Sofield & Salmond, 2003). Six studies

in this review either demonstrated a relationship between workplace violence and intentions to leave or included examples of these types of experiences in qualitative interviews (Barron et al., 2007; Cheung, 2004; Johnson & Rea, 2009; Joshua-Amadi, 2003; McKenna, Smith, Poole, & Coverdale, 2002; Sofield & Salmond). A study of over 400 hundred nurses in a northeastern hospital found that 67% experienced between 1 and 5 incidents of verbal abuse in the past month. Physicians were overwhelmingly reported as the perpetrators followed by patients and their families (Sofield & Salmond). The majority of the respondents indicated they believed verbal abuse caused turnover and a shortage of nurses. Fifty-seven of the respondents reported leaving a nursing job because of verbal abuse, but there was not a statistically significant relationship to intention to leave. Similar results were found by Barron, West, and Reeves (2007). In their study of 2,880 London nurses, two-thirds of the participants indicated that they experienced verbal abuse from patients, relatives, or peers in the past six months. The effects of the abuse on intention to leave a current position was statistically significant, but there was not a significant relationship with intention to leave the profession.

Horizontal violence is a specific type of workplace violence that occurs interpersonally between staff members (McKenna et al., 2002); it is also referred to as workplace bullying in the literature. This type of violence between nurses involves verbal abuse, humiliation, intimidation, and exclusion. Horizontal violence contributes to an attitude of suffering and feelings of having to prove oneself, which is consistent with oppression. McKenna et al. (2002) surveyed nurses in their first year of practice to determine their encounters with horizontal violence and distressing events. Over one third of the new graduates felt that learning experiences had been blocked and over 50% felt they were undervalued in their role and lacked supervision for the amount of responsibility they were given. In the descriptions of the most distressing events experienced,

the perpetrators were female the majority of the time (83%). As a result of these encounters, several of the new graduates lost confidence and required time off from work; one third of the respondents considered leaving the nursing profession. Almost half of the incidents were not reported and only 12% of the participants received any formal debriefing. The results of this study also indicated that immediate supervisors did not typically offer support and guide them towards a resolution.

In a descriptive study of 249 nurses with an average number of 20 years of experience, 27% experienced workplace bullying (Johnson & Rea, 2009). Nurses who experienced bullying were three times more likely to have intentions to leave the profession within the next two years. Not only were the nurses very experienced in this sample, but they were also highly educated with almost half of the participants holding a bachelor's degree and over 20% holding at least a master's degree.

The initial response to verbal abuse by the majority of the participants in the study by Sofield and Salmond (2003) was found to be anger. Feelings of powerlessness, harassment, and embarrassment subsequently followed, as well as a desire to problem solve. Verbal and emotional abuse by a patient's relative was described by one of the participants who had left nursing in the study by Cheung (2004). In an interview with a nurse leaving voluntarily, an account of two nurses engaging in a physical fight in the workplace was shared (Joshua-Amadi, 2003).

Verbal abuse can cause feelings of incompetence, humiliation, and embarrassment. Despite reporting high levels of abuse, nurses did not report high intentions to leave which suggests a tolerance to these acts. Gender role expectations and gender role socialization may be an underlying contributing factor to these findings. Underreporting is common in nursing,

possibly due to the fear of retaliation or belief that nothing will change to prevent future incidents (McKenna et al., 2002). While the quantitative data did not demonstrate a statistically significant relationship to intention to leave, there is some evidence to suggest that encounters with workplace violence were a factor for nurses who have left the profession. The impact of all types of workplace violence cannot be underestimated. Nurses who experience these types of acts repeatedly are likely to be dissatisfied with their work and may consequently develop intentions to leave the profession if they feel there are no worthwhile solutions (Joshua-Amadi, 2003).

Empowerment. Empowerment is the degree of formal and informal power an individual believes they possess. The research on empowerment and intentions to leave focuses on perceived access to power structures and decision-making capacity in the work environment; therefore, it is considered an organizational characteristic, rather than an individual characteristic. Perceptions of empowerment, both formal and informal, can affect a nurse's decision to stay in the profession. Jobs that allow visibility, flexibility, and creativity enable the construction of formal power. Peer relationships, networking, subordinates, and superiors are constructs that contribute to the development of informal power (Nedd, 2006). Six studies included either direct measures of empowerment or perceptions of access to formal or informal power structures (Barron & West, 2005; Barron, West, and Reeves, 2007; Flinkman et al., 2008; Fochsen et al., 2005; Nedd, 2006; Zurmehly, Martin, & Fitzpatrick, 2009).

A study by Nedd (2006) used four self-report questionnaires to assess whether perceived perceptions of empowerment related to intent to stay based on Kanter's theory of structural empowerment. According to Kanter, individual behavior is dependent upon power and opportunity, and organizational structures have a far greater impact on employee behavior than

personality characteristics (Manojlovich & Laschinger, 2002). The random survey population consisted of 206 registered nurses in Florida who were primarily female with a mean of 20.14 years in nursing. Three different instruments, including the Conditions for Work Effectiveness Questionnaire (CWEQ), were used to measure perceptions of power. The opportunity to develop knowledge and skills resulted in higher levels of empowerment, which was positively correlated with intention to stay (Nedd, 2006). The study supports Kanter's theory that employee behaviors and intent to stay are related to access to empowerment structures (Nedd, 2006). Individual characteristics were not found to be related to intent to stay, which is also consistent with Kanter's theory. The CWEQ-II was used in a study of 1,200 registered nurses in Ohio and the relationship between empowerment and intentions to leave the profession was found to be statistically significant; nurses with the lowest empowerment scores were more likely to indicate they would leave the nursing profession (Zurmehly et al., 2009). These nurses were also more likely to cite job satisfaction as a reason for leaving than for reasons of career advancement.

A study of almost 3,000 London nurses by Barron, West, and Reeves (2007) found that nurses who felt involved in decision making were less likely to intend to leave the profession. Similarly, nurses who felt they were not able to use initiative in their work were almost twice as likely to have left nursing (Barron & West, 2005). Nurses who feel their voice will not be heard and solutions are improbable make a choice to leave nursing (Joshua-Amadi, 2003). Lack of opportunity for professional development was strongly related to intentions to leave in two studies (Flinkman et al., 2008; Fochsen et al., 2005).

In summary, the research indicates that perceptions of formal and informal power play an important role in intent to stay or leave in nursing. Nurses who perceive higher levels of structural empowerment, feel involved in decision-making, and have opportunities for

professional development are less likely to intend to leave nursing. “Nurses are change agents, visionaries, active participants in learning, and advocates for their patients” (Thyer, 2003, p. 73). Organizations that fail to incorporate nurses into decision-making and issues that affect patient care increase feelings of oppression.

Nedd (2006) determined that the opportunity for additional knowledge development was critical to level of empowerment. Knowledge development may occur as a result of experience, training opportunities in the work setting, and in formal educational settings. Organizational structures and factors in the work environment can either enhance or impede empowerment perceptions, and therefore, it is essential to discuss other influences in the work environment that contribute to intentions to leave.

Work environment. This final section of the literature review on intentions to leave the nursing profession describes factors directly related to the work environment itself. The work environment includes issues related to management, salary, scheduling, collegial relationships, and workload which have all been analyzed in respect to intentions to leave. Management includes direct supervisors and those who hold power in an organization.

Manager support and ability was not found to be a statistically significant predictor of intentions to stay employed in the study by Tourangeau and Cranley (2006), but it was found to be related to job satisfaction which did have an effect on intent to remain employed. Nurses who felt their managers listened to their views the majority of the time were more likely to remain in their position, but decisions about leaving nursing were unrelated to managerial behaviors (Barron, West, & Reeves, 2007). The literature review by Coomber and Barriball (2007) supports these mixed results related to management and suggests that a leadership style which

facilitates motivation and participation relates to issues of empowerment, which has been shown to have an integral role in intent to stay, as discussed previously.

Salary and financial compensation holds a significant relationship to intentions to leave. In Chandra's (2003) conceptual piece, she informs us that when labor experts adjust nursing salaries to inflation, the salaries are at the same level as they were in 1992. Ingersoll et al. (2002) found that nurses who were satisfied with pay were more likely to remain at an organization. Additionally, two studies found that nurses who were paid more were found to be less likely to leave the profession (Barron & West, 2005; Barron, West, & Reeves, 2007).

Salary was the most frequently cited theme for considering leaving nursing in two studies (Flinkman et al., 2008; Fochsen et al., 2005). In the interviews by Cheung (2004), issues of pay were more often cited by men as reasons for leaving the profession than women. Job benefits had a statistically significant relationship to intention to leave the profession for men and white females in the study by Borkowski et al. (2007).

Salary itself may not be the main point of dissatisfaction, but rather related issues such as having to work additional hours to complete shift work (Tourangeau & Cranley, 2006), which may or may not be compensated. Furthermore, additional training and education in nursing "does not necessarily result in career progression or improved salary" (Fochsen et al., 2005, p. 342). The culture of nursing has a history of long hours and inflexible scheduling (Joshua-Amadi, 2003). Having to work mandatory overtime, which compromises personal time (Chandra, 2003) further relates to the issue of work hours. A more stable work schedule was found to be related to lower turnover intentions (Shader et al. 2001). Schedule changes can drastically alter home life and can decrease morale. Younger generations put a greater value on having control over work schedules than previous generations (Lavoie-Tremblay, et. Al 2008). Dissatisfaction with

the relationship between work schedule and well-being was strongly associated with intention to leave (Flinkman et al., 2008). Schedule changes and mandatory overtime often occur in response to staffing problems and high levels of patient acuity, which leads to issues of increased workload.

The nursing shortage has contributed to an increased workload which may decrease the interaction time between patients and nurses (Chandra, 2003). In the qualitative study of nurses in London, one nurse responded, "There is so much paperwork to do that there is not time for the patients" (Joshua-Amadi, 2003, p. 16). Concerns about patient care were revealed in the findings on moral conflicts, which clearly relates to nursing job dissatisfaction (Cheung, 2004). The inability to deliver high-quality care was strongly related to intentions to leave in the study by Reeves, West, and Barron (2005). Barron, West, and Reeves (2007) found that feeling valued by society and by their employer was the most significant factor in predicting intentions to leave the profession. In fact, nurses who had positive feelings toward nursing but viewed their working conditions and patient care poorly, had a low probability of leaving the profession. The researchers suggest that nurses may view problems as being related to their place of employment rather than their work as a nurse. However, it is also possible that nurses have become tolerant and accepting of poor working conditions and view them as "the norm."

Organizations cannot underestimate the impact of group relationships on the work environment. Work relationships for nurses typically involve co-workers, physicians, and other healthcare workers. Level of teamwork was found to be a statistically significant predictor of intention to remain employed (Tourangeau & Cranley, 2006). Shader et al. (2001) found high group cohesion to be related to increased job satisfaction and decreased job turnover. A positive perception of work group related to higher levels of job satisfaction and organizational

commitment in the study by Ingersoll et al. (2002). They also found favorable relationships with colleagues relate to a positive perception of the work environment.

Organizational commitment is the degree of attachment nurses have towards their employer (Tourangeau & Cranley, 2006). Organizational commitment was found to be highly related to job satisfaction and intent to stay in Tourangeau and Cranley (2006). Other research demonstrated job satisfaction to have a higher correlation with intention to leave an organization than intention to leave the profession (Lu et al., 2002). According to Ingersoll et al. (2002), there is a need to examine individual goals in relation to organizational goals in order to positively impact organizational commitment.

Summary of Intentions to Leave

This body of literature has led to many insights into nurses' intentions to leave the profession. To summarize, increased perceptions of job stress (Lavoie-Tremblay et al., 2008; Letvak & Buck, 2008; Shader, Broome, Broome, West, & Nash, 2001), the inability to provide safe and ethical care (Cheung, 2004; Hart, 2005), conflicts between work and family life (Duffield, O'Brien-Pallas, & Aitken, 2004; Flinkman, Laine, Leino-Kilpi, Hasselhorn, & Salantera, 2008), few opportunities for career advancement and professional development (Flinkman et al., 2008; Foschen, Sjogren, Josephson, & Lagerstrom, 2005), few opportunities to participate in decision-making (Barron & West, 2005; Barron, West, & Reeves, 2007; Joshua-Amadi, 2003), and inadequate financial compensation (Barron & West, 2005; Barron et al., 2007; Flinkman et al., 2008; Fochsen et al., 2005) have all been found to contribute to higher intentions to leave the nursing profession. This review of the literature has found that factors in the work environment are more influential on intentions to leave the nursing profession rather than individual factors, which was also found in the literature review by Coomber and Barriball

(2007), as well as in the meta-analysis of job satisfaction, behavioral intentions, and turnover by Irvine and Evans (1995). These research studies have been highly varied in their work environments, job roles, and geographic locations making conclusions about strategies necessary to keep nurses in practice difficult to synthesize. However, all of these relationships need to continue to be examined to determine the specific impact they have on length of tenure in the profession of nursing.

While this research has created a foundation for exploring why nurses leave the profession, much of what is known is not from the voices of nurses themselves. The majority of the studies utilized surveys to obtain data, and some of the instruments used were designed for groups other than nurses. Coomber and Barriball (2007) acknowledged in their review that while scales can be useful for comparison of job satisfaction sources, they may not be adequate in obtaining in-depth information due to the nature and complexity of nursing work. In order to be useful in making policy changes and improving work environments for nurses, scales need to develop from within the nursing profession and qualitative interviews should be used to gain greater insights into which factors are of most importance to nurses (Coomber & Barriball, 2007). As stated by Borkowski, et al. (2007) in their research on exploring nursing retention, “Reasons for diverse groups leaving their profession are not well understood at this time” (p. 167).

Delivery of healthcare services was a focus of many of the studies and little attention was paid to the impact of the work environment on an individual nurse that may lead to the decision to leave the profession. It is possible that the choices that were made about the factors to study in relation to intentions to leave prevented other relationships from being revealed. It also seems probable that the majority of the research on intent to leave the nursing profession has primarily been derived from knowledge informed by dominant discourses because of the power of the

medical model and patriarchal organizational structures. Furthermore, most of the studies were published in nursing management and administration journals or health policy journals. Few implications were related to the field of adult education and recommendations concerning curricula and pedagogy were rarely considered.

The literature on intent to leave nursing does explore many facets that may contribute to behavioral intentions, but it does not explore the gendered nature of the work environment or include the voices of nurses themselves. Even though most of the participants were women, none of the research studies reviewed mentioned that nursing is a predominantly female profession. Data on gender was typically collected in demographic data, but because of the small sample sizes of men, it is difficult to draw any conclusions about the influence of gender on intentions to leave the profession through quantitative analysis. Therefore, there is a need to study nurses' intentions to leave the profession qualitatively and to include gender as a central component of analysis. The perceptions of their experiences as nurses can help us to better understand how they perceive the influence of gender on their work, including their reasons for entering and exiting a profession that they have invested considerable time and effort.

Summary and Conclusions

This chapter reviewed the relevant literature regarding a proposed study examining the perceptions of nurses' intentions to leave the profession and the influence of gender in the decision-making process. An understanding of the theoretical framework of poststructural feminism was provided, as well as the rationale for selecting this lens in relation to the study purpose. A poststructural feminist lens incorporates the role of social structures on individual identities and includes critical exploration of identifying and analyzing power relations. Few studies have examined any issues surrounding the nursing shortage with a feminist lens, and the

nursing profession in general has rarely used such a theoretical framework to study itself. The profession of nursing has remained predominantly female through historical, social, and cultural influences, which affect nursing practice and workplace learning. A comprehensive review of the literature on intentions to leave the nursing profession was provided. This body of research has examined diverse concepts often associated with job satisfaction in an attempt to determine the most significant reasons for wanting to leave the nursing profession. However, because of the complexity of the work environment and the numerous variables examined, it has been difficult to reach many conclusions about the reasons that nurses may choose to leave the profession. The lack of qualitative research on this topic, the absence of a critical lens on the nursing shortage, and the paucity of research on the gendered nature of experiences in the workplace undergirds the need for this study.

CHAPTER THREE

METHODOLOGY

The purpose of this qualitative study is to explore the perceptions of female registered nurses who have intentions to leave the nursing profession with particular attention to the influence of gender in their decision-making process. In considering this purpose, a qualitative study utilizing a basic interpretive design was employed. This chapter will begin with a discussion of qualitative research, as well as the characteristics of qualitative research, and will also include the research design. Also critical to this study is the application of a feminist lens; therefore, a brief discussion of feminist methodology will be included along with the research design, as well as a detailed inclusion of researcher background, personal beliefs, and assumptions.

Qualitative Research Paradigm and Rationale

A paradigm is an interpretive framework that consists of epistemological, ontological, and methodological beliefs of the researcher (Denzin & Lincoln, 2005). Qualitative research has evolved from a paradigm that sees the world as socially constructed and subject to constant changes. The purpose of qualitative research is to understand how individuals make sense out of their experiences and to describe how they make meaning of their experiences (Merriam, 2002; Merriam & Simpson, 2000). Qualitative methods stem from a worldview that is holistic and the belief that multiple realities can be constructed from many different perspectives resulting in numerous meanings which are subject to change (Burns & Grove, 2007; Merriam, 2002). Because the purpose of this study is to explore participant perceptions of an experience and to critically examine influences on decisions to leave the nursing profession through a

poststructural feminist lens, a qualitative paradigm is the most appropriate choice of a research framework.

According to Denzin and Lincoln (2005), the four basic interpretive qualitative paradigms are: positivist and postpositivist; constructionist-interpretive; critical; and feminist poststructural. Within a poststructural paradigm, universal truths are challenged, as well as the construction of knowledge, in an effort to reach new understandings of a phenomenon (Merriam, 2002). Thus, any research study that is informed by a poststructural lens would more than likely make use of a qualitative framework, since qualitative methodologies seek to study how people construct their realities or how they perceive reality. The addition of feminism to this paradigm incorporates other characteristics into the research design and will be further discussed in this chapter. Qualitative research is particularly useful for exploring the influence of context on participant action and for understanding the process of how events occur (Maxwell, 1996). This study in particular is seeking to explore how experiences in the workplace can lead to intentions to leave the nursing profession, gain insights into this decision-making process, and how these participants are making meaning of their professional lives.

Qualitative methodologies can allow us access to information that may be unobtainable through quantitative methods; they allow for a greater depth of information through open inquiries and do not utilize standardized measures; qualitative research seeks to understand how people make sense of their worlds. The current body of research on the nursing shortage has not examined how nurses who are planning to leave the profession perceive their practice in a gendered field. Because of the lack of research in this area, an in-depth exploration of this topic is most appropriate. Also, it has been difficult to determine the factors that are most pertinent regarding the decision-making process surrounding leaving the nursing profession (Borkowski,

Amann, Song, & Weiss, 2007). Previous research has mainly used surveys to obtain data and many of the instruments used were designed for groups other than nurses. While surveys can provide useful information, the data obtained can be superficial and lack depth. Additionally, Joshua-Amadi (2003) suggests that nurses may resist making complaints on surveys because of a fear of retributive consequences, particularly if they believe the origin of the data can be traced. Even though this could be a concern for this study as well, confidentiality and anonymity will be clearly addressed with the participants by the researcher. The paucity of research on this topic and the possibility that survey data may not be accurately assessing the reasons nurses choose to leave the profession further undergirds the necessity to conduct this study through qualitative inquiry.

Patton (2002) describes questionnaires as photographs which capture an image at a moment in time while qualitative studies are more like movies which develop and change over time. In an effort to study human experiences and their perceptions of reality, interviews, observations, and documents are used to collect data in qualitative research. In a literature review of job satisfaction and nursing turnover in hospital based nurses, Coomber and Bariball (2007) call for qualitative interviews to be conducted to gain greater insights into the nursing work environment. This study utilized in-depth interviews, participant documents, and a researcher journal as sources of data to explore individual perceptions relating to the decision to leave the nursing profession. Without a deeper understanding of the issues that lead to career turnover, policy changes will not be made and work environments will not be improved.

Participants in qualitative methodologies are typically sought through a process of purposive sampling rather than probability or convenience sampling. The number of participants is generally small, but some studies have large sample sizes. In any case, the number of

participants directly relates to the nature and purpose of the research. The data are highly descriptive and a decision to stop collecting data is usually made when new ideas are not being obtained (Burns & Grove, 2007). Data collection must include descriptions and interpretations of the participants' social environment in order to gain an understanding of the complexity of a situation. It is extremely important for qualitative researchers to explicitly state their data collection methods, as the results are dependent upon the researcher's ability to conduct the study. Exploring perceptions of practice within a female dominated profession and influences contributing to intentions to leave the nursing profession is well suited for qualitative inquiry, because the phenomenon of interest requires obtaining rich descriptions of participant experiences.

Research Design Overview in Light of the Theoretical Framework

Methodology can be described as the principles and practices that guide a research study. Life experiences and perspectives often lead to the development of the research question, and the choice of methodology depends on the question that is being asked. The choice of a research methodology guides the researcher in her quest for knowledge and it often speaks to the values and beliefs of the researcher. In this way, all research is considered subject to interpretation and "is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied" (Denzin & Lincoln, 2005, p. 22). Within the qualitative paradigm, there are several methodological approaches and research designs including basic qualitative, phenomenology, ethnography, case study, grounded theory, narrative, critical, and postmodern (Merriam, 2002). The methodology for this study is a basic interpretive design guided to some extent by the theoretical framework of feminist poststructuralism.

Interpretive studies are guided by all of the central characteristics of qualitative methodologies and can seek an understanding of a process (Merriam, 2002). Orlikowski and Baroudi (1991) state “interpretive studies assume that people create and associate their own subjective and intersubjective meanings as they interact with the world around them” (p. 5). This type of research seeks to not only acknowledge meaning, but to discover how human experiences are impacted by social structures (MacIntyre, 2001). Orlikowski and Baroudi further explain:

The aim of all interpretive research is to understand how members of a social group, through their participation in social processes, enact their particular realities and endow them with meaning, and to show how these meanings, beliefs and intentions of the members help to constitute their social action (p.13).

Socio-cultural discourses can impact personal choices and “interplay with the construction of identities where women make sense of themselves through these discourses” (Gallant, 2008). Discourses are challenged and resisted in many ways by women, but they are always contextually bound and subject to change (Weedon, 1987). Because this study is investigating how practice in a female-dominated career influences intentions to leave the nursing profession, the choice of a basic interpretive framework is compatible with both the theoretical framework of poststructural feminism and the study purpose. Given the complexity of the workplace and of human decisions, a basic interpretive framework provides greater flexibility and less structure regarding research strategies, sampling procedures, and interview schedules (Denzin & Lincoln, 2005); the inclusion of a poststructural framework is particularly useful in researching issues related to the healthcare system (Cheek, 2000). Perceptions of reality shape decisions that are socially and culturally situated, and this research design promoted a variety of participant

responses during in-depth interviewing, while allowing for the research findings to unfold naturally.

This study is guided by a feminist poststructural lens, though it will follow the protocol of an interpretive study in light of a feminist perspective. Within a qualitative research design, certain characteristics are associated with feminist research. From a methodological perspective, feminism draws on both interpretive and critical perspectives (Gillis & Jackson, 2002) with feminist poststructuralism being a critical perspective in that it deals with power relations. Dominant discourses are shaped by power relations; when dominant discourses are recognized, they can then be altered and shifted (Gallant, 2008). A poststructural approach to the research process uncovers the assumptions that are present and what representations are absent (Cheek, 2000). Thus, critical theory can be used in interpretive research to expose practices that are socially constricted (MacIntyre, 2001; Merriam, 2002), and this perspective also includes feminist poststructuralism.

While all qualitative frameworks expect that researchers divulge their background and intentions, feminist methodologies, particularly feminist poststructuralism, further demand that researchers clearly state their biases and assumptions. Harding (1987) claims that by disclosing our subjective beliefs, our analysis becomes more objective because we are not hiding our intentions. Researcher subjectivity affects all aspects of the research process, and the researcher should never be viewed as neutral and value free in his/her approach. By doing this, the researcher appears as a real and visible being with specific intentions. Additionally, feminist researchers need to focus the lens they are using on their participants on themselves as well (Smith, 2005). Experiences as a woman and as a scholar must be continually evaluated by the feminist researcher in relationship to the research study (Gillis & Jackson, 2002). Further,

feminist poststructuralism highlights how one's positionality (i.e. gender, race, class, sexual orientation) in relation to the dominant culture shapes the knowledge production, including the research process (St. Pierre, 2000). The gendered nature of patriarchal societal structures affects subjectivity on a daily basis and can lead to "negative and conflicted ideas about what it means to live as a woman" (Bloom, 2002, p. 291). Thus, it is extremely important to make visible how positionality, including that of the researcher and of the participants, is present in the research process when guided by a feminist poststructural lens.

In general, feminist research uncovers the gendering of institutions and the cultural and historical structures that contribute to women's experiences (Smith, 2005). As stated by Lather (1991), "to do feminist research is to put the social construction of gender at the center of one's inquiry" (p. 71). The aim in feminist research is often to challenge knowledge production and bring light to the fact that there is not one rational, objective truth. Feminist methodologies challenge what is known and who can be a "knower" while problematizing the notion of truth (Hesse-Biber, Leavy, & Yaiser, 2004). Smith (2005) states, "Feminism has challenged the deep patriarchy of Western knowledge and opened up spaces for the examination of epistemological difference" (p. 88). Without questioning social structures, separation between the individual and their world occurs (MacIntyre, 2001). In addition to these aims of feminist research, there are also methodological principles in respect to the researcher, data collection, and data analysis which will be discussed later in this chapter.

A basic interpretive design is consistent with a poststructural feminist theoretical orientation and methodology. It requires the researcher to be open to a myriad of possibilities and to also possess a high degree of reflexivity in the research process. Gillis and Jackson (2002) define reflexivity "as the critical thinking required to examine the interaction between the

researcher and the data occurring during analyses” (p. 285). This process involves more than reflection on the research process; it “demands a steady, uncomfortable assessment of the interpersonal and interstitial knowledge-producing dynamics” (Olesen, 2005, p. 251). These personal views must be continually analyzed and clearly communicated (Gallant, 2008).

Engaging in self-reflexivity assists the researcher in representing the voices of the participants as authentically as possible (Gallant, 2008). Careful attention must be paid to highlight participants’ voices and their shifting identities without solely focusing on “otherness.” If the researcher is not vigilant in this process, further marginalization of the participants can occur, which is a tension of feminist research. Through the process of data analysis and interpretation, I did feel the presence of this tension. With the application of a feminist poststructural lens, participants can be portrayed as powerless and implicit in creating their own conditions of marginality. I made a conscious attempt to be aware of this tension and tried to present the individual voices of the participants by using thick, rich data.

Another tension particular to feminist poststructuralism is that patriarchal structures are often portrayed as causing oppression, thus, making this notion “a truth”, and this framework attempts to resist universal beliefs. Additionally, Francis (1999) states that feminist poststructuralism “pleasures in the deconstruction of current discursive practices, but suggests or builds nothing in their place” (p. 388-389), which means for this study, I may be able to problematize the workplace, but may be unable to offer solutions or alternatives. In order to address this issue, I asked participants for suggestions to improve any of the factors they discussed, and I also asked them about their educational preparation. The next section will discuss my background as the researcher; this explanation is critical in research studies guided by feminist poststructuralism.

Background of the Researcher

Some argue that it is essential for researchers to address potential influences on study conduction or the findings will not be interpreted as being credible (Gillis & Jackson, 2002). Because of the close proximity of the researcher to the data, the researcher must divulge his/her vantage point from where the research is being conducted. As a feminist researcher conducting a qualitative study informed by feminist poststructuralism, it is even more critical that I disclose my background and personal beliefs that may influence the research process. First and foremost, I am a white, married, heterosexual woman. I am aware that being white is a privilege and this factor may shape the interview process, particularly with participants who identify with races and ethnicities that are different from mine. Additionally, participants who identify as gay, lesbian, bisexual, or transsexual might not be open to discussing issues related to sexual orientation if they perceive me as a heterosexual woman.

Another important aspect of my background is that I have been a registered nurse for fourteen years. During my career in nursing, I have worked as a staff nurse, staff development instructor, and nurse educator. I am approaching this project from a position of privilege as an academic and as a doctoral student, and I am aware that my perspectives on the nursing shortage have been influenced by my graduate education. Additionally, many nurses in direct care positions may not have education beyond their nursing degree and I may be viewed as an outsider unable to understand their daily experiences in the workplace. However, I continue to work part-time as a staff nurse in a direct care position on a cardiothoracic post-operative unit and hope to be seen as someone who has a current perspective on nursing practice in the workplace. Furthermore, I teach student nurses in a similar clinical setting on a weekly basis, so I have the opportunity to frequently observe issues related to the work of nurses in direct care

positions. I recognize that through these observations and experiences, I often attempt to analyze how issues particularly related to gender, class, and power influence everyday life, particularly the working lives of women. According to Borbasi, Jackson, and Wilkes (2005), “Nurses as researchers may be better equipped than other social researchers to deal with contingencies in the field” (p. 493). I believe that my career in nursing has given me an advantageous perspective for conducting this research study and I am aware of my positionality. Being a nurse seemed to be an advantage most of the time during the interview process, because I understood the “insider” language regarding patient care and disease processes that the participant’s used to describe their experiences. However, in some instances it may have been a disadvantage because I may not have asked for enough clarification if I thought I understood the point they were trying to make.

In addition to my own experiences as a nurse, I also have a sister who is a nurse in a direct care position. She frequently shares her concerns with me about the work environment and job expectations, and she feels that her working conditions have deteriorated over the past few years. While she has not considered leaving the profession of nursing, my interest in this topic has been partially developed out of her dissatisfaction with her working conditions; the close relationship that we share has undoubtedly influenced my perceptions of the context in which patient care is currently being provided.

Based on my own experiences and perspectives, I believe that working conditions are not adequate for the work of nursing as it is conceptualized and that work environments will not change unless they are confronted by those who are most affected by them. Nurses are placed in a subservient position in relation to physicians in the workplace and in society (Davies, 1995). Physicians and administrators continue to wield the most power in healthcare organizations and the hierarchy that exists is maintained primarily based on white, heterosexual, male standards.

For these reasons, I believe that nurses are an oppressed group and have a tendency to exhibit oppressed group behavior. Additionally, I believe that qualitative methodologies can challenge the status quo and I contend that the majority of the research on intentions to leave the nursing profession has primarily been derived from knowledge informed by dominant discourses.

Therefore, I do not believe the sole purpose of feminist philosophy should be to seek equal rights and opportunities as men are perceived to have. Rather, I believe a goal should be to examine the conscious and unconscious ways women's experiences in the workforce have been socially and culturally influenced.

I am aware that these biases and personal experiences could have an effect in this study. But any experiences I had or did not have are also effects in the study; this is the point of feminist poststructuralism. Nevertheless, in order to minimize some of these effects, I consulted my advisor regularly, particularly in respect to data analysis and interpretations to decrease the possibility of researcher expectancy error. I also explored my personal subjectivities in my researcher journal and discussed insights with colleagues to heighten my awareness of my own perspectives. Additionally, I recognized that the participants' perceptions of the influence of gender in nursing may not be the same as my perceptions. For this reason, I asked for clarification of answers in order to prevent misinterpretation and I also conducted member checks. In order to prevent selection bias of the participants, I followed the specific selection criteria, so that I did not choose only participants that I believed would be most closely aligned with my views. Tisdell (2002) suggests selecting participants who are different than yourself; the participants in this study had varying levels of education and work experiences, which were different from my own and two participants in the study identified themselves as black.

As a woman and an educator in the workforce, I identify with the multiple roles of being a wife, mother, nurse, and doctoral student. I see my identity as constantly shifting and I value how context shapes women's lives and their experiences. I am aware that my own positionality shaped this research project and that as a feminist researcher, I am deeply involved in the research process. I recognize that I am very enthusiastic about this project and I made a conscious effort to allow for silence and reflection during the interview to not impose my perspectives onto the participants.

In summary, the exiting of registered nurses from the profession is detrimental to the healthcare system. Patient care is affected not only by the loss of expertise, but by the increased demands on workload that occurs as a result of a shortage of nurses. Additionally, as a nurse educator, I am saddened when nurses leave the profession, because I feel that some of the reasons leading to these decisions could be related to a failure of the educational system on a variety of levels. I continued to reflect on my personal beliefs and biases as this project unfolded. I agree with Patton (2002, p. 35) that "Looking deeply at other people's lives will force you to look deeply at yourself." I gained new insights into how women perceive their practice in a female-dominated profession and the influences in the work environment that contributed to their intentions to leave nursing.

Participant Selection

Participants in qualitative studies are actively engaged in the research relationship (Gillis & Jackson, 2002). From a feminist poststructural perspective, attempts should be made so that participants hold an equal position to the researcher. They are selected purposefully according to certain criteria in an effort to understand a particular phenomenon, as well as to provide rich, descriptive information (Patton, 2002). Sampling strategies utilized in qualitative research

include: critical case, snowball, criterion selection, and convenience (Gillis & Jackson, 2002).

Qualitative researchers often use more than one sampling procedure to obtain study participants.

For this study, snowball sampling and criterion sampling were used. Snowball sampling is sometimes referred to as network sampling. “Network sampling takes advantage of social networks and the fact that friends tend to have characteristics in common” (Burns & Grove, 2007, p. 346). Snowball sampling involves talking to people who can recommend potential participants who fit the criteria of interest (Patton, 2002). I communicated verbally and via e-mail with nursing colleagues who work in a variety of settings, family members, friends, and former nursing students to find participants in patient care positions who self-identified as having a serious intention to leave the nursing profession. I also contacted members of the Eta Eta Chapter of Sigma Theta Tau via a list-serve; permission was granted by the list serve administrator.

In qualitative research studies, participants are chosen according to purposeful criteria (Merriam, 2002). The participants in this study were selected according to the following criteria. They were registered nurses who:

- (1) had a serious intention to leave the profession.
- (2) had actively searched for other jobs or had taken steps to prepare for another career that did not require a nursing qualification (even if the skills and experiences as a nurse are a valuable asset).
- (3) were not looking to exit the workforce completely.
- (4) were currently working in a patient care setting.
- (5) had at least three years of experience in nursing.

Criteria for study participants were developed based on reviewing the literature on intentions to leave the nursing profession and in consultation with my doctoral committee. Because the purpose of this study relates to exploring the decision-making process of exiting a professional career, it was essential for the participants to have serious intentions to leave nursing for other types of work. Secondly, since the most serious consequences of the nursing shortage are related to patient care (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002), it is important that all of the participants be currently working in a position that concerns patient care. Thirdly, after three years of experience, nurses will have made the transition from school to work, and according to Benner's model of nursing skill acquisition, nurses with this amount of experience are generally considered to be competent nurses who are consciously aware of long-range plans and are able to effectively deliver patient care with an organized approach (Benner, 1984). Furthermore, at this point, they will be socialized into the profession, possess substantial knowledge regarding the work environment, and will not be leaving due to an immediate realization that they had chosen the wrong career. Ideally, participants would not necessarily be limited to the local geographic area, because within the central Pennsylvania area, there are several Magnet hospitals, which are healthcare organizations that have been recognized as centers of nursing excellence. These institutions typically have lower rates of job dissatisfaction and nurse burnout (Aiken, Havens, & Sloane, 2000). Having participants from only Magnet hospitals may not accurately reflect broader perceptions of factors in the nursing work environment that influence intentions to leave the profession. While the majority of the participants lived and worked in the central Pennsylvania area, they worked at diverse locations and most of them were not currently working at a Magnet hospital.

I had initially considered selecting participants who had the same initial nursing education, because there continues to be three different types of educational levels for entry into the nursing profession: a hospital based diploma program, an associate degree program, and a baccalaureate degree program. Research on intentions to leave the profession has revealed varying results in respect to educational level (Borkowski, Amann, Song, & Weiss, 2007; Coomber & Barriball, 2007; Duffield, O'Brien-Pallas, & Aitken, 2004; Ingersoll et al., 2002; Lu, Lin, Wu, Hsieh, & Chang, 2002; Noguera, 2006; Scott, Engelke, & Swanson, 2008). There is some evidence that nurses with a baccalaureate degree are more likely to leave the profession (Duffield et al. 2004; Scott et al., 2008) and it was hypothesized that nurses who have a baccalaureate degree upon entry into practice may not be as tolerant of poor working conditions (Scott et al., 2008). However, it was not possible to find participants who had the same nursing education as well as all of the other selection criteria. Eleven female registered nurses participated in this study and recruitment was terminated when redundancy of data was achieved (Patton, 2002).

The research plan was approved by the Pennsylvania State University Institutional Review Board and data collection did not proceed until approval was granted. The York College Institutional Review Board approval was also obtained in order to utilize the list-serve. Participants were given an implied informed consent form and they were made aware that they could withdraw from the study at any time. All participants were given the opportunity to create their own pseudonym and all but one of the participants selected one. No identifiable information regarding their name or place of work is revealed in the findings or in the discussion of the study. Participants were approached with sensitivity and I had an awareness that some issues related to their decision to leave nursing may have been difficult to discuss.

Data Collection

Qualitative data collection methods include direct observation, analysis of records and artifacts, field notes, and interviews (Patton, 2002). Multiple sources of data are utilized for qualitative studies, because a comprehensive view of the phenomenon of interest cannot be adequately obtained from a single source (Merriam, 2002; Patton). The typical data collection methods in qualitative research are interviews, observations, and the use of documents, pictures, or other artifacts related to settings. As stated by Gillis and Jackson (2002), “The complex nature of nursing lends itself well to study using multiple methods” (p. 30). For this study, data was collected from semi-structured face to face interviews, participant documents, and a researcher journal.

In-Depth Interviews

Interviews are frequently used to collect data in feminist studies (Gillis & Jackson, 2002) and can be unstructured, semi-structured, structured or conducted in focus groups (Fontana & Frey, 2005; Morse & Field, 1995). According to Hutchinson and Wilson (1994), interviews are conducted to gain insights into participant perspectives, which makes interviewing consistent with the purpose of this study. In addition to collecting descriptive data, demographic information regarding age, race, years in nursing, years in current position, work experiences, education, marital status, and family constellation was also collected.

Semi-structured interviews ask opened-ended questions, and they are useful in obtaining information relevant to the study purpose while allowing open opportunities for participants to respond (Merriam, 2002; Morse & Field, 1995). It is important to keep in mind that interview questions are not the same as research questions; rather, they are designed to gain an understanding of the phenomena of interest (Maxwell, 1996). Interviewing is a skill that needs

to be developed and researchers need to keep in mind the purposes of the study as they develop an interview guide of questions. Openness and emotional engagement are required by the interviewer in feminist research (Denzin & Lincoln, 2000). As stated by Maxwell, “The development of good interview questions requires creativity and insight, rather than a mechanical translation of the research questions” (p. 74).

In semi-structured interviews, a list of questions to be asked to each participant is used by the interviewer (Merriam, 2002; Polit & Hungler, 1999). Questions were prepared in a logical order for a semi-structured format and only one question was asked at a time. Even though each participant was asked similar questions, they were not necessarily asked in the same order. This interview format was flexible enough to create a dialogue with the participant, but it also ensured that insights into the phenomenon of interest were gained. The Interview Guide can be found in Appendix A. In light of the theoretical framework, I made an attempt to elicit information regarding how the participants make sense of their experiences within their socio-cultural contexts during the interview (Gallant, 2008). In order to help refine my interview questions, I practiced my interview questions with a nursing colleague and I consulted members of my doctoral committee regarding the questions before the first interview.

Critical to the interview process is the relationship between the researcher and the participant. Within a feminist methodology, it is essential for the researcher to engage in an interactive dialogue with the participant to promote a sense of collaboration (Lather, 1991). I recognized that my own multiple subjectivities as a woman, nurse, and researcher affected the interview process, as it does in all research situations. It is my hope that I was able to create a connection by being a woman and a nurse. As someone who was interested in hearing their voice and perspectives, to some extent, I approached the interview as a shared conversation in an

effort to establish rapport. It is possible that I may have been viewed as someone who was heavily invested in the profession of nursing, but I did not sense that participants were reluctant to share their reasons for wanting to leave the profession with me. As an initial effort to establish rapport, interviews were conducted with the date, time, and location chosen by the participants. The interviews were conducted over a period of three months, and I made a conscious effort to keep my schedule open during this period of time. Allowing participants to choose the setting in addition to leading the interview helps to establish a trusting relationship (Morse & Field, 1995). Information regarding the time, place, and location of the interview was recorded. As initial effort to create a conversational dialogue, the first question I asked all participants was to discuss their reasons for entering the nursing profession. Establishing the interview as a conversation can encourage the sharing of examples and stories, which can lead to rich, descriptive information, as well as fascinating analyses (Morse & Field, 1995).

During an interview, the researcher has “an internal self-dialogue” (Hutchinson & Wilson, 1994, p. 309) which involves thinking about the next question while listening to the participant’s response. Even though the researcher is experiencing this internal dialogue, it is important for the researcher to intently pay attention to the participant and to convey a sense of importance to her perspectives. Guided by a feminist poststructural methodology, I was particularly listening for how participant knowledge of the workplace has been formed, as well as how power and resistance impacted their decision-making process. Additionally, it is important to note that I will not be “speaking” for the participants, but will be attempting to present their perceptions (Gallant, 2008).

Interviews were all conducted face to face and were approximately 1 hour in length. All interviews were audiorecorded with a digital device. In addition to audiorecording the interview,

I wrote researcher notes immediately after the interview, particularly in relation to any information that was shared after the recorder was turned off and in respect to any nonverbal communication. Recorded interviews include more than words; they contain feelings and other forms of nonverbal communication, such as pauses, voice tone, and rate of speech. Therefore, it is essential for the researcher to note all observations, not just those limited to the words spoken. I listened to each audiorecording on the same day as the interview and wrote any additional notes or impressions. I transcribed ten of the interviews and one was completed by a professional transcriptionist. After the interviews were transcribed, I listened to each audiorecording again to check for accuracy to fill in any gaps. I also noted any pauses and emotions, such as laughter, on the transcripts. As a feminist researcher, I am aware that texts from interviews are distorted constructions “from words spoken by one person to words shaped into written form by another” (Lather, 1991, p. 94). Thus, interviews are influenced by the subjectivity of the researcher as well as her constantly shifting identity, and the discourse created between the participants and myself was continually under construction. Member checks were conducted with participants to ensure that I have accurately documented their perceptions and experiences. The member check gave participants an opportunity to voice additional perspectives, as well as an opportunity to review the initial transcripts. The audiorecordings will be kept for five years after the final dissertation defense and then the electronic files will be deleted.

Documents and Artifacts

In addition to interviews, participants were asked to share any documents such as journals, diaries, electronic communication, artwork, or other creative work that related to their choice to leave the nursing profession in order to gain insights into the decision-making process. Documents and artifacts can provide additional information that may not be revealed in an

interview and they are typically considered a less obtrusive way of data collection (Creswell, 2003; Merriam, 2002). They can also foster collaboration between the researcher and the participant while providing the participant with another way to promote voice through an object that has meaning to them (Patton, 2002). Most of the participants did not share any documents during the interviews. Two participants brought information regarding their new careers in home-based businesses and one participant shared a recommendation letter written by her boss in support of her future career plans. One participant gave me a copy of a book that spoke to her personal philosophy on living and she also sent me some recent poetry that she had written after the interview. Information regarding their perspectives on the documents was recorded and included with the raw data.

Researcher journal

In addition to documenting notes in respect to the interviews and transcripts, I kept a researcher journal to help promote reflexivity, which is essential in a feminist poststructural framework (Ortlipp, 2008). While keeping a reflective journal does not create complete transparency of the research process, it can expose tensions of the research process as well as researcher positionality (Ortlipp). Critical self-reflection guided the research design, methods, and approaches to the research process. Ortlipp also states that:

Keeping and using reflective research journals can make the messiness of the research process visible to the researcher who can then make it visible for those who read the research and thus avoid producing, reproducing, and circulating the discourse of research as a neat and linear process (p. 704)

These various methods of data collection lead to a deeper understanding of the participant's perspectives and were appropriate to the study purpose and theoretical framework. The next section describes the process of data analysis, which began simultaneously to data collection.

Data Analysis

The challenge for the qualitative researcher is to make sense out of a large volume of data to arrive at research findings without a set formula (Patton, 2002). The qualitative researcher must illuminate hidden data and assemble together pieces of a puzzle, which initially may seem unrelated. As stated by Morse (1994), "theory does not magically emerge from data" (p. 25). Marshall and Rossman (1989) describe data analysis as "a messy, ambiguous, time-consuming, creative, and fascinating process" (p. 112). It "begins immediately with the first data collection episode and continues throughout the study" (Gillis & Jackson, 2002, p. 185). This continuous process assists the researcher in developing additional questions to explore during future interviewing, and it can also be used to clarify data generated previously (Gillis & Jackson; Weiss, 1994). The primary process utilized to gain understanding for this study was from detailed analysis of the interview transcripts.

Burns and Grove (2007) describe three stages of qualitative data analysis: description, analysis, and interpretation, while Morse (1994) describes four sequential cognitive processes: comprehending, synthesizing, theorizing, and recontextualizing. Marshall and Rossman (1989) divide the analytic process into five procedures: organizing the data, generating themes and patterns, testing emergent hypotheses against the data, searching for alternative explanations, and writing the research report. Data analysis for this study used these processes as a guide to describe the data analysis procedure. Throughout all phases of the process, the qualitative

researcher attempts to analyze and interpret the data (Burns & Grove, 2007; Marshall & Rossman). Initial theories regarding the data analysis are often ambiguous and may not be accurate as the analysis unfolds (Burns & Grove, 2007).

The first step in data analysis involved conducting a content analysis of the data. During this phase, I immersed myself into the data by reading and rereading the transcripts, and by recalling observations of nonverbal communication (Burns & Grove, 2007). The feminist poststructural researcher utilizes a high degree of self-reflexivity in an attempt to analyze experiences without violating the subjectivity of the participant (Lather, 1991); as a feminist poststructural researcher, I am an active participant in the analysis process. As the researcher works to learn as much as possible about participant perspectives, categories emerge and similar data get clustered together (Morse, 1994). As Patton (2002) notes, “the first reading through the data is aimed at developing the coding categories or classification system” (p. 463). Typically, an initial reading of the data is conducted to develop codes, followed by a second reading to begin the formal coding process in an organized way. A formal coding process must be used by the researcher to organize the data in a systematic way that makes sense to them. Even though feminist poststructuralism problematizes the notion of categories, it is important for the researcher to develop a way to tell the data story, which is typically done by developing themes of findings, while recognizing that it would be possible to frame the data story in a different way.

Data may be organized using highlighters, numbering systems, cutting and pasting quotes or concepts onto a larger piece of paper or onto index cards. I initially highlighted passages that seemed significant to the decision to leave. I then wrote words or phrases on the passages to reflect a code. Each participant’s transcript was color-coded. After several readings of the data, researchers can begin to aggregate similar data into common themes (Morse, 1994). The codes

were then examined for the emergence of common threads from all of the individual transcripts. “During data analysis, a dynamic interaction occurs between the researcher and his or her experience of the data, whether the data are communicated orally or in writing” (Burns & Grove, p. 80). Patton discusses qualitative analysis as both a science and art. He states, “qualitative inquiry draws on both critical and creative thinking—both the science and art of analysis” (p. 513). It requires the researcher to engage in the creative process to analyze and synthesize the data. For these patterns to emerge, researchers must be open to all possibilities (Patton, 2002). This process of synthesis can be described as “the ability of the researcher to merge several stories or cases to describe the typical patterns or behaviors” (Morse, p. 30). The emergence of findings from the data is also known as internal convergence (Patton), which means that each category should be consistent internally (Marshall & Rossman, 1989). I re-organized the data several times before the five themes emerged. During this phase of the analysis, I made an effort to not read in-depth information about my theoretical framework, because I did not want to skew the data in any way and I wanted to make sure I was listening to the voices of the participants more than my own.

After patterns or themes develop, the researcher makes interpretations of the data. Not only are interpretations presented, but hypotheses are tested against the data (Marshall & Rossman, 1989). Apparent patterns must be challenged and alternative explanations must be offered followed by a demonstration of the most reasonable explanation for the findings (Marshall & Rossman, 1989). To this end, I not only searched for patterns that are similar, but also ones that were dissimilar. “The researcher must determine whether or not the data are useful in illuminating the questions being explored and whether or not they are central to the story that is unfolding about the social phenomenon” (Marshall & Rossman, 1989, p. 119). By

engaging in this process, I searched for alternative explanations; a failure to find strong evidence that refutes the research findings strengthens the principal explanation (Patton, 2002).

The feminist poststructural researcher attempts to illuminate dominant discourses that have influenced participant identities and their understanding of contextual power relations (Cheek, 2000; Gallant, 2008). With this in mind, I searched to identify any discursive practices which affected individual subjectivity (Copnell, 2008; Crowe, 1998). Within a feminist methodology, consideration should be given to “interpretations that imply the most effective interventions for improving women’s lives” (Jayaratne & Stewart, 2008, p. 55), because an aim of feminist research is to address and attempt to correct “both the *invisibility* and *distortion* of female experience in ways relevant to ending women’s unequal social position” (Lather, 1991, p. 71). In order to assist in meeting this aim and to make myself visible as the researcher, I included personal reflections on the themes with the findings that relate to the theoretical framework, and I expanded upon them in the final chapter. I specifically searched for the discourses that shaped participant perspectives in order to explore any dominant discourses that may have influenced nursing experiences and career decisions. Through my analysis, I was most interested in highlighting the ways that power intersects with everyday life, and I was not interested in interpreting the data in a way that called for large acts of resistance (English & Irving, 2008). Additionally, poststructural analyses are viewed as a partial understanding of reality, because it is impossible to completely capture a complete picture of the problem being studied (Cheek, 2000). As stated by Opie (2008), “the research report is limited in its representation of actuality, despite its apparent fullness...” (p. 366).

The final phase of data analysis involves theorizing, which “is a way of discovering the insignificance of the significant and the significance of the insignificant” (Morse, 1994, p. 32).

A particular strength of qualitative research is the ability to make a theory applicable to other settings or populations, which is known as recontextualization (Morse, 1994). The results of the research can demonstrate the efficacy of an established theory and possibly add new contributions to it. In feminist studies, explorations into policy changes which may “positively affect women’s lives” (Jayaratne & Stewart, 2008, p. 55) should be part of the theorizing process. Implications relating to the theoretical framework of poststructural feminism and recommendations for nursing education are discussed in Chapter Five. As can be seen, each phase of the data analysis contributes to the unique nature of qualitative research and is essential in developing a thorough understanding of the phenomena of interest.

Verification Strategies

Presenting evidence of scientific rigor leads to a greater value of the research findings (Burns & Grove, 2007). In qualitative research, several approaches can be used to establish the trustworthiness of the study (Gillis & Jackson, 2002). The terms validity and reliability are most often used to establish the degree of trustworthiness of a qualitative study. However, traditional standards of quality have been refuted by some qualitative researchers because of the positivist language that is used to describe the verification processes (Gillis & Jackson, 2002). Lather (1993) further argues this point in an effort to reframe validity for postpositivist research. Lincoln (1995) acknowledges that criteria for interpretive research are emerging, and she suggests that commitments are made to: establishing a relationship with the participants, using inquiry to foster action, and promoting social justice, which includes diversity, community, and caring. Her criteria for judging interpretive research are primarily relational and emphasize the relationship between the knower and what is to be known. To this aim, I worked to establish a

good rapport with the participants during the interview, and I offered practical implications for education to encourage action based on the findings of this study.

From a more traditional stance on trustworthiness, Morse (1994) describes six criteria that should be used to evaluate all qualitative studies regardless of methodology: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. In order to establish the trustworthiness of this study, I utilized the criteria proposed by Lincoln and the criteria proposed by Morse, which will be discussed further.

Additionally, Creswell suggests eight strategies that can be used to confirm the accuracy and credibility, thus achieving the criteria proposed by Morse. These strategies are: triangulation, which is the use of multiple sources to arrive at conclusions regarding the data; member checking, which involves presenting the themes back to the participants and allowing them to determine their accuracy; discussing the findings with thick, rich descriptions; disclosing an honest self-reflection of researcher bias; presenting information that is contrary to the themes; spending enough time in the field to develop a deep understanding of the phenomenon of interest; having a peer reviewer ask questions regarding the research process; and lastly, the involvement of an external auditor who is unfamiliar with the research project. The six criteria proposed by Morse will be expanded upon in the following paragraphs and the strategies suggested by Creswell will be incorporated to illustrate how trustworthiness of the research findings was achieved.

First of all, credibility relates to the truth of the research findings, as well as the trustworthiness of the researcher. Qualitative researchers should not aim to develop an absolute truth, but rather to present the truth as perceived by the participants (Morse, 1994). Within a poststructural framework, credibility also involves a commitment to establishing a relationship

with the participants and respecting their sense of self. In order to demonstrate credibility, triangulation of the data sources, which included interview transcripts, participant documents, and a researcher journal, were used to develop a deeper understanding of the issues influencing their intentions to leave the nursing profession. In this study, triangulation not only involved multiple sources, but the multiple voices of the participants. Comparing participant responses and perspectives was done to look for consistency in the data and to reach a deeper understanding of findings that are not consistent (Patton, 2002). This also means that consensus of data may not be achieved because the participants may have vastly different perspectives. It was essential to explore each of the participant's voices and not to misinterpret a unified voice if one did not exist.

While data triangulation was used to demonstrate research credibility, I utilized other strategies to establish researcher credibility. To begin with, I solicited input from my dissertation chair to review the findings and to question me regarding all aspects of the research process. Towards my own credibility as a researcher embarking on this qualitative inquiry, I have been a registered nurse for over 14 years, a nurse educator for 5 years, and a doctoral student for 4 years. My past and present experiences as a staff nurse have provided me with an insider's view of the typical work environment in which patient care takes place, and my academic experiences have prepared me to conduct a research study. My experiences within the nursing profession have given me the opportunity to hear perspectives of nurses who are dissatisfied with their career choice, which is part of the reason that this research topic is of great interest to me. Researcher background and biases were disclosed honestly and openly earlier in this chapter, which speaks towards my own credibility, and the researcher journal provided me with further opportunities for reflexivity. Another strategy I used to establish credibility was peer debriefing

with another doctoral student and with an educator. Discussions with these peers assisted me in developing my themes and enabled me to share my findings as they emerged.

Secondly, confirmability refers to obtaining affirmations from the participants of the data that has been collected. Qualitative researchers must keep in mind that “the informants are the primary gatekeepers and the researcher is the secondary gatekeeper” (Morse, 1994, p. 108). To achieve confirmability, member checks were conducted to determine if the findings made sense to the participants. Member checks were conducted via e-mail and a summary of the findings using excerpts from interview transcripts was sent to each participant. Member checks were returned by three of the participants and they did not report that the findings inaccurately reflected their experiences.

Thirdly, the criteria of meaning-in-context, recurrent patterning, and saturation was achieved by providing thick, rich descriptions of the participants’ perspectives, as well as detailed descriptions of the research findings. Meaning-in-context is “the contextualization of ideas and experiences within a total situation, context, or environment” (Morse, 1994, p. 106). This concept refers to the idea that the experiences and interpretations of events and signs are contextually bound and have particular meaning to the participants. The criteria of recurrent patterning is the repetition of experiences, expressions, or events that demonstrate a recognizable pattern, and saturation occurs when new information is no longer surfacing indicating a comprehensive view of the phenomenon of interest. Saturation was achieved with the eleventh interview. Incorporating the voices and words of the participants in the findings demonstrates these three criteria, and the choices of passages were carefully selected so that an accurate picture of these perspectives is portrayed.

Fourthly, rich descriptions of the research process and the research findings also lead to the concept of transferability, which is the degree that the findings can be expanded to other similar settings or contexts (Morse, 1994). In addition to including dense descriptions of the findings, information regarding the work context and participant selection was provided because the findings could be valuable to other settings and the research design may be appropriate for other contexts.

In summary, as a result of using the interpretive criteria suggested by Lincoln (1995), the qualitative criteria proposed by Morse (1994), and the strategies suggested by Creswell (2003), trustworthiness of this research study was established, thus demonstrating scientific rigor. Researchers must approach all phases of the research process with great integrity and a high regard for ethical conduct, which is also an essential tenet of quality interpretive research (Lincoln, 1995).

Chapter Summary

This chapter has delineated the methods that were used to study the perceptions of registered nurses who have serious intentions to leave the profession of nursing. The rationale for a qualitative paradigm and a basic interpretive research design has been provided along with detailed descriptions of the purposeful selection of research participants, methods of data collection and data analysis procedures. A discussion of the verification strategies that were used to establish trustworthiness was also included, as well as compliance with ethical and legal research practices.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

This chapter will present the findings of this study on female registered nurses who have serious intentions to leave the nursing profession. The purpose of this study is to explore their perceptions of the factors that have influenced their decision, with particular attention to the influence of gender.

The specific research questions guiding the study are:

1. What factors have influenced a female registered nurse's intentions to leave the profession?
2. How do female registered nurses who have intentions to leave the profession perceive their practice in a female dominated profession?
3. How do female registered nurses who have intentions to leave the profession perceive the influence of gender on their practice and/or their decision to leave?

This chapter will begin with an introduction to each of the study participants. The participant introductions, which are summarized in Table 1 on page 114, will be followed by a discussion of the findings of the study. Several themes emerged from the participant interviews, and these themes were analyzed from a poststructural feminist lens.

Introduction of the Participants

Semi-structured in depth interviews were conducted with 11 female registered nurses who all had self-identified serious intentions to leave the nursing profession. All of the participants had at least 3 years of nursing experience, and the years of experience ranged from 3 to 33 years. Participants ranged in age from 29 to 59 years and they had varying levels of initial education in nursing: 4 participants attended a diploma program. Three participants attended an

associate degree program, and four participants attended a baccalaureate degree program. One participant had a master's degree in nursing and one participant had a master's degree in education. Two participants had a baccalaureate degree outside of nursing, one participant had an associate degree outside of nursing, and one participant was currently pursuing a baccalaureate degree outside of nursing. Nine of the participants identified themselves as white and two participants identified themselves as black. Eight of the participants currently work in positions where their primary role is to provide patient care and one participant left her position in patient care between recruitment and the interview. Two of the participants work in positions within patient care, but they do not provide direct patient care on a daily basis; one works as a nurse manager and one works in providing patient and employee education. Pseudonyms were used to protect participant confidentiality and all but one participant chose their own pseudonym. The names of the organizations where the participants work will not be specified.

Genevieve

Genevieve is a 29 year old white woman. She has a baccalaureate degree and has worked as a registered nurse for 6 years in an emergency department in a small, suburban community hospital. She is recently separated from her husband and has an 8 year old stepson. She has considered leaving nursing for 3 years and plans to leave within two years to expand her home based beauty business. Genevieve brought her home business binder to the interview and shared with me some examples of training seminars and compensation examples. She was very excited about her future opportunities and felt that her work in her home business has given her self-esteem and confidence that she did not previously have. She also felt that she was able to spend more time helping people in her home business than she could as a nurse. Genevieve chose her pseudonym based on a family name.

Table I-Participant Information

Participant's Name	Age	Race	Years in Nursing	Education	Current work setting	Career Plans
Genevieve	29	White	6	Baccalaureate in nursing	Emergency Department	Expanding home based beauty business
Betsy	59	White	29	LPN, Baccalaureate in nursing	Orthopedic unit	Position in healthcare outside of nursing or administrative assistant
Millie	42	Black	14	Baccalaureate in nursing, post-master's in education	Maternity unit	Teacher
Rose	38	White	15	Associate in nursing, Associate in business	Cardiac unit	Real estate
Flash	55	White	33	Diploma in nursing	Home care	Position in healthcare outside of nursing
Ebony/Ivory	30's	Black	3	Associate in nursing, Baccalaureate degree	Medical surgical unit	Teaching or language interpretation
Deedee	49	White	27	Baccalaureate in nursing, Master's in nursing	Neonatal intensive care	Pet-sitting business or teaching management
Mary	57	White	36	Diploma in nursing	Pediatric home care	Secretarial work or healthcare administration
Nanny	54	White	29	Bachelor of arts, diploma in nursing	Patient and employee education	Episcopalian priest
Jewelrlyady	32	White	6	Associate in nursing	Home care (recently resigned)	Expanding Home based jewelry business
Moon	54	White	31	Bachelor's degree, diploma in nursing	Home care	writer

Betsy

Betsy is a 59 year old white woman who has been a nurse for 29 years. She initially worked as a licensed practical nurse before obtaining a baccalaureate degree. She has experience in orthopedics, dialysis and medical-surgical nursing. She currently works on an orthopedics unit in a small community hospital and describes her typical day as “overwhelming”. She is married to her second husband and has three children who are 39, 37, and 33 from her first marriage. Betsy has been trying to leave nursing for the past 4 years and has gone on approximately 15 interviews. She has searched for non-clinical positions in healthcare such as medical coding, case management, diabetes education, and patient registration. She has found that she is either over or under-qualified for other jobs, which has been very discouraging to her since she had always believed that holding a baccalaureate degree would give her more job opportunities. She plans to continue looking for job opportunities, but if she is unable to find anything, she plans to retire from her nursing position at the age of 62 and then pursue some other career paths, possibly in an office setting.

Millie

Millie is a 42 year old African American woman who has been a nurse for 14 years. She has experiences in rehabilitation, pediatrics, maternity, and cardiac telemetry. She currently works on a maternity unit at a large urban hospital in central Pennsylvania and describes her typical day as “unbelievable”. She is married and has three sons, ages 10, 13, and 15. She has considered leaving nursing for three years, and her family has been supportive of her decision. Millie had a significant event that solidified her decision to leave. She was scheduled to volunteer in her son’s classroom when she received a call from work offering her an additional money per hour to come in to work. She turned down the opportunity to go to work and after

she reflected on the situation, she realized her passion was in teaching. She recently completed a post-baccalaureate program in education and is searching for a job as an elementary school teacher. She did work as a permanent substitute for 10 weeks a few months ago and she loved it.

Rose

Rose is a 38 year old white woman who has been a nurse for 15 years. She has an associate degree in nursing and she also has an associate degree in business. Even though she has been a nurse for 15 years, she has only worked as a nurse for 8 of those years. Her work experiences have been in cardiology. She currently works on a telemetry unit at a large urban hospital in central Pennsylvania; she has worked at her current position for 1 ½ years. She is divorced and has two daughters, ages 10 and 18. Rose was forced to take time off from working in nursing as a result of a cervical spine injury that she sustained at work. During the period of time that she was unable to work, she entered the real estate business in new home sales. She fell in love with her career in new home sales, and she was very successful in the business. However, she decided to re-enter nursing two years ago, because she was working 60 hours a week. She made this decision to spend more time with her children and to concentrate on saving her marriage. Even though she ended up getting a divorce, she has decided to remain in nursing at this time, because it provides her with a steady income and regular hours, which she would not be guaranteed in the real estate business, particularly given current economic conditions.

Flash

Flash is a 55 year old white woman who has been a nurse for 33 years. She has work experiences in intensive care, cardiac rehab, home health, open heart surgery, nursing home, emergency room, and orthopedic rehab. She currently works as a home health nurse for a large healthcare organization in central Pennsylvania. She has worked in the field of home health for

the past 18 years and describes her typical day as “hectic”. She has a diploma in nursing and has some college credits. She is currently married to her second husband and has one son, age 25, from a previous marriage. She has been actively looking to leave nursing for the past five years and she has had some interviews over the past two years. However, she has been unable to find anything that has a similar level of compensation in anything she would be interested in such as sewing or gardening. She was offered a position at a medical insurance company, but the compensation and benefits were also not comparable. Flash recently moved to a different home care division with her employee because of difficulties with her nurse manager and to pursue a newly created job opportunity. Flash chose her pseudonym because she wished she had a superpower to get from place to place very quickly in her home care position.

EbonyIvory

EbonyIvory is an African American nurse in her 30’s. She has been a nurse for 3 years and has worked on a medical surgical unit in a moderate-sized urban hospital in western Pennsylvania since graduating from nursing school. She entered nursing with an associate degree and then obtained a baccalaureate degree. She is single and has one son who is 13. She describes her typical day at work as “hectic”. She has seriously been considering leaving nursing for the past year, and she has been carefully searching for other options. She is considering entering either teaching or language interpretation and she is currently taking college courses. She had been told that she would do well in language interpretation because she is very expressive. She chose her pseudonym because her nickname is “Ebony” and one of her co-workers is nicknamed “Ivory”. The day before the interview they were working together and she took care of a patient who had twin daughters with the same names.

Deedee

Deedee is a 49 year old white woman who has worked as a nurse for 27 years. She entered nursing with a baccalaureate degree and obtained a master's degree in nursing as a clinical nurse specialist. She has experience in medical-surgical nursing and in maternal-child nursing. She currently works as a nurse manager in a neonatal intensive care unit (NICU). Deedee started working with infants when she had the opportunity to work in a newborn nursery in Japan several years ago. Since then, she had worked in several neonatal intensive care units in central Pennsylvania and Maryland. She is currently married to her second husband and they are planning to move to the southwestern United States in the next month. She has considered leaving nursing for two years. She was seriously ill approximately one year ago and was diagnosed with a genetic pulmonary disorder, which has prompted her desire to move to a different climate. She would like to make a career change with her move and is considering starting a pet-sitting business or teaching college management courses. She describes her typical day at work as "frazzled." She chose her pseudonym because it is the name of one of her pets.

Mary

Mary is a 57 year old white woman who has been a nurse for 36 years. She is married and has two sons, ages 28 and 31. She has worked in pediatrics, geriatrics, medical-surgical nursing, and home health. She has a diploma in nursing and she did take some college courses towards a baccalaureate degree, but found it difficult to work full-time, attend classes, and raise a family. She was also frustrated because at the time, she did not receive credit for most of the coursework she had taken in her diploma program and would have had to take many similar classes again. Mary has wanted to leave nursing for the past 20 years. She did work as a director of a nursing home and hoped that if she had been able to further her education, she could

have worked in healthcare administration. She did consider entering teaching, but she expressed the difficulty she has had in making a career change due to living rurally, not having many computer skills, and needing a certain level of compensation. She has been working for an agency specializing in private duty pediatrics for the past 6 months. While it is a job that requires a nurse, she admits that it does not make the most of her nursing skills and is a position that could probably be done without a nursing education. Her most recent experience in nursing was in home health and she described her typical day there as “frustrating”.

Nanny

Nanny is a 54 year old white woman who has been a nurse for 29 years. She has a diploma in nursing and a liberal arts baccalaureate degree in comparative religion. She has work experiences in home care, rehabilitation, nursing homes, employee health, and infection control. She currently has a position in patient and employee education at a small, suburban community hospital in central Pennsylvania. Nanny became a single mother ten years ago and she has three sons, ages 19, 21, and 23. She describes her typical day as “scattered”. She has considered leaving nursing for five years. Nanny made the decision to make a career change after she had a conversation with her sons a few years ago about finding happiness and following their passion. Her middle son asked “Mom, when are you going to do that?” She discussed this moment as a turning point for her and decided to follow her passion, which she states is in the Episcopalian Church. Nanny aspires to become an Episcopalian priest and she is currently working on her application for seminary, which she hopes to enter next year. She has always wanted to enter the priesthood, but it was considered an unacceptable career choice for women when she was younger. She chose her pseudonym based on a family name.

Jewelrylady

Jewelrylady is a 32 year old white woman who has been a nurse for 6 years. She has an associate degree in nursing. She has experience working on a cardiac telemetry unit and in homecare. She is currently married and has 2 children, ages 4 and 10. Approximately one year ago, she became a consultant for a home jewelry sales company. At this point, she was working full-time as a home care nurse. She enjoyed her nursing position and found it to be “gratifying”. However, when she inquired about decreasing her hours to part-time to pursue her new business and for child-care conflicts, she was told that she would no longer have a job if she couldn’t work full-time. She then began working for a home care agency and between participant recruitment and the research interview, Jewelrylady made the decision to leave the home care agency due to issues involving patient safety and care that conflicted with her personal beliefs. She chose her pseudonym because she is now selling jewelry as her primary job.

Moon

Moon is a 54 year old white woman who has been a nurse for 31 years. She has a diploma in nursing and also has a baccalaureate degree outside of nursing. She initially dropped out of nursing and then returned to finish her degree after working as a nursing assistant for 3 years. Moon is a single mother of three children who are currently ages 21, 23, and 29. She has experience in medical surgical, spinal cord rehabilitation, NICU, and home health nursing. She currently works for a home care agency on a limited basis. She recently made the decision to not return to her full-time nursing position in a neonatal intensive care unit after an extended medical leave. She sustained a severe shoulder injury at her place of employment several months ago. As she prepared to return to her job, she realized that her time off gave her some new perspectives on life and she is now pursuing a career as a writer. She is also considering

working with special needs children. Moon was very introspective during the interview and she revealed that she was nervous to meet with me because of the realization that she was really going to leave nursing, which she had not considered before her injury. She brought a book entitled *The 55 Concepts: A Guide to Conscious Living* to the interview, and after the interview, she shared some poetry that she had written at a recent writing retreat, as well as the first chapter from a novel she has been writing. Moon was the only participant not to choose her own pseudonym and I chose her pseudonym based on a story she shared during the interview where she was part of a group of women who met during a solstice to give away something they were ready to get rid of in their lives.

Themes of Findings

Poststructural feminism resists notions of categorization, but in an effort to organize the findings, categories were created in order to analyze the data. Additionally, the participants discussed various reasons for wanting to leave nursing and had individual plans. Despite these individual differences, they reported many similarities in their work experiences as registered nurses. It is important to note that on another day or another point in the decision making process, the results of this study could have been different. In an effort to explore gender, participants were asked if they felt their experiences in nursing had been influenced by the fact that nursing is a predominantly female profession. Other interview questions focused on the factors that were influencing their decision to leave nursing and their future plans. While I was interested in hearing how they perceived the influence of gender in their work as nurses, I was most interested in analyzing the multiple ways that gender, as a social structure, influences individual decision-making regarding career choices and work experiences. Thus, the theoretical

framework of poststructural feminist served as more of a guide for data collection, and it served as a lens for data analysis.

All participants believed that their experiences in the workplace were influenced in some way by the fact that nursing is a female-dominated profession. None of the participants felt that they would change their mind about their decision to leave. Despite their intentions to leave the profession, most of the participants verbalized that they loved being a nurse and did not regret their decision to become nurses. Even though they had varying levels of educational preparation, all of the participants felt adequately prepared to work as nurses. Five major themes were discussed by the participants: feelings of duty and obligation, the power dynamics of the hierarchy, a growing incongruity between working conditions and patient care, interpersonal communication, and shifting perspectives on work and self. Because an aim of poststructural feminism is to look for not only what is present, but also what is absent, and to make the researcher present in the discussion, each finding will be followed by a brief researcher reflection. Table II on page 123 includes a data display of the major themes and subthemes of the study.

Feelings of Duty and Obligation

The first theme of feeling of duty and obligation relates to the desire to care for others and/or feelings of needing to meet the expectations of others. These perceptions of duty and obligation influenced the participants' intentions to leave the nursing profession in several ways. Their decision to enter the field of nursing was often based on a need to fulfill internal or external needs. Making efforts to fulfill obligations was a source of conflict at times for some of the participants and also impacted their decision making process about leaving the nursing

Table II-Data Display

Themes	Subthemes
Feelings of duty and obligation	<ul style="list-style-type: none"> ● In relation to family ● In relation to others
The power distribution in the hierarchy	<ul style="list-style-type: none"> ● Positionality in the hierarchy ● Lack of Compensation (The Catch 22) ● Lack of opportunities (Feeling stuck) ● Inaccessibility to power structures
Growing incongruity between working conditions and patient care	<ul style="list-style-type: none"> ● Workload ● Physical environment ● Technology
Interpersonal communication	<ul style="list-style-type: none"> ● Communication between nurses ● Approach to Diversity
Shifting perspectives on work and self	<ul style="list-style-type: none"> ● Separating work from self ● Finding Passion ● Concerns about the economic reality of leaving

profession. The participants did not acknowledge that these obligations had been driving forces behind their decision to leave; however, analysis of the data revealed that many of the decisions that had influenced their decisions in respect to their career in nursing surrounded these feelings. This theme will be discussed in relation to family obligations and duties and then in relation to others.

In relation to family. The influence of family on work as a nurse was revealed in different ways. For many of the participants, the choice to enter nursing was influenced by family members, and they had a desire to meet expectations to become a nurse. Millie said,

I always was told I was going to be a nurse. My mother told me that just as a little girl, that, you know, I was so caring, and I had such a compassion for little kids. So she thought, um, she-well, and I thought. But she just always said to me, ‘You’re going to

make a great nurse.’ And so it was always in my mind that that’s what I was going to do.

And that’s what I was going to be in life, was a nurse.

Nanny’s entry into nursing was influenced by both her mother and her father. She took science classes in high school to please her father, who was a scientist. However, she felt her aptitude was for the arts and philosophy, so she pursued those interests in college. After graduation, she found that she was not able to find suitable employment with her college degree. After spending time trying to “muddle” her “way through the world”, her mother told her to become a nurse.

Nanny said, “so I listened to my mother.... it suited me because I have a lot of background in science and a lot of compassion and a huge need to take care of people.” For many years, Nanny worked part-time in nursing and had the ability to choose her schedule to meet the needs of her family. She enjoyed the flexibility of her schedule and it allowed her to spend time with her children. When Nanny became a single mother after several years of marriage, her work schedule changed drastically. She stated,

I had to start working full-time. I had 3 teen and preteen kids that I had full responsibility for. He didn’t take any responsibility for them. I needed to find a day shift job because evenings weren’t working very well. I still have memories of phone calls about them at 9 pm.

In order to fulfill the financial obligations of her family, she took a different job within nursing. For Nanny, the choice to enter nursing was influenced by her parents and her career choices within nursing were driven by her need to support her own family.

Betsy and Mary both shared that their mothers wanted to be nurses, but couldn’t, so they felt that their mothers encouraged them to pursue nursing. Betsy further reflected on how this fact may be influencing her decision to leave by stating, “My mom always wanted to be a nurse.

Maybe I thought I wanted to be a nurse all the time because it was my mom telling me I wanted to be a nurse.” Betsy also had the realization during the interview that maybe one of the reasons she wants to leave nursing is to be able to spend more time on weekends and holidays with her second husband.

Deedee was the only participant who had a mother who was a nurse and she was influenced differently by this fact. According to a career survey, Deedee was well suited to work with people and from her mother’s example, she thought that nursing would be a good choice. However, she revealed that her mother didn’t want her to become a nurse, because she thought that women were limited to teaching and nursing for careers and she wanted “more” for Deedee. Her mother encouraged her to work in a nursing home in the hopes of discouraging her, but Deedee loved her experiences working there and caring for others.

Flash’s entry into nursing was influenced in a different way by her family. Her feelings of duty to become a nurse manifested from her experiences as a caretaker for her father who was a double amputee and an alcoholic. She stated the “caretaker thing came naturally.” Flash did not believe that she had the ability or the resources to become a nurse, but she had a supportive guidance counselor who encouraged her. For Flash, nursing offered a way out of a difficult childhood.

Besides feeling influenced to enter the field of nursing by their families, some of the participants entered nursing in order to be able to economically provide for their families. Rose was pursuing a degree in business when she became a single mother. She entered nursing school when she realized there were more job opportunities. She said, “I went to look at the want ads and I noticed all of these ads for nursing. And it was like something clicked, ‘what am I going after?’ I might not be able to guarantee income for me and my child.” This realization

caused her to “switch gears” in order to fulfill obligations to her daughter. Rose was the only participant who had previously left nursing for another career. She worked for several years in real estate before she returned to nursing less than two years ago. She came back to nursing in an effort to have a more regular schedule because her marriage was failing, and she also wanted to spend more time with her children. Unfortunately, her marriage ended in divorce, but she was thankful she had the opportunity to spend more time with her daughters and felt that her decision to leave real estate was a good decision for them as well.

Similar to Rose, Jewelrylady was also a single mother when she was in nursing school. Even though she previously wanted to be a nurse, she too knew that her career choice was “a means to an end” because she would be able to provide for her daughter. Jewelrylady’s work perspectives were further influenced by her duty to her family when she started to feel that her work as a nurse was negatively impacting her family life. She felt obligated to work around her husband’s schedule and strongly conveyed that family needed to come first; she needed to put her philosophies of raising her children before her work. Before she made the decision to leave nursing, Jewelrylady changed positions within nursing for different work hours, because she felt like she was missing too many things with her children. However, her new job was during the day and she had to send her 3 year old son to a daycare. Even though she shared that the daycare center provided very good care, her son did not respond well to the change and she shared that “it nearly killed him and it killed me to drop him off every day.” She then took a job at a different home health agency to work less hours, but due to ethical conflicts, she left that position between recruitment and the interview. Jewelrylady’s feelings of obligation to her family influenced her entry into nursing and they subsequently play a role in influencing her decision to leave the profession.

Like Nanny, Moon became a single mother after she was a nurse. At one point, she was working at 3 different hospitals to meet the financial needs of her family. Moon shared that she believes the work family balance is “impossible”, because of all the obligations that need to be fulfilled. In respect to trying to maintain a balance between the two, she said,

You feel like an octopus; you’re never really doing anything. You’re too tired because you were up with your kid all night. You’re too tired to be up with your kid all night because you had 3 admissions [new patients] at the end of your shift.

Fulfilling family obligations was important to Moon but she also verbalized that she placed a high value on her work.

Mary changed jobs and work schedules several times over the years to meet family needs. As a working mother, she found it difficult to meet her husband’s expectations for housework. She said that he grew up in an “immaculate” household and socioculturally, it was expected that she take responsibility for the majority of the household tasks and child-rearing. She felt that gender did influence this perception and while she felt that more men today help out at home, she went on to say that for many, “the brunt of childcare is on women.” Additionally, Mary discussed her decision to not leave nursing earlier because of her familial obligations. She felt that she was not able to acquire additional education or pursue another career path because she didn’t want “to take away from my family any more than I did already. I guess it wouldn’t have hurt for a few years, but I just didn’t do it.” She said that initially, she did not have the money to go back to school when her children were younger and as they got older, she felt obligated to provide them with a college education rather than herself. Mary also verbalized that work options were limited for women at the time when she was choosing a career, which was also echoed by Moon and Flash. The need to meet obligations and duties towards their families

was an influence on career decisions for these participants and these feelings permeated into aspects of their work lives.

In relation to others. For the participants, this sense of obligation and duty extended beyond family and into their work as nurses. The participants expressed overwhelming desires of wanting to take care of others, which influenced their choice of nursing as a career. As stated by Mary “I just wanted to help people.” Moon’s impetus to enter nursing was “to save all the world.” The majority of the participants spoke of their feelings of duty towards others in relation to their patients. They often found it difficult in the workplace to meet patient needs, so they were unable to fulfill these personal feelings of obligation towards others.

Genevieve entered nursing after she realized she would be unable to perform euthanasia on animals as a veterinarian. However, she felt that she would be able to help individuals who were suffering. She was very clear that she not only wanted to care for patients, but she also wanted “to take care of their family.” Genevieve acknowledged that her desire to care for others was becoming a significant source of stress for her. She said,

Just the stress when you are there and not being able to leave it there. You can’t you worry about your patients, their family, and it’s just a very high stress job....I constantly worry about what has happened or when someone passes away or especially the young deaths....The mother of a 23 year old that just lost.. who just died after having a baby from a PE [pulmonary embolism] that another hospital blew off. Screaming that screech of a mother losing her child is just is just something you can’t get out of your head.

{Pause} So that’s the stuff that makes it hard to sleep at night.

Not only does Genevieve feel responsible towards her patients, but she also feels an obligation to nursing students to make sure they have good experiences when they are shadowing in her

department. She said that she frequently serves as a preceptor to students and that her co-workers know that she would never leave nursing without finishing the rotation with a student.

Similarly, Moon felt particularly tied to some of her patients in home health. One of the reasons that she is still working in nursing at this time is because of her commitment to a homecare patient she has been seeing for 11 years. She also talked about how she stayed with an 11 year old who was watching 7 younger children because his grandmother had to go to the welfare office. She understood that the woman did not have a car and could not afford to take a cab. She knew the child was scared, so she stayed and helped take care of all of the children instead of leaving them alone. Moon also spoke about the deep connections she had with her hospice patients and she often felt compelled to attend their funerals. However, she said she realized this feeling of duty was becoming problematic when she was on friendly terms with the funeral director where she lived, which lead her to change positions within nursing.

Mary felt that the sense of duty towards others that nurses possess is often exploited in the workplace. She said that because women are compassionate, organizations are able to push them into doing more because they know nurses “are not going to let the patients go” and will continue to work hard to care for people. Also related to the influence of gender, Jewelrylady perceives that male nurses focus more on the intellectual aspects of care rather than the emotional and psychological aspects. She says she feels obligated to provide nurturing to her patients and that she feels conflicted when she is unable to provide this type of care, which happens very often. Betsy and Millie also shared that they feel their obligations to care for patients are often unmet in the clinical setting. Ebony/Ivory said, “The hardest part of my job.....taking care of my patients, like giving them the best care that I can give them, that I should give them, that’s the hardest part.” When a nurse’s duty towards their patients is not met,

they often feel guilty. Some of the participants felt guilty about not meeting their obligation to care, particularly when patients had poor outcomes. The inability to provide care they felt should be provided was influencing the decision to leave nursing for many of the participants. Ebony/Ivory shared after the interview that she felt conflicted about leaving nursing, because she knows that she is a good nurse and patients deserve to have the best care.

In addition to feeling a sense of duty towards patients, Nanny also shared that she feels obligated to serve as a guide for other nurses. About her current role in nursing, she said, "I feel like I am a coach to them [employees] and I am trying to empower them." Her desire to guide others is also one of the reasons Nanny would like to leave nursing for the Episcopalian priesthood, which she feels is not going to be easy as a middle-aged, white woman. She said:

People want somebody to love them who is real; want somebody to love them even though they're not perfect you know, and to me that's what God's message is all about. Every time you fall down, you have a chance to stand up and turn around. Every single time, there is no limit to that.

Additionally, Nanny shared a somewhat different perspective regarding nurses' feelings of duty to care for others. She believes that nurses are not good at establishing boundaries, which enables others to take advantage of them and that the duty nurses feel towards patients can have adverse consequences. She stated:

Nurses take on the responsibility of everybody in their environment and all of their behavior as if they could really influence it and they really believe that they can and they really can't. We can educate, we can empower, but often we disempower because we take on the responsibility.

Poststructural reflections. This finding incorporates data which are gender related, but not gender specific, particularly in respect to the concept of gender role socialization. The participants openly shared their reasons for entering nursing and I was particularly struck by the power of parental influences in their career choice, which was also an influence for me. Even though it was evident that many of the decisions they had made stemmed from their feelings of obligation and duty to others, there was very little negativity expressed towards meeting these duties. The women in this study felt compelled to care for their families even if that meant not pursuing their dreams at a certain point in their lives. In analyzing this data, I also realized that seven of the participants were single mothers at some point during in their careers. Being a single mother may limit career opportunities and prevent a woman from making a career change because she may not have the time or financial resources to pursue additional education.

In general, the participants felt compelled to “please” others and tried to conceal the difficulties they faced in the workplace from patients. It is significant to note that there were very few references to gender in discussing career choice or familial obligations. A few of the older participants acknowledged that career choices were limited for women. Otherwise, the discussion surrounding the influences related to career entry did not include any references between gender and nursing. Mary was the only participant to perceive that women are exploited in the workplace by organizations based on their caring nature. Through hearing the voices of the participants, I was able to see that being a woman did influence their career choices in ways that are often not consciously visible and the inability to fulfill obligations of caring was affecting their decision to leave.

The Power Distribution in the Hierarchy

The second theme of power distribution in the hierarchy concerns how power the participants' perceptions of power have influenced their intentions to leave the nursing profession as well as their perceptions of the work environment. The workplace was conceptualized as having a hierarchical structure. The participants perceived that they had a lack of power in the workplace and that power was distributed inequitably. Power within the workplace was sensed as omnipresent and was not something they perceived as having. The power distribution in the hierarchy affected their positionality, compensation, opportunities for advancement, and access to power structures. All of the participants had work experiences in healthcare organizations, which influenced their perspectives of the work environment and on their intentions to leave nursing. Gender was seen as an influence on the power structure in the hierarchy in various ways, which will be discussed within the subthemes.

Positionality in the hierarchy. Positionality in the hierarchy refers to an individual's position in relation to systems of power and privilege. The participants perceived that they were positioned at the bottom of the organizational hierarchy in the work environment, which Deedee described as "very political." She felt that some individuals unfairly received rewards based on their relationships with those in power, which affected positionality in the hierarchy. Participants felt that they were positioned below insurance companies, administrators, physicians, nurse managers, and patients. There was a strong sense that organizations cared more about money and productivity than they did about employees. Because of being positioned low on the hierarchy, they felt tremendous pressure from above. As stated by Mary, "I can see everybody being pushed from the top down." In addition to feeling this weight from above, there was also a sense that every action is always being monitored. Betsy said, "They're always

on the backside of your computer looking to see, how well you do things. Of course, it's on your evaluation too. You must do everything perfectly in an imperfect world" and Ebony/Ivory said, "You're under such a microscope of trying to get everything done, and I think that we lose out and our patients lose out, because it's not fair." The presence of power was continually felt and was not seen as being relinquished often. Jewelrylady stated, "It gets taxing after awhile to have to answer to a higher power that is really not for the good of the patient or for us." There was a sense that organizations gave confusing messages regarding the work of nurses. In a cynical tone, Rose stated, "They want nurses to be more autonomous, more independent but then they run after us and tell us what to do." The participants felt they often received contradictory messages about their job role from their organization which made it difficult to focus on patient care.

Being positioned low on the hierarchy instilled a fear of repercussions and fear for job security among the participants. The current job market for nurses is not as open as it was a few years ago and some of the participants acknowledged that the current attitude amongst employers was "If you don't like it, you can work somewhere else, but good luck getting a job." They often felt forced to comply with organizational rules and regulations because they were worried about keep their job. As stated by Flash, "I can't afford to piss them off and not have a job." Additionally, Mary shared that she feels nurses are being viewed as "a dime a dozen" and are given the impression they can easily be replaced in the workplace.

Insurance companies. Some of the participants verbalized negative feelings about how the domination of the hierarchical structure of the health care system adversely affects the point of care and contributes to the position of nurses within this structure. Mary, Flash, and Nanny all verbalized that insurance companies push the reimbursements in the clinical setting, which

places them at the top of the hierarchy, and Moon discussed the fact that they are the driving force behind patients being pushed out of the hospital before they are ready to be discharged. Flash shared her experiences as a home health nurse trying to meet the regulatory requirements that drive reimbursements. She stated,

I think the worst part in home health is that it is regulated so much. For years, we were behind closed doors like the red-headed step child, and about 8 years ago, all of the sudden somebody said ‘Home health is out there. Are we regulating them?’ And they began all this new stuff with regulation called OASIS (Outcome generated, meeting your goals) and you have to do all this and you have to learn how to answer the questions. It’s incredibly time intensive, and we have stupid things, like if we have a home health aide in a patient’s home, you can’t charge Medicare to do the supervision unless you have a skilled need to go. Yet you have to supervise the home health aide every 14 days. You certify patients for 60 days, and you have to then re-certify them and you have to absolutely re-certify them within a 5 day window. And that 5 day window doesn’t matter if it’s a weekend or a holiday. You have to re-certify within that 5 day window or you’re out of compliance. It is incredible. And if you don’t have a skilled reason to visit the patient, you can’t charge for it. So you eat yet another visit. So it’s very, very much regulated.

Flash went on to say that nurses must be diligent when admitting patients, because if the patient fails to show improvement, insurance reimbursements are not received, which does not only affect the organization, but it also may prevent patients from receiving beneficial care.

Administration. The participants felt that administration did not have an accurate picture of the reality of patient care or provide support for their roles, which caused feelings of

frustration. Nanny said, “Sometimes I wish there was a little more from upstairs who really took ownership of what I do to support that. But I just don’t think they understand the importance of that.” Moon stated, “You just get so tired giving in, giving in, and then the feeling of the inequity of what they’re all worried about up there and what’s actually going on down here.” Moon further elaborated on how she views attempts by the organization to make nurses feel valued. She shared:

It’s all over everything right now. It’s the mentality of the whole country, like ‘the people down here’...or even if they have like a little ‘let’s throw peanuts to the monkeys.’ They have some little special day in the cafeteria, and they would try and then give us some dumb little thing that said [name of workplace] and you’re like ‘How much did that cost?’ Somebody is missing something somewhere. It’s like shut up and be good and here’s your little thing.

Jewelrlylady stated, “And I do feel like there is definitely a hierarchy.” She went on to say that she believes that society does not always view nurses as intelligent beings and still gives more respect to physicians, which maintains the position of nursing below medicine on the hierarchy.

Physicians. In general, the participants felt that physicians were placed over nurses in the workplace hierarchy and some participants discussed how physicians exerted power over them. Several of the participants verbalized that they had been demeaned by physicians.

Jewelrlylady stated, “I think everybody has been demeaned by a doctor at some point in time.”

Rose, who had left nursing for a period of time, found that she was respected more earlier in her career by physicians. When she returned to nursing in a different geographic location, she was surprised at the lack of respect she was given by physicians, which has impacted her decision to leave. In regards to her previous experience, she said,

You were held to the fact that you worked hard and you had a knowledge base and sure you might not be as educated, but you certainly weren't demeaned the way that I find I am up here and that's probably one of the bigger reasons I don't want to stay where I am. I don't want to be demeaned and disrespected and I am constantly by these physicians up here.

Rose further shared that she feels it is inappropriate "for physicians to attack a nurse" because they don't know an answer to something that is either outside of their scope of practice or related to an event that occurred when they were not present, which "happens all the time."

Ebony/Ivory also mentioned that physicians make nurses feel responsible for events that happened when they were not present and she said, "you just have to handle it." Even though Ebony/Ivory did acknowledge that this behavior occurs, she overall described her interactions with physicians as positive. Nanny and Jewelrlady both shared positive encounters with physicians outside of the workplace; Deedee and Moon both verbalized that relationships between physicians and nurses in NICUs are generally positive because of the nature of the work environment. On the other hand, Flash felt that many of her interactions with physicians had been negative over the years. She stated:

The doctors still treat you like dirt after all these year. After 33 years, you would think we would have made an 'in road' in the way doctors treat nurses. Have we? No. We're held to the standard and we're not allowed to say. And these doctors can call you a stupid ass and not get into any trouble.

Furthermore, Flash discussed that she recently overheard a physician say, "Tell that nurse, she's going to do it my way and not hers" in reference to a dressing on a wound. Because she knew that the physician was not a wound specialist, an area she had both education and experience, she

was particularly offended by the comment. Flash also shared that she has friends who have had similar experiences, particularly with surgeons. She went on to say “They make you feel bad, which in turn makes you afraid to call them. Which in turn affects patient care, and if you’re afraid to call somebody about something you really should, that’s a problem for the patient.”

Nanny offered insights into these types of physician behaviors. She has the opportunity to work with physicians through her job in education and she believes that physicians feel threatened when they’re not in a position of making decisions, which can be a catalyst for negative behaviors towards nurses. She described a new electronic system that can assist physicians in making patient diagnoses based on assessment data, which she feels is a valuable tool because initial diagnoses are often wrong, which can delay proper treatment. However, she shared that physicians are not embracing the system, because it takes away their decision making power. Nanny further elaborated on how the power dynamic of physicians affects patient care. She said:

I don’t know what their mindset is, why they don’t think...why they think everything they learned is all they need to know. I don’t know what that’s about and not all of them are like that, but many of the older ones are. And I see them perpetuating myths and poor diagnostics and you know poor patient care and I see them perpetuating that in the people that they teach. And that really concerns me.

Nanny does feel that younger physicians are more receptive to using diagnostic tools and are not as threatened as older physicians, which promotes a more collaborative relationship with nurses. However, she acknowledges that a power dynamic still exists between physicians and nurses.

Mary also felt that younger physicians are more collaborative in their approach with nurses, but she also shared that she had been yelled at by physicians in the past. Mary she does

not currently interact with physicians on a regular basis in her work in home health, but from her past experiences, she perceived that the low positionality of nursing influenced communication between physicians and nurses. She said, “Years ago, they treated us like handmaidens and you had to learn if something was wrong how to say it and let them think it was their idea.” Flash made a similar comment in respect to communicating patient needs to physicians.

Further exemplifying the power dynamic between physicians and nurses, Jewelrylady shared an instance of resident physicians asking her to show them how to do a basic clinical procedure. Even though it was a skill she knew how to do and was willing to teach them, she still felt like they were the ones in a position of power during the encounter. She also shared that she believes gender does influence interactions with physicians she has worked with who have primarily been male, but she does not feel like she is treated any better by female physicians, which she attributes to some of the physicians being from other countries. She said, “I think that a lot of the times, the cultural thing is, whether it be gender or not, nurses are below them, that’s how they’re looked at, like servants, like ‘you are here to serve me’ kind of thing.”

Like Jewelrylady, Rose attributed some of the negative behaviors towards nurses from physicians as being culturally influenced. She said, “I believe that the influx of different cultures is influencing that particular aspect of [Pause]...You’re not held in high esteem in middle eastern countries. It’s true that many physicians are coming out of middle eastern countries.” Rose went on to share her perceptions of physicians from European countries by stating that they “see nurses as lower than them because their education level is so much higher”. She also said:

We’re actually getting diminished from female residents from those countries, as well as male physicians from middle-eastern countries. So it’s an interesting thing that is going on. I think in American society men still have thatwomen aren’t good enough. But

society doesn't accept that from American men. We don't have to deal with it. But different cultures don't know how to take it when we speak out.

A few of the participants felt that male nurses were treated better by physicians than female nurses. Male nurses were also perceived as having a higher place on the hierarchy and were less likely to accept adverse working conditions. Flash said that male nurses "are not going to take that crap from doctors. If they do, well they'll just find something else to do."

Being women influenced how they were positioned in the hierarchy and there were also perceptions that having more men in nursing would elevate their positionality and improve the work environment. Flash said:

If there were more men in nursing, more men in management, things would be different.... you know men look at things more analytically, more from a time management perspective...I think with more men they would um manage things more differently because they think differently than women.

Direct managers. The term direct manager refers to an immediate supervisor in the workplace. Several of the participants disclosed issues they had with their direct managers, which were influencing their decision to leave. Some managers were described as exerting power over the participants without knowing all of the facts, and they were perceived as making decisions with few explanations or rationale. Flash described her new manager as someone "who just rolled right over" and made it very clear that she was in charge. In respect to her previous supervisor, Nanny said, "She is authoritarian and has ADD [attention deficit disorder] unbelievably and all of the sudden she decides we're doing this, everybody is doing this! And then 3 weeks, everybody's doing that." Moon found out from her co-workers that her manager wanted to take her staff nurse position while she was out on a medical leave. This partially

influenced her decision to not come back to her nursing position after her medical leave because she felt that work environment had become hostile.

In her previous nursing job in home health, Jewelrylady asked to cut back her hours to work part-time and was told by her manager that she would have to leave if she was no longer able to work full-time. Regarding this encounter, she stated, "I really felt, obviously felt like I was not appreciated at all. So it was hurtful to me to be put in that position." Nanny had a similar event happen in her previous nursing position. She was called into her director's office and was told that her job in Employee Health was now going to incorporate Infection Control. Her director told her that if she was not willing to do both, she would no longer have a job. While Nanny was not particularly upset at this decision, she did perceive that she was not included in the decision making process regarding her new job role.

Patients. In addition to feeling positioned low in respect to the organization, administration, and physicians, some of the participants also felt positioned below patients. The participants were adamant about their compassion and respect for their patients, so they found it particularly difficult when patients infringed upon this relationship. Betsy and Flash both talked about how patients and their families exert power over nurses. Betsy said:

Well I can say the patient has so many more rights than you do. Um [I] used to come in and they would listen to what you said, they would believe you and now any little thing they can argue against, they will. They come in all knowing and everything. Um they tell you what they're going to do and it's allowed. It doesn't matter what the rules in the hospital are around visitors. with all this MRSA [methicillin resistant staphylococcus aureus] and VRE [vancomycin resistant enterocci] going around you know why would you want to bring your newborn in to see grandma who had elective surgery, you know it just,

nothing makes sense and right away they cry to administration, you know they get to do whatever they want to do . You can't have order or try to run a place when they can do everything, anything they want to do. Like if you enforce the fact that you can't come in unless you're 12, the next guy won't. They'll say so and so left me do it. I know that's an age old problem, that's nothing new, but the supervisors and administrators don't back you up cause they're in a corner because that person is looking down their eyes.

Flash was particularly upset regarding one patient encounter, because she was reported for treating the patient rudely after she explained that home care nurses cannot make visits if a patient is able to leave their home independently. She said:

It's now become if the patient says something negative about you, it doesn't matter whether you've been doing the right thing, it's that the patient said something bad about you. Now it's customer service, customer service. It doesn't matter what you do, if someone complains about you, she looked like this, she was rude, she told me I can't be homebound and nobody else ever said that. And then I get in trouble. It's gotten that it's that crap instead of helping and these days it doesn't matter how many 'At a boys' you get the 'Aw shucks' are up at the top and the 'At a boys' don't take any of the 'Aw shucks' down. You have to watch every word you say and exactly how you say it and the look on your face.

Perceptions of the organizational structure and interactions with physicians, direct managers, and patients lead to the perception that nurses were positioned low on the organizational hierarchy, which affected other aspects of their access to power structures.

Lack of Compensation (The Catch 22). While none of the participants made direct complaints about their salaries as nurses, issues with compensation were a source of frustration.

Compensation includes more than salary; it also includes benefits and rewards in respect to work. Flash, Mary, and Jewelrylady, who all had experiences in home health care, verbalized that they were often unable to complete their charting during the time they were seeing patients. They also reported that they felt like they were penalized when they were unable to complete their work in the allotted hours. Jewelrylady said,

If you don't meet your requirements, they're actually not going to give you a raise, so you kind of want to brush it under the table so unfortunately you're doing extra work, but you don't want anyone to know because you want to get a raise....So it's kind of a catch
22.

Flash stated, "They tell you you're not allowed to work off the clock but it's impossible. If you have too much overtime, then you're counseled. Yet they tell you, you can't work off the clock, but yet they give you more work than you can do in an 8 hour day. So you're caught sort of between." Additionally, they shared that because many home-health nurses do not want to look inefficient and unable to do their job in the time frame set by the organization, they often complete documentation at home after their shift is over and do not report their time. Another issue concerning compensation that is unique to homecare is the use of one's personal vehicle for travel. Flash and Mary both felt that they were not adequately reimbursed for travel expenses. In fact, Mary verbalized that since she had left her job in home health for private duty, she was saving \$200 per month.

In a similar way, Nanny stated that she occasionally needs to come in on the weekends to complete her job, which is not a salary position and that she does not punch in for her time. Betsy verbalized that nurses in her organization are only permitted to clock in 7 minutes before a shift starts, which is not an adequate amount of time to prepare for a patient assignment. Many

of the nurses she works with come in much earlier so that they can be adequately prepared to care for their patients, which is time that is not compensated and often discouraged by employers. Along the same lines, Jewelrylady talked about the fact that nurses often do not get out of work on time despite having set work hours. While this time is financially compensated, it is an infringement on personal time, which does not have a monetary value.

Also in respect to compensation, Betsy has found it unacceptable that staff nurses at her organization are all paid at the same rate regardless of educational preparation. She said, “There’s a 2 year nurse, the 3 year diploma, then the 4 year. And really, none of them make a difference in your pay scale and that was the biggest disappointment.” When Betsy decided to return to school to become an RN, she decided to pursue her baccalaureate degree, which involved a greater investment of time and money. She went on to say, “It hasn’t really paid off because I am making the same amount of money that the person that went to [name of associate degree program] is making...It’s not made a difference and that’s not fair, It’s just not fair.” Betsy additionally discussed the fact that rewards are more plentiful in the corporate world where her sister works.

All of the participants spoke about a love for learning and opportunities for continuing education were discussed as job benefits. In their current organizations, the participants felt that these opportunities were few and far between. They expressed frustration at having to fulfill mandatory organizational education that is not always adequately compensated. It was expressed that in the past, nurses were given the opportunity to attend these educational programs during certain periods of time, which was usually incorporated into the work schedule. However, many of these required programs are now offered on-line, which does not provide adequate opportunities to learn or review skills.

Some of the participants liked the increased flexibility of these programs, but overall, the change in delivery method was viewed by the participants as being valuable to the organization, but not always effective as an educational methodology. Furthermore, most of the participants verbalized that they were unable to complete the computer modules during work time and often had to complete them at home. Betsy shares her perspective on this change, “It used to be you were sent to meetings. If you were off that day, you were paid for it and now they’ve just initiated the fact that everything is pretty much done on-line so that you don’t have to go in and they don’t have to pay you.” Ebony/Ivory also verbalized that she has to complete work related competencies and education on her own time. Rose said:

I think they’re like cramming too much...at our hospital, stuffing stuff down our throats and there’s been a lot of back and forth of your required training if you can do it at home and get paid. And...there’s something that just came out on our floor that the managers aren’t going to pay people to do it at home anymore and I don’t think they can do that under some of the laws.

Genevieve, who works every weekend, said she was often expected to come in for mandatory meetings during the week on her days off and she was frustrated that she did not receive her typical hourly wage for this time. She expressed that she loves to learn and is willing to meet her professional obligations, but her organization does not create enough incentives for nurses to attend additional educational trainings. She pointed out the fact that Pennsylvania now requires a certain amount of continuing education credits for licensure renewal and that there are often not continuing education credits rewarded for educational programs, which does not create incentive to attend. Betsy commented that even when educational opportunities are offered during the work day, there is no time to attend them.

In addition to not being compensated adequately for completing mandatory educational requirements, the participants discussed that many organizations are currently not paying nurses to attend additional educational programs such as conferences, which were viewed as job perks. Deedee shared her view of organizations limiting access to these types of programs. She said:

A lot of places you know they're cutting out conference pay and conference days and things for the nurses to feel better about themselves and they're stressed anyway and they have no release...they have nothing to look forward to at work like conferences or anything and then you wonder why they don't work well together and why they're in bad moods. I think that people look at the bottom line and they don't realize the bottom line is not always the best thing to look at.

Even when choosing to attend an educational program on one's own time, Mary and Betsy both stated that it is difficult to arrange the work schedule to have a certain day off.

In respect to gender, there was a sense amongst the participants that the perceived lack of compensation is related to nursing being a female profession. Mary, Moon, Flash, and Nanny, who had all been in nursing for over 25 years, acknowledged that there were not many career opportunities for women when they entered nursing, which has contributed to nursing being a female profession. As stated by Mary, "You could push women to do more than you can push men to do and you don't get compensated the same way that men do." Rose shared that she was compensated at a much higher rate in real estate, which she described as a more male dominated profession. She said that nursing is a "pink collar" profession. She went on to say that the term "pink collar" is associated with being paid less and being demeaned. Rose perceives nursing to be somewhat between a blue collar profession and a white collar profession, because there are varying levels of education and opportunities for nurses. She feels there is a dichotomy within

the profession because of these differences and that it is related to the fact that nursing is a female profession.

Lack of Opportunities (Feeling stuck). The power of the hierarchy also influenced the participant's perceptions of opportunities to advancement. There was a sense that there were few places for nurses to be promoted to and neither education nor experience seemed to count in seeking other positions within nursing or outside of nursing. Millie, Deedee, and Mary all used the phrase "feeling stuck" to describe the lack of mobility nurses often feel in the workplace.

Genevieve felt this lack of mobility was influencing her decision to leave nursing. In response to being asked about opportunities to advance in nursing, she expressed there are very few opportunities in nursing management where she works because people stay in those roles for many years. She feels advancement opportunities are limited and that that in her home based business, she could move up "without someone else having to die or retire or quit." She goes on to say, "I became a charge nurse after a year and I've been on every committee I can be on...I found I hit the ceiling after a year which is weird."

Betsy shared that she was told by her professors in a baccalaureate program that she would have more opportunities within nursing and she has not found that to be true, because she has not been able to get other jobs within nursing that she believed she was educationally and experientially qualified to perform. She said, "I'm actually angry that I can't get the job that I thought that I could having all this experience."

While Genevieve and Betsy felt that advancement opportunities were limited despite having baccalaureate degrees, Rose and Mary felt their opportunities were limited by not having a baccalaureate degree. Rose described opportunities for advancement as "few and far between" and "selective". She feels particularly limited because she only has an associate's degree.

Additionally, she discussed that the hospital where she works is no longer offering a forgivable loan for education, which she considered using for advancing her nursing education. Her oldest daughter is getting ready to enter college, so she does not have the financial resources for herself right now. She described her current lack of options for further education as “a dead end.” In comparison to the other participants, Deedee did feel that she had more career mobility than other nurses because of holding a master’s degree, and she also had experiences in management and education.

Mary shared her experience of applying for a position as the director of nursing at a nursing home, which was a job role she had previously held. During her interview, she said that she was able to answer all of the questions they had about the position and then they said, “Don’t you even have an associate degree?” This caused Mary to feel that none of her experiences in nursing were valuable and she went on to say,

I’ve been working 30 years. I can run a nursing home, a 200 bed nursing home, run a floor, know how to work with people, but I don’t even have an associate degree. That’s where it has put us down to. That’s all that counts.

Mary took a position at the facility where she interviewed as a staff nurse. The director of nursing position was given to someone with a master’s degree in nursing, who had no experience in such a role. She went on to say that the new director totally “ripped the department apart” and two-thirds of the staff left their jobs, because of dissatisfaction with the manager.

In addition to the participants feeling that opportunities for advancement and career mobility were lacking, there was also a sense that nurses are not recognized for the work that they do. For example, Deedee reviews nursing surveys as part of her role in nursing management. She acknowledges that nurses overall report that they do not feel valued. She

stated that “across the board” scores are consistently low on statements such as, “I receive recognition for what I do” and “I feel that people understand or recognize me for the hard work that I do.”

Genevieve acknowledged that she often does not feel rewarded for the work that she does as a nurse. Furthermore, she felt that being a woman influences receiving recognition and she shared that she had recently heard a motivational speaker at a presentation relating to her beauty business who said, “The last time a lot of women hear applause is at their high school or college graduation.” She found this message to be very powerful and decided that this statement is reflective of her experiences in nursing. Genevieve believes that women need to be recognized for accomplishments even if they seem minor to others. She feels that her other business gives her the opportunity to both give and receive rewards. The lack of rewards and acknowledgement in nursing is a factor that is influencing Genevieve to consider leaving nursing.

In respect to gender and advancement opportunities, the participants perceived that male nurses have more opportunities for advancement and that they are promoted more easily. Millie discussed her perceptions of two men who were in her nursing program. She said:

I remember when I was in nursing school, there were two men, two young men that were in nursing school along with us. I kind of think they got away with more. And what I mean by that, like, sometimes they didn't have their papers ready, or the, the professor wasn't on them as much as, you know, on the girls. And I just think it was just more, like, a double standard. And I was like, oh, this is kind of, like, not fair. But I see these guys working at the hospital now, and they're in, like, big management positions. They were goofballs when we were in school. You know, and I just think because they don't stay as nurses. They, they move on into something, you know, like managing the floor.

You know, like, so I do think that they get, they get a better, um, deal...than we do as nurses.

Similar to Millie, Ebony/Ivory stated that male nurses “are asked to do more things and are given more responsibility.” She also discussed the fact that she has never seen a manager confront a male nurse about a problem, which is not the case for her female-coworkers. Mary perceived that the influence of gender outside of the workplace was a factor influencing her opportunities for advancement. She discussed the fact that she has wanted to leave nursing for many years and feels that being a woman, specifically a wife and a mother, limited her educational opportunities. She said, “Men get freed up easier and are able to make those moves and get the education.” Overall, the participants perceived that career advancement was limited and the influence of gender was visible in their perceptions of job mobility within nursing and in their conversations concerning barriers to advancement.

Inaccessibility to Power Structures. Because the participants perceived that nurses are positioned low on the organizational hierarchy, they also expressed that their voices are often not heard or valued. This lack of voice was seen as contributing to a lack of access to power structures. They shared many examples of how this lack of voice made them feel powerless, and at times, frustrated and angry. Some of the participants were very discouraged when they made attempts to offer solutions to problems and were met with resistance from their direct managers. Betsy said:

I just think, nursing doesn't have a spokesperson anymore, they don't have unions... there's no, no one to really speak for us but the women that do the work....It's kind of like they are not taken seriously. They'll speak up to the nurse manager, but it gets filtered at that level what goes on to the rest it's what. It's at her discretion, what she wants to pass

on. I ran into that at dialysis too. There were things that weren't going to cost anybody any more money and I would wonder why so and so didn't get back to me and I found out it was the nurse manager who decided what would go on to the next level, to her boss, and what wouldn't.

Rose shared that one of her major frustrations at work is not receiving a verbal report from the emergency department when a patient is admitted to her unit. She gave an example of a solution that she proposed to her nurse manager regarding this issue. Regarding her proposal, she said, "I don't think it went anywhere." She went on to say that she would "love to see follow up" in some way when she offers a solution to a problem. She feels she did her job "as a pion" and would "like to know it went somewhere." The lack of response from their direct managers was viewed as silencing their voice and was a source of dissatisfaction.

Jewelrylady and Mary both had experiences with direct managers that influenced their decision to leave a previous job in nursing. For instance, Jewelrylady noticed that something had been done incorrectly during a home care visit that could potentially have negative consequences to the patient. She brought the incident "to the attention of management" because she felt that additional education needed to be provided so similar issues did not occur. However, she said "nothing was done." Due to this incident and a few other similar situations, Jewelrylady decided to leave the home care agency, because she felt she could no longer be a part of an organization that did not hear her voice or address issues related to patient safety. During the interview, Jewelrylady also shared that she feels nurses should be given more of an opportunity "to have a stronger voice in what patients need" and that "it gets taxing after awhile to have to answer to a higher power that is really not for the good of the patient or for us." She went on to say that this lack of voice eventually leads to burnout.

Mary's lack of voice with her manager concerned computerized documentation. She said that her manager called her and asked why her documentation was not in the computer on time. Mary was perplexed because she knew that she had completed her documentation. She said her manager further accused her of not having it completed and "was really ignorant" about it. Mary told her manager she would check and get back to her in five minutes. During this time, she said, "I went and wrote up my resignation." She also used this time to call the computer tech person who verified that Mary's documentation was in fact in the computer.

Flash took a new job because she was having difficulties working with her new nurse manager. She also was presented with an opportunity to take a position that involved direct patient care part of the time and education part of the time. After she took the position, she was never given the opportunity to do the education portion of her job. This event led her to become increasingly dissatisfied with her work and regarding this situation, she said, "I have no recourse. I have none. No recourse whatsoever, so I just do the job that is given to me. And search everyday for a new one." She went on to say that she went to the human resources department at her organization and they told her that there wasn't anything they could do and they could not get her another job. The only option they offered her was to confront her. Flash became very emotional during the interview about this situation and she also shared that many of her co-workers had also complained about the manager and "nothing was done." Flash went on to verbalize her feelings about not having a voice. In respect to her manager, she said:

If you say something that she doesn't like, then you're a complainer. If you talk to someone else about a problem, then you're a silo for discontent.....that's the mentality...I can't go to anybody. I just keep in my little shell.

Flash acknowledged not having anyone to listen to you “is very hard to reconcile” and she also said, “it makes it very hard to sleep at night knowing I just have to keep my mouth shut, but I have to keep my mouth shut to keep my job.”

Moon feels that the lack of voice in nursing is more of a problem now than it used to be. She describes herself as being from the ‘70s “where we were burning down buildings”. She thinks maybe that it is a different time and that there is a “passivity among the younger nurses.” Moon feels that some of her co-workers blindly follow everything they are told to do without asking questions, which was not her experience when she worked at a hospital that was unionized. She went on to say:

Hey guys, you have a voice here...It’s almost the loss of the voice and they pretend they care about the nurse and they don’t at all.... ‘why are you putting up with this, why aren’t you opening your mouth?’ The point is they don’t feel like they can.

Moon also stated that attempts to make nurses feel heard at her organization may be well-intentioned, but they are not successful. She gave an example of an educational program that she attended that focused on “owning your own process.” She became quickly disenchanted and spoke up during the presentation and said, “A nurse working at 3 am who has not peed or had a cup of coffee does not care about owning their process.” Even though she made an attempt to have her voice heard, she said, “They didn’t hear me. They didn’t hear anything I said.”

In response to a question on whether there was any one event that made her seriously consider leaving nursing, Ebony/Ivory initially answered that nothing came to mind. A few minutes later, she said that something had happened to her in the workplace that made her question whether she wanted to remain in nursing. She shared the following:

I was having a bad day and we had students, and somewhere along the line, someone made this claim that I attacked them. And I think that the way the whole situation played out, like no one said anything until the work day was over and then they made a phone call. They like called all these people and you know the directors and heads of everything, but nobody at the time had stopped and asked any questions or reported anything, said anything you know...I was just like attacked about everything in my nursing and I was like...really upset and just really you know angered and was like 'what me?'. I just felt like me as a nurse was attacked in this position where there was nothing I could do, um nothing I could say, and I was like 'this isn't nursing'...I come here every day and bust and do the best to take care of my patients. You know helping anybody do anything else for their patients. How can anything that I do for my job even be translated into an attack or a bad situation?... I just felt really vulnerable, and really like (sigh) maybe I don't want to be in nursing in that situation.

It was evident from talking to Ebony/Ivory that she still could not believe that this had happened to her and that no one stopped to ask her about the situation or what she might have said to a student that could have been perceived negatively. She was deeply hurt by this incident.

The participants shared many examples of feeling unsupported in the work environment, and they felt their voices were not heard when they attempted to address concerns, propose solutions, or verbalize their perspectives. In sum, the power structures present in the organizational hierarchy impacted many aspects of their work and consequently were influencing their decision to want to leave the nursing profession.

Poststructural reflections. The participants had a clear perception that organizations exerted power over nurses and they were very aware of the hierarchical structure. I found the

language they used to talk about their positionality as significant; the participants often used the generic term “they” to describe authority. They also used language to indicate “being below”. In considering the poststructuralist notion that the first word in a binary is considered favored and more powerful, I found it significant that if a reference was made to being “at the bottom”, a previous wording would reflect being at the top. Even though masculine pronouns were used to discuss physicians, only a few participants verbalized that gender differences between physicians and nurses may influence disrespectful and demeaning behaviors. Moving beyond gender, there was not much discussion relating to the differences in educational level between nurses and physicians.

The negative encounters with direct managers were an unexpected finding. The participants described incidents that were concerning and they perceived that very little could be done to combat these types of behaviors. Most of my personal experiences with managers have been positive. However, direct managers seem to be in difficult positions because they are trying to follow organizational rules and emulate the leadership style dictated by the organization while trying to manage employees who feel they lack access to power structures. Two participants did verbalize that the work environment can be affected by the politics of the organization, but there was not any discussion regarding the positionality of direct managers in respect to the organizational hierarchy. Direct managers were usually referred to with feminine pronouns or names and gender could be an influence on their positionality within the hierarchy.

In the conversations surrounding salary, I was surprised to note that they were overall satisfied with their pay. However, they did not always feel intrinsically or extrinsically rewarded for their work or knowledge, which affected their perception of their value within the organization.

Growing incongruity between working conditions and patient care

The participants discussed how various elements in the work environment were preventing them from being able to provide adequate nursing care to patients. Many of the participants felt that the role of the nurse had changed significantly over the years and that nurses could no longer do the role they were educated to perform. As stated by Betsy, “Nursing isn’t what it used to be.” This sentiment was echoed by Deedee, Mary, and Flash. The participants felt a tremendous pressure to meet all organizational standards, which they felt were incongruous with high quality patient care. Many of the participants verbalized that they did not feel nurses were able to spend enough time with patients, which was influencing their intention to leave the profession. They felt that they had entered nursing to perform a certain role and the inability to do this work was frustrating. The three factors that were discussed by the participants as having a negative impact on their ability to provide good patient care were: 1) workload, 2) the physical environment, and 3) the use of technology in the clinical setting.

Workload. There is not a standard definition of workload in respect to nursing, but it can encompass activities related to patient care, time required to complete these activities, tasks that are not directly related to patient care, and tasks that do not involve patient care (Morris, MacNeela, Scott, Treacy, & Hyde, 2007). All of the participants in this study spoke about their workloads as being unrealistic. High workloads often affected patient care, which the participants viewed as no longer being a priority for the organization. Millie described her workload as “unbelievable” and she went on to say that because of the number of patients she has to care for she often leaves feeling that many patients are “uncared for.” Betsy said nurses “have too many patients to actually get your job done and do it right” and she described the amount of work nurses have to do as “overwhelming.”

These same sentiments were both echoed by Genevieve and Flash who stated, “It’s an absolutely undoable thing that is asked almost on a daily basis.” Moon shared that staffing patterns have changed in the NICU where she worked and nurses now have to care for more patients than they have had to in recent years. Furthermore, she stated:

Initially we could still do what I was taught to do. When I was first a nurse, people stayed in the hospital 3 or 4 days for a hernia repair, gallbladder for a week. People came in the night before. It sounds cheesy, but you gave them backrubs and you did mouth care and you did these things, which is why I was a nurse. I wanted to give that care to patients.

Even though Nanny and Deedee do not spend a majority of their workday directly caring for patients, they also perceived their workloads as being high. As a manager, Deedee has 24 hour accountability for her unit and when talking about her typical day she said, “It’s just one thing after the next, after the next, and before you know it, it’s 3 o’clock and you haven’t even done anything that you needed to do.” Nanny stated that she “can barely keep up on a day to day basis.”

In addition to feeling like it was difficult to complete work in a given time frame, Ebony/Ivory discussed that she feels a constant demand to always be doing more. She said:

There’s a lot of expectations for what you’re supposed to do, what you should do. And it’s almost like impossible, and they don’t really tell you anything but get it done...you want me to do this, but I mean like how? How do I incorporate that with what I’m already doing?

Not only was workload negatively affected by the amount of patients the participants were expected to care for, but it also was affected by the acuity of the patients, which was perceived as

being irrelevant in making decisions regarding workload distribution. The care that patients require in today's healthcare environment is complex and as stated by Nanny, "Our ability to treat people has changed so much in the past 40 years." Millie, who works on a maternity unit where the patient population is typical thought of as "well" described many of her patients as not being healthy and "literally sick."

Patient assignments were described as being calculated based on numbers and ratios rather than on patient needs and complexity. For instance, Mary, Flash, and Jewelrylady all stated that they were required to see 5 patients per day in home-health regardless of the fact that a new patient or a complicated wound dressing could take several hours. Because of this emphasis on number of patients rather than acuity, a nurse may not be assigned the same patients, which these participants found to be not only personally dissatisfying, but as potentially detrimental to patients due to a lack of continuity in their care. This disregard for patient acuity was also discussed by the participants who worked in hospital settings.

Mary discussed the fact that even though healthcare has advanced in many ways, the high workload prevents nurses from following procedures correctly. She said, "the conscientiousness has been lost and there's so much more potential for complications and for getting into trouble faster." Nanny, who is responsible for teaching infection control practices talked about why even a simple practice such as hand-washing can be difficult to achieve at times. She said, "A CCU nurse is doing 4 things in 20 seconds and thinking about the next 10." The amount of work the participants were required to perform combined with organizational standardization of assignments based on numbers rather than patient acuity prevented the participants from being able to provide the patient care they felt needed to be performed. The amount of work required

on a daily basis and the exclusion from decisions regarding workload were both a source of dissatisfaction for the participants.

Physical environment. The physical environment itself was discussed as a factor which was influencing the decision to leave nursing to some extent. To begin with, the participants spoke about the creation of more private rooms for patients in the hospital setting, which has increased the size of nursing units. This unit design was viewed as being created for customer satisfaction without regard for the increased strain and additive time that would be placed on nursing staff. The participants felt that units that were spread out were not conducive to patient safety and that supplies were not always readily accessible. There was the perception that every extra physical step takes away time from patient care. Additionally, it was seen the large nursing units are physically taxing and can lead nurses to exhaustion by the end of their shift. Genevieve is exceptionally dissatisfied with the unit layout in the emergency department where she works because it prevents her from being able to visualize all of her patients which she feels is unsafe to do before patients are stabilized. Betsy was not only frustrated at the amount of walking she has to do at work, but also about the fact that every door is locked and requires a badge entry. While she understands that this may be necessary as a safety measure, it takes extra time to not only reach a destination, but to enter it. She feels it is unacceptable to be walking a long distance with dirty linen and said, "They have made everything hard and that all adds time to your shift." Even though Deedee works with infants in her work setting, she discussed the impact of obesity on the physical environment. She pointed out the fact that special equipment is required to care for obese patients which takes additional time to operate. Furthermore, it requires a large storage space, so it may take time and effort to obtain it from its location. Also in respect to equipment, Moon shared that in the hospital where she worked that the computers the nurses were supposed

to take into patient rooms to document patient care were actually too large to fit into the doorways, which complicated the documentation process and prevented nurses from spending additional time at the bedside.

Flash and Mary both discussed their challenges with the physical work environment in their jobs in home health. While their physical environment is much different, they shared that geographical location was often not factored into their daily assignments, which caused them to spend a significant portion of their day driving between patient locations. Flash talked about the physical toll that driving can place on your body as well as the fact that locations may not be physically safe. Additionally, Flash and Nanny both shared accounts of situations where they had felt unsafe at a patient's home. The physical environment posed challenges in a variety of settings and contributed to feelings of dissatisfaction for the participants.

Technology. The incorporation of technology, particularly computerized documentation of patient care, was a source of discontent for almost all of the participants. They felt that computerized documentation had exponentially increased the time they had to spend on charting, which took significant time away from patient care. Flash described the documentation in home-health as being “incredibly time intensive.” Similarly, Genevieve, Millie, Jewelrylady, and Betsy also discussed the fact that they spend a significant portion of their day on documentation. For example, Betsy said, “You spend all of your time like at the computer now. And it’s so important that everything be documented, documented, documented. It’s almost as important that you document it even if you don’t do it.” This perception that the organization viewed documentation as more important than patient care was shared by some of the other participants as well. There was a sense that some of the documentation they were required to do was

unnecessary and prevented them from providing quality patient care despite the fact that the documentation may appear complete.

A few of the participants felt that the use of computers for documentation of patient care placed a physical barrier between the nurse and the patient, which they found to be dissatisfying. Moon said, “There is something lost when a nurse comes in and is so into the computer. There’s something that changed with the interaction and it puts a barrier there....It’s a symbol of where we are, we don’t interact.” Genevieve elaborated on this concept of a barrier and shared that patients perceive that nurses are not paying attention to them, because they are spending too much time at the computer. Also, Millie shared that there are some handheld devices that are not so obtrusive to bring into patient rooms and they can make documentation easier, but there are not enough available for all of the nursing staff.

It was also discussed that there is a tremendous amount of dependence on technological equipment and when equipment is not readily available or working properly, it causes tremendous frustration. Betsy noted that because she frequently gets interrupted when she tries to sit down and chart, she constantly has to sign in and out of the computer, which takes valuable time. Furthermore, she discussed the fact that the documentation system does not always run smoothly, and it can take time to open the necessary programs.

Nanny did discuss some positive aspects of the uses of technology in healthcare and how computer systems are valuable in tracking information on trends related to infections. However, she also acknowledged how time consuming data entry is and she shared that it is a skill she does not enjoy. She describes doing data entry as “the worst days of my life.” She feels it takes time away from aspects of her job she feels she excels in performing. She went on to say that there is a person who volunteers to do the data entry. For liability reasons, her organization almost

stopped allowing the volunteer to do this work, which created angst for Nanny. While Nanny acknowledged that the use of technology is valuable for her work, it also requires a significant amount of time to utilize.

While the use of technology in healthcare can be a positive tool for patient care, the participants overall felt that it decreased not only the time they were able to spend with patients, but the quality of the interaction. In a previous nursing job, Mary had the opportunity to work in a Veteran's hospital, which was ahead of the curve with computerized documentation. Mary said she was able to manage her job there "taking orders off all day", but felt she was stuck "shuffling papers" and that she is "a people person". She went on to say:

I went into nursing because of the nursing part, and I know you need good nurses to do all of this and....but things have just so shifted that now the RN's aren't doing what they should....And I think a lot is being missed because you're trained to notice all these things, but now you're not on the first line to notice.

The participants shared openly and honestly regarding their experiences in the nursing profession. It was that they felt frustrated when they were not able to provide the care they felt patients required and that they were educated to perform. The work environment was seen as infringing on the nurse patient relationship, which was leading some of them to consider leaving the nursing profession. For many of them, the work that nurses perform today was not in line with the role they had anticipated performing. During the interview, Ebony/Ivory shared that patient care is the "least that you do." Because of the amount of work nurses are assigned to do, patient care is not always provided optimally. The work environment was portrayed as being chaotic on a regular basis by the participants. The incongruity between the work environment

and the ability to provide excellent patient care lead some of the participants to reflect on how they viewed work in relation to their self, which leads to the next theme.

Poststructural reflections. Initially, I did not see the presence of gender in this finding, but with further analysis, I was able to see it embedded throughout these subthemes. First of all, the discourse of caring is visible, because the participants felt they were unable to provide the “care” they were educated to perform. Being in a discourse of caring is related to the socio-cultural constructed image of the nurse and is associated with feminine attributes. Secondly, the participants felt that their workloads were often unrealistic and they spend significant time performing tasks that were not related to the caring aspects of nursing. They were spending time performing tasks that took time away from patient care, which devalued the caring essence of nursing work. Additionally, they did not feel involved in decision –making related to workload distribution, the physical environment, or technology. Some of the participants did question the reason behind the focus on documentation and performance of the measurable, objective aspects of their work, rather than the more subjective, emotional aspects of their work. An important concern that the participants had was that “proof” of care was emphasized over actual performance of care, which also is a devaluation of the caring work of nursing. In respect to the environment and technology, fields such as architecture and information technology remain socially constructed as masculine occupations (Dubeck & Dunn, 2006). This may provide some explanation as to why nurses were not overly involved and possibly excluded from decisions regarding unit designs or computerized technology. While the conscious influence of gender is not present in this finding, there is an unconscious presence that would not have been visible without careful examination and reflection through a feminist poststructural lens.

Interpersonal communication

Interpersonal communication in the workplace was seen as challenging to the participants. In general, participants perceived communication skills to be lacking in the workplace. Failures in communication often caused relationships to be strained, and most of the participants were perplexed about the reasons that communication was not always effective. Not all interactions between nurses were perceived to be negative, but interpersonal relationships in the work environment were viewed as an influence on the potential decision to leave nursing. Several participants discussed their perceptions of how nurses interacted with each other in the work environment and gender was seen as influencing how nurses communicated with each other. A few participants expressed that effective communication with patients needs to be culturally sensitive; there was a sense of frustration when they felt that communication did not meet their expectations. The first subtheme of this finding concerns the perceptions the participants have of the communication patterns between nurses and the second subtheme concerns approaches to diversity.

Communication between nurses. The participants discussed their interactions with other nurses in the work environment and frequently shared that communication was often ineffective for various reasons. Nanny, Deedee, and Jewelrylady all suggested that nurses could benefit from more education on communication skills because ineffective methods often lead to frustration between co-workers. Examples of problematic encounters and potential reasons behind ineffective communication patterns were discussed by the participants.

Mary perceived that the level of respect nurses have towards each other has deteriorated over the years. She feels that nurses do not demonstrate compassion towards each other and that behaviors are not always professional. She discussed the fact that she felt rewarded when there

was respect and camaraderie between peers in the past. Mary also found great satisfaction when nurses worked together to get a job accomplished. She feels that these types of relationships are lacking in today's work environment and finds this to be a source of dissatisfaction.

Jewelrlylady provided an example of how the work environment impacts communication between nurses. She discussed how nurses would negatively communicate with her when she was working as a charge nurse on a telemetry unit. In this role, she was responsible for making decisions about patient assignments and the flow of patient care. She said that she felt a high level of "animosity", both verbally and nonverbally, towards her from the other nurses when she worked in this role. She attributed the negative behaviors to be the result of stress. She felt that her co-workers would project their frustration to the charge nurse. Jewelrlylady went on to say, "It's a hard dynamic to just be involved with."

Gender was discussed as an influence on interpersonal relationships and communication styles between nurses. Genevieve stated that there is a lot of "cattiness" between female nurses and she feels that nurses frequently talk negatively about each other in the workplace. She perceives nursing to be "competitive" and stated that nurses often put each other down in an effort to make themselves feel better. Genevieve said that she goes to work with a positive attitude, but finds it difficult to maintain it because her co-workers are very negative. She feels that "nursing would be so much better" if the negativity was not present. She recognizes that this type of behavior is not healthy, but said, "I don't know how to stop that or what to do to even make it better." Even though Genevieve has only been a nurse for a few years, she feels that her relationships at work have deteriorated. She talked about the fact that they used to be a "very tight knit group of people" who "did birth, life, and death together". She feels that the managers do not do enough to support positive relationships in the workplace and that when people work

together and have more camaraderie, negative attitudes dissipate. Genevieve mentioned twice that if the nursing profession would place a greater respect on Florence Nightingale as a role model that behaviors in nursing would be more positive.

Like Genevieve, Ebony/Ivory also talked about the “cattiness” between female nurses. She shared that nurses disclose a significant amount of personal information during the work day. She made the observation that even though nurses often share the intimate details of their lives at work that many of them do not spend much time together outside of the workplace. When I asked Ebony/Ivory why she feels this happens, she replied, “Maybe because all that sharing makes you vulnerable.” She believes that nurses often share information in an effort to relate to each other and to help each other solve problems; she stated that it can be “therapeutic”.

Betsy, Deedee, and Rose all talked about how nurses have a reputation for “eating their young”. Deedee said this is something that is always discussed “but nobody does anything about it”. There was a sense that because nurses are not effective in their communication, they take it out on each other, and Flash said, “We are just a self-destructive bunch. We truly are.” Rose shared a story about a recent event where she witnessed an older nurse “reaming” a new nurse. She said that she “stepped in to help her” and doesn’t understand why this type of behavior happens. In respect to this encounter, she said, “I thought, we can’t do this to our new nurses. We have to encourage them, we have to help them any chance we get. If not, they’re going to be gone. We’re going to be suffering because they’re not here to help.” She felt that this type of behavior leads nurses to want to leave the profession and discourages people from entering nursing.

There was a sense among the participants that male nurses are able to mediate relationships between female nurses. Genevieve said that male nurses get female nurses “to

focus on something else” and “bring the conversation back to the patient”. She further stated that male nurses “don’t worry about the same things that women do” and that female nurses frequently discuss personal issues, such as their children and relationships, in the workplace. Ebony/Ivory also perceived that male nurses do not engage in personal conversations in the workplace. She said, “I think that people pretty much have the same idea: men are different... they’re not going to get into a whole bunch of he said, she said.”

Deedee shared her perspectives of the different communication styles between men and women. She said:

Men are more willing to talk, you know. [When] they have something that is bothering them, they’ll talk about it and they’ll move on. Where women are more passive-aggressive, you know. They keep stuff in and it either comes out in an explosion or they hold grudges for long periods of time. And that’s what I have found over the years and it drives me crazy. And you know, it’s just, I just find women to be a little more petty and jealous. They’re just very...I’m a woman too, and I can be like that as well, but for some reason they just seem to have this issue with other people, when things happen to other women, to other people in general you know just being real negative.... We have a lot of nurses who have been there 15, 20, or 25 years and they’re just in that mode of life that maybe it just hasn’t worked out they way they wanted it too, but anyway, it’s just a lot of negativity.

Deedee only works with one male nurse on her unit and she describes him as “really easy to work with”. She talked about how is he able to communicate effectively with her and said, “He’s right up there, he’s up front with what he needs and what he wants. If he has an issue with me or with someone else, he gets it right out and then moves on.” Deedee shared that she

organized a reading group on her unit surrounding the book “Crucial Conversations” by Harry Patterson. She said the staff members who have been reading the book have found it helpful for both personal and professional communication because it is not easy to have difficult conversations. She is hoping that the discussions surrounding the book will enhance approaches to communication between nurses. Deedee finds it very frustrating that nurses often bring issues to her instead of each other and want her to “deal with it”. She said the problem with that approach is that each person has a different perspective on the situation and she then finds it difficult to help them reach a solution. She went on to say that she has tried over the years to make “it very clear that if you come to me with an issue about someone else, you better have talked to that person first” because she believes it is better for people to try to solve problems with each other before they escalate. However, she admitted that the women she works with do not always utilize this approach and they often “triangulate” with each other instead of addressing problems. In respect to the women she works with Deedee said, “They’re big about bitching and moaning, but when it comes down to doing something about, they don’t want to do it. It’s really hard to work with.”

Moon shared a different perspective regarding gender and communication between nurses. She feels that the lack of a supportive work environment influences communication rather than gender itself being the influence. Moon perceives that ineffective communication between nurses often stems from dealing with difficult situations regarding patient care. In her work as a NICU nurse, she talked about how difficult it is to deal with the death of babies and how premature infants often look abnormal. She went on to say that these situations are always difficult, but then you start questioning why they happened “to the woman with fertility problems and this was her last chance.” Witnessing these events can cause moral stress for the

nurse and Moon said that instead of nurses “going there” in their minds and talking about difficult cases, they say things like “Hello, do you see what she did to the schedule?” Without an opportunity to express feelings, Moon believes that emotions come out in negative ways towards each other.

Moon discussed how having a venue to share feelings in her work as a hospice nurse promoted effective communication between nurses. She said that her co-workers respected each other and they had regular opportunities to meet with a psychologist to discuss difficult issues with each other. She feels that because they had an opportunity to acknowledge emotions in a safe environment they did not take out frustrations towards each other. Moon said she hates that many women believe that women cannot work together effectively. She said, “That’s not true. It doesn’t have to be that way, because it was mostly women at hospice. I hate that because we had the best group of people I ever worked with.” Moon shared that in her experiences as a hospice nurse, they did not question each other about decisions that were made. She said that they all respected each other and recognized the fact that if someone made a “decision on call at 3 am” that it was the best decision that could have been made, and accepted that “in the light of day with 3 people looking at it, maybe the decision would have been different but it was 3 am.” Moon was very insightful into how time, perspective, and circumstances influenced communication between nurses and without consideration of these factors, negative behaviors would persist. The participants acknowledged that communication between nurses is often suboptimal. There were differing perspectives on why these ineffective patterns occur, but they were a source of dissatisfaction for the participants and an influence on their decision to leave nursing.

Approach to Diversity. In addition to communication difficulties with co-workers, there was a sense that communication with patients could be improved. A few of the participants did not feel that nurses are culturally competent in their approach with patients, which influenced how they perceived their co-workers. They were frustrated at the inability of nurses and other healthcare providers to see issues from perspectives that were different from their own. They felt that patients were sometimes judged unfairly for having different values and beliefs, which could negatively affect their care.

Mary spoke about her current job in working with pediatric patients in their home. She felt that nurses “have to be like a chameleon” and make an effort to “fit in” with the family in order to provide the best care. She went on to say “You have to be patient and you can’t be judgmental, which was always part of nursing.” Mary feels that her role with families is “to direct them to do things right” and “you can’t force your beliefs on how to do it on them.” She does not feel that younger nurses are able to do this very well and are too directive with families. She said that sometimes they “put them down” and that with experience she hopes they will learn “to let go a little bit.”

Moon shared how she had learned from her experiences in working with diverse populations in both home care and the neonatal intensive care unit. In respect to her experiences in home care in an urban area, she said:

You went from both ends of the economic spectrum and the cultural spectrum and I found I have learned more respect. I found I had to deal with my own racism. I had to deal with my own fear. When I went into the projects...we are all racist. We have a racist society. I try to think I’m real cool, but I’m not. It’s like embedded in our society almost.

She talked about how working in lower socioeconomic areas helped her to confront her own racism. She described one experience where she was very scared and knew that when she entered the neighborhood, it was obvious that she “didn’t live there”. At this point, she became more afraid when an African American man approached her. She was surprised to find that he was greeting her because he knew she must be here to see a sick child in the neighborhood and he offered to show her where she lived. About her experiences with diverse populations in home care, Moon said, “I found people to be kind.”

Moon’s experiences in home care taught her to be more cognizant of people’s needs and gave her insights into how socioeconomic factors influence beliefs and perspectives. Moon discussed the fact that she worked in a hospital with a religious affiliation that was not very tolerant of diversity. She felt that many of the nurses she worked with were not adept at working with families who shared different beliefs and perspectives. She was proud of the fact that she was able to connect with people and take the time to understand their situation. She said that she would frequently “bond with people who had more issues or more problems.” Moon talked about one family specifically who were very young and had an infant in the neonatal intensive care unit. She felt that no one else wanted to deal with their issues and did not take their concerns for the infant seriously, because they did not feel this family had the ability to provide the necessary care. However, Moon was able to teach them and assisted in making arrangements for the young family to be able to care for their baby at home; she shared that they sent her the most thoughtful thank you card she had ever received as a nurse. Because of her various experiences, Moon was able to alter her own approach with patients.

Rose talked about the importance of finding commonalities with patients and how nurses need to vary their approaches. She feels that she has the ability to adapt to different situations,

which is a skill that enabled her to be successful in real estate. She said that when you are walking into a patient room, “You don’t know exactly what this person’s education level is, their occupation, their sets of morals and beliefs.” She went on to say, “Every single time you have a patient encounter, it’s different and you have to adjust and be amenable.” Rose believes that nurses who are unable to find connections with patients are not able to communicate effectively.

Additionally, Deedee finds it very “disappointing” that “people are very judgmental” of others who have different values and beliefs, as well as those who have addiction problems. She said, “I feel like...I feel like I am constantly correcting people.” She goes on to discuss how she views these judgments and provided an example on drug-addicted mothers. She stated:

It’s mean and hateful and you don’t know their story. And when you find out their story...I have not met a mother yet who was on drugs that said, ‘I’m really glad that my baby is off the wall. I’m really glad that I did this to my baby.’ It’s just so, it’s just...When I was younger, I used to think ‘how could she do this to her baby?’ But as I have gotten older, I realize how strong the addiction must be that she could do this even when she’s pregnant...and it’s so discouraging to me and it’s not in every area, but it’s bad here. I think it’s because a lot of people are born here, live here, they work here. They don’t go anywhere else and there’s issues with you know...the population changing. We’re getting a lot of Hispanic culture and people who don’t speak English and they’re very judgmental about that. You know and I think just life experiences helps you with that because they are very disparaging towards people who don’t speak English.

These four participants were very cognizant of the need to provide patient care that is culturally competent. Ineffective communication patterns were a source of frustration for many of the participants, and they were seen as influencing relationships between nurses; several of the

participants noted that there needs to be more emphasis on communication techniques in nursing education and in workplace education.

Poststructural reflections. The participants were clear in their views that communication was not always effective in the workplace, but they did not spend much time discussing their relationships with other nurses. Ebony/Ivory did point out that nurses she works with do not spend much time socializing outside of the workplace. Her response that sharing intimate details of one's life during the workday can make an individual feel vulnerable is very insightful. Do nurses share personal information at work in an effort to express feelings regarding difficult ethical situations related to their job role? Are they not able to spend time together outside of work because their lives as working women are demanding? These two questions have caused me to stop and reflect on the ways in which the influence of gender may remain very invisible.

There were references to the adage that "nurses eat their young", but they did not associate this behavior with a lack of power or being in a female-dominated profession. Some of the participants expressed that they were not tolerant of these types of behaviors, but were unsure of how to address them other than not engaging in them. In some ways, they were exercising a capacity for agency by serving as role models. Reflection on this finding raises some crucial questions: What are relationships like between women in other careers? Are these types of behaviors present in careers that are not occupationally segregated by gender? If so, is it due to oppressive working conditions or have they been exposed to effective communication techniques? Does socialization into nursing affect communication patterns?

The participants did speak about cultural and socio-economic factors as influencing approaches to diverse patient populations, but other than Moon, there was no discussion related

to race. Gender was not discussed as an influencing factor on approaches to diverse groups in the healthcare environment. In a poststructural framework, discourses are viewed as being influenced by language, which is socio-culturally constructed. It may not be considered “acceptable” to openly discuss issues such as race and ethnicity in some discourses. All of the participants lived and worked in central Pennsylvania except for Ebony/Ivory, which is to say that they were possibly engaged within similar discourses. Additionally, the focus of the study was not related to social structures other than gender, so questions were not specifically asked about other social constructs that may be an influence on the decision to leave.

Shifting Perspectives on Work and Self

This finding relates to a shift that the participants were experiencing in respect to their beliefs about work. Most of the participants were working full-time, and work was an important part of their lives for many reasons. Even though work was seen as a central part of their lives, they were experiencing a shift in their personal views regarding work, which was affecting their decision to seriously consider leaving nursing. Personal health was a catalyst for this shifting perspective for some of the participants. Several of the participants had experienced health issues that were attributed to work-related stress and others had previous health conditions that were exacerbated by job stress. For a few of the participants, a health crisis provided them with an opportunity to reflect on the role of work in their life.

As they began to separate their work identity from their personal identity, they began to consider how their work experiences may be different if passion was present. Along with these shifting perspectives, the participants were also faced with the reality of leaving nursing, which was their current and stable means of employment. This theme of “shifting perspectives on work and self” is divided into three subthemes: 1) separating work from self, 2) finding passion, and 3)

concern about economic realities of leaving. This finding was placed last to signify the feminist poststructural tenet that identity is constantly shifting.

Separating work from self. The participants were in the process of re-evaluating the place and value work had on their personal identity. They were taking a critical look at how work was affecting their personal lives and they were contemplating the affects work had on their identity. Being a nurse was a significant part of who they were and how they identified themselves, but they did not want it to be their defining identity. Work was a place of tension for the participants, and they realized this was affecting them physically and mentally. Because of this, they began to perceive that the work they were required to perform in their roles as nurses was not compatible with how they wanted to live their life at the present time.

Jewelrylady, who has a chronic pain condition that is exacerbated by stress, said “You know, you have to take care of yourself too.” She began to feel that the work-family balance she had been trying to maintain was spinning out of control and she said, “I’m not sacrificing my own philosophies on raising my children and trying to make that all work together.” She decided that her family should be the most important focus in her life. Jewelrylady realized that her career in her home jewelry business could provide her with a similar income level and allow her to feel more balanced in her life. She also felt that she was sacrificing her values and beliefs, because nursing had been turned into a business. For this reason, she felt she could no longer be a part of nursing because it was ethically difficult for her to reconcile some of the practices she had witnessed. She also shared that the jewelry company she works for operates under the philosophy that work is a way of life which should bring joy to one’s life and should be viewed as a way to “give back” to others.

Moon had an accident at work that resulted in a serious shoulder injury; she was unable to work as a nurse for several months. During this period, she spent time engaging in a spiritual journey. She said, “For me it was a chance to really...to focus on who I am, what I want, all those things.” In respect to her injury, Moon stated, “It was a gigantic reset for me.” Before her accident, she had not considered leaving nursing because she was very “enmeshed in it”. She discussed that she came to realize that in her career as a nurse, she was constantly giving and saying “here, here, here”. She said that she “sacrificed” her family, as well as everything else in her life for her work. She went on to say she doesn’t know how many times she said to her kids that she couldn’t do something “because work was more important.” Moon talked about the fact that work was where her identity was. She acknowledged that she had experienced job burnout at some times in her life, but she was grateful for the lives she had been able to touch in nursing.

After her injury, Moon decided that she had to make some changes for herself, particularly in respect to her erratic work schedules. She said, “I had to say no, I’m not doing it. My old [self]...it would have been where I got my worth, my sense of self, my power and I was so important and all that crap.” Moon began to question why her personal identity was so tied to her identity as a nurse. She came to the realization that “It’s not who I am, it’s what I do.” In respect to her decision to leave nursing, Moon said, “When you start walking ahead, you can’t go back. It’s like you discovered pieces of yourself. You can’t turn back to it.” She went on to say that you just can’t forget “about that woman that’s out here” and be tempted to fall into the same traps again. She felt that her decision to leave nursing was part of her personal journey for herself and she also said, “I just keep trusting that if I walk my path, it will be okay.” Moon was the most articulate participant about her identity shift and her need to put self before work to have balance in her life.

Genevieve expressed regret that she has missed family events, such as weddings and funerals, because of her work as a nurse. Genevieve talked extensively about the importance of taking time for self. She stated that she does not want to become “hardened” like some of the older nurses that she works with. She perceives them as having a high degree of negativity and believes they are generally unhappy. Genevieve feels that the beauty company she works for emphasizes the power of positivity in one’s life and the importance of caring for self; she views her work environment as a nurse as not positive, which does not nourish the self. She believes that because she had learned the importance of caring for one’s self, she was only depressed for two days after her husband asked her for a divorce. Genevieve had wanted to leave nursing before her separation, but now she recognizes how valuable her learning in her other job has been to her personally. In respect to nursing, she said, “I love the profession, but it’s just what we’re given now is not what I need from it.”

Betsy talked about the fact that she had loved her work as a nurse in the past. She stated that her work “had totally consumed” her because she “was so happy with it.” She also identified with the American ideal that hard work was part of life and would eventually be rewarded. In recent years, Betsy has been feeling burned out from her work and went to see a counselor in the hopes she could figure out if she was truly tired of nursing or whether she was just ready to retire. She said, “I can’t believe that I would be tired of nursing. I just couldn’t accept that I guess.” Betsy did not find the counseling to be overly helpful, but she did realize that she was the only one who knew the reasons why she wanted to leave nursing. When asked if any events in her personal life were influencing her decision, she was surprised when she acknowledged that her second marriage was influencing her decision. She said, “I realize now that there is a lot more to life than the job, than nursing.” She no longer wanted to work

weekends and holidays, because she wanted to spend more time with her husband. After the interview, Betsy revealed that she was grateful for the opportunity to talk about her experiences in the workplace and her desire to leave nursing. She found that it was a cathartic experience for her and allowed her to think about her future career options in a different way.

Millie, Mary, and Flash discussed how fatigued they feel after their shift is over, which leaves them with little energy to do anything else. Millie works two twelve hour shifts on weekends and admits that she does not have the energy to interact with her family when she comes home from work on Sunday; she showers and goes to bed. About her decision to leave, Millie said, “This is what I need to do for myself. You know, and I don’t want to do 12-hour shifts. I don’t want to work night shift. I don’t want to come home dead beat.” Mary and Flash both discussed how their work not only caused them to feel fatigued, but also depressed. They felt that their work experiences were the sole factor contributing to their depression. In respect to her previous job, Mary said, “emotionally and physically, I had it, I couldn’t do it anymore” and “I can’t believe I stayed there as long as I did, because it was killing me.” Flash became emotional when talking about her experiences with depression and is still struggling to manage the symptoms. She thought that she was doing better for awhile, but because she is continuing to have difficulties with her nurse manager, her depression has gotten worse. Flash thinks that the only way she will not be depressed is if she finds a new job.

Deedee also shared that her work has contributed to health problems. She shared that the stress of her job role has contributed to dental problems, because she clenches her teeth at night and some of them have become cracked. She sees her current work identity as a problem solver, and she believes this role has taken a toll on her life. Additionally, she had some serious health issues in the past two years that resulted in an extended hospitalization. She shared that this

event “really impacted my decision.” Deedee is very humble about her accomplishments at work, and it is evident from our conversation that she is a well respected manager. Even though she is viewed as a “good” manager, she disclosed the fact that she rarely receives compliments from her staff. While she does not feel that she needs continuous praise, it is difficult to be responsible for complex issues in the work environment on a daily basis. In discussing her role in continually trying to solve problems, Deedee describes herself as “a human trashcan”. She used this phrase a few times during the interview; her work identity was associated with a negative image in her mind and she had a need to separate this identity from the image she had of herself.

Identity is fluid and constantly shifting; the participants had viewed their identity as a nurse as their primary identity. For various reasons, they began to contemplate how this identity was affecting all aspects of their lives and the way they viewed themselves. Through this process, they found themselves seriously considering leaving the nursing profession. As part of this process, some of the participants embarked on a journey in search of finding passion in their work and possibly their lives.

Finding Passion. For many of the participants, nursing was fulfilling an economic need, but it was not currently being seen as fulfilling their passion. While many of the participants shared that they still had passion for the nursing profession, there was a sense that their work was not bringing joy to their lives and they were in search of passion in their work. Nanny and Millie both shared with me that they had a profound moment which lead them to decide to pursue their passion.

Nanny shared that her significant moment occurred when she was talking to her teenage sons. She said:

I was preaching to them about following your love and finding your passion and the things that nobody told me. What I learned as a child was do the hardest thing, because that's the best. [Laughter] If it's hard, then it's good, and you have to succeed at the hardest thing. And I was preaching that sometimes the easiest thing is what you could be doing. You don't always have to be doing the hardest thing. Because the easiest thing is sometimes easy, because it brings you joy and you want to do it. So I was preaching that, and my oldest son said to me during the conversation so 'When are you going to do that?' [Pause].....That was a real life changing experience for me. And I said, 'I don't know'. It just wouldn't leave me alone. So at that time, I started looking at what really my passion was, [it was] for the church. That is where my passion is, in the Episcopal Church. That is where my joy was.

Nanny started looking into what she would need to do to fulfill her passion. While it is not an easy process, she has taken steps toward entering the priesthood. She took a ministry class at a college and served as an intern at a church. She has been invited to submit an application and plans to apply for seminary.

Similar to Nanny, Millie had a significant experience involving her children that made her decide to follow her passion in respect to work. Millie shared:

Maybe about two years ago, I got a call from work. And boy, were they desperate for help. They were offering two tier bonus of 20 dollars an hour. I know, awesome money. I'm, like, ahhh. And so I remember the girl who called me. I'll never forget this. And that morning my, my, my day was to go to [son's name] classroom and help his teacher...And I told [name] no. I said, 'I can't go because I'm helping in my son's classroom today.' And I sat here and I thought about it, and I said, 'Oh my goodness. I

just turned down an extra 20 dollars an hour... That's crazy? Call her back.' [laughing]

And it was no struggle. Like, it was no struggle. I had such peace to turn down that money and go into help, to go to my son's first grade classroom and help out for two hours. And I realized, you know what, where's my passion?

After this experience, she searched for educational programs that she could complete as a second-degree student and chose to attend a state university in her area that offered a master's degree in education. About her decision to leave nursing to pursue a career in education, Millie said, "I have no regrets. I would not want to be a nurse for the rest of my life."

Deedee discussed the fact that she feels she is very good at her job as a manager, but it was never her career aspiration. She had actually interviewed for an educator position when she was offered the nurse manager position. At the beginning of the interview, Deedee said one of the biggest reasons she wanted to leave nursing was because she was "tired of working with women." Later in the interview, she said:

I don't even know if it's just the man woman thing..I think I'm just tired of people. You know, I've always been an animal lover. I do a lot of work with the SPCA. I have a dog and 3 cats and I really think I might want to go into working with animals.

Because of her health problems, Deedee's physician recommended that she consider moving to the southwest and she is moving in a month. She is taking her move as an opportunity to make a career change and is considering starting a pet sitting business. She discussed the fact that she has always loved animals and said, "I never remember considering being a veterinarian or anything when I was a kid. I never really considered that, but if I had to do it all over again that's the direction I would go." Deedee believes that working with animals would bring great joy to her life and would involve interpersonal interactions that are less stressful.

Jewelrylady and Genevieve both spent a significant amount of time talking about their home businesses and the personal rewards they have received from working with women in a different setting. They were both very excited about their new career ventures and neither of them expressed the same level of energy when talking about their experiences in nursing. They both brought information related to their new careers to the interview. Genevieve felt that her life had been consumed by nursing and said, “So I’ve found a very wonderful business that I’ve seen things that can happen and I’m still helping people and bettering lives.” She told a story about a woman who had difficult life circumstances that she was able to help “feel good about herself.” She said that her home business afford her the opportunity to spend time with women, which she “can’t do at the bedside.” She went on to say, “And I might not be healing anybody physically, but I mentally am doing the things that I have never had.” Genevieve took the time to show me some of the training materials from her home-based business that are used to promote positivity and feelings of self-worth. She discussed how this education has helped her in both her personal and professional life. She does not feel that her experiences with workplace education in her role as a nurse have fostered taking the time to care for self or the importance of having passion in life. Similar to Genevieve, Jewelrylady perceived that she was able to help people more in her home-based business than she was as a nurse. She feels that leaving nursing is part of her personal journey that has been created for her by God to use the skills she has developed as a nurse to help people in other ways and find her passion in work.

Rose is also in search of passion in her work. She feels that she is a good nurse, but she is not passionate about her job. She shared that her true passion is in real estate and in response to being asked what her reasons would be for leaving nursing a second time, she said:

Becoming a successful businesswoman, career woman, being at the top of my game, being number 1 again. That was just me, I was number 1 wherever I went. You know, I'm always earning the most, selling the most, earning the trips, getting the prizes. That was just me....So that's what I would be looking forward to most, just being on top, being number 1.

She discussed how she mentored other women in the real estate business and she was very proud that two of them are continuing to be extremely successful using the skills she helped them to develop.

Moon shared that many people are taken aback that anyone would want to leave a steady job in an unstable economy to pursue another career and have passion about one's work. She agreed that while it seems like an unwise decision to leave nursing for a career in writing, she shared the following about her intentions, "It's like my soul is saying you have to or you're gonna die in some way. It may be a spiritual death, but you're gonna die if you don't listen to your heart and go with it." Moon discussed the fact that what we perceive as our safety nets are often traps, which we don't recognize and they can prevent us from moving forward. She cautioned that individuals need to look carefully at what we believe are our safety nets, because they may "become the things that twist around the turtle's neck." Moon was recently asked to conduct a writing workshop, which she is very excited to do. She also shared that she had the opportunity to present some of her work to her a graduate writing class last year and that she received many compliments about a novel that she has started about a woman experiencing domestic violence. Moon is already a published writer and went on to say, "I made my decision and I'm not going back....this is what I know I was here to do." After the interview, Moon sent me poems that she had written during her recent writing retreat. She gave me permission to

include one of her poems, entitled “My Demon” which symbolizes her current journey in life; it can be found in Appendix B.

Concern About Economic Realities of Leaving. Despite the participants’ desires to find their passions and create separation between their personal and professional identities, they were also faced with the reality that leaving nursing was not going to be easy for many reasons. All of the participants felt that the skills that had obtained from their work in nursing would be helpful and transferrable to a new career. Even though most of the participants were hopeful that they would be successful in making a career change, there was a sense of ambivalence about their decision, which was sometimes revealed after the audiotape was turned off. In response to the question, “Is there anything that could change your mind about wanting to leave nursing?” All of the participants answered “no”. However, during the interviews, almost all of the participants shared that they may not completely leave nursing despite having strong intentions. Some of the participants felt that they may need to stay working as nurses on a limited basis for economic reasons while pursuing new career opportunities, and some of the participants were uncertain whether they would ever be able to walk away from nursing completely. Even the participants who seemed to be the most certain of their future plans had a moment of uncertainty. Millie was the only participant who had completed an educational program in preparation for another career, and she shared that she planned to work some shifts as a nurse in the summers and had already discussed this with her nurse manager. Additionally, she acknowledged that she would have to continue working as a nurse until she found a teaching position.

There was a sense among the participants that life changes and that so do plans. The participants realized that circumstances beyond their control might impact their career plans and they may not be able to leave nursing as intended. Ebony/Ivory said, “You know and it’s like

time and opportunity. You could plan for everything and you know...get nothing, so life happens and things change.” Rose has had intentions to leave nursing since she re-entered it over two years, but stated, “In the middle of my plan, I broke my leg and got a divorce so my plan might seriously change.” Later in the interview, she reiterated, “I have a plan, but plans always change.”

The decision to leave nursing was not easy for most of the participants to make. Genevieve, who wants to leave nursing within two years, admitted that when she is reminded of why she was drawn to nursing “it’s very much a struggle to decide to leave eventually.” Moon shared that even though she had made up her mind about her intentions to leave nursing that she was nervous to talk about her decision. She said, “I’m open and I talk all the time and why I think I was nervous is to really say ‘I think I’m done being a nurse’.” She found it difficult to really acknowledge that she was going to leave nursing, which had been a large part of her life for over thirty years. Even though she felt that she could no longer work as a nurse, she was “flabbergasted” to find herself saying it. She also admitted that if anything changed in her life, she may need to work as a nurse again, because she had already begun using her retirement savings for her living expenses to pursue her writing career.

There was a veil of doubt about the decision to leave nursing and some of the participants had stayed in nursing because it was comfortable and safe. In making her decision to leave, Jewelrylady said, “There’s fear too, that you’re going to jump from the frying pan into the fire.” Even though Jewelrylady had left her current job in nursing, she revealed that she was not sure whether she would ever be able to completely give up nursing. Work was a central part of these participant’s lives and they were becoming more aware of how they had personally been affected by their work as nurses. Many of the participants were searching to find passion in respect to

work, but there was also a reality that time, resources, and support would be necessary to change careers, which may limit their opportunities.

Poststructural reflections. As the participants provided insights into their decision to potentially leave nursing, it seemed they were experiencing mobile subjectivities in respect to work. The participants had acquired new knowledge about themselves as individuals, which altered their beliefs about work. They were still within the discourse of nursing as they were moving to position themselves in a new discourse. During the data analysis process, I was able to feel the presence of a constantly shifting identity for each participant.

Through their stories, I also recognized that the process of changing careers or jobs requires time, money, and support. For these reasons, it was difficult for some of the participants to make career moves. In considering the demographics of the women I interviewed, it is interesting to note that five of them are over the age of 50; four of them had been single mothers at some point during their career as nurses. Did they want to leave nursing earlier but didn't have the necessary resources? Did they not even consider making a career move until their children were older? Mary was the only participant who verbalized that she felt she was not able to pursue additional education because of her roles as a wife and mother. Millie was successful in returning to school to pursue her degree in education. It is important to note that she had a supportive husband and she took classes during the day while her children were all in school. She also continued working as a nurse on weekends. Gender was mostly an unconscious influence in this process.

Chapter Summary

This research study has explored factors which influence a registered nurse's decision to leave the nursing profession, and this chapter has presented the major findings from face-to-face

interviews conducted with participants who have serious intentions to leave. Perceptions relating to positionality and power structures were found to be influencing the decision to leave nursing. In particular, organizational structures were found to be influencing individual perceptions and experiences in nursing. In relation to the research questions, the five major themes were all found to be influences on the decision to leave the nursing profession. The participant's perceptions of their practice within a female dominated profession can primarily be seen within the themes of the power distribution in the hierarchy and the growing incongruity between working conditions and patient care. Throughout all of the themes, the influence of gender, both visible and invisible, was present in many of the findings. While gender was not consciously viewed by the participants as having a direct influence on the decision to leave nursing, it was perceived to be an influence on their practice. The discussion of the findings in respect to the current body of literature and in light of a feminist poststructural lens will be presented in the next chapter.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

The purpose of this study was to explore the perceptions of female registered nurses who have serious intentions to leave the profession of nursing with particular interest on the influence of gender. This chapter will begin by contextualizing the study by reviewing my reasons for conducting the study and its theoretical grounding in feminist poststructuralism. Next, the findings will be discussed in relation to the current body of literature on nurse's intentions to leave the profession and in relation to the theoretical framework. Finally, there will be a consideration of the implications for theory and practice in both the fields of adult and nursing education, as well as recommendations for future research.

The participants of this study were all female, registered nurses with at least three years of experience in the nursing profession. They all had serious intentions to leave the profession of nursing, and worked in positions that directly impacted patient care in various settings. Semi-structured interviews were conducted with 11 participants. The specific research questions that guided this study were:

1. What factors have influenced a female registered nurse's intentions to leave the profession?
2. How do female registered nurses who have intentions to leave the profession perceive their practice in a female dominated profession?
3. How do female registered nurses who have intentions to leave the profession perceive the influence of gender on their practice and/or their decision to leave?

The first section of this chapter contextualizes the study in a feminist poststructural framework.

This is followed by a discussion of the findings in relation to the relevant literature and in respect

to the theoretical framework. The third section will discuss the implications for practice, particularly in respect to nursing education, as well as implications for further research. The chapter concludes with my reflections and concluding thoughts related to this research study.

Contextualizing the Study:

Nursing in a Feminist Poststructural Frame

This study grew out of my own experiences as a registered nurse and my belief that the position of the nurse is socially and culturally influenced. The profession of nursing has remained a predominantly female profession, and only a few studies relating to the nursing shortage have placed gender at the center of the inquiry (Herron, 2007; Jones & Gates, 2004; Seymour & Buscherhoff, 1991). I wanted to conduct a research study that was meaningful to the profession of nursing, to educators, and to women in the workforce. In light of the current nursing shortage, which is expected to increase (AACN, 2009; Allen & Aldebron, 2008; Buerhaus, 2008; Buerhaus, Steiger, & Auerbach, 2003), I made the decision to explore the reasons nurses may choose to leave the nursing profession in an effort to highlight socio-cultural factors which may influence career turnover in nursing. The profession of nursing has been socially constructed as a feminine occupation and has been influenced by factors, such as gender role socialization and gender oppression, which warrant exploration in relation to women's career choices.

The current literature base concerning factors that may influence a registered nurse's intention to leave the profession consists primarily of quantitative studies, which have not adequately represented the experiences and perceptions of registered nurses regarding their work experiences or their professional turnover. Many of the factors which have been found to increase a nurse's intentions to leave the profession are related to the work environment rather

than individual characteristics. Thus, it is important to qualitatively explore factors which are influencing women's' decisions to leave the nursing profession, and this research study gives voice to the individual nurse, which has been largely absent from this body of literature.

Furthermore, this body of literature has not fully taken into account issues, such as power and positionality that are present in socio-cultural structures, which includes the workplace. This study sought to explore all of the influencing factors relating to the decision to leave nursing, including the influence of gender. The participants did not discuss the influence of gender extensively in their conversations with me. However, this research study makes an attempt to unveil dominant discourses that shape women's' experiences in nursing and in respect to their career intentions. Therefore, the findings of the study are discussed in light of a feminist poststructural framework, which provided a lens for exploring the conscious and unconscious presence of gender.

As discussed in Chapter Two, the theoretical framework of poststructural feminism not only seeks to explore social structures, such as gender, race, class, and sexual orientation, but the influence of these structures on the self. Major tenets of poststructuralism are: questioning the idea of truth, gender in relation to structures of oppression, a constantly shifting identity, deconstruction, and the role of power in relation to all of these factors. Poststructural feminism resists positivist assumptions, such as the notion of one truth and rationality as devoid of subjectivity; further, knowledge is seen as socially constructed (St. Pierre, 2000). Multiple truths exist and perspectives of reality are not accurate to those who are excluded from the production of knowledge (Lather, 1991).

In this framework, an understanding of power has been greatly influenced by the work of Foucault (Allen, 2005). Power is seen as mobile and something that circulates, which each

individual having the capacity to exert agency. Power and knowledge are viewed as being intimately connected (Foucault, 1980), and by analyzing the circulation of power, areas of resistance can be explored. Foucault also believed that power should be studied from the bottom, rather than from the top (Bradbury-Jones, Sambrook, & Irvine, 2007). Foucault's framework can be utilized to understand notions of power differently, and thus to challenge power structures that are based on social structures, which in this study is focused more on gender. Poststructuralism can highlight how gender has been influenced by "the interrelationships among power, knowledge, and discourse" (English, 2006, p. 20). Poststructural approaches to research, including poststructural feminist approaches, "value plurality, fragmentation, and multi-vocality" (Cheek, 2000, p. 6). Within a poststructural framework, data analysis is not considered to be a complete understanding of the issue being explored, because it is impossible to capture another person's reality completely, as that reality is always changing (Aranda, 2006; Cheek, 2000).

Within all feminist frameworks, there is a close relationship between the researcher and the participant, and in feminist poststructuralism, an emphasis on the notion that it is impossible to ever completely separate one from the other in the research process (St. Pierre, 2000). Each individual is affected by the other through the research process. Even though I used a semi-structured interview format, I made a conscious effort to keep the tone of the interview conversational, though it was primarily about the participant and her experiences as a nurse, as well as her future plans. To this aim, I did not take many notes during the actual interview and the first question I asked all participants concerned their decision to enter nursing. I disclosed my background as an educator, researcher, doctoral student and practicing nurse to the participants. I also verbally and non-verbally acknowledged similar experiences in my own practice as a nurse

in an effort to convey respect for their knowledge and experiences. A hallmark of poststructural feminism is the notion of constantly shifting identity. During the interview process, I felt my own identity shifting between researcher, nurse, educator, and student. I was personally affected by hearing some of the participants' experiences in the workplace. I felt privileged to hear about their new career plans, but at the same time, I was disheartened to hear some of the negative encounters they had experienced in the workplace. The next section analyzes the findings of the study in relation to the literature and in respect to a feminist poststructural lens.

The Findings In Light of the Literature and the Theoretical Framework

This qualitative study expands the body of literature on nurses and their intentions to leave the nursing profession. The participants had a wide range of experiences, ages, length of time in nursing, as well as varying educational backgrounds, which is consistent with the current body of literature that personal characteristics alone are not indicative of intentions to leave nursing; there is not a typical profile or particular demographic characteristics that have been found to accurately predict individuals who are more likely to leave the nursing profession. Through the conversations with the participants, the influence of gender was revealed in a number of ways. The findings suggest that women's career choices, work experiences, and decisions regarding professional turnover are influenced by socio-cultural constructs. Work experiences and career intentions are affected not only by social structures, but also by the intersection of these structures on the self.

This study supports the poststructural notion that social structures do affect identity development in respect to career decisions and work experiences. The findings of this study support the previous body of literature that organizational and structural factors are more of an influence on the decision to leave. While career decisions are an individual decision, they are

socially and culturally situated by the presence of external structural factors. As stated by Hayes (2000), “Social structures shape both our external circumstances and our internal consciousness” (p. 26). The participants’ work experiences and career decisions were found to be influenced by the intersection of socio-cultural structures on the self.

As discussed in Chapter Four, poststructural feminism resists the notions of categorization, but in an effort to coherently tell the data story, the data analysis coding process, resulted in themes of findings. The nurses in this study discussed many factors which were influencing their decision to leave the nursing profession. Five themes emerged from the data: (a) feelings of duty and obligation, (b) the power distribution in the hierarchy, (c) growing incongruity between working conditions and patient care, (d) interpersonal communication, and (e) shifting perspectives on work and self. Salient aspects of the themes will be discussed in relation to the relevant literature discussed in Chapter Two and in light of a feminist poststructural lens. Most of the findings of this study were consistent with the current body of research on this topic and some new findings emerged that had not previously been discussed in the literature relating to leaving the nursing profession. This discussion will make an effort to support, expand, or contradict what is currently known in respect to registered nurses who have serious intentions to leave the nursing profession. There will also be an effort to reframe previous findings using a feminist lens.

Feelings of Duty and Obligation

This finding relates to feelings of duty and obligation, which often were connected to their entry into nursing and subsequently to their intention to leave the profession. The participants expressed general feelings of wanting to care for others, which influenced their entry into the profession. This finding lends support to previous research that entry into nursing is

often related to a desire to care for others (Francis, 1999; Seymour & Buscherhof, 1991). This theme includes a discussion regarding entry into nursing and work decisions, which relate to this sense of duty and a discussion of the need to meet obligations to others. This will be followed by a discussion of the theme through a feminist poststructural lens.

Career choices. The participants discussed various influences in relation to career choice and career decisions. Many of the participants were encouraged by others to become nurses, particularly by their families. A few of the participants reported being supported to enter nursing because of their caring nature. Three of the older participants acknowledged the fact that career choices were very limited for women when they were deciding on a career direction. Nanny shared that she was not able to enter the Episcopalian priesthood when she was younger because it was not considered an acceptable career for women at the time. For two participants who were young, single mothers, nursing was a career choice that would enable them to provide for their families, and six of the participants were single mothers at some point during their careers as nurses.

Beyond the influence of family on entry into the profession, work schedules and job choices were often made to meet family needs. Even though job choices had often been made to fulfill familial obligations, the majority of the participants in this study did not perceive that their reasons for wanting to leave nursing were related to work-family conflicts. Previous research has shown that work-family conflicts are associated with a higher intention to leave nursing (Flinkman et al., 2008) and a shorter tenure in nursing (Duffield et al. 2004), but the results of the present study do not support this finding.

However, work-family conflicts did discourage some of the participants from leaving the nursing profession at an earlier time or from seeking additional education. Lynn and Redman

(2005) found that nurses with families who were dependent on their income were less likely to intend to leave nursing, which is supported by the findings of this study, particularly considering that only two of the participants have small children at home. Additionally, these participants both shared that they had spouses who were supportive of their decision to leave, but they also acknowledged that they needed to earn a similar income in their new careers in order to meet the economic needs of their family. In considering the challenges involved in making a career change, it is important to discuss how gender may impact the timing of an individual's decision to leave nursing. Women in the workforce have been found to have more responsibilities at home than men in the workforce and they continue to be primarily responsible for household duties and childcare despite the number of hours they work per week (Hochschild & Machung, 2006). These responsibilities may preclude them from making career changes, and it can be argued that the socialized role of women in the home continues to be a source of conflict for women in the workforce. The participants articulated some of the challenges they had faced in caring for their families while working as nurses. Even though they did not discuss work-family conflicts as being influenced by gender, there is a clearly a gendered dynamic present.

Duty towards others. For the nurses in this study, the role of caring for others and fulfilling obligations extended from the home and into the workplace. In addition to having feelings of duty and obligation towards their families, the participants had these feelings towards others as well, particularly patients. The participants felt obligated to provide the best patient care possible, including the emotional and psychological aspects of care. The participants had numerous concerns regarding patient care, and they expressed levels of personal dissatisfaction in not being able to meet patient needs. This finding supports the work of Cheung (2004), who found that nurses who had left the profession often perceived that their values, standards or

beliefs were compromised, and the work of Hart (2005) who found that ethical climate of the work environment influenced a nurse's decision to leave the profession if they felt patient care was compromised. This finding provides further evidence that the inability to do the caring work of nursing has an influence on intentions to leave the profession.

Language and the discourse of care. In analyzing this finding through a feminist poststructural lens, it is pertinent to discuss how language influences individual subjectivity in respect to career choices and work experiences. Language conditions identity, which can be conceptualized as a practice with individual subjectivity residing in a "rule-bound discourse" (Butler, 1990, p. 184). The language associated with nursing is feminine (caring, kind, nurturing), which has influenced the social construction of nursing as a female occupation, and it has also situated the subjectivity of a nurse as a care-taker. The career choice of nursing remains socially constructed as a feminine occupation (Davies, 1995). As stated by Rose, it is a "pink-collar" profession. There was awareness by some of the participants that they were encouraged to enter nursing because it is conceptualized as a "good" career choice for women. There was awareness that feminine attributes such as caring, empathy, and compassion are associated with the nursing profession, but the participants did not explicitly acknowledge that they were encouraged to become nurses by others because of their gender. The participants made very few references to gender in discussing their entry into the nursing profession, but there was some awareness that women did not always have the same career opportunities as men. This finding supports the literature base on the influence of gender role socialization in making career choices. Herron (2007) also found that gender role orientation is an influence on career choice and practice in nursing.

This finding also supports the notion that women are socialized to put the needs of others first and they are assumed to possess natural caretaking skills. The participants who made work decisions to benefit their families did not express that it was because they were women and they did not express regret towards their families; it was expected that they would fulfill their familial obligations. The influence of gender was present in this finding, but mostly on an unconscious level, which supports the works of Bierema (2003) and Clark, Caffarella, and Ingram (1999) that women often lack gender consciousness in relation to career experiences. Poststructural feminism is valuable in shedding some light on the insidious nature of gender unconsciousness. The process of making meaning from our experiences is based on particular ways of thinking, which structures our subjectivity (Weedon, 1987). Davies (1995) suggests that the visible nature of gender makes it a familiar concept which is associated with certain behaviors; these normal expectations often function in a way that conceals the role gender plays in organizational structures, relationships, and cultures. Because our subjectivity is socially and culturally constructed, alternative explanations to gender inequalities may not even be recognized, or they may be ignored because they may seem monumental to address (Bierema, 2003).

Additionally, the participants discussed the importance of providing holistic care to patients and one participant acknowledged that this attribute may be exploited in the workplace. In Traynor's (1997) analysis on the discourse between nurses and managers, he argues that direct care nurses "tended to develop a subjectivity forged out of a sense, on the one hand, of moral agency in their caring 'duty' and, on the other, of exploitation by managers and 'the system' as a whole." This dichotomy can place the nurse in a position of self-sacrifice. Then, nurses have "to contend with what appears to be a dichotomy between the duty to care for others and the right to control their own activities in the name of caring" (Muncey, 1998, p. 411). The inability to fulfill

their obligations to adequately care for patients was a source of dissatisfaction to the participants and was causing them to consider leaving the profession. This finding seems to point to the possibility that the reasons for entering nursing might be related in some ways to the reasons for exiting nursing, which has not been discussed in the literature on intentions to leave. The value that nurses place on their relationships with patients cannot be underestimated. As stated by Bierema (2001), “Relationships and caring are important aspects of women’s identity” (p. 58).

The Power Distribution in the Hierarchy

This theme relates to the participant’s perceptions of power and access to power structures in the workplace that have influenced their decision to leave the nursing profession. The healthcare organization was portrayed as patriarchal and hierarchal by the participants, which was perceived as adversely affecting their work experiences in several ways, including opportunities for advancement and level of compensation. They felt positioned below insurance companies, administrators, physicians, and patients. The work environment in healthcare systems has traditionally been hierarchical and patriarchal in structure (Davies, 1995; Fletcher, 2006; Kane & Thomas, 2000; Reverby, 1987), and the presence of women decreases at higher levels on the hierarchical ladder (Bierema, et al., 2002; Dubeck & Dunn, 2006). The power distribution in the hierarchy was perceived by the participants as affecting their positionality in the organization, their opportunities for advancement, their level of compensation, and their access to power structures. The subthemes related to this finding will be discussed in the context of power within a feminist poststructural framework.

Positionality, language and power. The feminist poststructural notions in regard to positionality and power are relevant in providing some analysis here. Positionality is the vantage point from which one views the world (Ogle & Glass, 2006). In discussing their positionality,

the participants used language to reflect being “below” or “at the bottom”, which reflects their sense that power is often exerted over them and their access to power structures is limited. The participants perceived that the workplace was constructed by those in power and the reality at the top is not the same as the reality below. The participants discussed how insurance companies drive patient care and the difficulties nurses have in meeting regulatory requirements. A few of the participants reported that they felt like they were constantly being watched, which relates to Foucault’s concept of hierarchical observation. This concept of centralized observation is typically discussed in reference to Foucault’s (1980) discussion of the Bentham Panopticon, which is a prison design that allows an overseer to view all of the prisoners from the watchtower (the panopticon) in the center; the prisoners are unable to determine if they are being watched. Interestingly, Foucault initially discussed hierarchical observation in respect to medical institutions in seeing how space was managed and inscribed for constant observation of patients (Foucault, 1980). The belief that one is being watched causes an individual to act and perform in certain ways. This self-surveillance is a disciplinary form of power where we discipline ourselves (Brookfield, 2005); we perform certain actions because of the possibility that we are being observed.

Building on the Foucault’s notion of hierarchical observation is the concept of normalizing judgment, which relates to how individuals monitor themselves in comparison to normative standards (Bradbury-Jones, Sambrook, & Irvine, 2008). Four of the participants reported that they were unable to complete their work as home health care nurses during their assigned work hours. They all verbalized that documentation was sometimes completed in unreported hours, because there could be repercussions for not completing work in a timely manner. By having awareness that others received repercussions, nurses carefully monitor their

own behavior. Additionally, managers were giving the participants the impression that other nurses were able to complete their work on time. Some of the participants realized this was not true when they had the opportunity to speak to other home-health nurses. It is important to note that these participants all worked at different home health care agencies, so this practice did not only occur at one place of employment. The discussion surrounding a lack of compensation in respect to completing required work is particularly striking. The fact that nurses who are working to meet the needs of patients are not compensated, and possibly reprimanded, for not being able to complete their work in the time frame mandated by an organization does not seem to value the contribution nurses make in the community. This finding lends support to the work of Tourangeau and Cranley (2006) that having to work additional hours to complete shift work is a source of dissatisfaction for nurses, and it expands this work because the source of discontent is deeper than the actual completion of the work. Additionally, the concepts of hierarchical observation and normalizing judgment as forms of disciplinary power are further supported through electronic patient documentation, because all information regarding patient care is stored and can be recreated at any time. Thus, not only are actions being watched, but a nurse can be held responsible for them at multiple times in the future. Furthermore, electronic medical records can store the date and time information was entered, noting the timeliness and efficiency of task documentation, which can reinforce the perception of a lower positionality in the hierarchy.

Also related to positionality, is the language the participants used in reference to the organization and those above them. They often used words such as “they” or “them” with no names or position mentioned, which implies a sense of a nameless, faceless organizational construct with no personal connection or contact with the nurses. Sumner and Townsend-Rocchiccioli (2003) suggested that “the perceived inanimacy of the organization” (p. 166)

creates a problem for the nursing profession because nurses value the human connection in their work.

Additionally, many organizations have worked to flatten their hierarchies because of increased competition and the need for efficiency (Mojab & Gorman, 2003). However, a criticism of this model is that it prevents power differences from being visible, because organizations are now outsourcing certain types of work, which can create an “illusion of worker autonomy” (Mojab & Gorman, 2003, p. 232). Because nurses are essential for the functioning of healthcare institutions, their work is not outsourced, which may affect their positionality within the organization if other jobs that were typically below them on the hierarchy, such as housekeeping and food services, are no longer employed by the organization. In any case, a lack of contact between nurses and organizational administrators can lead nurses to perceive that they have a low positionality and limited access to power.

Furthermore, nursing has historically been positioned below medicine on the organizational hierarchy (David, 2000), and this study reflects that is the perception of the participants. Participants discussed episodes of verbal abuse by physicians and patients when describing some of their experiences at work, and several of the participants discussed “being demeaned” by physicians. The participants did not spend extensive time during the interview discussing specific physicians or particular encounters; many of the references to physicians were general comments. A few of the participants used words such as “servant” and “handmaiden” to describe how they were treated by physicians at times. Some of the participants acknowledged using approaches with physicians that played on this power dynamic to make physicians feel like they were in control regarding patient care decisions. In a poststructural framework, language is socially constructed by those who wield the most power

(Doering, 1992). As stated by St. Pierre (2000, p. 485), “Language gathers itself together according to socially constructed rules and regularities that allow certain statements to be made and not others.” In the healthcare system, physicians wield significant power, which influences how they communicate with nurses and how nurses navigate communication with them.

Many of the participants were dissatisfied with the relationships between nurses and physicians, and it was evident that they often felt disrespected. There were no studies reviewed that specifically examined nurses’ relationships with physicians and intentions to leave the nursing profession. However, Tourangeau and Cranley (2006) found that level of teamwork was a statistically significant predictor of intention to remain employed and Shader et al. (2001) found high group cohesion to be related to increased job satisfaction and decreased job turnover. The findings of this study support the importance of fostering collegial relationships in the workplace, which includes the relationships between nurses and physicians.

Additionally, in the literature relating to intentions to leave the nursing profession, any type of behavior that intimidates, patronizes, or disrespects another person is considered to be verbal abuse (Sofield & Salmond, 2003). Episodes of verbal abuse are categorized as a form of workplace violence, and incidents have been found to be high in healthcare institutions (Sofield & Salmond, 2003). None of the participants specifically identified the encounters they discussed as “abuse” or any type of “workplace violence”. When the participants discussed the negative behaviors expressed by physicians or managers, they did not verbalize that any of these incidents were ever addressed by administrators and only participant shared that she had filed a report with human resources. This finding seems to suggest that nurses may be tolerant to these types of behaviors as suggested by Sofield and Salmond (2003) and supports the research study by

Johnson and Rea (2009), which found that nurses who experienced workplace violence were more likely to have intentions to leave.

Furthermore, in the research studies by Cheung (2004) and Joshua-Amadi (2003), nurses who had left nursing or were at the point of leaving nursing discussed experiences with workplace violence. However, the majority of the studies examining the relationship between workplace violence and intentions to leave the profession did not demonstrate a statistically significant relationship. This study provides some evidence that workplace violence is an influencing factor on intentions to leave and certainly warrants further investigation. The conflicted relationships between nurses and physicians may not only be related with differences in positionality, but also to differences in class. Class differences between nurses and physicians have deep historical roots as previously discussed in Chapter Two and are partially due to the differences in educational preparation between nurses and physicians. Having a low positionality influenced the participant's experiences in the workplace, which affected their perceptions of how nursing knowledge was viewed within the organizational hierarchy.

Knowledge and power. The participants felt that the power structure in the hierarchy influenced their access to learning both formally and informally, as well as their opportunities for advancement. They reported that it was difficult to complete mandatory educational requirements during the work day, and some participants were not compensated for completing them outside of work hours. In general, the participants did not find this type of education to be meaningful to their nursing practice and completed it because it was required. Some of the participants discussed the fact that benefits to attend educational conferences and to advance educational level had been significantly cut back or eliminated by their organization. The lack of support for education contextualizes the belief that knowledge development was not necessary to

perform their job duties and by not giving nurses time to learn new information reinforces the notion that the role of the nurse is “to do”.

In addition to feeling that there was little support for expanding knowledge, the participants also felt that there were few opportunities for advancement. Three participants used the phrase “feeling stuck” in respect to advancement opportunities; for example, Genevieve stated that she felt like she “hit the ceiling” after only a few years in practice. Deedee verbalized that she feels nurses often perceive a lack of career mobility, but she felt that she does have career mobility since she has a master’s degree and experience in management. However, other participants felt that neither education nor experience was valued in the workplace. Betsy expressed dissatisfaction that she did not receive a higher level of compensation for having a baccalaureate degree, because she had more education and had invested more time and money than nurses who had attended associate degree program.

On the other hand, Mary felt that she did not get an administrative position that she felt she was qualified for because she only had a diploma in nursing. For these participants, it seems that neither knowledge derived from education nor knowledge developed from experience was valued in their workplace or to potential employers. Having limited opportunities through healthcare organizations to gain additional knowledge, and having a lack of opportunities for career mobility impacted the way these participants perceived their value to the organization.

This study supports the findings of Fochsen et al. (2005) and Flinkman et al. (2008) that a lack of professional opportunities is related to higher intentions to leave nursing. Furthermore, Nedd (2006) determined that the opportunity for additional knowledge development was critical to level of empowerment, which was found to be positively related to intentions to stay within the profession. In relation to adult education, Daley (2002) found that nurses often attend

continuing education programs to learn about the care of a specific patient, which underscores the value of promoting educational opportunities for nurses. The finding that a lack of opportunities is an influence on intentions to leave adds depth to the previous research. In a feminist poststructural lens, the participants not only had difficulty in acquiring knowledge, but they felt excluded from knowledge production.

Gender and power. As the participants described their work experiences in respect to positionality, career opportunities, and compensation, they did make some references to the influence of gender. Even though physicians were referred to as male, most of the participants did not attribute negative physician behaviors to be the result of socio-cultural structures. One participant did state that female physicians do not generally treat nurses any better than male physicians. When asked if their experiences in the workplace were influenced by the fact that nursing is a female profession, the participants all answered yes and then the subsequent conversation often surrounded to male nurses.

Some participants felt that male nurses were treated better by physicians and had greater advantages in the workplace, particularly in respect to advancement opportunities, which was also found by Porter (1992) in his research on gender and power in the hospital environment. There was a sense that the glass ceiling existed even within a female dominated profession. These perceptions do have some validity, but research related to the presence of men in nursing administration has been varied. Studies have shown that men are more likely to hold a leadership position in nursing (Evans, 2004; Whittock et al., 2002), but Snyder and Green (2008) reviewed data from the National Sample Survey of Registered Nurses for a period of over twenty years and did not find that men are disproportionately represented in nursing administration. However, comparisons of career development have found that even when men are not present in

greater numbers in leadership positions, they typically have a more linear trajectory than women (Tracey & Nicholl, 2007), partially because masculine traits such as objectivity, stability, and assertiveness are characteristics valued in the hierarchy.

While men may not receive more promotions, they may have more advantages in the workplace than women by making more money and having more linear career trajectories. One participant questioned if men make more money than women in nursing, and male nurses have been shown to have an economic advantage in nursing by making an average of 11% more than female registered nurses (U.S. Department of Labor, 2007). In this study, the participants seemed satisfied with their salaries as nurses and did not discuss the wage gap. The present study does not support previous research that demonstrated that salary itself is a reason for leaving nursing (Barron & West, 2005; Barron, West, & Reeves, 2007; Flinkman et al., 2008; Foschen et al., 2005).

Despite the perceptions that male nurses receive preferential treatment in the workplace, the participants did verbalize that there is a need for more men in nursing, and they believed that the presence of more men in nursing would be advantageous to the profession, which was also found by Herron (2007). The participants perceived that men are more outspoken in the workplace and would not be as willing to put up with adverse working conditions, therefore increasing positionality. Research has shown that men have higher intentions to leave nursing than women (Barron et al., 2007) and that higher numbers of men have actually left nursing for another career (Barron & West, 2005), so it is possible that men within a female-dominated profession feel more constrained by gendered social structures in the work environment.

Voice and power. The participants in this study did not feel that they possessed much power within their organization and their attempts to exercise power were often met with

resistance. They often felt powerless in regard to decision-making, and they resisted speaking up if they perceived that their voice had previously been ignored. Nurses are socialized to follow rules (Farrell, 2001) and to not act in ways that are disruptive to the organizational social system. They often adopt strategies of non-confrontation in an effort to survive in a patriarchal environment, which can silence their voice.

The few nurses in this study who gave examples of situations when they had voiced concerns regarding either patient care or work distribution (Flash, Jewelrylady, and Mary) all perceived that they met resistance from their direct managers, and they all felt that they had faced repercussions. Furthermore, in some cases, participants felt that they were berated by their managers before they had an opportunity to share their perspective. In a study exploring women's workplace learning, Howell, Carter, and Schied (2002) found that there was a subtle message within the organization that the only acceptable voices from women are those that are "cheerful, positive, and supportive" (p. 118), and women who do not utilize voice in this way were viewed as "deficient, not team players, uncooperative, and unwilling to accept decision-making responsibilities" (p. 118). In the literature, direct managers were not found to be an influencing factor on intentions to leave the profession (Barron et al., 2007; Coomber & Barriball, 2007; Tourangeau & Cranley, 2006). The findings of this study do not lend support to previous research and point to the possibility that direct managers may play a critical role in influencing the decision to leave the nursing profession. It is possible that nurse managers are often in a difficult position, because they are working within the realms of the patriarchal, hierarchical organizational structure to manage a group of employees who are primarily women.

Based on the interpretation of the data in this theme, structural barriers in the workplace affect positionality, access to power structures, advancement opportunities, and compensation

are an influence on the decision to leave nursing. In general, the participants did not seem to attribute their lack of power, lack of opportunities for advancement, or lack of voice as being only related to gender inequity or the occupational segregation of nursing as a female profession, but there was some awareness that gender does influence work experiences, particularly in respect to advancement and voice. According to Bierema (2001), “Too many women overlook, discount, or conceal their knowledge of gendered power relations” (p. 60). In a way, the participants were exerting power and demonstrating a capacity for agency by stating an intention to leave the profession.

Incongruity between working conditions and patient care

The participants discussed often feeling like they were unable to provide adequate nursing care or have a sense of completion about their work. Overall, they felt that they had received an adequate education to perform as a registered nurse, but several participants stated that they felt unable to do the job they were educated to perform and voiced that they did not have enough time to spend with patients. They specifically felt unable to spend time connecting with patients and providing basic nursing care, such as emotional support. The participants discussed several factors that interfered with their ability to care for patients or perform their job role. The three main factors discussed were: (a) workload, (b) the physical environment, and (c) technology.

First of all, the participants perceived their workload to be high. They used words such as “hectic”, “chaotic”, “frazzled”, and “unbelievable” to describe their typical day at work. These descriptions create a picture of continuous action with little time to reflect on the care they were responsible for providing or the work they were performing. The descriptions of their work day seemed to reflect similar sentiments regardless of age, years of experience in nursing, or

work setting. The participants perceived that little regard was given to patient acuity and workload was distributed based on numbers, rather than patient needs. The complexity of patients needing healthcare has increased tremendously, and the participants who had long tenures in nursing discussed how patient needs had changed over the years. The organizational structure was found to influence workload distribution, which ultimately impacts patient care and the satisfaction of the individual nurse. This data supports the findings of Barron et al. (2007) that feeling overworked contributes to higher intentions to leave, which was also found by Joshua-Amadi (2003). The relationship between workload and intentions to leave the profession has not been studied extensively, and this finding adds depth to the previous literature base and suggests that a high workload does influence intentions to leave the profession. Further analysis on the issue of workload will be offered in the next section.

Secondly, four of the participants were dissatisfied by their physical work environment. Newer inpatient units were described as large and unit designs were not described as conducive to performing their job. This finding suggests that practicing nurses may not have input into decisions regarding unit designs or that enough consideration was given to functionality. Additionally, two participants who had experiences in home health reported that geographical locations were often not factored into their patient assignments. The finding that the physical environment was an influence on intentions to leave the profession is a new finding and was not found in the body of literature reviewed. Furthermore, many of the studies exploring the work environment were conducted with hospital-based nurses, so this finding points to a need to explore the physical work environment for nurses in a variety of settings.

Thirdly, the participants expressed dissatisfaction with technology in the workplace and voiced that computerized documentation had increased their workload, which they felt had not

been adjusted to reflect the increased time it takes to document electronically; this was a surprising finding and was not discussed in the body of literature on intentions to leave. The participants reported that some of the documentation they do is mandated by regulatory requirements and does not improve patient care. They also felt that the inherent message from the organization is that particular aspects of care must be documented, regardless of whether this means adequate time can actually spent performing the care. Additionally, a few of the participants perceived that technology has removed some of the human aspect from nursing care, because computers create a physical barrier between the patient and the nurse; this point was made by even the youngest participant in the study. The influence of technology on workload and as a potential cause of nursing turnover was not found in the literature.

As stated previously, the participants perceived that there was a lack of support for the caring work of nursing and this finding lends further support to previous research that the inability to provide adequate patient care is an influence on the decision to leave nursing (Joshua-Amadi, 2003; Cheung, 2004; Reeves, West, & Barron, 2005). Additionally, the study by Reeves, West, and Barron found that nurses who were dissatisfied with their ability to provide patient care rated their working lives and conditions less favorably, and this finding was consistent regardless of whether or not the participants felt they had received an adequate educational preparation for nursing. The participants were not dissatisfied with nursing itself, but rather by the inability to do the work of nursing. This finding adds depth to the previous research on intentions to leave by bringing forward technology and the physical environment as influences on workload.

Discourse, knowledge, and caring. In analyzing this finding through a feminist poststructural lens, it is pertinent to discuss the caring discourse of nursing. It is also important

to discuss the potential ways in which organizational structures contribute to the factors that impede nursing work and how the influence of gender was present in this finding. Culturally and historically, the foundation of nursing practice has been in relation to caring (Colliere, 1986; Sumner & Townsend-Rocchiccioli, 2003). The profession of nursing has been constituted as women's work with duty towards others to be performed generously and with great compassion (Crowe, 2000). In opposition to this traditional construction of nursing work is the reality of managed care, which currently shapes the structure of nursing practice (Crowe, 2000). The discourse the participants described being situated in did not seem to value the caring discourse of nursing, which supports this concept that the culturally constructed discourse of nursing is not in alignment with actual practice.

Applying a feminist poststructural lens to this finding connects back to the notion that the caring work of nursing is not highly valued within healthcare organizations and suggests that nurses are unable to practice in ways which maximize their level of knowledge and skill (Colliere, 1986; Duchscher & Myrick, 2008). Caring practices enable nurses to derive knowledge regarding individual patients (Muncey, 1998), and nurses connect "feelings" about patients to what they rationally know in order to provide care. For example, physician orders often result from a collaboration between a nurse and a physician, although the nurse's knowledge in bringing forward concerns is typically not recognized (Duchscher & Myrick 2008; Porter, 1992), thus, hiding a nurse's contribution to patient care (Davies, 1995; Fletcher, 2006). Deconstruction of the dominant discourse reveals a lack of respect for the knowledge and caring practices of nursing, and situates nurses in a medical discourse. The effect of this practice is that knowledge from the medical discourse excludes knowledge from the nursing discourse (Cheek, 2000).

Furthermore, organizational culture in healthcare institutions has transformed from one of public service to one of a business model (Duchscher & Myrick, 2008). This cultural shift de-emphasizes relationships between healthcare providers and patients, which are the foundation of nursing practice. The medical discourse dominates the language in healthcare (David, 2000), and organizations are dependent on illness, rather than wellness, for profits. These structural factors lead to uncertainty about the role of nursing, and this study supports the findings of Daley (2000) that ambiguity about work roles and responsibilities occurs when differences exist between nursing subculture and organizational subculture.

In respect to the environment and technology, fields such as architecture and information technology remain socially constructed as masculine occupations (Dubeck & Dunn, 2006). This may provide some explanation as to why nurses were not overly involved and possibly excluded from decisions regarding unit designs or computerized technology. Adequate nursing care was portrayed by the participants as encompassing more than performing tasks and documenting. The emphasis on time on task is magnified with the use of computerized technology. “Conformity to task/time imperatives attests to a highly structural efficiency model of nursing organizations” (Farrell, 2001, p. 28). This finding reflects the fact that socio-cultural influences related to economics and technology can prevent nurses from feeling they are providing adequate nursing care for patients. A lack of respect for the human aspect of nursing work, can lead to victimized behaviors, such as a lack of autonomy, helplessness, and powerlessness, in nurses (Roberts, 1983; Sumner & Townsend-Rocchiccioli, 2003), which can affect communication between nurses.

Interpersonal Communication

The participants perceived that workplace communication between co-workers is often ineffective and is a source of tension in the workplace. Some of the participants expressed that attitudes and verbal, as well as nonverbal, communication between co-workers was negative at times. Conversations between nurses were discussed as centering on topics other than patient care such as children, attire, and co-workers. Participants discussed how women “are” with each other, and the adage that “nurses eat their young” was a phrase used by several participants. A few of the participants felt that men were able to communicate more effectively in the workplace and did not engage in conversations unrelated to their work. Moreover, they were able to be “up front” with their needs.

The participants were unsure of what could be done to change ineffective communication patterns amongst nurses, but they were clear that such behaviors are unacceptable and can discourage nurses from remaining in practice. Expressing negative behavior, including intimidation, humiliation, criticism, and denial of opportunities, is referred to as horizontal violence (McKenna et al., 2003). A research study examining the effects of horizontal violence on new graduates found that the majority of the participants had experienced some form of horizontal violence and 34% had considered leaving nursing because of the episode (McKenna et al., 2003). As stated previously, teamwork and group cohesion have been found to influence intentions to leave (Shader et al., 2001), and satisfaction with collegiality was found to be an influence on intentions to stay in a nursing position (Lynn & Redman, 2005; Tourangeau & Cranley, 2006). This finding provides further support that poor interpersonal relationships are an influence on career turnover in nursing.

A few of the participants attributed negative workplace behaviors and communication styles to be the result of stress. Moon felt that these types of behaviors are the result of not having a venue to express feelings about difficult situations. Nurses have tremendous responsibilities in the work environment and the effects of stress can manifest themselves in many ways, including the use of communication patterns that are not therapeutic. Previous research has found that higher levels of job stress are positively correlated to intentions to leave the profession, particularly for younger nurses (Lavoie-Tremblay et al., 2008; Letvak & Buck, 2008; Shader et al., 2001). This study expands the body of knowledge on job stress and intentions to leave nursing, because it adds depth by describing some of the sources of stress, including communication patterns.

In addition to being frustrated with ineffective communication with other nurses, four of the participants discussed being disappointed by the lack of cultural sensitivity demonstrated by other healthcare providers. They felt that patients were sometimes unfairly judged without consideration for individual perspectives. These participants particularly discussed the importance of being sensitive to issues, particularly related to class and ethnicity, in caring for patients. Dissatisfaction with a lack of cultural competence was not discussed as being an influence on the decision to leave nursing in the literature.

From a feminist poststructural perspective, gender was perceived to be an influence on communication patterns between nurses. The patriarchal structure of healthcare organizations maintains gendered power differentials (Fletcher, 2006). Nurses may engage in negative behaviors towards each other if they do not feel they have access to power structures, which leads to the use of techniques that are passive and indirect (Roberts, 1983). While oppression theory has long been believed to be the cause behind negative interactions between nurses,

Farrell (2001) further argues that some workplace practices are under the control of nurses themselves, which opens up the possibility for changes in the work environment. Although it is difficult to deviate from long-held beliefs (Tisdell, 1998) and practices, expressions such as “nurses eat their young” need to be re-worded in an effort to deconstruct workplace practices that lead to interpersonal conflicts. Without heightening awareness of behaviors which maintain the status of nursing as women’s work, nurses will continue to engage in self-defeating behaviors in an effort to “relieve the tensions that arise out of situated subservience” (David, 2000, p. 85) which keep them situated on the margins of the healthcare system.

Shifting Perspectives on Work and Self

The participants expressed the need to shift their perspectives on work and the role it had in their life. Many of the participants discussed that they needed to care more for themselves, which was influencing their decision to leave nursing. The majority of the participants had experienced serious health problems in the past few years, which seemed to serve as a catalyst for re-thinking the role work played in their life. The participants who discussed the effects work had on their health were aware that this was an influence on their decision to leave. They were attempting to step beyond the influence of the work environment in an effort to listen to themselves. They were in a place of shifting from their identity as a nurse, which centered on the desire to please others, towards an identity that centered more on a desire to please the self.

With these shifting perspectives, there was also a sense of fear about leaving nursing, because it was a “safety net.” Some of the participants had wanted to leave nursing for a long time, but had experienced barriers, such as not having the time or the money to pursue another career. Many of the participants verbalized that if their new career plan did not work out, they could always return to nursing, and they were also aware that they may not be able to fully

support themselves economically in their new career initially and may need to work part-time as a nurse.

The decision to leave was not easy to make for most of the participants, which is consistent with the findings of Cheung (2004). Even though they expressed dissatisfaction with some of the elements in their current work environment, they mainly discussed nursing as a profession in positive terms. All of the participants discussed factors that were sources of dissatisfaction in nursing, but many of the participants wanted to leave nursing to pursue a passion. The desire to find passion in their work was important for them and speaks to a need to reconceptualize the relationship between work on individual subjectivity. This finding points to a need to develop a greater understanding of the role of work in people's lives (Barron et al., 2007).

The participants had intentions to enter a wide range of careers, which is consistent with the findings of Duffield et al. (2004) who found that nurses who left occupied a wide range of positions outside of nursing. They also found that nursing education prepared nurse for work outside of nursing, and those who had left the profession did not find it difficult to adjust to working in a non-nursing position. Most of the participants in this study planned to seek job roles where they would be working more independently than they were in their roles as nurses. Additionally, many of them were seeking roles where they would still be in a service position, but one they hoped would lead to a better care of the self. The socialization of women into their roles as nurses can lead to a lack of care for self, which can be emotionally exhausting contributing to burnout and professional dissatisfaction. Future career plans have not been included in the research studies relating to intentions to leave, so this finding expands the previous body of research and is worthy of further exploration.

In a poststructural feminist framework, subjectivity is not fixed and the individual is a site of conflicting subjectivity (Weedon, 1987). Most of the participants seemed to strongly identify with their identity as a nurse. They espoused the attributes associated with nurses in many aspects of their lives, which created a personal identity that was tightly bound to their work identity, which may explain why the decision to leave nursing was a source of struggle for many of the participants; they were still positioned within nursing, but repositioning themselves for another career. However, it is possible to be “in multiple, shifting discourses” at one time because “the self is not coherent” (Francis, 1999, p. 21). Even though leaving one’s career demonstrates a capacity for agency, the decision is limited by available career options, support for further education, and financial status, which demonstrates that societal structures do influence individual decisions regarding career choices. As stated by St. Pierre (2000), “a subject that exhibits agency as it constructs itself by taking up available discourses and cultural practices and a subject that, at the same time, is subjected, forced into subjectivity by those same discourses and practices” (p. 502). They were in the process of deconstructing their experiences as nurses and reconstructing them for a new career, which supports the poststructural notion of a constantly shifting identity.

Summary of the Discussion

The findings in this study have contributed to the existing body of literature on intentions to leave the nursing profession and highlights the need to reframe some of the issues that are contributing to the nursing shortage. This research study offers support and depth to what is currently known on this topic and has given some new insights into the reasons nurses may choose to leave the profession. Based on the discussions with the participants, it is evident that there is some dissatisfaction with certain aspects of their work and they have experienced

varying levels of stress due to multifaceted issues, but not all of the participants were leaving nursing due to issues of dissatisfaction with the profession. This work has created a foundation for examining the influence of gender on professional turnover for female registered nurses. The use of a feminist poststructural lens is a valuable framework for studying nurses, their work environments, and career development.

Implications for Practice

Based on the findings of this study, there are several recommendations for practice. It is important to keep in mind that some of the women in this study wanted to leave the nursing profession in order to pursue their passions; it is not my intent to make suggestions that would compel nurses who want to pursue second careers to remain working as a nurse. It is unknown as to whether changes in the work environment would alter the decision to leave. However, there are recommendations for both the fields of nursing education and adult education that can be gleaned from the findings of this study. It is imperative that these fields pose challenges to the social construction of nurses and their work, which can ultimately influence practice and retention in a profession that is already experiencing a shortage of workers.

Implications for Nursing Education

After critically examining the role gender plays in the nursing profession, there are some strategies that can be employed in nursing education to address concerns voiced by the participants in this study that were influencing their decision to want to leave the nursing profession. The majority of the recommendations are specifically for nursing education, but some broader implications for educators who work with nurses in the workplace will also be discussed. Poststructural feminist pedagogies extend the theoretical foundations of the framework into teaching practice (Tisdell, 1998). In general, feminist pedagogies emphasize

trust, mutual respect, and collaboration, and poststructural pedagogies call attention to practices which marginalize and oppress related to class, race, gender, ethnicity, and sexual orientation. Poststructural feminist pedagogies also acknowledge emotions and investigate how social systems operate, which are both relevant to the nursing profession. Furthermore, this type of approach to teaching can connect individual beliefs with theory (Larson, 2005).

My first recommendation for nursing education is to include discussions about feminism and feminist theories to heighten awareness of particular socio-cultural issues that shape women's experiences in respect to work. Nursing education has not typically included discussions about the fact that it is a women's profession or included the history of nursing from a feminist perspective (Roberts & Group, 1995). Nurse educators can work to heighten awareness of the influence of gender role socialization on career choice and workplace experiences. Teaching student nurses about the forces of oppression that have shaped the profession can lead to rich dialogue and personal insights about the historical roots of nursing (Kane & Thomas, 2000), which can raise consciousness of issues that may be the result of gender discrimination and gender role socialization.

Secondly, more time needs to be spent discussing nursing's positionality within organizations and all of the elements within an organization which impact the role of the nurse beyond the care of patients. These discussions should be facilitated at the undergraduate and graduate levels. Nurses need to be given the space to talk about the forces that have socially constructed their position in health care from a gender standpoint. Gender is socially and culturally constructed in the constitution of organizations through an emphasis on masculine attributes such as rationality and efficiency (Davies, 1995). Discussions surrounding topics such as the glass ceiling would also be pertinent. While all of the participants in this study agreed that

gender does impact work experiences, most of the direct responses concerned the presence of men in nursing, which underscores the need to heighten awareness regarding the multiple ways that gender influences the workplace, both consciously and unconsciously.

Thirdly, nurse educators need to increase dialogue within the classroom. Communicative dialogues allow both teachers and students to gain deeper insights into problems which exist. Dialogue and self-awareness are needed to move beyond a state of dualism, which prevents nurses from developing new possibilities for practice (Fletcher, 2006). By creating opportunities for discourse, space can be created to explore systems of privilege and oppression in respect to the positionality of nurses and their practice. Furthermore, engaging students in communicative dialogues encourages the development of voice. In this study, the participants did not feel that their voice was often heard in the workplace and they had a lack of access to power structures. Educators can facilitate the development of voice so that nurses are able to more fully describe the work that they do, their role in the healthcare system, and the value of caring practices. This work must be facilitated during the education process and supported by organizational culture. More emphasis needs to be given towards promoting a sense of voice and discussing ways to confront issues in the workplace. Nursing education needs to include more than information about patient care; it also needs to call attention to structural issues around organizational culture which affect nursing practice.

Nurse educators can call attention to the importance of caring for self and teach techniques for self-nurturance. The participants in this study experienced adverse effects on their personal health as the direct and indirect results of their work as nurses. Several of the participants developed their own coping strategies to deal with difficult issues, and a few acknowledged that they changed positions within nursing in order to care for themselves more

effectively. Based on the findings of this study, nurses have the propensity to care for others before caring for themselves and spaces need to be created for self-nurturing practices in education and in the workplace. Healthcare providers often deal with difficult ethical dilemmas and organizations need to provide opportunities for debriefing and make efforts to connect nurses and other healthcare providers to mental health professionals on a regular basis. Opportunities to debrief can also promote collaboration between nurses and physician (Nathaniel, 2006), which was a source of dissatisfaction for the participants.

Finally, nursing education programs need to critically examine their approach to recruitment into the profession. Nurse educators can pose challenges to the socio-culturally constructed image of the nurse, which tends to be white, female, and subservient, and work to transform it from one of a handmaiden to one of an educated professional. Furthermore, recruitment into nursing needs to be conceptualized differently. Duffield, Aitken, O'Brien-Pallas, and Wise (2004) suggest that promoting nursing as a career that can lead to diverse work opportunities in other fields could potentially enhance recruitment into nursing. Promoting nursing as a career with a multiplicity of future work opportunities has the potential to increase recruitment and also attract diversity into the profession.

Implications for Adult and Continuing Education with Nurses

In addition to implications for nursing education, there are also implications for adult educators involved in workplace education based on the findings of this study. The participants in this study viewed continuing education in the workplace to be directed at meeting organizational standards and delivering good customer service rather than enhancing skills or knowledge of the nurse. Workplace education needs to be designed to be meaningful and useful to nurses and not simply as information to meet organizational standards. The findings of this

study suggest that during a typical day, nurses do not have much time to engage in activities beyond their assigned workload. With this in mind, organizations need to develop ways of restructuring work schedules and workloads to provide nurses with greater opportunities for participation in education and organizational decisions which affect healthcare delivery.

Healthcare organizations need to invest time and energy into leadership development. The participants in this study felt disconnected from administrators and perceived that they were unaware of workplace conditions and the realities of nursing practice. There is a need for organizations to support leadership practices which increase administrative visibility. Regularly soliciting feedback from nurses and other healthcare providers promotes a sense of voice.

Adult educators in various settings can work to address issues discussed in this study that impact nursing retention, the work environment in healthcare organizations, and women's career development. Curricular, organizational, and pedagogical changes are essential if nurses are going to be prepared to deal with career challenges that may influence their retention and tenure within the profession.

Limitations and Implications for Further Research

This study has provided a foundation to support future research on the factors that influence a female registered nurse's intentions to leave the nursing profession. To my knowledge as the researcher, this is the first study in the United States to qualitatively explore the reasons women may choose to leave the nursing profession. Like any study, the present study has strengths and limitations, which set the stage for further research. While this research study had a strong rationale and methodology, there are some limitations worthy of discussion.

In this study, participants were limited to female registered nurses who had varying levels of education, and to those who voluntarily stated they had intentions to leave. A second

limitation to this study is that it only focused on the influence of gender as a social structure. Additionally, within a feminist poststructural framework, the experiences of the participants are socially and culturally situated, which somewhat limits generalizability.

The first recommendation for future research is to replicate the study, possibly with a larger sample size. A second recommendation would be to conduct a longitudinal study to determine if intentions translated into actions, and to explore any additional factors which may have influenced their final career exit. A third research study could be conducted with nurses who have already left the profession to gain insights into their current work experiences and to evaluate how their nursing skills transferred into their new career. Fourth, a similar study should be conducted with male registered nurses who are considering leaving the profession of nursing to explore the factors that have influenced their decision, particularly in light of the fact that men have been found to leave nursing at a higher rate than women (Barron & West, 2005; Barron et al., 2007). How does working in a female-dominated profession influence their decision? Even though there are significantly more women than men in nursing, it would also be prudent to attempt to replicate some of the previous studies on intentions to leave with an equitable distribution of men and women in order to determine if there are appreciable differences between the two.

A fifth recommendation for future research is to explore the influence of other social structures, such as class, race, ethnicity, and sexual orientation in relation to both the nursing shortage and professional turnover. It is important to note that in the present study, two of the participants were African American, female registered nurses and no effort was made to recruit a diverse sample. People of color, particularly African Americans, are underrepresented in the nursing population compared to their number in the general population and compared to their

representation in the workforce (U.S. Department of Labor, 2008). While neither of these participants discussed issues related to race or ethnicity as factors that were influencing their decision to leave the nursing profession, it certainly raises concerns about the socio-cultural structure of healthcare organizations and retention of diverse groups in the nursing profession.

A sixth recommendation for further research is to replicate this study with women who work in other careers that are considered to be feminine occupations. Further research exploring women's career development from feminist perspectives could lead to the development of a new model of career development, because current models do not incorporate power structures and positionality.

A seventh recommendation is to further explore the relationship between entry level education and tenure in nursing. The varying levels for entry into the nursing profession somewhat hinder standardization of nursing education beyond skill preparation. Previous research by Duffield et al. (2004) and Scott et al. (2008) found that nurses who have a baccalaureate degree upon entry into practice have a shorter tenure in nursing. Therefore, more research needs to be conducted to determine if differences exist in respect to work experiences and career development in relation to educational level. If differences are found to exist, they must be critically examined and explored.

An eighth recommendation is for research to be conducted to further explore the relationship between organizational structures and career turnover intentions in nursing. A few studies in the literature relating to intentions to leave have used Kanter's model of structural empowerment (Manojlovich & Laschinger, 2002; Nedd, 2006; Zurmehly, Martin, & Fitzpatrick, 2009), but they did not examine the underlying reasons behind findings of dissatisfaction relating to nurses' experiences in the workplace. In general, organizational theory does not incorporate

power as being present other than in a hierarchy (Bradbury-Jones et al., 2007). The findings that technology and the physical environment influence the decision to leave nursing warrant exploration. There is also a need to investigate the impact computerized documentation has had on nursing workload, as well as how technology has influenced power dynamics within organizations. Utilizing a feminist poststructural lens to examine issues of power related to technology in healthcare could be valuable towards extending the theoretical framework of feminist poststructuralism into organizational research.

Finally, more research in general needs to be conducted on the nursing shortage and career turnover in nursing utilizing feminist frameworks, and it would be appropriate to replicate some of the previous research on intentions to leave the nursing profession using a feminist lens. Despite the growing body of research demonstrating that nurses are dissatisfied with their working conditions and opportunities for professional development, few preventative measures have been employed. Research on strategies to improve nursing retention needs to continue to be explored, as well as the socio-cultural influences that may be hindering strategies from being developed or implemented.

Researcher Reflections

In developing this research study, I had the intention of being able to recommend strategies that may prevent nurses from leaving the profession in an effort to alleviate the nursing shortage. However, I came out with a much deeper sense of the choices women make in their lives in respect to their careers, their families, and themselves. I feel that women's career changes need to be supported and space needs to be created for the presence of a constantly shifting identity. With our working lives becoming longer, it may not be realistic to expect an individual to work in the same profession for over 40 years, even in a profession such as nursing

which has diverse work opportunities. While I feel that the work environment for nurses needs to be radically changed, individuals need to create their own personal journey which enables them to have a healthy balance between their work life and personal life.

The importance of caring for the self and of these participants listening to their own inner voices was an unexpected finding in this study. The women I interviewed were very articulate about their work experiences, and I found them to also be courageous for planning to make a career change at a difficult economic time. I had assumed that the participants may be dissatisfied with nursing and may be angry or frustrated during the interview. Even though some of the participants were frustrated about working conditions and one participant actually verbalized being angry about her work experiences, they were positive about the opportunity to discuss their experiences and decision during their interview.

Concluding Thoughts

Florence Nightingale was a feminist, though her contributions to this vein of nursing are often disregarded. In her time over 100 years ago, it was believed that every woman would make a good nurse. She however realized that the role of the nurse was not easy and required specialized education and skills (Nightingale, 1860). She also recognized the danger in occupational segregation and encouraged women to do the best they had to offer with the abilities they were given, rather than choosing work suited for women or choosing men's work to simply prove herself. In her famous book, *Notes on Nursing: What It Is, and What It Is Not*, she writes "And as a wise man has said, no one has ever done anything great or useful by listening to the voices from without" (Nightingale, p. 135). By utilizing a feminist poststructural lens to share individual voices from within nursing to explore work experiences and career turnover, the influence of gender in women's lives can be better understood and open spaces for discourse in

an effort to develop solutions for issues that are the result of socio-cultural influences. As stated by Kane and Thomas (2000), “We must look for what has been overlooked, unconceptualized, and not noticed in the lives of individual women (nurses)” (p. 18). Conducting this research study has been a valuable personal journey for me, and I am grateful that I had the opportunity to explore work experiences and career choices with these women.

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APPENDIX A

Interview Guide

1. As you know, I am trying to understand what makes nurses decide to leave the profession of nursing. I would first like to learn about your reasons for entering the nursing profession?
2. How would describe your typical day at work?
 - a. How does this description match your expectation of what you thought your job would be like as a nurse?
3. If you could have a superpower at work, what would it be?
4. Do you feel you have been provided with adequate education to meet the requirements of your job?
 - a. Do you have any recommendations for education (i.e. technology, policies, continuing education) in the workplace?
 - b. What recommendations do you have for nursing education?
5. What has influenced your decision to leave the nursing profession?
 - a. How long have you thought about leaving?
 - b. Has the work environment influenced your decision?
 - c. What factors outside of the work environment have most impacted your decision?
6. Is there anything about your work that would change your decision?
7. Do you feel your experiences at work have been influenced by the fact that nursing is a predominantly female profession?

- a. If yes, in what ways?
8. What are your plans after leaving nursing?
 - a. What makes this job/career appeal to you at this time?
 - b. Will your experiences and skills as a nurse be useful in this job/career?
 9. What TV, book, or movie character in the health profession do you most identify with as a nurse? Why?
 10. Is there anything else that you can think of that may help me understand why nurses leave the profession?

APPENDIX B**Poem Shared by Moon***My Demon*

Twisting, gnawing
Talons shred flesh
blood gushes
gashes in my soul.
My soul
a newfound bubble
iridescent
light on a dragonfly's wing
trees whispering my truth.
Fragile
Scarred
Frigid blast of demon's breath
form dissolves to dust.
Demon sleeps
Soul remembers
emerges
reforms
Stronger
Stronger
Dust becomes paper
Paper becomes steel
talons lose their sting
shimmering light reborn

VITA

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Education

MSN, Widener University, Clinical Nurse Specialist in Adult Health, August 2001
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Assistant Professor of Nursing, York College of Pennsylvania, York, PA
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Publications

Lutter, S. L. (2008). Psychosocial aspects of infertility. *Advance for Nurses*, 10(13), 29-30.

Harne-Britner, S., Kreamer, C., Frownfelter, P., Helmuth, A., Lutter, S., Schafer, D. J., & Wilson, C. (2006). Medication calculation skills of practicing nurses. *Journal for Nurses in Staff Development*, 22, 190-195.

Selected Presentations

Infusing a Feminist Pedagogical Approach into Nursing Education, poster presentation at the Drexel University Nursing Education Institute Conference in June, 2010

Novice Faculty as Effective Mentors in Education and Research, poster presentation at the Drexel University Nursing Education Institute Conference in June, 2010

Creativity in the Nursing Classroom, oral presentation at the Drexel University Nursing Education Institute Conference in June, 2009

Intent to Leave Nursing: A review of the literature, poster presentation at Wellspan Research Conference in April, 2008

Transfer of Training, presented at American Association of Adult and Continuing Education Conference (Norfolk, VA), October, 2007

Medication Calculation Skills of Practicing Nurses, poster presented at Pennsylvania Adult and Continuing Education Research Conference in February, 2007 and Sigma Theta Tau Eta Eta Chapter poster night April, 2007