REWORKING PROFESSIONAL IDENTITY: PROCESSES AND PERCEPTIONS OF EXPERIENCED NURSES

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Dedication

I dedicate this dissertation to my family of loyal supporters

ABSTRACT

Reworking Professional Identity: Processes and Perceptions of Experienced Nurses

In this grounded theory study, I explored experienced nurses' perceptions of being professional. Since there were few nursing research publications on how experienced Registered Nurses (RNs) understand the meaning of being professional, I began data collection with general questions about how RNs understand being professional. I gathered data through 21 open-ended, tape-recorded interviews, simultaneously collecting, transcribing, and analyzing data. Theoretical sampling guided the selection of participants and literature, and grounded theory coding processes moved analysis from a descriptive to a theoretical level.

The central problem for nurses emerged as *dissonance,* which they addressed, resolved, or managed using an iterative three-stage process that I named as *reworking professional identity*. In Stage 1, *assuming adequacy,* nurses develop technical task competence, accept untested assumptions about their competence and professional identity, and experience diminished awareness of actual practice competence and colleagues' perceptions of that. *Assuming adequacy* occurs through *concentrating on technical task* performance and *neglecting reflection* on that performance. In Stage 2, *realizing practice*, nurses become increasingly aware of work contexts and discrepancies between their expectations and experiences. They compare their expectations and experiences, encounter *dissonance*, and begin to address those. In Stage 3, *developing a reputation*, nurses actively determine how they will become known as professional

nurses, choose their work standards, and decide whether and how they will promote nursing.

The stages are repeated as new discrepancies occur, enhanced awareness dawns, practice changes, learning is undertaken, or when experienced nurses move to being relative novices in another work area. With each iteration of *reworking professional identity*, nurses move through the stages more quickly and at a different level, again reworking their professional identity. *Reworking professional identity* is influenced by three contextual factors: expectations, at societal, professional socialization, workplace, family, and personal levels; perception of the status accorded by others to nursing; and supportiveness in terms of acceptance, assistance, and advocacy from others in the workplace. The implications of this study relate to changes needed for nursing education programs, workplaces, and professional nursing socialization.

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Experienced Nurses' Perceptions of Being Professional

Introduction

In this chapter, I introduce myself, my interest in the domain of this study, and the traditional process of professional socialization of Registered Nurses (RNs). All three serve as background for general questions guiding this research.

My Story and My Interest

Since my story is set within the context of baccalaureate nursing education, I identify two basic types of baccalaureate nursing programs. The first type is designed to provide further formal nursing education for RNs holding the basic 2-year diploma in nursing and who have several years of nursing work experience. This program, also known as a Post-RN, BN/RN, or degree completion program, requires the equivalent of 2 years of full-time study but is more commonly completed on a part-time basis. In this study, a reference to a baccalaureate or BN/RN program specifies this type of program (unless otherwise noted). My references to learners, RNs, or nurses refer to participants in such programs. The second type of baccalaureate program, also known as a basic baccalaureate, generic, or BN program, requires 4 years to complete and is taken by university students who have no previous education or experience in nursing. I have taught in both program types.

I came to teach the introductory nursing course in the BN/RN program at the University of New Brunswick (UNB) from a varied 15-year professional teaching career. Initially, I had taught basic baccalaureate nursing students at Dalhousie University and

Mount Saint Vincent University. I used a flexible design that facilitated learning and took into consideration the learners' needs and experience. Later, I taught beginning diploma nursing students where I was expected to follow a rigid curriculum that did not consider the learners' own practical wisdom or experiential knowledge.

Later I was employed for 10 years with the Association of Nurses of Prince Edward Island, the provincial organization providing professional services to RNs. There I worked closely with practising nurses to create and deliver programs on relevant professional and educational issues and to provide resources to committees mandated to ensure adequacy of professional standards and education. During that time, I began to teach courses in the UNB BN/RN distance program on a part-time basis in PEI where I could again build upon learners' experience to facilitate learning. All of these experiences helped me understand nursing education from various perspectives.

In 1991, I came to Fredericton to teach full-time in the UNB BN/RN program. For 5 years, I was also Assistant Dean of the UNB BN/RN program where I was not only responsible for guiding appropriate curriculum changes but also for recruiting and retaining learners. My frequent contact with nurses and their questions and comments about the program helped me better understand their current perspectives. These contacts also helped me question the role of baccalaureate education in the professional socialization of nurses. If nurses are already professionals, what does further education do to enhance that professionalism? How can programs provide relevant educational experiences that influence professional development? I have also explored some questions about nurses' learning. My research involvement, for example, has focussed on

establishing trust in the distance nursing classroom (Buchanan & MacIntosh, 1997), the process of becoming nurses (MacIntosh, 1996; MacIntosh, MacKay, Mallet-Boucher, & Wiggins, 1998, in press), and the influences of technology on learning from the learners' perspective (Post, Carusetta, Maher, & MacIntosh, 1998; MacIntosh, 2001). Such research has furthered my understanding of the potential linkages between the processes of learning and becoming professional nurses, but I still had questions, for example, about how nurse educators can facilitate learning to be professional and how nurses can further develop their professionalism.

Teaching the introductory course in the BN/RN Program also helped me question its intended professional socialization of RNs. This course is designed to help provide a framework within which learners explore foundational concepts of the nursing paradigm and develop skills of scholarly writing, critical thinking, and critical reflection. We at UNB's Faculty of Nursing believe that such a combination of theory and expression skills will help learners examine their own perspectives on the nursing profession and its foundational concepts as well as their own experience. During each term, learners have often told me that they develop a new understanding of the profession of nursing. For example, some talk more about working with clients rather than caring for patients, finding balance between valuing technical skills and valuing relationships, and about being professional. These changed perceptions of RNs may reflect a further development of their professionalism. I did not ever formally explore such changes nor did I ask learners to explain how they thought these changes occurred. I did often question, however, what factors or dynamics facilitated these changes. I knew that I had designed

classroom discussions and assigned readings to reveal different perspectives on concepts, and these efforts may have influenced the learners' perceptions of these professional concepts. But I did not know, for example, if there were other and unintentional influences at work that had little to do with the intentional classroom processes.

As for my own professionalism, I knew the generic criteria for professions accepted by nursing (I articulate those in chapter 2). But during my own basic nursing education, I had been helped to learn through discovery and inquiry, and these methods helped me to question issues when I felt uneasy with them. I had questioned the fit of the accepted generic criteria with nursing as I earlier had learned and practised it, but I had not yet explored whether others shared my unease. My experience in facilitating nurses' learning in a variety of programs and settings made me think critically about the potential inadequacy of those criteria for experienced nurses. Finally, I decided to carry out this current study in order to help illuminate experienced nurses' meanings of being professional and how those meaning constructions were influenced.

Professional Socialization of Nurses

Professional socialization is the process whereby individuals acquire knowledge and skills as well as values and behaviours appropriate to a profession (Chitty, 2001). Traditionally and generically, four goals of professional socialization apply: learners will learn appropriate technology, internalize the culture, find a personally and professionally acceptable vision of the role, and integrate the role into other aspects of life (Cohen, 1981, p. 15). The process of the professional socialization of nurses usually began within basic nursing diploma education programs, developed through nursing experience in the

workforce, and continues for RNs who enroll in the BN/RN program after working for several years (Cragg, 1991). In doing so, they become "RN learners" a term used by Throwe and Fought (1987). Through such programs, diploma-prepared nurses with previously acquired technical skills appropriate for hospital-based work, become baccalaureate-prepared nurses with broadened perspectives on the profession and with the skills required to work in a greater variety of settings (Cragg; MacIntosh & Wiggins, 1998). Resocialization is a term some use to describe this process (Chitty; Cragg; Rather, 1992, 1994). I prefer the term socialization for reasons that I explain later.

Most diploma programs have taught nursing concepts and technical skills in rather behaviourist ways to ensure standardized procedural performance. Authority figures directed the learning of required facts and skills through prescriptive learning experiences. Seldom did these teachers invite critical examination of the philosophical origins of nursing knowledge or how a practitioner's technical knowledge is, or should be, situated within a wider context of professional concepts, values, and behaviours, as, for example, conceptualized by Clandinin and Connelly (1995, 1996; Connelly & Clandinin, 1988). In short, reflective practice was not encouraged. When the diploma nurses enter the BN/RN program they expect more of the same expository, authoritative, and prescriptive approaches.

To counteract this technical and un-self-aware approach, the BN/RN program uses adult learning approaches deliberately to change these expectations; that is, to help learners use more sophisticated thinking about being professional. Specifically such activity includes critical reflection and discussion of the profession; that is, professional

knowledge in general, and the nurses' own professional concepts, values, behaviours, and workplace experiences (Boud & Walker, 1991, 1998; Ferry & Ross-Gordon, 1998; Loustau, 1993). Rather than simply accepting knowledge presented by experts (as in diploma programs), the nurses are now expected to act as experts in their own learning, using their past work and study experiences as data for analysis and grounding for new theoretical information (Baskett & Marsick, 1992; Knox, 1992; MacKeracher, 1996). When the nurses first encounter such expectations and learning activities, they sometimes feel confused and anxious (MacIntosh & Wiggins, 1998), unprepared to assume responsibility for directing their own learning, timid about sharing their experiences, unused to listening to the experiences of others, and uncertain that their shared experiences could develop their knowledge. During the term, however, most nurses begin to see themselves and their profession differently. Some may also experience a perspective change process which is named transformative learning in the adult learning literature (Cranton, 1994; Mezirow, 1991, 2000). Do the differences in learning activities between the two programs influence how nurses themselves understand their professionalism?

Purpose

I wanted my study to explore, from the learners' perspectives, how they construed their meanings of being professional and their perceptions of various influences as they defined them over time. I believed that such an enhanced understanding of being professional could help us educators construct more appropriate formal educational processes and thus honour the learners' experiences. As I searched the nursing research

and practice literature, I could find no similar formal investigations.

Significance to the Field

I believe that my intended research would be significant for four reasons. First, in 1915, Abraham Flexner published a list of criteria that, he argued, characterized professions; later in 1959, Bixler and Bixler elaborated somewhat on those criteria and promoted them as criteria by which nursing should judge itself (Creasia & Parker, 2001; Flexner, 1915). In the succeeding 60 years, most fundamental nursing textbooks continue to use these criteria but few nursing scholars have addressed them critically to ascertain their contemporary relevance or usefulness. And are these traditional criteria of professionalism used by practising nurses today? Might other professions that have adopted Flexner's criteria also be interested in such an examination?

Second, rapid and far-reaching recent changes in the Canadian health care system have influenced how nurses do their work, for example, fewer new graduates are being hired into permanent full-time positions. These changes may also influence how nurses view being professional and whether they consider their work environments conducive to professional behaviour. Are working conditions in today's hospital field of practice now antithetical to being professional? To understand the views of experienced nurses who have reflected upon their profession, research could help answer this key question.

Third, baccalaureate programs are designed to influence the professionalism of learners but few, if any, studies reveal how learners themselves understand and articulate their professionalism as a changing phenomenon. Do nurses consider that their professionalism changes as they pursue further education at the baccalaureate level, and if

so, how? Do nurses identify how workplace experience contributes to their being professional?

Fourth, the nursing literature is unclear about what to call the actual and intended outcomes of baccalaureate education on professional socialization. Some authors describe them as a process of socialization (Chitty, 2001), others use the term resocialization (Cragg, 1991; Rather, 1992, 1994), and still others describe it as a transformative learning process (Callin, 1996). The terminology used by nurse educators to refer to such complex cognitive, affective, and behavioural processes is inadequate and confusing. What terminology would be most appropriate to describe the influence of baccalaureate education on nurses' professionalism?

Given these types of questions and my own need to examine them, I designed this research study to reveal the nuanced meanings of being professional as experienced nurses understand and express them, and to be able to theorize about relevant factors and dynamics. In the next chapter, I place the study in the context of existing published research from the fields of nursing and adult education on professional socialization, resocialization, transformative learning, knowledge development, and adult learning.

CHAPTER 2

Initial Review of Relevant Literature

Introduction

In many research methods, the researcher "first reads the literature of the field to the fullest coverage possible, from which he [*sic*] deducts or synthesizes a framework, usually theoretical, to study and verify his [*sic*] research" (Glaser, 1978, p. 31). In contrast, grounded theory researchers limit the initial literature review for two reasons: they do not want to be distracted by preconceived concepts while they seek concepts emerging from the data, and they cannot identify relevant literature before concepts have emerged from the data (Glaser). However, grounded theory researchers consider it appropriate to understand the field in which the study is situated, so I outline here relevant literature from nursing and adult education on professional socialization, resocialization, and the potential for such socialization to be transformative, as well as literature on knowledge development and adult learning. In grounded theory, after researchers have inductively generated the central concepts in the theory, they seek relevant literature for integration into the findings as additional data. My further exploration of this literature related to the emerging concepts appears throughout chapters 4 and 5.

Professional Socialization

A profession is defined as "an occupation that requires extensive education or a calling that requires special knowledge, skill, and preparation" (Kozier, Erb, & Blais, 1997, p. 3). As early as 1915, Abraham Flexner spoke publicly about the criteria for

professions and their membership. According to Flexner's criteria, professions have: essentially intellectual operations; scientific bases; practical applications; lengthy education; self-organization; and altruistic motivation (1915, p. 904, 1930). Flexner accepted that medicine, law, engineering, and theology were professions. He omitted nursing. Despite this omission, nursing scholars over the past fifty years have adopted and refined Flexner's criteria. Most general nursing textbooks describe characteristics of professions derived from Flexner's criteria and demonstrate how nursing meets these externally developed criteria. From current nursing textbooks, professions have: relevance to social values and needs; a lengthy and required education; a code of ethics; a mechanism for self-regulation; research-based theoretical frameworks as bases for practice; a common identity and distinctive subculture; and members who are motivated by altruism and committed to the profession (Chitty, 2001; Doheny, Cook, & Stopper, 1992; Lindberg, Hunter, & Kruszewski, 1998; Zerwekh & Claborn, 1997). These scholars and others conclude that, according to these criteria, nursing is a profession and nurses must, by definition, be professionals.

Most nursing scholars and practitioners have used these criteria assuming that identification as a profession is essential to maintain and enhance the independent status and credibility of nursing vis a vis other health care processionals and the general public. Notwithstanding the underlying assumption that to act professionally is a necessary good in itself, some nursing scholars have challenged some of the values underpinning Flexner's criteria because: "embracing the masculine orientation to professionalism embodied in the work of Flexner and others, supported the existing patriarchal order,

thereby prolonging the subordination of nursing to male-dominated professions" (Chitty, 2001, p. 153). The purpose of my study is not, therefore, to return to basics and determine the relative value of recognizing nursing as a profession, nor to examine processes of professionalization at the collective level. My focus is on experienced nurses' own constructions of being professional, what may be problematic about that, and how they manage any issues they identify, within this whole context.

It is puzzling to me that diploma-prepared nurses have been initially socialized as nurses but have not usually been acknowledged within the profession as professionals. In the United States of America (USA), distinctions between technical (diploma-educated) and professional (degree-educated) nurses are clear: one must have a baccalaureate degree in nursing to be considered a professional nurse (Brooks & Shepherd, 1992; Sullivan, Brye, Koch, Olson, & Shabel, 1984). This distinction is less clear in Canada. My experience with nurses is that they accept the description of nursing as a profession but seldom call themselves professionals. Such self-constructions underlie my interest in this current study.

Phases of Professional Socialization

Professional socialization is the process whereby individuals acquire and integrate into their lives the expected knowledge, behaviours, skills, attitudes, roles, and norms deemed appropriate and acceptable to the profession (Cohen, 1981; du Toit, 1995; Oermann, 1991; Pilhammar Andersson, 1993). Currently, there are considered to be three phases in the professional socialization of nurses: the process begins within basic nursing diploma education programs, develops through nursing experience in the workforce, and

continues for RNs who decide to further their education in BN/RN programs (Cragg, 1991). With the increasing trend to require baccalaureate degrees as the minimum level of education for entry into nursing across Canada, I believe that this three-phase process may fade in the future but the underlying issues around socialization processes would still apply. It would, later, be useful to study how basic baccalaureate programs address the socialization of beginning professionals.

Most nursing students begin their professional socialization process within initial 2-year nursing diploma education programs. As students, they adopt norms, roles, skills, and knowledge necessary to function effectively as committed employees in well-defined roles within structured work environments (Brooks & Shepherd, 1992; Duff, 1989, 1997; Sullivan et al., 1984). For example, they acquire the basic knowledge required to become competent, caring, and skilful in providing care for hospitalized patients. They learn that their behaviour is guided by the nursing Code of Ethics for Registered Nurses (Canadian Nurses Association, 1997). They become aware of the self-regulating functions of the profession because there are mandatory requirements for initial examination and registration of nurses (hence the term Registered Nurses or RNs) and annual licensing in order to practice legally (see for example, Nurses Association of New Brunswick, 1984). Many nursing students are motivated by altruism and view nursing as a life-long work of caring (Chitty, 2001; Kozier et al., 1997). They become aware of, and fill, appropriate roles in relation to others, both patients and other professionals. Nursing students learn how to follow procedures, protocols, and policies that guide practice within the hierarchical institutions that will employ them. They learn respect for those in positions

higher up the hierarchy. In my experience, when such nurses graduate, they can provide technically excellent care within the expected parameters.

In essence, professional socialization in this initial phase is not usually an affectively or epistemologically challenging experience. I have found that beginning nurses often eagerly but uncritically adopt the attributes they perceive to be those of their desired profession and they learn professionally-determined, appropriate technical procedures for responding to predictable situations. The process has been described as one of transferring existing identification to the new reference group (Maltby & Andrusyszyn, 1997). Learners adopt the concepts, values, and behaviours in order to fully identify and be identified with the profession.

The next phase of the professional socialization process for nurses occurs in the workplace (Chitty, 2001; Cohen, 1981; Cragg, 1991). Here, nurses further learn to enact their understanding of professional roles and relationships. Historically, nurses have been guided by a strict code of behaviour in workplaces. In the late 1800s, working nurses were not allowed to marry, smoke cigarettes, drink alcohol, or have their hair done at a beauty shop (Zerwekh & Claborn, 1997). Until the1960s, nurses were expected to conform by wearing white uniforms and caps, standing when a doctor entered the room, showing deference to senior nurses, and carrying out doctors' orders without question. Such expectations influenced nurses who often valued their own views less than they valued those held by physicians, were reluctant to challenge another professional directly, and felt powerless within the structures of their work environments (Ellis & Hartley, 2001; Lindberg et al., 1998; Zerwekh & Claborn).

Such strong influences on nursing came from religious values, military institutions, and women's ascribed caring roles in society (Kozier et al., 1997). Nurses shared the religious values of self-denial, service to others, acceptance of low pay, commitment to duty, and altruistic visions of work; all leading to them being an easily dominated group. Times of military conflict often accentuated the need for nurses who were recruited to care for injured soldiers within strictly controlled environments. "From the late 1800s until just recently, female nurses were *twice* socialized into the feminine role of submissiveness, dependency, and subservience, first as women in our culture, second as nurses in hospital-based schools of nursing and hospital work environments" (Baumgart & Larsen, 1988, p. 68). Women were socialized to be nurturing and caring and it may have appeared as natural that many women would become nurses. Indeed, when I entered nursing, there were very few men in nursing. Some modification of these original nursing values has occurred over the last 25 years.

In essence, phase 2 of professional socialization involves a process of RNs developing their practical knowledge base. This development is essentially technical and procedural as nurses enhance existing skills through practising and learn new skills through on-the-job learning and emulating others. RNs still tend to stay focussed on illness perspectives and to sustain deferential behaviours to physicians and senior peers. This phase of professional socialization may contain little critical examination of epistemology, personal value systems, or how decisions are made in practice.

Some RNs choose to continue their formal education by enrolling in BN/RN programs, phase 3 of professional socialization. For these nurses, the baccalaureate

experience often serves both to expand and challenge their existing professional attributes (Cragg, 1991; du Toit, 1995; Lynn, McCain, & Boss, 1989). Expansion may occur through studying science and humanities courses that contribute adjunctive knowledge and help expand the theoretical rationale behind nursing actions. As they expand their specialized body of knowledge, skills, sets of concepts, and theory related to nursing, they begin to understand how nursing knowledge is organized and so may recognize new knowledge and apparent gaps in accepted knowledge (Donald, 1995). For example, learners may acquire an expanded framework of the foundation of nursing and its history, the nursing paradigm and its basic concepts and attendant theories, and professional patterns of knowing (Carper, 1978; Fawcett, 1984).

In essence, the BN/RN experience can be both personally and professionally challenging for nurses. As learners, they are encouraged to acquire and practice the processes of critical thinking and critical reflection within a supportive learning environment so that they may examine their previously unrecognized or unexamined assumptions underlying the profession and their own practice (Cragg, 1991; Kozier et al., 1997). During this program, most learners challenge their own understandings of nursing, acquire critical perspectives of the profession, and become involved in asking questions designed to further the profession (Cragg; Rather, 1994; Reed & Procter, 1993b). In my experience, nurses often feel personally challenged by examining their professional perspectives because the personal and professional identities are closely intertwined. The extent to which learners may experience a resulting perspective transformation varies.

Resocialization

Some literature refers to this baccalaureate phase of professional socialization as a process of resocialization (Cragg, 1991; Queen, 1984). On the face of it, the term professional resocialization implies beginning a process of becoming professional again or a process of becoming a different professional. But RNs, by definition, are already practising members of the nursing profession and know its values. The implied meaning of resocialization is questioned by other scholars (Clare, 1993; Lynn et al., 1989; Sullivan et al., 1984; Throwe & Fought, 1987); I, too, am uncomfortable with the concept of resocialization because it lacks congruence with what we intend in BN/RN programs. I use the term socialization throughout the remainder of this study to describe the life-long process of professional socialization; however, I believe that we need more clarity in terminology related to professional nursing socialization. Now I turn to the structure of the nursing paradigm to provide an understanding of the context within which professional socialization occurs.

The Nursing Paradigm

This section explores briefly the nursing paradigm, its historical evolution, and the structure of nursing knowledge. One characteristic of professions originally identified by Flexner is that they operate from a unique body of knowledge that is developed through research within the profession (Cohen, 1981; Lindberg et al., 1998; Pilhammar Andersson, 1993). A philosophical framework organizes this body of knowledge and delineates the areas of interest for professional practice and research. This framework in nursing is called the profession's paradigm (Fawcett, 1984). BN/RN programs

contributing to the professional socialization of nurses are designed to help learners examine their understanding of the body of unique nursing knowledge, the paradigm that organizes it, and the structure and assumptions underlying professional knowledge.

The profession of nursing began to develop in the 1970s its own theoretical explanations of practice, in contrast to its historical reliance on the biomedical model, which for example, contributed to the focus on technical skills to meet patient needs that were related to body systems as defined by physicians (Rutty, 1998). Many early nursing education programs adopted a functional approach and focussed on teaching technical skills in relative isolation from interpersonal aspects. By the 1950s, in addition to these essential technical skills, nursing began to integrate theories derived or adopted from other disciplines such as psychology, sociology, or medicine (Lindberg et al., 1998; Rutty). By 1970, nursing had begun to identify its own body of knowledge and had moved away from complete reliance on other disciplines (Rutty). When I began my own nursing education in 1968, the nursing education leaders acknowledged important adjunctive knowledge contributed by other disciplines but they showed a distinct emphasis on, and enthusiasm for, the developing body of knowledge unique to nursing.

As the nursing profession evolved during the 1970s and 1980s, diverse theories developed to describe nursing, with foci varying from functions of nursing to relationships in nursing. "Nursing theories address and specify relationships among four major abstract concepts referred to as the metaparadigm of nursing--the most global philosophical or conceptual framework of a profession" (Kozier et al., 1997, pp. 29-30). There is general agreement that the four paradigmatic concepts are: nursing, person,

health, and environment, and their interrelationships. Each nursing theory addresses these concepts and their interrelationships from a perspective that is characteristic of, and appropriate to, the specific theory (Fawcett, 1984; Hickman, 1995; Lindberg et al., 1998). No single theory has been considered appropriate for application in diverse nursing situations nor for all nurses. Such an acceptance of multiple theories in nursing has enabled a broad range of acceptable descriptions of the paradigm concepts rather than prescribing a single definition of each.

In my experience, RNs who enrol in baccalaureate education are often unfamiliar with the concept of a paradigm, the argument that nursing knowledge is structured within a paradigm, the formal theoretical interpretations of its central concepts, and the range of theoretical underpinnings of nursing. This observation is not surprising: the RNs' earlier diploma education was focussed on technical and concrete knowledge and practice. By working, these nurses have often developed eclectic views of nursing's knowledge base. For this reason, the first courses in BN/RN programs are used to explore various formal theoretical and personal descriptions of the concepts of the nursing paradigm and to enable nurses to explore their own eclectic views in relation to formal theoretical perspectives. I find that this process is often an eye-opening experience for them as they identify how they relate the paradigm concepts to their own practice. I find some of their eclectic views of nursing quite intriguing: these nurses have practised nursing without being fully aware of how formal nursing knowledge is developed and structured but they have created their own workable intuitive explanations. These practical perspectives and the tacit knowledge cause me to question whether some of the formal nursing theories

have paid adequate attention to how nurses construe their actual practice.

Professional Knowledge

One of the important functions of professional socialization processes is the development and understanding of professional knowledge. But what is professional knowledge? "Professional knowledge is not facts or information. Rather it is the application of knowledge through the use of critical thinking skills in clinical judgement that results from knowledge of the patient" (Eisenhauer, 1998, p. 52). Clandinin and Connelly (1996) have conceptualized professional knowledge as a landscape with space, time, and place components where theory and practice interface.

Prevailing views of the landscape of professional nursing knowledge have been strongly influenced by the work of Carper (1978). She classified knowing in nursing into four patterns: ethical knowing, empirical knowing, aesthetic knowing, and personal knowing. Later nursing scholars critiqued and expanded Carper's work (Berragan, 1998; Heath, 1998; Jacobs-Kramer & Chinn, 1988; Johns, 1995; Silva, Sorrell, & Sorrell, 1995; Stein, Corte, Colling, & Whall, 1998; White, 1995) and included two more patterns: unknowing (Heath; Munhall,1993), and sociopolitical knowing (Heath; White). The unknowing pattern describes a condition of being open and acknowledging that one does not yet know something or understand someone. The sociopolitical pattern involves looking more broadly beyond individual relationships to consider the assumptions underlying the health care system, culture, and society and their influences on clients' and nurses' lives. Eisenhauer's (1998) definition above shows the interrelatedness of the patterns of knowing identified by Carper and others. When formal nursing theories are

categorized, they are often clustered according to those patterns of knowing. In this way, the nursing profession applies those patterns of knowing to its understanding of itself. (See Appendix A for additional literature describing in detail these patterns of knowing.)

BN/RN programs include discussion of these patterns of knowing in nursing and how these patterns may operate in actual practice. If nurses understand each of these patterns of knowing and their interrelationships, they are freed from the constraints of acknowledging only one pattern as credible (Jacobs-Kramer & Chinn, 1988). I find that nurses beginning BN/RN study are often most comfortable with the empirical pattern of knowing because their previous diploma studies taught a focus on observable events and technical processes. As nurses in BN/RN programs acquire more conceptually sophisticated understandings about the profession of nursing, the concepts of the nursing paradigm, and the patterns of knowing identified by Carper and others, they become better prepared to examine critically their own practice.

Research on Professional Socialization of RNs as Learners

Next I outline how published nursing research has conceptualized and studied professional socialization. The research on professional socialization revealed several research studies concerning RNs in baccalaureate programs. Throwe and Fought (1987) called them "RN learners." Some of those studies focussed on RN learners (Cragg, 1991; Periard, Bell, Knecht, & Woodman, 1991; Witt, 1992; Wong, Kember, Chung, & Yan, 1995; Wong et al., 1997; Woodman, Knecht, Periard, & Bell, 1991). Some studies of professional socialization did not include RN learners at all (du Toit, 1995; Pilhammar Andersson, 1993; Schutzenhofer & Musser, 1994; Wilson, 1995). Some studies

compared RN learners with learners in basic generic nursing programs (Brooks & Shepherd, 1992; Chornick, 1992; Greenawalt, 1996; Lawler & Rose, 1987; Lynn et al., 1989; Thurber, 1988), with Associate Degree Nurse (A.D.N.) learners in the USA (Brooks & Shepherd; Lawler & Rose), and with practising RNs (Caffo, 1992; Greenawalt, 1996; Mathews & Travis, 1994). Most of these studies reported no statistically significant results for comparisons between learner groups on their professional socialization; however, in some studies, RN learners scored higher on professionalism than other learner groups (Brooks & Shepherd; Chornick, 1992; Lawler & Rose; Lynn et al.; Thurber). Researchers explained these findings using factors such as RNs' longer time within the workforce and their demonstration of professionalism by enrolling in baccalaureate study.

Some of these studies compared learner groups at one point in time (Brooks & Shepherd, 1992; Chornick, 1992; Greenawalt, 1996; Lawler & Rose, 1987); others compared groups of learners over time (Caffo, 1992; Lynn et al., 1989; Thurber, 1988). When compared on entry to and exit from programs, RN learners showed increases in teaching/collaboration roles, interpersonal communication skills, and professional development (Lynn et al.; Witt, 1992), and development of trustworthiness, tolerance for ambiguity, self-concept, and professional goals (Periard et al., 1991; Woodman et al., 1991). Professionalism generally increased over time within programs (Caffo; Cragg, 1991; Lynn et al.; Witt).

Many researchers selected one attitude, skill, characteristic, or behaviour as an indicator to measure the professional socialization of learners. Indicators included:

nursing performance (Chornick, 1992; Lynn et al., 1989; Schutzenhofer & Musser, 1994; Witt, 1992); critical thinking (Brooks & Shepherd, 1992); ability to reflect on practice (Wong et al., 1995; Wong et al., 1997); personal autonomy (Caffo, 1992; Periard et al., 1991; Schutzenhofer & Musser, 1994); professionalism (Brooks & Shepherd, 1992; Greenawalt, 1996; Lawler & Rose, 1987; Periard et al., 1991; Schutzenhofer & Musser; Thurber, 1988; Woodman et al., 1991); and development of professional role and image (Caffo, 1992; Cragg, 1991; Greenawalt, 1996; Lawler & Rose, 1987; Lynn et al.; Witt). RN learners in one study experienced burnout less often than their practising counterparts who were not studying (Dick & Anderson, 1993). Several scholars used existing scales or developed their own to measure professionalism (Brooks & Shepherd; Greenawalt; Lawler & Rose; Lynn et al.; Periard et al.; Witt; Woodman et al.). Overall, these studies indicated that RN learners showed some increase in professional socialization, no matter how it was measured, over the duration of formal programs and generally showed more professionalism than other learner groups studied.

Many studies recommended the use of qualitative research to further describe the experiences of RNs within baccalaureate programs, their process of professional attitude formation, and their perceptions of change. Only one researcher, Rather (1992, 1993, 1994), actually used a qualitative research method, phenomenology, to understand the lived experience of RNs as learners. She reported that RNs often found the thrust in BN/RN education toward professionalism disempowering because they already saw themselves as professionals; however, they valued the opportunities such programs offered for professional growth (Rather, 1993). Other studies recommended that future

research be approached from the perspective of the learner (Maltby & Andrusyszyn, 1997; Rather, 1994). "Because of the dearth of holistic studies from the [RN learners'] perspective, we do not know what they perceive is most important about their return to school experience" (Rather, 1994, p. 263). Some authors recommended using the framework of transformative learning to understand RNs' experiences in BN/RN programs (Duff, 1989; Maltby & Andrusyszyn; Periard et al., 1991; Rather) because RN learners "do not need resocialization into the profession. They need to work through the process of perspective transformation to be empowered" (Maltby & Andrusyszyn, p. 10). No research on professional socialization, however, was reported from the learners' perspectives nor did any use the qualitative method of grounded theory.

RNs as Adult Learners

Four factors about RNs as adult learners are relevant for this study and these factors are grounded in the established adult education literature. The factors are: current work and past learning experiences influence new learning (Knox, 1992); the novice to expert pathway influences learning (Benner, 1984, 1995; Cash, 1995); critical reflection can help learners use their past experience in future learning (Brookfield, 2000a; Kolb, 1984; Schön, 1987); and many nurses as women may prefer relational approaches to learning (Baxter Magolda, 1992; Belenky, Clinchy, Goldberger, & Tarule, 1986; MacKeracher, 2001). Although I outline each factor separately, I realize that they operate in various integrated ways.

I have found that, as adult learners, RNs are interested in learning what is relevant to their practice within often complex and unpredictable environments. As they work,

they may perceive gaps between what they originally learned and what they see they need in order to practice. "There are no universal rules, as taught by professional schools, to apply in these situations, and professionals use reflection-in-action and reflection-on-action to deal with most situations [they confront]" (Baskett & Marsick, 1992, p. 10). In BN/RN programs, experienced nurses learn to engage in critical thinking and critically reflective processes to assist them in dealing with such uncertainty (Bennett & Kingham, 1993; Clinchy, 1989; Davies, 1995; Duff, 1997; Greenwood, 1998; Jones & Brown, 1991). When they learn processes of reflection-in-action and reflection-on-action, learners may develop increasingly effective practice (Schön, 1987). In BN/RN programs, nurses become used to reflecting on actual practice experiences in which they felt challenged to make decisions.

Because of their past experiences, nurses often begin BN/RN programs uncertain of their abilities to learn in such a different environment and may need help to develop more appropriate learning skills for this new academic environment (Beeman, 1990; MacIntosh & Wiggins, 1998; Queen, 1984; Taylor, Marienau, & Fiddler, 2000). Their past experiences with learning were based usually in diploma nursing programs where authority figures directed the learning of required facts and skills through prescriptive learning experiences. Such experiences influence their expectations of and interactions within baccalaureate learning environments (Baxter Magolda, 1992; Brooks & Shepherd, 1992; MacKeracher, 1996; Weiss, 1984). In addition, nurses in BN/RN programs sometimes feel threatened when they encounter new learning approaches (Duff, 1989; Maltby & Andrusyszyn, 1997) such as reflecting critically upon the profession, their own

professional values, and their work experiences. As adult learners, nurses have years of nursing experience and can contribute illustrations from their practice to classroom discussions when they become comfortable enough to voice them (Caffarella & Barnett, 1994; Duff, 1989; MacIntosh & Wiggins; Sullivan et al., 1984). In my experience, some nurses as learners need help to develop an understanding of what influences their current learning and to identify and challenge their own epistemological assumptions. As adult learners, nurses can also help others to develop and identify assumptions and current knowledge.

RNs have accumulated practical expertise that can be built upon if appropriate learning environments are created. Knox's (1992) research with physicians and continuing education showed that experienced practitioners as adult learners were different from beginning practitioners as learners in that they had developed expert ways of practising. Their expertise provided a framework for making sense of practical situations and knowledge and this framework helped to organize new knowledge and experience.

In nursing, Benner (1984, 1995; also Cash, 1995) described the cumulative and developmental progress of nurses through five levels: novice, advanced beginner, competent, proficient, and expert. Benner described novice nurses as basically rule-governed whose behaviour was limited and inflexible. Advanced beginners performed acceptably and could identify recurring aspects of situations. Competent nurses established a perspective and intervened following analytical contemplation. Proficient nurses perceived situations as wholes and acted in relation to the larger picture. Expert

nurses had an accurate intuitive grasp of situations which influenced their actions (Benner, 1984, pp. 20-33). Nurses at each of these levels have different value perspectives and use different frameworks to understand situations. Each RN has particular learning needs and each responds to BN/RN education in ways very different to their responses in diploma programs, depending on their current practice perspectives.

As adult learners, RNs are encouraged to use their past experience as a basis for critical thinking and reflection upon their assumptions about the nursing profession in general. Kolb's (1984) experiential learning model is relevant here. Kolb conceptualized learning as a holistic, cyclical process that involves the whole being. Professional knowledge and learning are interwoven with the adult's perception of self-concept and self-esteem. "When learning is conceived as a holistic adaptive process, it provides conceptual bridges across life situations such as school and work, portraying learning as a continuous, lifelong process" (Kolb, p. 33). My experience with RNs indicates that learning influences not only their practice but also their personal lives.

> To understand learning, we must understand the nature and forms of human knowledge and the processes whereby this knowledge is created. . . . Knowledge is the result of the transaction between social knowledge and personal knowledge. The former, as Dewey noted, is the civilized objective accumulation of previous human cultural experience, whereas the latter is the accumulation of the individual person's subjective life experience. Knowledge results from the transaction between these objective and subjective experiences in a process called learning. Hence, to understand knowledge, we must understand the psychology of the learning process, and to understand learning, we must understand epistemology - the origins, nature, methods, and limits of knowledge. (Kolb, pp. 36-37)

The Kolb model incorporates the dialectics of concrete experience and abstract conceptualization, of active experimentation and reflective observation. Since "learning is

the process whereby knowledge is created through the transformation of experience" (Kolb, p. 38), Kolb highlights the process of adaptation, recognizes knowing as a continuous process, and anticipates that learning transforms experience.

The knowledge and skills of reflective judgement are particularly useful to adult learners as they integrate their new learning into the known context of their lives. "Unlike authority-based beliefs or emotional commitments, judgements derived from the reflective thinking process remain open to further scrutiny, evaluation, and reformulation; as such, reflective judgements are open to self-correction" (King & Kitchener, 1994, pp. 7-8). King and Kitchener argued for two requirements for reflective thinking: the reflective thinker must hold epistemological assumptions that allow the understanding and acceptance of real uncertainty, and the presence of ill-structured problems. This argument means that BN/RN programs that help learners examine their epistemological assumptions and analyze ill-structured problems may facilitate the development of the learners' reflective thinking. Does such help influence the development of nurses' meanings of being professional?

When RN learners develop reflective thinking skills, they may more easily move into critical reflection. Brookfield has defined critical reflection in four ways (2000a). Because the focus of my study involves appraisal of how people contextually construct and deconstruct their experiences and meanings (Brookfield, 2000a, derived for example from Dewey, Lindeman, and Horton), I chose to use Brookfield's (1998) definition of critical reflection as: "uncovering and investigating [causal, prescriptive, or paradigmatic] assumptions, and on appraising whether assumptions are accurate, valid, and truly

grounded in the context from which they spring, or if they have been uncritically assimilated from external authority sources" (p. 5).

Research indicates that many women may learn in some ways that differ from many men's experiences (Belenky et al., 1986; Gilligan, 1982; MacKeracher, 2001). This factor is relevant to planning learning opportunities in BN/RN programs because the large majority of these learners are women. Themes of connectedness recur in the literature about women's learning (Belenky et al.; Gilligan; Hogsett, 1993; Loughlin & Mott, 1992; MacKeracher; Olesen, 1994). If many women learners benefit from opportunities that foster appropriate connections with other learners, these opportunities need to be facilitated. Some women learners given their previous socialization to be deferential, silent, or otherwise to devalue their own experience and knowledge may also need help to find their confidence and voice their values and tacit knowledge.

Baxter Magolda (1992) asserted that learning was a relational activity that valued relating to and connecting with others as part of learning. She articulated three principles that underlie teaching from this view: validate learners as knowers to promote their voices; situate learning in the learners' experience to legitimize their knowing; and, define learning as a joint construction of meaning to empower learners (Baxter Magolda). These principles fit with Kolb's (1984) assertion that knowledge is closely interwoven with and interpreted by experience. Baxter Magolda's three principles recognized that knowledge was personally created, learners have long been carrying out processes of making meaning, learners have experience to which new knowledge may be connected, meaning is ascribed and influenced by experience, and making meaning can empower

people. In the UNB BN/RN program, adult learners have the qualities articulated by Baxter Magolda and we try to apply her three principles within our program. Do our attempts influence how nurses develop meanings of being professional?

The close interplay among a number of adult learning factors could contribute to a complex framework for understanding how RN learners experience the process of BN/RN education. BN/RN programs use such strategies as building upon learners' past knowledge and experience, respecting the context within which their knowledge is shaped, recognizing the influence of their previous learning experiences, facilitating critical reflection, connecting with their learning preferences, and facilitating their understanding of themselves as learners. As nurse educators, we expect that such programs will further the process of professional socialization. How do these adult learning strategies influence the process of professional socialization in BN/RN programs? Do these processes assist nurses to create professional meaning for themselves? To what extent is the professional socialization process experienced as transformative as nurses create new personal meaning and knowledge?

Transformative Learning

Because the literature indicates that there is potential for professional socialization to be transformative, I include here a concise exploration of transformative learning. Two perspectives of transformative learning are found in the adult education literature: the rational perspective (Collins, 1996; Cranton, 1994; Mezirow, 1991, 1996, 2000; Stange, 1995; Taylor, 1997) and the depth psychology perspective (Dirkx, 1997; Grabove, 1997; Scott, 1997). I describe the learning process, the learner, the facilitator roles, and the

foundations of the rational perspective because of its potential relevance to adult learning in BN/RN programs. I do not include discussion of the depth psychology perspective because it is less commonly related to formal learning programs.

In the rational perspective, learners hold meaning perspectives or frames of reference which are structures of assumptions and expectations through which they filter experiences, "predisposing [their] intentions, expectations, and purposes" (Mezirow, 1998b, p. 4). A frame of reference is composed of two dimensions. These are habits of mind, or sets of assumptions, and resulting points of view, or clusters of meaning schemes, which express points of view (Mezirow, 1998c, 2000). Habits of mind, are "broad, abstract, orienting, habitual ways of thinking, feeling, and acting influenced by assumptions that constitute a set of codes" that reflect the existence and influence of collective social or cultural values (Mezirow, 1997a, pp. 5-6). "Habits of mind become articulated in a specific point of view--the constellation of belief, value judgement, attitude, and feeling that shapes a particular interpretation" (Mezirow, p. 6).

The habits of mind or sets of assumptions used by people to interpret and shape their world fall into the categories that are sociolinguistic (social norms, cultural canon, and language), psychological (self-concept, personality traits, and early life influences), epistemic (sensory preferences and learning styles), moral/ethical (conscience and moral norms), philosophical (religious doctrine and world view), and aesthetic (values, tastes, standards, and judgements) (Mezirow, 2000). Transformative learning involves recognizing these habits of mind or sets of assumptions, critically reflecting upon the learner's own assumptions supporting habits of mind and points of view, and rational

discourse with others (Callin, 1996; Cranton, 1994; Mezirow, 1991, 1998a).

Rational discourse facilitates the examination of assumptions. Mezirow (1998b) earlier described rationality as "assessing reasons supporting one's options and choosing the most effective means available to achieve one's objectives" (p. 2). Discourse "is that specialized use of dialogue devoted to searching for a common understanding and assessment of the justification of an interpretation or belief" (Mezirow, 2000, pp. 10-11). Mezirow later (2000) preferred the term reflective discourse to rational discourse. Reflective discourse involves "assessing reasons advanced by weighing the supporting evidence and arguments and by examining alternative perspectives" (Mezirow, p. 11) and "'trying on' other points of view, identifying the common in the contradictory, reframing, and looking for synthesis" (Mezirow, 1998b, p. 3).

Transformative learning takes place across all domains of learning, instrumental (technical knowledge, adding to meaning schemes) and communicative (practical knowledge, learning about meanings). It is experienced as emancipatory through the creation of critical self-reflective knowledge (Cranton, 1994, 2000; Garrison, 1997; King, 1996; Mezirow, 1991, 1995b, 2000). Transformative learning may occur through either subjective or objective reframing. Objective reframing involves "critical reflection on the assumptions of others" and subjective reframing involves "critical self-reflection of one's own assumptions" (Mezirow, 1998b, p. 6) "Transformations may be focussed and mindful, involving critical reflection, or the result of mindless assimilation - as in moving to a different culture and uncritically assimilating its norms, canon, and ways of thinking" (Mezirow, p. 5). Learning may occur through four processes: elaborating existing frames

of reference, learning new frames of reference, transforming of points of view, or transforming of habits of mind (Mezirow, 1998c, 2000). Critical thinking, reflection, critical reflection, and critical self-reflection are incrementally developed (but not linear) dynamics that facilitate learning in the rational perspective of transformative learning (Birx, 1993; Tucker, Foreman, & Buchanan, 1996). Learners make meaning through active discourse with others and through rational, analytical, logical, and mainly cognitive processes (Baskett, Marsick, & Cervero, 1992; Galbraith, 1991; Kintgen-Andrews, 1991). Emotions are frequently activated, but are not, in themselves, at the core of the transformative process in this perspective (Ettling & Hayes, 1997a, 1997b; Mezirow, 1997b).

BN/RN programs help nurses identify and examine sociolinguistic, psychological, epistemic, moral/ethical, philosophical, and aesthetic habits of mind in relation to the profession and their practice. Nurse educators encourage opportunities for rational reflective discussions with other learners that may in turn stimulate affective learner responses (Duff, 1989; Maltby & Andrusyszyn, 1997; Sullivan et al., 1984). There is potential for this experience to be transformative. Whether it is actually experienced as transformative remains to be studied.

In the rational perspective of transformative learning, the adult learner lives and learns within a social context that constrains, both implicitly and explicitly, the development of meaning schemes and perspectives. Learners develop awareness and understanding of existing social constraints as well as internal constraints so that they may later free themselves and their thinking (Callin, 1996; Cranton, 1998a, 1998b;

Galbraith, 1991; Mezirow, 1995a). Transformative learning involves social interaction, rational reflective discourse, and involvement of the learner with others, so learning is mainly a group or social process rather than an individual one. Nurses have adopted the values of the profession through their initial experiences with professional socialization, but they may be unaware of how these values impose constraints on, or expand, their thoughts and actions. Nurse educators in BN/RN programs facilitate learners' reflection on such values and constraints by engaging them in group discussions within courses.

Using the rational perspective, teachers or course leaders may facilitate transformative learning by deliberately creating situations in which learners are likely to experience a disorienting dilemma, examine the assumptions associated with this disorientation, and challenge these assumptions (Callin, 1996; Cranton, 1997; Mezirow, 1991, 2000; Reed & Procter, 1993a). Teachers can also provide a supportive environment in which learners can experience disorientation and process their responses to it (Group for Collaborative Inquiry, 1997; Johnson-Bailey & Cervero, 1997). Transformative learning may be facilitated or triggered by others but learners retain responsibility for transforming their own perspectives (Boud & Walker, 1991, 1998; Reed & Procter, 1993b). In the UNB BN/RN program, we try to stimulate reflective discussions, and guide and encourage learners to learn how to identify and examine their assumptions, if and when they are ready.

The anticipated process of transformative learning from a rational perspective is that learners become autonomous, socially responsible thinkers who recognize, and who become free from, distorted meaning perspectives (Mezirow, 1989, 1996). The origins of

the rational perspective of transformative learning are grounded in the philosophical foundations of critical social theory, which contributes the recognition of a social consciousness, power relationships, the identification of a personal and social self, the relationship between learning and change, the relationship between the knower and the known, and the interest people have in participating in changing themselves and existing systems (Allen, 1990; Kincheloe, 1991; Welton, 1995a, 1995b).

I found few published articles about transformative learning in the nursing literature and very few of these were concerned with the perspectives of RN learners themselves. Reports by Periard et al. (1991), and Woodman et al. (1991), outlined different aspects of a study that used Mezirow's framework as the theoretical base. My expectations that a description of learners' experiences were part of the study, however, were not fulfilled; both reports described findings resulting from scales used to measure aspects of professionalism. While other literature discussed the theoretical importance of transformative learning theory as a perspective for understanding the experience of RN learners (Callin, 1996; Duff, 1989; Maltby & Andrusyszyn, 1997), the nursing research literature did not show evidence of this emphasis.

Professional Socialization and Transformative Learning

Because the concept of transformative learning encompasses a number of processes used in BN/RN programs, for example, critical thinking, critical reflection, self-reflection, I discuss it here in relation to professional socialization in BN/RN programs. Designers of BN/RN programs characterize professional socialization as a movement from a focus on technical skills and routines toward critical reflection on the whole

profession and the learners' actual nursing practice. Professional socialization has been occurring to some degree experientially for these nurses in their workplaces before they even entered the program. How do they understand and describe such socialization? How do they see baccalaureate programs as contributing to or hindering their being professional?

RNs in baccalaureate programs indicated that "although the new knowledge and skills they acquired in their . . . programs were invaluable, it was the ability to view familiar situations in new ways that caused the change in their practice" (Callin, 1996, p. 28). This perspective change may reflect transformative learning. These nurses used their nursing experience as a position from which to begin to examine and question their existing nursing practice. To do this kind of thinking, they learned critical thinking and critical reflection skills to bring their values and assumptions to a level of awareness, to name them, and to discuss them. These RNs identified and examined assumptions underlying accepted nursing practices and they were encouraged, supported, and assisted to explore them (Duff, 1989; Maltby & Andrusyszyn, 1997; Witt, 1992). Some nurses, according to my own experience and the literature, find this process uncomfortable; some find it liberating. The following detail on this process explains why and when that discomfort may happen.

The ideas and perspectives that these learners encounter in BN/RN programs are designed to differ from and challenge their existing ideas and perspectives. The process of deliberately and critically examining nursing values and practices may cause nurses to experience discomfort, confusion, and frustration: feelings which are not part of the usual

process of professional socialization described earlier. But they are accepted as part of the transformative learning process (Brookfield, 2000b; Callin, 1996; Cranton, 2000; Mezirow, 1991, 2000; Throwe & Fought, 1987). RN learners may experience "disorienting dilemmas" (Callin) or situations in which they find that their usual frameworks do not explain or fit what they encounter (Cragg, 1991; Mezirow, 1991; Rather, 1993). Then they have to make a choice: one option is to maintain the usual framework in the face of this new situation, in spite of its inadequacies, and reject the possibility that the usual framework does not fit (perhaps by redefining the situation); another option is to accept the challenge presented by the situation, recognize the inadequacy of the usual framework, let go of previous perspectives, and explore the possibilities of adopting a different framework for this situation. The latter choice and its processes are characteristic of transformative learning as described above.

Adult learners generally benefit from a learning environment that facilitates beginning to reflect critically on their usual world view, their assumptions, and on the implications of these perspectives (Callin, 1996; Cranton, 1994; Mezirow, 1991, 1995b). They may become aware of previously unrecognized assumptions through activities designed to review and question practice. They may even begin to recognize their own roles in reinforcing the status quo (Burge & Haughey, 1993; Clare, 1993; Rather, 1992, 1994; Stange, 1995). In BN/RN programs, learners can discuss where they learned to show deference to physicians, for example, and can describe the sanctions they experienced when they did not defer in appropriate ways. But it may be more difficult for them to recognize that such deference perpetuates that expectation not only for

themselves but also for the profession as a whole (Clare). In perpetuating such patterns, they become enforcers of the status quo. Most nurses, for example, can identify situations in which they have felt powerless and where they lacked effectiveness in dealing with the system. Through critically and reflectively examining such situations, they may also learn how to see and speak differently.

Learning in North American BN/RN programs is facilitated through adult learning strategies and processes that acknowledge learners' expertise and engage them in examining that expertise. Educators try to strike a careful balance between showing respect for learners' existing knowledge and experience and challenging the assumptions that underlie that knowledge and experience (MacIntosh & Wiggins, 1998; Rice, 1992; Sullivan et al., 1984; Weiss, 1984). In spite of such good intentions, some educators may create learning situations which, in effect, ignore or do not adequately use the nurses previous knowledge and workplace experience (Callin, 1996; Loustau, 1993; Rather, 1994). Adult learning strategies and curricula that share power and decision making about what should be learned and how, provide respectful choices to learners (Clare, 1993; Rice; Sullivan et al.). The key processes that are designed into these activities are those of critical thinking and reflective examination of perspectives related to professional expertise. I believe that these two processes show a transformative learning framework more than a socialization framework.

Transformative learning is most likely to occur when learners are helped to examine assumptions that underlie their personal frameworks and to understand the implications of using such frameworks. Learners may see the need to learn how to view

the world differently and most RNs report that this is a transformative process that affects them both professionally and personally (Allen, 1990; Callin, 1996; Cragg, 1991; Rather, 1992, 1994). Duff (1989) recommended Mezirow's theory of perspective transformation as an appropriate framework for future research in nursing.

How BN/RN programs engage learners in transformative learning may be a fundamental question for the development of professional expertise but it also presents ethical issues. If learners are encouraged and supported to examine critically all aspects of the profession, where may this critique lead? Are there logical stopping points beyond which learners will not go, experiencing potential but recognizing environmental limits? Are there points beyond which educational programs cannot ethically or politically encourage transformative learning? When does the profession become something completely different because of critical reflection? Do programs or learners consider limits on what is open for examination? How might these constraints be set, recognized, and communicated?

In summary, my initial literature review uncovered some confusion among the concepts of professional socialization, resocialization, and transformative learning in relation to nurses and their professional socialization. It also revealed many quantitative studies of professional socialization and showed a lack of evident research both on professional socialization from nurses' perspectives and on transformative learning experiences of RN learners at the baccalaureate level. Therefore, I decided to focus my research on how experienced RNs construe the meaning of being professional.

The limited published research about being professional from RNs' own

perspectives indicated that a qualitative research approach was appropriate. The process I used to select an appropriate methodology for this research, the rationale for my choice, and the description of actual methods follows in chapter 3.

CHAPTER 3

Research Methodology

Introduction

The very limited body of knowledge about being professional from RNs' own perspectives indicated that a qualitative research approach was appropriate in order to establish at least a tentative theory and further directions of inquiry. In this chapter I outline the qualities of the constructivist research paradigm, explain my choice of grounded theory methodology, detail the procedures used for simultaneous data collection and analysis, and explain how I ensured trustworthiness of the study.

Constructivist Paradigm

The research paradigm used by researchers reflects their philosophies and values about how the world operates; specifically, about "being, knowing, and doing" (Ely, Vinz, Downing, & Anzul, 1997, p. 230). My responses to the three philosophical research questions (ontology, epistemology, and methodology) asked by Guba and Lincoln (1998) place this research within the constructivist paradigm (Appleton & King, 1997; Denzin & Lincoln, 1994; Guba & Lincoln, 1994). The ontological question refers to the form and nature of reality accepted in the study (Guba & Lincoln, 1998) or "ways of being" (Ely et al., 1997, p. 230). I believed that participants, who are individually and collectively influenced by their own contexts, construct their own reality. I considered that each participant's perception of reality was legitimate and that such perceptions reflected how participants saw their life worlds at any given time. This view is congruent with the constructivist paradigm in which multiple constructions of reality are accepted and

theoretical constructs are developed that explain people's understandings and actions within the social contexts studied (Eisner, 1997; Guba & Lincoln, 1998). The epistemological question refers to the relationship between the knower and the known (Guba & Lincoln, 1998) or "ways of knowing" (Ely et al., p. 230). My perspective is that the knower and the known cannot be separated; knowers can create knowledge and meaning only within the understanding of their own life contexts. In this study, I expected that understanding the meaning of being professional would develop as participants interacted with me; this interactive response is also congruent with the constructivist paradigm which recognizes that individuals create knowledge (Campbell & Bunting, 1991; Harding, 1991; Kincheloe & McLaren, 1998; Olesen, 1998). Respectful conversational exchanges created opportunities for me to understand and explore participants' meanings of being professional within relevant social contexts. "Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry" (Denzin & Lincoln, 2000, p. 8). The methodological question for any research project refers to the defined strategy for data collection, analysis, and interpretation (Guba & Lincoln, 1998) or "ways of doing" (Ely et al., p. 230). In this study, I engaged with each participant in a dialogical relationship to explore meanings of being professional.

The constructivist paradigm contains many appropriate research methodologies which I reviewed before choosing grounded theory. I chose grounded theory over case study, which delineates components and dynamics in a bounded context focussing on

experiences of individuals (Stake, 2000); ethnography, which interprets people's experiences by understanding their own complex cultural settings (Atkinson & Hammersley, 1994; Denzin & Lincoln, 1995; Hammersley, 1990) and creating cultural understandings (Tedlock, 2000); participatory action research, which strives to empower participants and improve the quality of their experience through processes that use their own knowledge (Kemmis & McTaggart, 2000; Reason, 1994; Schratz, 1993); focus groups, which gather collective understandings of people with similar characteristics (Kreuger, 1994); and phenomenology, which focuses on extensive rich descriptions of the essence of human experience with a particular phenomenon (Colaizzi, 1978; Holstein & Gubrium, 1998; van Manen, 1997).

I chose grounded theory because it begins with a broad area of inquiry, its data gathering uses relevant sources able to inform the researcher, and its analysis moves the data beyond description to a theoretical level (Glaser & Strauss, 1967). MacDonald and Schreiber (2001) highlight its versatility: "Grounded theory is a methodology that can, and does, evolve and change within the sociopolitical, economic, and intellectual context" (p. 50). The grounded theory method has been used from a wide range of viewpoints, for example modernist (MacDonald & Schreiber) and feminist approaches (Wuest & Merritt-Gray, 2001), so it provided enough scope for my own constructivist approach. Within the constructivist paradigm, "a grounded theory is the researcher's construction of the participants' constructed definition and resolution of the situation and should be immediately recognizable to participants in the study" (Milliken & Schreiber, 2001, p. 179).

Grounded Theory

Grounded theory has its theoretical underpinnings in symbolic interactionism which focuses on the meanings that people give to events they experience (Bigus, Hadden, & Glaser, 1994; Glaser, 1994; Glaser & Strauss, 1967; Kools, McCarthy, Durham, & Robrecht, 1996; Wuest, 1995). Symbolic interactionism is based upon principles that humans interact with each other, consider each other's actions, and ascribe meaning to symbols in their lives (Beck, 1999). My use of grounded theory was designed to illuminate participants' own meanings of being professional and to develop an initial theory of being professional. Theory is considered the "complex of concepts, assumptions, biases, attitudes, stances, and formal theories [that] provide the material for the interpretive frameworks through which we make sense of the world, carry out personal, civic, and professional lives, and conduct research" (Ely et al., 1997, p. 226). Grounded theory as method generates theory that is either substantive, that is, related to an empirical area of inquiry, or formal, that is, related to a conceptual area of inquiry, both of which are considered middle-range theory falling between the level of a working hypothesis and a comprehensive grand theory (Streubert & Carpenter, 1999).

Grounded theory research begins with a broad area of inquiry rather than with a specific narrow research question (Beck, 1999; Glaser, 1978). Glaser identified two typical questions that guide grounded theory researchers' entry into the field. The first guiding question refers to identifying the main problem for people in the field and the second refers to determining what accounts for most of the variation in processing, addressing, or resolving the identified problem. The more specific research question

emerges later from the data as issues or problems of concern to participants surface during the research. In grounded theory, then, there is no assumption that the researcher is an expert or knows in advance the issues or problems that will surface as important for participants; hence, no specific research question is articulated before the research begins. Also for this reason, many grounded theorists do not recommend carrying out thorough literature reviews before beginning the research. The grounded theory method respects that people experience realities differently, are creators of, and connected to, their knowledge, and are able to engage in respectful research conversations that uncover their knowledge and the social contexts within which it is held. Through these processes, the grounded theory researcher develops a theoretical understanding of what is going on in the data based upon participants' perspectives drawn from actual data collected rather than from the researcher's own conjecture or predictions.

When interviews are a main source of data in grounded theory studies (Polit, Beck, & Hungler, 2001) the strategy of simultaneous data collection and analysis means beginning the analysis with the first interviews and continuing it throughout the process of collecting and analyzing additional data (Glaser, 1978). Grounded theory analysis involves substantive and theoretical coding (Beck, 1999). Substantive coding means assigning codes to each line of data, generating action codes that use actual words of participants, comparing codes with other codes and data, and clustering similar codes into initial categories (Beck). Substantive coding increases the researcher's awareness of sensitizing concepts to use as starting points for further data collection and analysis (van den Hoonaard, 1997). Theoretical coding means sorting categories by similarities and

differences, examining relationships among substantive codes, and asking appropriate questions of the data to elevate them to a theoretical level (Glaser). "Generating action codes facilitates making comparisons, a major technique in grounded theory" (Charmaz, 2000, p. 515). Constant comparisons between concepts, categories, incidents, and data help the researcher to identify relevant connections and the contextual conditions that influence those connections. Coding, memoing, and constant comparative analysis indicate where issues, gaps, or questions still remain about the data as well as how the emergent theory is taking shape. Theoretical sampling means that the researcher intentionally uses the emerging analysis to guide subsequent data collection and analysis to try to revise or confirm hunches and address issues, gaps, questions, or relevant concepts arising from previous data analysis (Strauss & Corbin, 1990).

Relevant literature is considered data so it is important to engage in theoretical sampling of the literature as the researcher becomes sensitized to emerging concepts. For example, when I conducted the literature review before my research I could not have anticipated that I would need to explore such concepts as workplace learning and dissonance. Because I found these concepts relevant, I incorporated relevant literature on them into the presentation of findings. Data collection and analysis proceed until no new concepts are identified; that is, until data saturation has been reached (Morse, 1995). Memo writing is the researcher's process of recording ideas, thoughts, insights, and questions that assist in exploring codes and their interrelationships and that enhance the researcher's understanding of the data (Glaser, 1978). These memos become the basis for the final written grounded theory report.

The Research Process

I found writing this method section challenging because grounded theory is not a linear research process; my actions did not occur separately or within discrete time frames since they were integrated into a methodological whole. However, a text format demands a sequential style of reporting so this chapter reports on the selection and characteristics of participants, data collection and analysis, some accompanying reflections on the challenges, and my strategies for ensuring trustworthiness of the whole study. Throughout this dissertation, I use the grounded theory traditions of italicizing the concepts and processes that emerged from analysis and incorporating relevant literature as data.

Participants in the Study

In grounded theory, the criterion for initial sample selection is a situation or people who know something about the issue of interest. The initial selection criteria were that participants in this study were:

- able and willing to be interviewed in English
- able to articulate their experience
- living within New Brunswick
- enrolled in the University of New Brunswick BN/RN Program
- successful in the first nursing course between September 1998 to April 1999, and
- willing to engage in a research conversation about their perceptions of being professional.

These criteria were designed to select participants based on their potential knowledge about being professional and their familiarity with an educational experience which may

have influenced their awareness of this knowledge. I chose the particular learner cohort who completed the first nursing course in 1998-1999 because they did not experience my teaching them (as would be the usual procedure); my sabbatical period during that time enabled me to stay at arm's length from their course experiences.

After approval to proceed from the appropriate UNB research ethics review committees, I sent a letter to potential participants inviting them to contact me directly if they were willing to participate in the described study and if they had questions (see Appendix B for the letter of invitation to participants). The letter fully explained the study's goals and data gathering procedures, privacy measures, freedom to withdraw at any time, and stated that no comments about the program or courses of an evaluative nature would be either elicited or included. I assured participants that no feedback about their identity or content shared by them would be given to the BN/RN Program and that pseudonyms would be assigned to each participant to ensure confidentiality.

I asked the BN/RN Program office at UNB to send the introductory letters to a small sample of the nurses (six at once). When those interested returned their responses to me, I made telephone contact, explained the study, answered questions, and made an appointment for an interview. Participants chose the location and time of interviews since they best knew their family and work environments and schedules. Following interviews and analysis with this initial sample, I was guided by theoretical sampling for subsequent interviews. More letters were sent out with the same contact process. At one point, I received only two responses to the six letters sent and I did not know how long to wait for them to contact me before sending out letters to different people. I was concerned that the

process just to make contact with potential participants was taking a long time. My supervisor and my committee agreed that I could contact potential participants by telephone after letters had been sent out to speed the contact process. This strategy worked very well: most subsequent telephone calls indicated strong interest and intention to participate.

Characteristics of participants. In grounded theory interviewing, the goal is to seek as many properties of emerging core concepts or processes as possible. The number and characteristics of participants is less important than seeking and accounting for variation within the process (Glaser, 1978). Sampling is not based upon any preconceived ideas because the researcher cannot know in advance what or whom to sample or what concepts will emerge as crucial to understanding the emerging problem and process. The strategy of theoretical sampling is used to inform data collection. Theoretical sampling is the process of guiding future data collection based upon the analysis of data already collected that has revealed concepts or issues that need to be pursued in order to pursue hunches, enhance conceptual density, and eliminate gaps in data. In short, theoretical sampling determines what further data to gather from which sources until saturation is reached.

Once I began interviewing and analysis, I used theoretical sampling to guide my ongoing selection of participants to assist in pursuing and generating variation in concepts or categories as they arose in the data. I used interviews to gather some demographic data such as participants' locations, employment status, length of time working as a nurse, current area of nursing practice, and marital status; all because of their potential influence

on findings. As concepts emerged, I began to wonder about factors such as geographic location, work settings, and experiences with learning, so these factors were sampled specifically. For example, I had a hunch that nurses working in community agencies might feel influences on being professional that differed from influences on nurses working in institutions so I included some of them in the study. I asked them specifically about the emerging concepts of *status*, *autonomy*, *pace of work*, and *working relationships*. As the study progressed, I included participants who lived within northern Nova Scotia and Prince Edward Island, who worked in a variety of workplace settings, and some who had not yet taken nursing courses toward the baccalaureate degree and some others who had graduated from the UNB BN/RN Program within recent years. These last two groups of participants were chosen to clarify my hunch about the influence of the BN/RN Program on professional identity; that is, that nurses who had not yet taken courses may not yet have had opportunities to reflect on their professional identity whereas those who had graduated from the program would have had such opportunities.

The selection of participants proceeded until I found no new data of significance; that is, when my analysis revealed saturation of categories in the data and when I found no new categories. When I began, I could not know the number of interviews I would undertake until saturation occurred but as I proceeded, I believe that I found saturation within 21 interviews. Various authors indicate that saturation often occurs between 20 and 50 interviews (Gillis & Jackson, 2002; Polit, Beck, & Hungler, 2001).

The final group of 21 participants showed the following characteristics. Nursing experience ranged from 3 years to 34 years. These participants lived and worked in a

variety of urban and rural communities in New Brunswick, Nova Scotia, and Prince Edward Island. Eighteen participants were employed in full-time positions or worked a combination of full-time hours in more than one position; 3 worked part-time. Sixteen worked in staff nurse positions; 5 worked in management or supervisory positions. They worked in a variety of clinical areas including critical care units, medicine, surgery, psychiatry, and several community agencies. Eleven participants were married with children at home, 1 was divorced with children at home, and the other 9 were either single, divorced, or married with grown children or no children. Twenty were female and 1 was male. Two had taken no BN/RN courses and 2 had graduated from the BN/RN program more than 5 years ago. I interviewed participants from small work units, small communities in small provinces, and identifiable workplaces. These conditions render me ethically unable to provide detailed participant profiles without creating a risk of identifying participants.

Context

The grounded theory method provides a rigorous strategy for developing theory related both directly to data and also to social contexts (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1994, 1998). "Context captures the social world of the individuals engaging in the phenomena under study. The context accounts for the setting as well as the events impinging on a particular setting" (Chenitz, 1986, p. 42). The contexts within which the participants in this study have both developed and revised their meanings of being professional emerged as strong influences on that emerging process. Germane contextual influences included system-related *expectations*, *perceived status*,

and *supportiveness*. Because these contexts involved aspects of the structure and functioning of the current health care system, employment status, workplaces, social support both inside and outside workplaces, and financial climates, I pursued them during further data collection from interviews and from the literature to uncover as wide a range of variation as possible. These contextual influences are discussed in detail in chapter 4.

Simultaneous Data Collection and Analysis

In grounded theory, data may be gathered from observations, written documents, literature, or most commonly through interviews (Polit, Beck, & Hungler, 2001). Grounded theory methods also admit as data knowledge from the researcher's experiences and relevant literature (Baker, Wuest, & Stern, 1992; Glaser, 1978). I used interviews as the main data source in my study but I also used relevant literature to expand my understanding of the participants' constructions of being professional. The rationale used by those grounded theorists who recommend not doing a thorough literature search prior to the study is based upon the observation that "Often, reviewing the academic literature is of limited use, since it rarely is focused on the problem of a given population as identified by that population" (Schreiber, 2001, p. 58). The literature I examined during my research, however, relates directly to emerging concepts.

As I wrote, I used the grounded theory tradition of integrating relevant literature where appropriate throughout the findings. Theoretical sampling directed me to seek and read literature about concepts relevant to the emerging social problem and process and so I sought additional literature on subjects such as *dissonance*, nurses' work, job satisfaction, workplace learning, and adjustment of new graduates to the work

environment. Theoretical sampling also led me to further examine these specific concepts in subsequent interviews and to return to previously analyzed transcripts to reexamine how such data had been coded.

In grounded theory, data collection and analysis proceed simultaneously. When data collection involves interviewing, grounded theory uses an open interview guide and begins with several questions that become increasingly specific as the study progresses (Beck, 1999). I initially guided my research conversations by a few initial questions to facilitate participants' talking about being professional and to begin my understanding of their perspectives. These questions referred to how participants described the meaning of being professional, how they developed their own meanings of being professional, how they thought their meaning of professional may have been influenced by educational experiences or those in other contexts, and whether and how their meaning changed over time. (See Appendix B for the Initial Interview Guide.)

The locations and times for the interviews varied but they were all chosen by the participants. I interviewed several participants in quiet and private spaces in their own homes. I also did several interviews in neutral spaces where I had booked rooms in local libraries, hotels, or hospitals. I used my office for one interview by unplugging the telephone and placing a "do not disturb" sign on my door. I travelled to the preferred locations as necessary. My preference was to conduct only one interview per day, for several reasons: such interviewing requires intense concentration and I was concerned that fatigue might interfere with my ability to listen attentively and follow up on cues, and I needed time between interviews to make analytical memos, transcribe tapes, and begin

at least preliminary analysis. I diligently checked recording equipment and carried back up tapes, batteries, and recorders but I did not ever need them. I began each conversation by reviewing the study design and ensuring that the participant understood the interview process. I reviewed the measures to ensure confidentiality and informed consent, explained how the tape recording helped me attend fully to the conversations, and answered any questions from participants. Then I asked them to sign two copies of a consent form, one of which they kept, the other I filed. Then I turned on the tape recorder and began the interview.

An important feature in qualitative research is the researcher being the key instrument of data collection. Thus I had to learn to attend carefully to my choice of words, my body language, my appearance, and to my developing interview skills. As I introduced the study, I used that time to begin to establish a relationship with each participant. During each interview, the opening question can be used to convey respect and to demonstrate unconditional acceptance for each participant (Schamberger, 1997). While I followed a tentative interview protocol, I pursued leads and cues as they arose and I used participants' words to delve more deeply. "Wordings cannot be standardized because the interviewer will try to use the person's own vocabulary when framing supplementary questions" (Britten, 1995, p. 252). During each interview, I jotted only brief notes that acted soon afterwards as prompts to pursue points without interrupting the participant's train of thought.

Between interviews, I transcribed the audio tape-recorded interviews with wide margins to allow room for coding. I analyzed the transcriptions and my own analytical

memos, read more literature, and reflected on my own questions and responses to the interviews. As I transcribed tapes, I moved the transcribed files into the Ethnograph (1996) computer program to facilitate retrieving passages that I had coded in similar ways. I found this strategy to be a time consuming process until, after about six interviews, I felt more comfortable with the program.

As I noticed that concepts began to emerge through the early interviewing and analysis, I initiated theoretical sampling. "Theoretical sampling is sampling on the basis of concepts that have proven theoretical relevance to the evolving theory" (Strauss & Corbin, 1990, p. 176). I used the emerging concepts to move the subsequent interview conversations beyond the initial general focus on participants' perceptions of being professional and how they thought those perceptions were influenced. Van den Hoonaard (1997) names these emerging concepts "sensitizing concepts": "The sensitizing concept is a construct that is derived from the research participant's perspective, uses their language or expression, and sensitizes the researcher to possible lines of inquiry" (p.1).

As I used this process of theoretical sampling of sensitizing concepts, my interview guide changed. As interviewing and simultaneous analyzing progressed, then, they revealed concepts such as lacking competence, developing competence, *moving* to different work situations, finding a *mentor*, becoming a *mentor*, noticing workplace conditions, and earning respect. I pursued these concepts in subsequent interviews to broaden and deepen my understanding of them. My use of constant comparative analysis involved frequently re-analyzing previously analyzed transcripts in light of more recent transcripts; such iterative practice revised my lens for viewing data and revealed aspects

or concepts not initially seen.

Conceptual Density

Pursuing relevant sensitizing concepts arising from interviews assists in developing conceptual density. "Conceptual density refers to richness of concept development and relationships--which rest on great familiarity with associated data and are checked out systematically with these data" (Strauss & Corbin, 1994, p. 274). The process of constant comparative analysis contributes to familiarity with data and conceptual density and builds details of categories related participants' expressed meanings (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin). My own constant comparative analysis enabled me to develop a conceptually dense theory that revealed patterns of interaction and changes in interaction processes, rather than merely develop a description of these data.

Analytical memos are crucial to grounded theory because they act as an audit trail of the researcher's reactions to each interview, sudden ideas, coding insights, and critical questions. I found memos useful in building density of concepts and categories as they indicated additional directions for theoretical sampling. Immediately following each interview, I made memos or field notes about details of the interview, ideas for questions, suggestions for future interviews, and notes about what I had and had not heard. As recommended by Glaser (1978), I recorded, analyzed, and coded these memos following each interview to provide direction for the next interviews. I wrote memos, both spontaneously and deliberately, about each interview, the codes, categories, and relationships as they developed. I kept paper available for recording sudden insights and

questions as they surfaced during my daily life routines. The fundamental goals in memoing "are to theoretically develop ideas (codes), with complete freedom into a memo fund, that is highly sortible" (Glaser, p. 81).

Initial Analysis

"A fundamental feature of grounded theory research is that data collection, data analysis, and sampling of participants occur simultaneously" (Polit, Beck, & Hungler, 2001, p. 216). Glaser (1978) explains how analysis fractures data and begins to move them beyond empirical description. Such analysis involves closely examining and re-examining data and assigning codes to reflect meaning. "Coding is a process used to conceptualize data into patterns or concepts" (Polit, Beck, & Hungler, p. 390). Grounded theory uses two types of coding, substantive and theoretical (Beck, 1999). Beck describes the first type of coding, substantive coding, as consisting of level 1 or open coding and level 2 or selective coding. Open coding begins to break data into small pieces which are assigned codes.

I began my fracturing analysis with level 1, or open coding, to begin to break data into small pieces. Initially, I used participants' own words as "in vivo" codes (Strauss & Corbin, 1994), writing them in the wide transcript margins as I read and re-read transcripts while listening to the tapes. "Because this type of coding is based on facts, it limits the imposition of the researcher's biases" (Morse & Field, 1995, p. 159). Open coding names and identifies concepts, categories, properties, and dimensions by examining data closely and coding each unit of data in as many ways as possible (Strauss & Corbin, 1990). I found that coding interviews line by line enabled me to assign more

than one code to a particular passage of data. After six interviews, my initial open coding resulted in 127 codes before I had to begin clustering them. My open coding ended when it yielded a core category.

In general, in grounded theory, the researcher looks for a core category that represents a central or basic social problem and a process by which it is managed or resolved by participants (Fagerhaugh, 1995; Glaser, 1978, 1995). A basic social process is "conceptually developed to account for the organization of social behavior as it occurs over time" (Bigus, Hadden, & Glaser, 1994, p. 38). "A process must have at least two stages. . . . Process is a way of grouping together two sequencing parts to a phenomenon" (Glaser, 1978, p. 74). After analysis of the first six interviews, I detected the emergence of a core category that I initially called "striving to be a professional" and which ultimately evolved to become a basic social process called "*reworking professional identity*." I recognized the process characteristic in these data because there appeared to be eight stages, the process was central to the data, and my categories were all closely related to it. To build my understanding of the process, I continued interviewing, coding and recoding with each interview, comparing incident to incident, concept to concept, and concept to incident, as recommended by Glaser and Strauss (1967).

As coding continued, I began to identify and link concepts across data and to cluster codes based on similarity and dissimilarity of content and to identify provisional categories from these (level 2 or selective coding). I created categories by condensing level 1 codes holding similar meaning. I compared categories with other concepts, incidents, and categories across all the interviews as analysis continued. I revised or

discarded category labels when they no longer worked and I created more appropriate ones until all data were eventually categorized (Ely, 1991).

> The second step in the coding process is to categorize, recategorize, and condense all first-level codes, ensuring that all concepts remain unchanged unless they become irrelevant as more incoming data are analyzed and interpreted. The goal is to identify the relationships of the dimensions or the properties of the categories. (Morse & Field, 1995, p. 160)

Through the process of combining similar codes, the initial 127 codes were subsequently collapsed, first into 13 categories with 75 concept codes, and, later, expanded into 25 categories that better identified the emerging process and its stages. For example, codes labelled "enhancing my professionalism", "working toward professionalism", "wanting to improve", "recognizing professional ideals", and "trying to live up to expectations" collapsed into a category that I initially called "striving" and which ultimately became the substage "establishing patterns of practice" in the stage of *developing a reputation.*

Selective coding explores further codes and categories that connect with the core category. "Once concepts that show some relatedness are identified, the literature is reviewed to help generate further questions and research problems. As this circular process continues, some concepts begin to appear more prominent than others" (Morse & Field, 1995, p. 160). Processes of coding proceeded back and forth between these different levels until I understood what was going on in the data. I also read relevant literature on the emerging concepts to seek further understanding. During and after such substantive coding, I began theoretical coding to take the analysis into a theoretical realm.

Theoretical Coding

The second type of coding used in grounded theory is theoretical coding.

"Grounded theory provides a way to transcend experience--to move it from a description of what is happening to understanding a process by which it happens" (Artinian, 1998, p. 5). My substantive coding had revealed rich descriptions of participants' experiences and perspectives about being professional, how those changed over time, and what influenced that understanding. I now needed to analyze these rich descriptions further in order to move them to a theoretical level. I used the process of developing theoretical codes to take data beyond descriptive details, to "conceptualize the empirical substance of the area of research" (Glaser, 1978, p. 55). Theoretical coding directs questioning and examination of data in theoretical rather than descriptive terms so that categories and their properties are sorted by similarities, connections, and conceptual orderings (Glaser). It is essential to building grounded theory because it "focuses on how substantive codes relate to each other, weaves the fractured pieces of the story back together again" (Beck, 1999, p. 214).

I assigned theoretical codes to show how concepts and categories related to the emergent basic social problem, which was dissonance. The codes also helped me understand the emerging core category which represented the basic social process that participants used to address dissonance; I initially named this core category "striving to be a professional." Theoretical coding also identified the contextual conditions underlying the categories, their contexts, properties, processes, and consequences. For example, I saw how a category of "bringing self to nursing" eventually became part of the contextual influences on the emergent process and thus became labelled in the social context under the broader category of expectations.

I used Glaser's (1978) descriptions of the 18 coding families to determine the most appropriate set of questions with which to interrogate and elevate these data to a theoretical level. I used Glaser's coding family of the 6 c's: "causes, contexts, contingencies, consequences, covariances, and conditions" (p. 74) to interrogate data and I wrote memos relating to each of these questions about each category code. Using the 6 c's in theoretical coding elaborated the process and was instrumental in surfacing contextual elements as crucial to the emergent process.

Theoretical Sensitivity

In grounded theory, theoretical sensitivity of the researcher is important for data collection and analysis. Such sensitivity develops as the researcher becomes very familiar with the data, questions it, and opens up thinking about it (Strauss & Corbin, 1990, 1994). My theoretical sensitivity developed through reflecting on my own understanding of what I brought to the study, my increasing familiarity with the data, and my thorough coding practices. For example, in the role of researcher as instrument, I was sensitive to language in the data, insightful, creative, and discerning in ascribing meaning to data (Strauss & Corbin, 1990). My disciplinary background, work experience, and current work-related ongoing contact with other RNs also influenced what I brought to interviewing and data analysis. I enhanced my familiarity with the data during analysis by accurately transcribing interview tapes myself, and later, by playing the audio tapes while analyzing their transcripts. Such a concentrated focus deepened the sensitivity of my analysis and allowed more questions about meaning constructions to surface. I felt as if I were still present with participants.

Saturation of categories becomes apparent when "in coding and analyzing both no new properties emerge and the same properties continually emerge as one goes through the full extent of the data" (Glaser, 1978, p. 53). I proceeded with interviews and analysis until data saturation was reached. When no new concepts emerged and no new properties of categories were identified (Glaser; Morse, 1991, 1995), I stopped interviewing. I sensed beginning saturation when, during later interviews, I began to recognize similarities in the stories of participants and was unable to uncover new insights. The amount of data in each category is not theoretically important to the process of saturation (Morse, 1995); hence, some categories are characterized by more concepts and more data than others.

When I became sure that all categories had become saturated and no new concepts or categories were emerging, I took some time to revisit all data including interviews, memos, and literature to ensure that I understood them in light of the emergent process. When I was content that I understood the process, I began to return to participants for a second interview to share my findings at the theoretical level and to confirm meanings established from analysis of the 21 interviews, memos, and literature.

I used the second interviews to review with participants their contributions to the data, my overall interpretations, and the emerging process *reworking professional identity*. I checked whether the meanings that I derived fit with participants' perceptions and showed where they contributed to my emerging understanding of being professional. I offered each participant my interpretation of patterns in their own meanings as well as in the collective data, and so this second interview had potential to generate transferable

knowledge for their own use (Artinian, 1998; Glaser, 1978). No participant disagreed with my construction of the process and all supported it as being familiar to their own careers. Several participants said that they had benefited from being involved and reflecting upon their own processes of becoming and being professional. I later prepared and gave to all participants an overview of the basic social process of reworking professional identity.

Criteria for Trustworthiness

In the naturalistic paradigm, trustworthiness is the term used to establish the worth of a research study and it uses four criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Glaser (1978) articulated the four criteria by which to assess grounded theory as fit, work, grab, and modifiability. I describe each of these criteria and the strategies used to meet them.

Credibility

The criterion of credibility assesses whether multiple realities were acceptably identified and described as judged by those whose perspectives are represented. Key strategies used to establish credibility are prolonged engagement, persistent observation, negative case analysis, member checking, peer debriefing, referential adequacy, and triangulation (Lincoln & Guba, 1985). Credibility is also influenced by the researcher as a person and previous reputation as a researcher (Kvale, 1995). Several of these strategies helped me to establish credibility.

In terms of prolonged engagement and persistent observation, I used in-depth interviews that lasted from 60 to 90 minutes during which I pursued participants' leads

and language cues, explored with them their own understandings (Morse, 1998), and I raised additional concepts that had surfaced in previous interviews. All interviews continued comfortably until participants indicated that they were "professional-ed out" (Lynn) or could think of no new ideas to share. At the end of each interview, I offered to continue dialogue with participants should they think of something they wished to add; three later contacted me with additional thoughts. I kept notes about my observations within interviews. I was alert to, and pursued, observations that might illustrate variation on relevant concepts; for example, in an interview where I noted that the participant had not spoken about feeling a need to change jobs, I asked her about this. She indicated that she had not experienced it but she reflected that practising for only 3 years might be a reason relevant to her answer.

After I transcribed and analyzed the interviews, I returned to participants in a second interview to check whether the meanings derived fit with their perceptions; that is, I conducted member checking (or called communicative validity by Kvale, 1995). I was somewhat anxious about conducting these second interviews because it meant exposing my emerging interpretations of others' perspectives. What if I had not understood their perspectives well? My concern was unfounded. The second interviews were a very positive experience for me in that participants validated whole-heartedly the emergent process, saying such things as "it's so familiar" or " that's my career" and frequently nodding their heads. Most thanked me for showing them a new way of looking at their experiences.

As part of the process of peer debriefing, I explored and discussed analytically

with my peers many aspects of the research. I took opportunities to present at professional conferences my emerging understanding of the data and was impressed with the resulting interest and stimulating questions. I had planned to retain data from one interview for examination following generation of the theory to comply with expectations for referential adequacy (Lincoln & Guba, 1985) but I did not do this. I questioned the effectiveness of doing this because some analysis has already taken place in the mind of the researcher during the interview.

Transferability

Transferability assesses the extent to which the researcher has reported on the study clearly enough to enable others to assess similarities between the context of the study reported and their own relevant context, has articulated the theoretical stance that guided the study, and has used thick description and purposeful sampling. Such detail enables those who may wish to use the findings to make informed assessments. I have described the theoretical stance of naturalistic inquiry used in this study and the assumptions that guided it. I have shown how this study remained true to these principles. My respectful interviewing style and the acceptance of participants' knowledge of their own perspectives were effective in obtaining rich, and sometimes moving, accounts of participants' experiences. Audio-taped interviews ensured against loss of thick description. My ongoing analysis of the interviews informed the direction for ongoing sensitive theoretical sampling of subsequent participants and literature. Should other researchers wish to assess this study for transferability, my thick description of the context and process should enable them to understand the environment in which these

data were gathered and the boundaries within which this understanding was generated (Morse, 1999). When I shared my findings with my peers, I found that they quickly identified with the process; another indicator of transferability.

Dependability

The criterion of dependability is closely linked to that of credibility. Often demonstrations of credibility are sufficient to establish dependability (Lincoln & Guba, 1985). Dependability refers to the researcher's effort to explain decisions and the changing conditions within the research that influenced the decisions. I kept memos and notes of decisions related to the evolving design during the study. As I made different decisions in relation to sampling, I documented them, as with all decisions affecting the study design. These notes form an audit trail for tracking all my decisions. (See Appendix C for an example of some items from the audit trails.)

Confirmability

The criterion of confirmability examines whether others would find the same categories in the data. An audit trail, or inquiry audit, shows fair representation of the meaning found, dependability of the process of inquiry, and that the products of inquiry are supported by the data (Lincoln & Guba, 1985). I kept notes on how the core category evolved and how the categories related to it developed over the course of the study to show how the concepts and categories were grounded in the data. The verbatim quotations from participants that illustrate categories and stages of the emergent process enable others to determine whether my coding reflects the data.

In the second round of interviews, the emerging findings were returned to six

participants for their assessment. Their responses indicated strong acceptance and connection to the process. In one instance, the category label "wearing blinders" which had been an "in vivo" code, did not ring true for 1 participant, but my category description of "assuming adequacy" did resonate with her experience. I therefore changed the code label to be more relevant to general participant experience. In the rest of the interviews, the congruence was so strong that I did not return to the other 15 participants as I had initially intended.

Establishing the trustworthiness of the interview transcriptions is seen as a fundamental component of rigour in qualitative studies but it is not often addressed (Poland, 1995). I did hire someone to transcribe for me four interview tapes but I soon found that I preferred to do the transcription myself. When occasional words were difficult to hear, my recent familiarity with the situation enabled me to discern exactly what had been said. I found too that with another person transcribing, I had to return to tapes myself to fill in gaps or errors where her lack of familiarity with data and with nursing made some interesting mistakes. It was much more satisfying, although time-consuming, to transcribe my own tapes. By listening to tapes while reading and analyzing each transcript, I further ensured accuracy and inclusiveness of the transcripts. The notes and memos about my observations where there were questions at the time also formed part of the data.

Fit, Work, Grab, and Modifiability

One way of considering trustworthiness specifically in grounded theory is to use Glaser's (1978) four criteria of fit, work, grab, and modifiability. Fit refers to how well

categories of the theory fit the data. The fit must not be forced and, since the categories are generated directly from the data, this should not be a problem with grounded theory. It is possible to describe the "emergent fit" of categories as the research proceeds (Glaser). I believe that my theory has surfaced directly from the data, as the verbatim quotes of participants included in chapters 4 and 5 illustrate.

The criterion of work relates to the ability of the theory to explain what happened in the data. Categories must fit together and explicate the action or "what is going on" in the data (Glaser, 1978, p. 4). The theory should be able to interpret what is happening in the area under study. Returning to participants and sharing the emergent process revealed to me that the theory worked for them. They felt that it captured their experience with becoming and staying professional within a variety of contexts. They showed no trouble relating to the theory as exemplifying their own process of becoming and sustaining being professional.

The criterion of grab identifies the power of the theory to be interesting and useful. Those reading the theory, to whom it is relevant, should find enough explanatory power to render the findings engaging and relevant; this result was very clear when I returned to participants to ascertain their responses to the theory. As I have shared my findings with colleagues, they too have found them of great interest indicating how they make sense in terms of their own careers. Even a few colleagues in the Faculties of Sociology and Education at UNB have indicated to me that my process of reworking professional identity resonated with their career paths.

The criterion of modifiability refers to the flexibility of the theory so that it can

work the data. As the data are analyzed, the theory must be able to be modified to retain its relevance to new understandings of the data. Developing the process of *reworking professional identity* found in the data underwent several iterations before I was confident of meeting this particular criterion. At the earliest identification of the process, I perceived eight stages which I eventually modified into four and subsequently into three distinct stages. I made many sketches of the process as it evolved during my analysis and writing.

I advance the previous section as argument that this grounded theory study has met both the general criteria for trustworthiness of qualitative research and the specific criteria for quality in grounded theory.

Ethical Considerations

The key ethical considerations in this study were access, confidentiality, and role clarity. I arranged access to potential participants meeting the inclusion criteria by sending a letter through the University of New Brunswick BN/RN Program office. In this way, the Program Office did not need to release student names and addresses to me. Both the Dean of the Faculty of Nursing and the Assistant Dean of the BN/RN Program gave me permission to contact BN/RN students in this way. The Assistant Dean of the BN/RN Program agreed in writing to send out my letters of introduction for the study through her office. The Faculty of Nursing Ethical Review Committee agreed in writing that ethical approval from the Faculty of Education Ethical Review Committee was sufficient. The letter I prepared for potential participants invited nurses to contact me directly if they were willing to participate in the described study or if they wanted more information.

(See letter of invitation to potential participants in Appendix B.) When those people interested responded, I made telephone contact, explained the study, answered questions, and made an appointment for an interview. The participants' preferences for the location and time of interviews were respected.

I ensured confidentiality of participation. The letter fully explained the study's goals and data gathering procedures, privacy measures, freedom to withdraw at any time, and that no comments about the program or courses of an evaluative nature would be either elicited or included. No feedback about the identity of participants or opinions shared by participants was given to the BN/RN Program. Pseudonyms were assigned to each participant to protect any public use of data from identifying participants. I was very clear about my role as a doctoral student in relation to the research and explained that the interview was not connected to my former or future role in the BN/RN Program. I did not solicit nor accept evaluative comments about either the program or the courses.

I had minimal control over some conditions that had potential to influence the conduct of this research. Since I had worked closely with learners in this baccalaureate program for several years, I had to be alert to the possibility that I may have become desensitized to some issues and that I could over-emphasize others. My close association with the program could have led me to make unwarranted assumptions. My past experience could have guided me to expect certain responses from participants so I was vigilant and open to pursuing whatever ideas emerged. On the other hand, my past experience may have made me a more credible interviewer to participants and may have enhanced my theoretical sensitivity, allowing me to perceive cues that might otherwise

have been lost.

I documented clearly my assumptions, ideas, thinking process, research decisions related to questions asked and experiences explored, and I connected with others who would assist me in monitoring whether I was being unduly influenced by my past experience as a teacher in the program. Although I planned to begin interviewing learners whom I had never taught, theoretical sampling led to interviews with learners from former years, some of whom I had taught. I was critically self-aware of my reactions and expectations in interviewing these nurses.

I anticipated that geography could pose limitations on this study because there was only a small group of learners located in Fredericton. This did not prove to be a limitation. In spite of the fact that learners who had completed the first nursing course were located all over New Brunswick, northern Nova Scotia, and in Prince Edward Island, I travelled to interview learners in their home communities. Although this distance made interviewing both costly and time consuming, I was able to engage in face-to-face interviews with all participants. Related to geography, another limitation was imposed because this research was not initially funded. Later, I was unable to accept a SSHRC Fellowship for various personal reasons. Expenses for travel to conduct interviews and transcription services were, however, covered through a small grant from the University of New Brunswick Vice-President (Academic)'s Office.

Delimitations

My research plan imposed conditions on this study. Courses in the UNB BN/RN program are offered by teleconference to groups of learners at several sites. I usually

teach the first course in the BN/RN Program but I was not teaching during the academic year 1998 to 1999. It was crucial, therefore, that my study begin with this cohort of learners; I felt it was important that I interview learners whom I had not had an opportunity to influence in the classroom.

Assumptions

Seven assumptions guided this research; one relating to the context, three relating to the participants, and three relating to the method. Before these details, I need to clarify the single background assumption which is that nursing is considered a profession (see chapter 2). Regarding the context, I assumed that the first nursing courses in the baccalaureate program begin the process of influencing awareness of the professional lives of nurses. Regarding participants, I first assumed that nurses who had completed their first nursing courses would be able to reflect on the meaning of being professional. Second, I assumed that these nurses would be willing to take the time necessary to participate in interviews. I found that access to learners who could make appointments for interviews during July and August was reduced because of their family and work commitments. I also returned to work in July following my sabbatical. For these reasons, although I initiated the interview process in June as soon as approval of the proposal and ethical review were achieved, I conducted few interviews until the fall. The process of interviewing then had to be worked into my schedule of teaching and other work commitments as well as into the schedules of participants so the last of my initial interviews took place in June 2000. The second round interviews were completed in April 2001. Third, I assumed that these nurses were interested in the meaning of being

professional. Regarding the method, I first assumed that guided interviews were the most effective way to understand the meaning of being professional and its development. Second, I assumed that the method of guided reflection would not be a negative experience for participants. Third, I assumed that grounded theory was an appropriate qualitative research method. All of these assumptions held true. I found that participants were not only able to identify their meanings of being professional but that they were eager participants who expressed genuine interest in my findings.

Personal Reflections as Researcher

On the whole, the process of conducting this research was a positive and interesting one for me. But three areas generated concern: initial interviewing, being a novice grounded theory researcher, and needing support. I experienced some angst early in the first interviews. I had planned to use very open questions designed to hear concerns and descriptions of participants. My disciplinary background had prepared me well to be a listener; however, I learned that I sometimes needed to probe more specifically in interviews. Eventually, with practice and mentoring, I reached a successful balance between hearing participants' stories and directing questions during interviews. As I gained experience in interviewing, I also felt more confident knowing when and how far to pursue points. Another concern about interviewing related to the fact that I had to travel to reach about two-thirds of participants. For these interviews, I always had some trepidation that the participant would not arrive after I had driven so far. My fears were unfounded. Everyone always came and seemed so grateful to me for listening! One participant was late arriving because of traffic. In another instance, I had arranged to meet

a participant at home and it grew dark and rainy as I was driving into the country outside an unfamiliar town. I became aware that I needed to watch the landmarks very carefully so that I could get safely back to my hotel afterwards. When I finally arrived at the home on a long, dead-end road, there was a large dog tied in the driveway. I began to wonder whether I should go in but I had invested so much just to get there, that I did. Of course, I was welcomed warmly with hot tea and willing participation, and so the trip was worth it!

I carried initial concerns about being a novice grounded theory researcher, but I found that I could calm these concerns by frequent meetings with the grounded theory expert on my committee. When I wondered how to proceed, she was always accessible. When I tried to begin to write about the process, I inadvertently created a lengthy descriptive account of my findings that was not representative of a theoretical level of understanding. My inexperience left me perplexed about writing at a theoretical level, and for a while, I doubted my ability. It took me several meetings, many contacts with other grounded theory students, and many hours of effort before I succeeded in "getting" it. When I did, I felt such relief!

With respect to needing support, my concern stemmed from crossing disciplines with my study. The discipline of nursing seems more frequently than the discipline of adult education to define specific methodological traditions within the field of qualitative research. I felt an acute need to know whether my supervising committee would accept the grounded theory style of writing for a thesis in the Faculty of Education. At one point, I circulated a draft of the emerging process without the associated contextual background. In retrospect, I should have included this but I was anxious to know whether the format

would be acceptable before I invested more effort. Receiving general support enabled me to proceed with the writing. Overall, e-mail conversations with members of my Committee, particularly my supervisor, enabled me to seek and obtain responses and support relatively quickly. This was important to me because I was also working much of the time I was studying.

I have learned a great deal about conducting grounded theory research. I feel much more confident in myself as a researcher and much more competent in using the method. I found two absolutely exciting times in the research: the first related to discovering the emerging process and the second related to hearing participants confirm that the findings made sense to them.

I have described the grounded theory method as I used it for simultaneous data collection and analysis, coding, sampling, and writing. From these data emerged a basic social process illuminating how experienced RNs perceive their development as professionals. It is now time to present those findings here.

CHAPTER 4

Findings: Contextual Influences on Reworking Professional Identity

Introduction

I present the findings in two chapters and use two grounded theory traditions in writing these findings; first, I highlight in italics the stages, processes, subprocesses, and contextual influences of the substantive theory, second, I treat relevant published literature as data and incorporate it as appropriate throughout the findings chapters. In chapter 5, I describe findings that reveal the substantive theory, a three-stage process by which nurses in this study work out personal understandings of professional identity and identify their efforts in continuing to rework this understanding over their careers; a process I have named as *reworking professional identity*. Here in chapter 4, I describe findings that reveal the closely-related contextual influences that mutually interact to shape both the three-stage process and each other. These contextual influences are presented before chapter 5 to illuminate the process and to contextualize that detailed explication of the process and its stages, with supporting data and literature. I have selected participant quotations to illustrate the concepts and processes. The first names in the text are pseudonyms for participants in this study.

> Any social theory . . . must show how any situation/experience is distinctively, particularly, locally itself and yet/also constituted by and exemplary of social forces which lie in, around and beyond it. The most "trivial" incident, understood in this way, can reveal certain basic and necessary relations intrinsic to the social organization and forms of consciousness as a whole. (Bannerji, 1992, p. 78)

Three interconnected salient contextual influences actively influence the process of *reworking professional identity*: *expectations*, *perceived status*, and *supportiveness*. I

use *expectations* as an umbrella concept for the qualities, skills, and roles expected from nurses by others at four levels--society, professional socialization, workplaces, and families, and by themselves, intrapersonally. *Perceived status* is defined here as the nurses' impressions of the relative position accorded to nursing by others and nurses' understanding of how much they are formally sanctioned by others to exercise professional autonomy and to show caring behaviours. *Supportiveness* as a contextual influence is defined as the extent to which the nurses perceive personal acceptance, assistance with adjustment to and accomplishment in the workplace, and others' advocacy. *Supportiveness* is evident in contexts of working relationships with others; the nature of interactions with mentors, peers, and other professionals; and the perceived characteristics of the work atmosphere. All these contextual influences vary with place, person, and time; exist within, and beyond, nurses themselves; and shape the process of *reworking professional identity*. How individual nurses see, assess, and respond to their contexts varies.

> At the personal level all the little nastinesses and nicenesses of daily life, far from being trivial or irrelevant, are in fact the very building blocks of the maintenance of the sub-culture, making some feel welcome and others unwanted and ill at ease. (Greed, 1990, p. 152)

Although contextual influences in this study affect each other as well as the process of *reworking professional identity*, they are isolated here to show their range and intensity; to avoid essentializing and reducing the process itself, and the nurses' experience of it; and to account for diversity in how nurses rework their professional identity. Table 1 summarizes contextual influences, context, and properties which I now illuminate.

Table 1

Contextual Influences: Context and Properties

Influences	Context	Properties
expectations	society	gender socialization
	professional socialization	respect; competence; confidence, professional identity
	workplace	workload; pace
	family	roles; economics
	personal	view of nursing; responses
perceived status	autonomy	decision making
	value of caring	hierarchy; caring
supportiveness	working relationships	assistance; interaction
	atmosphere	attitudes; opportunities

Influence of Expectations

The influence of *expectations* is defined by nurses in this study as the qualities, skills, and roles anticipated from them in many different contexts. I used the Strauss and Corbin (1998) analytical device known as a conditional matrix to organize what I call the various contexts and their properties of the influence of *expectations* (Strauss & Corbin use the term levels): the property of gender socialization within the context of society, at the community level; properties of respect, competence, confidence, and professional identity within the context of professional socialization, at the organizational level; properties of workload and pace of work within the context of workplaces, at the institutional level; properties of roles and economics within the context of families, at the

group level; and properties of perspectives on or views of nursing and nurses' responses within the personal context, at the personal level. I used Glaser's (1978) theoretical coding family of degrees to "let relevant degrees" (p. 75) of categories of contextual factors emerge. Table 2 summarizes the contextual influences of expectations which I now explicate in some detail using the comments of participants.

Table 2

Influence of Expectations: Context, Properties, and Dimensions

Context	Properties	Dimensions
society	gender socialization	extent of gendered roles amount of influence on choice
professional socialization	respect competence confidence professional identity	extent of assuming being respected; degree of competence; extent of confidence; extent of assuming being professional extent of protective work environment
workplace	workload pace	extent of heavy workload relative pace of work
family	anticipated roles economics	extent of child care responsibilities degree of managing multiple roles amount of work needed relative value of nursing jobs
personal	view of nursing responses to workplace	nursing as career to nursing as just a job degree of awareness of practice level of motivation

Expectations: Societal Context

Societal expectations for men and women are often based upon perceptions of gender-related roles. These perceptions similarly apply in relationships between nurses, a predominantly female group, and physicians, a predominantly male group. In health care

environments, "the female approach of putting their own interests aside, adapting to the existing structure of the system, fits fine with the male approach of dominating what is done" (Dahlberg, 1994, p. 400). There have been some changes in gender proportions in the health care field with increasing numbers of female physicians, but the majority of physicians are still male and most nurses are still female so relationships between these groups have not changed much in many workplaces. "Gender is a social construction" (Pennell & Flaherty, 1993, p. 320) and gender identity is an individual construction (Severiens & ten Dam, 1997) so the quality of work relationships is not predictable if those relationships are based solely upon observable gender behaviours. Joanne asserts that female physicians adapt to working within a male-dominated profession and do not impress nurses as willing to connect with them as women: "The women who have succeeded in the [medical] profession are perfectionistic in my opinion. . . . They have much higher expectations [of nurses] than the male physicians but they've battled in the woods, in the big, bad, boys' world." Joanne thinks that female physicians have to adopt qualities of the dominant male group to thrive and that appearing to connect with female nurses might place them at risk within that group. Her view may be supported by Strong-Boag's (1979) presentation of an historical perspective on Canadian female physicians.

> Most female doctors interpreted their lives in terms of unique female qualities. At the same time their indoctrination as medical experts confirmed their membership in a middle-class professional elite. For all their battles with male doctors, the majority finally shared that group's essentially conservative approach to radical social change. (p. 129)

Beagan's (2001) recent research with medical students indicated that female medical students learned to conform to male gender-influenced expectations. "Women . . .

become more-or-less men during medical training, 'almost hyper-masculine in their interactions', 'much more like men in terms of thought processes and interactions with people.'" (p. 286). Such socialization fits with Joanne's observations about female physicians.

In this study, the nurses perceive that society expects nurses in general to be selfless, pleasant, passive, accepting, caring, nurturing, and dedicated and to provide necessary services promptly and willingly. Although these expectations are often associated with societal expectations of women, they are generally applied to men who also enter the nursing profession. Nurses "are expected to function in organizations in which relations of domination and subordination are the norm" (Purdy, 1997a, p. 197). Such societal expectations lead many nurses to feel that they deserve or must accept low pay, and accept full blame for low pay, often must work within unequal relationships, must take verbal abuse from others, must "wait on" patients, and must avoid confrontation in the workplace (Kristina, Wendy, Ruth, Brenda). Many of the nurses in this study often expect to diminish their own achievements and the value of their work in deference to others (Helen, Kristina). The nurses' experience with gender-related socialization ranges from socialization beginning some years ago that influenced the older nurses to limit their expectations to more recent socialization influencing younger nurses to be more effective in articulating their rights and expectations (Kristina, Ruth).

Societal expectations influence some women's choices to become nurses. In this study, reasons for entering nursing range from always wanting to be a nurse to making a conscious selection of nursing as a career to not seeing many other real alternatives when

choosing a career. The societal perception of caring as women's work makes nursing a 'natural' choice for some women. As Lynn recalls,

> Women were raised as the care givers. We were influenced by our parents, stereotyped. . . . When I graduated from high school, the guidance counsellor offered you: a nurse or a teacher. . . . I've always been the smoothing type. Just having that natural characteristic. . . I was drawn to nursing.

In this study, the perception of limited career options occurs whether nurses choose nursing when very young or later in life; whether 30 years ago or 3 years ago. In another study, limited career alternatives were perceived as a result of societal expectations that women would accept work that was undervalued by society as a whole (Chiantera, 1996). Even in recent years when more career options are perceived to be more open to women, various economic, family, and geographic conditions influence women's abilities to adopt some of those other career options (Helen, Wendy).

Expectations: Professional Socialization Context

Professional socialization is the second context in which certain *expectations* influence *reworking professional identity*. The process of professional socialization begins in nursing education programs and continues in the workplace following graduation. Professional socialization in education programs allows graduates to develop respect for self and also various levels of self-confidence and awareness of professional competence. Professional socialization is defined as the process whereby individuals acquire knowledge, skills, attitudes, beliefs, norms, values, and behaviours appropriate to a profession (Chitty, 2001). In this study, the nurses' experiences in education programs indicate that they have learned nursing knowledge; acquired, but not mastered, numerous

skills; understand many nursing values; and know the expected nursing behaviours but that they do not internalize all of these professional competencies before graduation. Further development has to occur within the workplace. Table 3 sets out the properties and dimensions of context of professional socialization.

Table 3

Professional Socialization Context: Properties and Dimensions

Context	Properties	Dimensions
professional socialization	learning to respect and be respected	extent of assuming being respected
	learning competence and confidence in skills and behaviours of professional nurses	degree of competence extent of confidence
	learning that nursing is a profession	extent of assuming being professional
	trying skills in practice courses	extent of protective work environment

Respect is a strong property of professional socialization; it stands out in what these nurses recall learning about being professional when they were students. In nursing education, they learn to respect themselves and others and to be respected, are taught that nursing is a publicly respected profession, they learn how to show respect to others, and they anticipate being respected as professionals by others. Having, building, and keeping self-respect are related to having positive and congruent feelings about oneself (Millie). Maintaining integrity, setting standards of personal interaction, and working toward practice competence begin to build self-respect in the nurses when they were students. In

nursing education programs, some nurses in this study recall experiencing as students a strong emphasis on appearing confident so that patients will respect them as nurses. These graduates begin their practice *assuming adequacy* of respect and competence; as if wearing blinders that diminish their awareness of actual personal competence and actual respect accorded by others. Such blinders permit believing and acting as if one "knows it all" and expecting to be respected and treated as professionals (Lynn). Cowin's (2001) research found that, "Student nurses expect that they will be comfortable with and confident of how they feel and think about themselves as graduate nurses" (p. 322). In this study, Gail says, "many of us when we first started out didn't know that we didn't know everything. That first year was quite a learning experience."

Existing research has articulated the struggles to develop professionally and the associated stress experienced by nurses during the first year of practice (Duncan, 1997; Kelly, 1992, 1998). Kelly (1996) found that the stress experienced during the first year of work was influenced by expectations of self and others and by professional socialization. Steffy's (1989) work with newly employed teachers pointed to similar challenges in the education field since new teachers "are generally ill-prepared to deal with the pragmatics of day-to-day life as a classroom teacher" (p. 20). The experience of the professional socialization of engineers created stress in that engineering "students may have learned how to be professional in theory, but they did not translate that theory" (Dannels, 2000, p. 25) easily to workplaces.

In this study, some nurses learned more accurate acknowledgement of their beginning competence level as graduates and how to manage such limited competence. "I

think we all started out with fear and trembling" (Olivia). In these cases, nurses begin professional practice *assuming adequacy*, that is, wearing blinders as a protective function like safety glasses. The function of these blinders then changes: nurses use the blinders to remind themselves to work within their limited competence and to disguise that limited competence from others; for example, "putting on an air" when approaching patients and: "I also had the sense that, even if I didn't know, I could give . . . the sense that I knew. I could hold my ground" (Terri). Vera and Connie agree that showing confidence with patients is important. Recent research by Beagan (2001) with medical students showed similar expectations: "Even if I don't know what I'm doing, I can make it *look* like I know what I'm doing. . . I get the trust of the patient" (p. 283).

During socialization in the workplace contexts, nurses who have been taught to respect others automatically respect them only until they notice that their colleagues do not really deserve such respect. The consequence is feeling and showing a diminished, or total loss of, respect for them. Those colleagues have to earn back the lost respect of those nurses, a task which is difficult to do (Millie). The nurses begin to discover through experience that they are not automatically accorded respect by others and also that they are personally responsible for earning the respect of others (Lynn). The nurses note that respect earned may also be lost by the actions of others which inadvertently reflect poorly on themselves as individuals or on the collective profession, thus placing respect sometimes outside their control. With increased experience, the nurses' confidence and competence command respect from others (Irene).

In this study, socialization within nursing education programs teaches that there

are consequences associated with not conforming to expectations. The consequences experienced by nurses in this study range from criticism, as Ruth mentions when she acts outside expected parameters, "It always got me into trouble for reaching beyond myself. Even in training, I was raked over the coals for that," to actual removal from the school, as Terri recalls, "It was called 'nurses training' so you had to be trained to act a certain way, and if you didn't, you were out!" For the most part, nurses learn to walk a fine line between taking responsibility for the care they give and accepting directions and complying with the expectations of others. Student nurses have to accept conformity as the norm. "Everybody seemed to know their place. . . you never crossed a certain line" (Terri). "The teaching, when you're taught, it's a hard line" with little room for judgement (Fred). This requirement for conformity in nursing schools is achieved in general by using oppressive strategies to socialize nursing students (Benson, 1991; Rather, 1994).

Nursing education has changed, however, over the span of years represented by graduates in this study. As Brenda, a more recent graduate, says, "We were encouraged not to wear the nursing caps because [they symbolized] a submissive role... In a profession, you don't take that submissive role. You try to be an advocate to yourself and to nursing." Patty, speaking of changes in practices such as measuring the length of uniform skirts and standing to show respect for physicians, says, "That went by very quickly after a while." Irene recalls having a course on professionalism in her program and Vera says the director of her nursing school "was the epitome of professional ethics and so I think I caught that from her more than it was taught." Some nursing education

programs now intend to distribute power more equitably and to exert less control over learners, thus leading to more critical views about the dangers of behavioural conformity (Clare, 1993; Marks-Maran, 1999; McBride, 1999). Some more recent graduates in this study recall instructors who show emotion by hugging students and patients, actions which would have been unheard of for earlier graduates. In summary, professional socialization acts to influence expectations in both subtle and not-so-subtle ways.

Expectations: Workplace Context

The workplace is the third context in which various *expectations* influence the process of *reworking professional identity*. Workplace expectations are characterized by properties of workload and the pace of work. Nursing education programs provide clinical learning experiences in a variety of workplace settings, but as learners, nurses are not exposed to the work environment in the same way as they experience it as graduates. "Neophytes to the hospital are likely to experience theory-practice dissonance in that hospitals have different rules and objectives from the educational establishment and also different power relationships" (Philpin, 1999, p. 1328). Professional socialization in nursing schools includes viewing nursing as a respected profession but this ideal sometimes disguises, at least at first, the fact that others do not respect nursing as highly as nurses do. When nurses are newly employed, they assume the same level of support and respect that they received earlier as practicum students. The extent of actual support they get in their workplaces then influences their movement through *assuming adequacy.* It is only later in the process that nurses become aware of and address discrepancies between their own career perceptions and expectations of professional identity and those

observed in their colleagues. Table 4 sets out details of the workplace context.

Table 4

Workplace Context: Properties, Dimensions, and Consequences

Properties	Dimensions	Consequences
workload	extent of heavy load	little reflection; work through breaks; tired no control; routine practice cannot see beyond status quo practice
pace	relative pace of work	run off feet; reduced time to expand practice and learn stagnation; low satisfaction; need to set priorities for what can be done

In this study, the workplace context frequently involves heavy workloads and rapid pace. Working conditions hinder *reworking professional identity* when time for reflection is reduced because of those heavy workloads and very fast paces of work. With nursing shortages, sometimes staff do not get vacation time and proper meal breaks and are called back to work extra shifts (Wendy, Brenda). Wendy expresses concerns about the working conditions and nurses' responses.

> I think nurses are coming to work when they are too exhausted and they shouldn't even be there. You know they're not even safe to be doing a shift but they come in because they know that the person that was left would not be able to leave if they didn't show up.

In very busy situations, "you're run off your feet" (Wendy). Fred adds that "because there have been so many cut-backs, our patients are way heavier" because they have "central lines, people getting TPN, and some getting chemo on our [surgical] floor." Helen states that the pace of work seems to be influenced by "this kind of institution clock, that says within an hour" certain care should happen and, in her broader view, this prevents other

desirable care from being done.

When the pace of work requires working to capacity, it reduces the nurses' time and energy to extend their practice and to engage in, or even to contemplate, activities to develop their practice. They feel torn between their commitments to develop their professionalism and their commitments to their patients. The pace of work is tiring and interferes with managing both.

> Plus, we get called back all the time. And it's really hard because your heart is with the patients but where do you draw the line? You have a home, you have a life, and you have other commitments other than work. (Joanne)

Feeling little time for professional development is not unique to nursing. "The hectic pace of high school teaching and such stressors as maintaining a safe environment for students and staff left teachers weary and often unwilling to participate in learning activities after school or on weekends" (Scribner, 1999, p. 256). Feeling that there is no control over busy working conditions and that responses must be made without hope of changing such conditions leads to feeling like being a victim of one's own productivity. As the nurses do more with less, they feel they are expected to do even more with even less (Patty) and to do more than one thing at a time (Debbie). Brenda says that a professional is "a very good juggler." When nursing units are very busy, when nurses are floated to units (suddenly required to work for a shift or part of a shift on a unit) outside their expertise, and when nurses are new graduates or new to a unit, being expected to work safely in such fast-paced environments appears unrealistic but there is little apparent choice. To refuse to work would compromise patient safety.

Several workplace factors influence the third stage of the overall reworking

process, namely *developing a reputation*. One factor is the extent to which nurses can see or act beyond the status quo in the workplace. This capacity is limited when practice is confined to routines and others diminish nurses' efforts and belittle their contributions. Nora says that nurses who work in such environments over a long period of time appear less responsive. However, those outward appearances may be somewhat deceiving because, even though "you get this hard shell, you still feel inside" (Nora). Sarah indicates that it is difficult to manage these circumstances.

> I think workload and job satisfaction have more of an effect on professionalism than anything. I think people know what they should be doing and know what they want to do. . . . I think it affects people's self-esteem about their work and then it just snowballs.

Nursing students in Smith's (1998) study "were dismayed and surprised by the way in which trained nurses sometimes upheld the status quo and they explained this in terms of hierarchy, patriarchy, and other social processes" (p. 897). These factors also influence appearing to be unable to see beyond the status quo in the current study.

When a workplace restricts approaches outside the norm, or when nurses perceive that learning may not be possible, nurses stagnate and develop reputations that reflect reduced professionalism. Some workplaces interfere with self-directed learning by not fostering learning or creative approaches (Merriam & Caffarella, 1999). Nora describes the result of that: "I often feel like a robot. It's like I'm bathing another body [makes deliberate, slow, scrubbing motion on her forearm], and it's awful, and I hate that." Performing a series of tasks does not foster professionalism. Having a low position in the agency hierarchy is uncomfortable. "You know the medical profession! There's some

older [nurses] around who still . . . have that opinion that they're a little lower on the totem pole" (Olivia). Working in hierarchical work settings has been known to reduce satisfaction with work (Adams & Bond, 2000). Tonuma and Winbolt's (2000) description reflected factors leading to stagnation: "Rigid hierarchical structures, disempowerment, the routinism of care combined with negative nursing attitudes, behaviours and language dehumanise nursing and reduce care to a series of tasks" (p. 214). Beagan (2001) reported that physicians deliberately used the medical hierarchy to discourage medical students from asking questions or being critical and to gain compliance. I question whether nurses are influenced by a similar use of the hospital hierarchy.

Conditions in the workplace influence *choosing* and meeting a range of *standards*. The expectations in some workplaces to speed up physical care at the expense of meeting patients' emotional or social needs may create conflict between personal and workplace standards. Busy workplaces require that nurses set priorities because the hours of their shifts are limited. Reflection on such choices reveals a range of responses, some of which indicate that nurses may create tension among themselves. Responses range from accepting the limitations imposed by the pace of work, to struggling to maintain higher standards, to making efforts to change the workplace. By choosing certain responses, nurses find that they are sometimes at odds with their colleagues.

> I was sort of judging the quality of the work of the nurse before me, saying, "why didn't she get this done? Why didn't she get that done?" And then setting my priorities for the day, and perhaps, some of the things I chose not to do, were the same as the other nurse chose not to do. And then I got thinking, OK, there's no way we can get everything done anymore and the line of what you judge as "must do" and "may do" keeps dropping. There's more things that must be done that are sliding over into the other and you're having to justify that to yourself all the time.

> So that if I move some of those "must dos" into the "may dos," that's probably what she did too. So maybe she was doing her job. She just chose her priorities differently than me and I wasn't giving her the benefit of the doubt. And then you go to give your report to the next nurse, and you can tell by the expression on her face, [she] is judging your priorities differently than you did yourself. (Sarah)

Kelly's (1998) research showed that getting through the workday required making choices about what could get done and this decision-making created uneasy feelings. Workplace conditions in my study often require caring within chaos (Nora), having to make risky decisions about care (Sarah), and being challenged to figure out the limits of what can be done safely (Joanne). Björnsdottir (1998) found that the main characteristics nurses identified in their work were its excessive volume, complexity, and uncertainty.

Sometimes the public notices how the workplace influences nurses because they can "often see the running and, if they're at all trained [they'll say] you didn't go eat yet, or they'll see you eating a sandwich, standing up, writing your notes, and they say 'Ahhh'" (Joanne). Nurses become concerned about burning out when work patterns are developed that involve persistent self-sacrificing. Extended exposure to very busy workplaces diminishes nurses' sensitivity to caring and desires to improve. "At some point, you just give up trying. You just get through the day. And people have lost their conscience about their work out of an attempt to survive" (Sarah).

Wendy thinks that nurses may inadvertently be partly responsible for some current workplace conditions and that they should also take responsibility for changing them.

> This isn't something that has just happened overnight because this was predicted years ago. As [it began, nurses] just agreed, and now nurses aren't getting their vacations, nurses are working overtime. They've allowed some of that to happen. . . . You have to say "no" because if you say "no" and stand up, then that's when it's going to clear the way, and make our career and our profession a better

profession for the young people to go into.

Some nurses in this study find workplace expectations more manageable and that this enhances their professional identity. Working in community settings, clinics, or patients' homes involves different paces of work because the focus is more often on one patient at a time and the external conditions are less chaotic. The same is true of some institutional settings but those do not predominate in this study.

Expectations: Family Context

The family is the fourth context in which various *expectations* influence the process of *reworking professional identity*. Its properties are anticipated roles and economics. Anticipated roles are defined here by the responsibilities imposed on nurses by family expectations and may be influenced by gender-related expectations. Economics here refers to the varying needs within each family that nurses be gainfully employed and contribute to family income. Table 5 sets out the properties, dimensions, and consequences of the family context.

Table 5

Family Context: Properties, Dimensions, and Consequences

Properties	Dimensions	Consequences
anticipated roles	extent of child care responsibilities degree of managing multiple roles	interrupt career process; fatigue; limited time
economics	amount of work needed relative value of nursing jobs	stability, survival to frills; benefits

Anticipated roles of the nurses within their families most often involve child care, homemaking, transportation, and organization. When they are not caring for their own

children because of work, nurses are often responsible for arranging child care especially when spouses also work shifts (Helen). Nurses must plan carefully to keep the family and child care organized while working shifts and this management of multiple roles can be stressful (Kristina). These roles "involve continual processes of evaluating and reevaluating goals, choices, tradeoffs, etc., related to coordinating working and mothering" (Crawford, 1999, p. 4). Child care may involve taking children to a sitter overnight (Wendy), moving children from playing with friends to where they will be safe while the nurse works evenings or nights (Joanne), and, with older children, being uncertain about what they are doing while there is no one at home (Olivia). Being called back to work additional shifts, managing children's illnesses, or getting family members to various activities and appointments require alternative plans. Working shifts in fast-paced and stressful environments limits the nurses' abilities to respond to sudden changes in family conditions. The one male nurse and 8 of the 20 female nurses in this study do not have children or have grown children who have left home. The remainder work to juggle child care with other multiple life roles and identify this process as very demanding and a strong influence on their engagement with the process of *developing professional identity*. Family conditions influence the pacing of the process of *reworking professional identity* by altering freedom to participate in the workforce. Sometimes nurses stop work to have or raise children (Terri), work part time when children are small (Kristina), or work to put spouses through education programs (Irene). Such tasks influence the progress of the nurses' careers, their participation in activities and organizations that promote nursing, and their focus on professional development over a

career.

Economics defines the family expectations of nurses to be gainfully employed and to contribute to family financial support. In this study, economic expectations range from the family needing nurses to work part time, to full time, or even to working two jobs to earn required money. The nurses' roles in this study range from being the main income supports for themselves and their families (Millie, Brenda, Connie) to providing desired or essential second incomes (Vera, Debbie). Generally, the nurses' incomes are reasonably steady and most nurses hold unionized positions that give access to family benefits, such as job security and health insurance. The requirement that nurses contribute income to the family means that most are unable to stop work completely, even during difficult times or feeling stuck in unpleasant workplaces. "People feel trapped, you know. If you earn $40,000, you need that $40,000. It's not easy to give that away and even to go part time. It's not realistic for most people" (Sarah).

Economic needs impose challenges to balance the nurses' personal and professional identity development needs with family and work-related demands. When nurses work part-time, this relieves some pressure of juggling but it imposes other limitations from the reduced income (Joanne). When nurses work while their spouses study, this solution provides essential income but delays nurses' ability to promote their own professional development. Most nurses, then, have to juggle expectations associated with multiple life roles of nurse, family member, and a member of society.

Expectations: Personal Context

The personal is the fifth context in which various *expectations* influence the

process of *reworking professional identity*. It contains the properties of individual views of nursing as a concept and nurses' responses to workplace conditions. Table 6 sets out the properties, dimensions, and consequences of the personal context.

Table 6

Personal Context: Properties, Dimensions, and Consequences

Properties	Dimensions	Consequences
view of nursing	nursing as career to nursing as just a job	promotes the process inhibits the process make a living
responses to the workplace	level of motivation fatigue	growth to burnout try to excel to put in time

When nurses are unable to see the need to develop, they inhibit the growth of their professional identity. One example occurs when nurses think that nursing is just a job or a way to "make a living" rather than regarding it as a career (Fred). Olivia says that the process of *reworking professional identity* is inhibited "if you go to work every day just to bring a pay cheque home and you're not there because you like what you're doing." "A lot of people at work don't care like they should and it's easy to get into that. Why should I bother to try to change anything?" (Anna). *Reworking professional identity* is promoted when nursing is viewed as a career (rather than only a job) and when self-esteem, interest in learning, personal insight, and interpersonal skills are strong. With such promoting conditions, the nurses achieve competence more quickly, they can extend vision beyond tasks, and their increased awareness boosts self-esteem and self-confidence. "As I became more self-assured and I was able to be less frightened by the work-related stuff, I was able to go beyond that" (Ruth).

The level of nurses' motivation and the degree of fatigue are dimensions of nurses' responses to the workplace; for example, "it's hard to be what you should be when you're tired" (Anna). Sarah identifies that accumulating fatigue reduces nurses' abilities to move through the process.

> When people stop acting professionally, it's associated with fatigue and burnout in the area, and when you start seeing unprofessional behaviour, or thinking someone's acting less professionally, it's usually from exhaustion, whether that is today's exhaustion, or this year's exhaustion.

Grunfeld et al. (2000) defined burnout as "the psychological state resulting from a prolonged period of high stress in their professional lives" (p. 167). Demerouti, Bakker, Nachreiner, and Schaufeli (2000) found that "long-term exposure to job demands leads to feelings of exhaustion" (p. 456). Recognition or anticipation of burning out is a motivating factor in the choice to seek other work situations for most nurses in this study and is therefore strongly linked to moving through the process of *reworking professional identity*. Sarah's description of fatigue (above) is congruent with the perspectives on burnout in the research literature and this study.

> Personnel may be more susceptible to burnout when working in areas where there is a lack of encouragement to be self-sufficient, tasks are not clearly defined, rules and policies are not explicitly communicated, there is a lack of variety and new approaches, and the work environment is not very attractive or comfortable. (World Health Organization (WHO), 1998, p. 100)

Many nursing workplaces mentioned in this study have several of these burnout risk qualities. Anna explains her response to the workplace: "I think of people who may be burned out, not at a certain level, because they need a change, and I am seeing that in myself. . . . I'm getting ready for a change . . . because nothing's a challenge anymore"

(Anna).

The nurses' responses to fatigue and reduced motivation are influenced by relationships with their co-workers. If more experienced co-workers are supportive, new nurses feel comfortable seeking help and asking questions. Some, like Brenda, do request help: "You learn a lot more by working with other RNs. Some of the RNs aren't as open as I feel I am. I'm always like, Help me! Help me!" Learning and developing professional identity are enhanced with such support. Others, like Sarah who had just changed jobs, say they do not mind being watched over while learning new things: "It's very, very different than I've [been used to]. They can hang around all they like with those, because I don't have a clue what I'm doing. I can remember what it felt like to be a brand new grad!" Olivia is also open to learning from colleagues who are open to helping. Some nurses also respond to work situations in ways that identify reasons to hope for improvement for the profession, for themselves, for patients, and for the work situations (Ruth, Vera, Irene, Kristina).

Levels of personal motivation influence professional responses. When motivation is low, nurses can be seen to respond by "just putting in time" at work or "waiting to retire" (Debbie). With higher motivation, they are pulled to develop a professional reputation because they can see that they are making a difference in people's lives: "You're going to do what you can to provide what they want" (Vera), "That's the most important thing. Come the end of the day, if you're able to make a difference in their [patient's] day, because their days are awful" (Joanne). Other personal factors influencing responses include various interfering priorities from family or personal health concerns

(Wendy). In summary, *expectations* work to impose influences on how nurses experience the workplace context and attend to *reworking professional identity*.

Influence of Perceived Status

Perceived status, the second contextual influence, is defined here as the nurses' impressions of the position accorded to them by others and also their own understanding of who has formal sanction to influence their work. The two key contexts in which this influence operates are autonomy and the value of caring. I define autonomy as the amount of independence nurses have to make and implement care decisions and the value of caring is as the extent to which the actions and practice of caring are considered important by all the nurses' colleagues.

Perceived status is influenced by conditions such as the amount of autonomy in selecting, pacing, and sequencing work; relative closeness of supervision and proximity of co-workers, such as working together for eight to twelve hours or working independently; time and breadth of focus, such as working with one patient in an Intensive Care Unit or at a patient's home (as opposed to juggling many patients and managing related departmental interruptions); and the accorded value of caring. Fred says that the status of nursing is also influenced by society's perception of professions. "To be in one of the professions isn't quite as good as being rich without working but it is considered a worthwhile thing to do" (Fred). Table 7 shows the contextual influence of *perceived status* and its related contexts and properties.

Table 7

Influence of Perceived Status: Context and Properties

Influence	Context	Properties
Perceived Status	autonomy	amount of independence, degree of control, extent of hierarchy in care decisions, respect, and partnerships
	value of caring	value and status of caring, hierarchical workplace relation, caring to curing, extent of resource allocation, degree of gendered expectations

Perceived Status: Context of Autonomy

Nurses feel a sense of autonomy and that their work is valued when they have independence in decision-making, for example, changing treatments without an order or consulting physicians about care. Elaine speaks of changing patients' dressing protocols and of calling physicians to inform them, expecting that such changes will gain physician approval. Nurses also identify that verbal rewards for taking initiative, respectful communication, and trusting relationships with other professionals are further evidence that their opinions and work are valued. Gail explains that she enjoys excellent working relationships with other health professional colleagues whom she consults about patient care. Connie expects, and finds, that physicians respect her nursing knowledge and expertise. Nurses' experiences of workplace autonomy are influenced by the relative importance of caring and curing, freedom in decision-making, accessibility of support and resources, and time allowed for caring.

The amount of autonomy varies with workplace settings. Non-institutional or less

structured workplaces such as patients' homes tend to foster greater autonomy, accord status and respect to nurses, facilitate partnerships with physicians and other professionals, and induce expectations of independence. Gail, Connie, Elaine, Terri, and Lynn all enjoy such workplaces now. Institutional settings, however, tend to be more autocratic workplaces where nurses have less autonomy and have to learn to manage the consequent power and control conditions from their disadvantaged position.

The amount of autonomy accorded to nurses also influences their freedom to try to do things in new ways or to try new things (Elaine). Daley (2000) reported research that indicated how nurses often felt blocked in their use of new information by organizational structures and political issues. Fred is concerned about his lack of autonomy to make decisions about care and having to carry out orders that he may question.

> I feel it hard to accept that I am being professional when I am handing somebody a little cup with 10 pills in it . . . and you want to say "is that with mayo or without?" When you're dealing with that sort of thing everyday, and you have no influence over it, that's frustrating [but] I do it because I'm making a living.

Fred's concern is not uncommon. Wade's (1999) concept analysis of autonomy reinforced that blindly following physician's orders and doing tasks routinely were not qualities associated with nurse autonomy or professionalism. Fred says that working conditions for nurses would be improved if nurses were allowed to control their own workload by determining when patients could be discharged from hospital and when units could cope with admitting more patients. Nurses' autonomy in managing environments to the advantage of patients varies with such influencing factors as support from nursing

superiors (Gail), length of time nursing in that unit (Kristina), credibility developed (Olivia), respect accorded by others (Patty), and other's perceptions of the need for collaboration with nurses, peer support, and experience.

Perceived Status: Context of the Value of Caring

Most nurses in this study accord high status and great value to caring. Nursing education prepares nurses to value, and provide personal and technical care for people unable to care for themselves. The value nurses place on caring contrasts with the relative values placed on caring and curing by hierarchical institutional work environments and society. Caring has less perceived value and lower status than work done by other health professionals (Kristina). Dahlberg (1994) asserted that a reduced status of nursing as a profession resulted from greater esteem accorded to other health care professions. Liaschenko and Fisher's (1999) work indicated that nursing work, like other gendered labour, was often poorly articulated, leading to lower perceived status of the work.

Nurses in this study observe the importance of caring relative to curing. "We're just the nurturers, the carers, not to say that we're not intelligent people, but that's not what we're first thought of. We're there to give support, or to help somebody along, or to ease their pain or something like that, but we're not thought of as being the ones who can fix" (Nora). From this lower status, nurses feel judged in negative ways on their caring (Helen); "When we don't seem caring, we've failed. And yet it's hard to give to that individual patient when there's so much chaos going on" (Nora). Kelly (1998) reported that many nurses had accepted blame for not meeting their own caring ideals.

Inadequate staffing allocated to accomplish nurses' work, little autonomy, and

little power are interpreted by the nurses in this study as signs that the system does not value caring enough to provide adequate and necessary resources. In addition, some administrators seem to make changes without hearing or heeding nurses' concerns or input, leading to even more perceptions of little support and power (Helen).

Influence of Supportiveness

Supportiveness is the third major contextual influence on the process of *reworking professional identity*. *Supportiveness* is defined here as nurses' perceptions of the extent of collegial acceptance, assistance with adjustment and work accomplishment, and advocacy by others for their needs. *Supportiveness* therefore refers to the extent to which work relationships provide effective assistance, the qualities of interactions with mentors, peers, and other professionals (for example, as handmaidens or colleagues), and the nature of the workplace atmosphere. Table 8 shows the contexts and properties of *supportiveness*.

Table 8

Influence of Supportiveness: Context and Properties

Influence	Context	Properties
supportiveness	workplace relationships	degree of proximity, amount of latitude, amount of assistance, relative position, degree of stress
	work atmosphere	amount of acceptance, amount of support, extent of growth

Supportiveness: Workplace Relationships Context

Relationships vary according to how closely nurses work with others, the degree of perceived latitude for individual action, and the relative hierarchical positions of other professionals. Workplace relationships influence the nurses' handling of conflict, the support of co-workers (nursing superiors, peers, newer graduates), and the relationships with physicians, other professionals (social workers, occupational therapists, physical therapists), and patients. The nurses' management of these relationships and the outcomes of that management are influenced also by the psychological atmosphere. It is no surprise that the second major contextual influence, *perceived status*, links to the supportiveness influence in complex interactions.

Here I restrict focus to the affective elements experienced by the nurses. Since few nurses work in isolation from other workers, they must have trust and confidence in each other's work. Workplace relationships are formed not only to direct patient care, ensure acceptable performance, support nurses, but also to address satisfaction needs: "Work is not simply about money but about satisfying our human need for self-expression, innovation, community, and purpose" (Deems, 1998, p. 132). The workplace affective relationships reported here range from supportive to unsupportive. *Supportiveness* depends on the degree of collegiality between nurses and between nurses and physicians, on partnerships between professionals, and on evidence of mutual trust and respect. Sometimes physicians respect nurses' opinions: "'you're the one with the patient, what do you think?'" (Elaine), and "The doctors will say, 'well what do you suggest we do?'" (Irene). Nurses who work in such partnerships with physicians and with other nurses

experience a great deal of autonomy and respect; they can make suggestions, ask questions, and give and receive feedback (Anna, Connie, Terri, Wendy). However, such partnerships require delicate handling and consistent performance: "We've got to continue to be professional and keep our standards up or we're not going to have that partnership. [We]'re going to lose it" (Elaine). Relationships with physicians are important because physicians "have a profound influence on how we feel day to day, even how you feel about yourself, your job" (Fred).

Duncan (1997) argued that "the components of a climate supportive of nursing include team work, acceptance, a sense of personal importance, the freedom to ask questions, and good fellowship" (p. 225). The need for such supportive qualities is evident in *reworking professional identity*. Supportive relationships facilitate working in interdisciplinary teams that value nursing but it takes time to build respectful teams (Gail, Connie, Anna, Elaine).

Mentoring facilitates asking for and offering help and increases co-operation and personal connections (Debbie, Connie). "For my co-workers, you have to use that professionalism in your job as you're demonstrating how you want them to work . . . as a role model" (Irene). When nurses feel supported, they often feel encouraged to enter formal study or to learn informally (Vera). Support buoys up peers and wanting to act professionally becomes contagious (Gail, Elaine).

Sometimes nurses do not feel supported in relationships. Brenda's uncomfortable experiences with some physicians involve her determining how to get what patients need--without annoying the physicians and maintaining her professional integrity. When

physicians respond to nurses' suggestions or requests for patient care with sarcasm, demeaning comments, public tirades, or temper tantrums, nurses may feel frustrated, unappreciated, and diminished (Patty). Then some nurses respond with sarcasm of their own. For example, when Nora assessed a patient and decided to call a physician at home at night to seek a change in care, she felt he spoke to her in a demeaning manner. Her own sarcastic response was "I don't call you because I'm lonely" (Nora). Millie's experience leads her to assess physicians before according them professional status. Some nurses become reluctant to protect physicians because of their previous interactions.

> If a patient or family requests to speak to the physician. . . and the physician is avoiding them like the plague because he doesn't want to deal with the problems, what usually the nurse will say is, 'Well, he's tied up somewhere. . . . He's not here today.' . . . Make excuses for them. No way! Why? Who are we benefiting? (Joanne)

Nurses may experience stress from working with unsupportive or untrusted peers. When nurses are concerned about patient safety, they feel they have to advocate strongly for patient safety, inform patients of risks directly, or make suggestions about care (Patty). Some nurses, like Millie, report those peers who do not meet adequate standards, but then she has to become involved with formal investigations of those situations. Others, like Fred, cover up inadequacies in others but they then must protect patients themselves: "It's not that there aren't any professional people on that floor, they do say things to their boss, but there is no mechanism" to address poor practice. Reporting to higher authorities might work but it would be risky: "If there was a saint or something there, somebody who says 'I don't care about my job,' but you can't really cut your own job off" (Fred). Joanne has similar concerns.

> At night, the physician was there [he had been drinking] and the GP [General Practitioner] was there. He [physician] had to put in a pacemaker. And I said [to GP], 'you know and I know what kind of shape he is in; you're not leaving; you're staying'. And he [GP] did. . . . [Until the system could address this], the nurses went to bat for those patients and made sure that their care was the best care they could give and made sure that his practice was covered by another physician.

New nurses who are aware of their low hierarchical position may be reluctant to ask questions or approach some more experienced nurses who can appear "intimidating" (Debbie). Irene recalls her earlier experience of being a new graduate and now she watches others who respond to new graduates with less respect than she would like to see. Nurses also find it intimidating when nurses who feel burned out and take time off from work are criticized by colleagues who compare their own levels of fatigue and diminish the others' needs to take time off. Sarah, for example, is concerned about these unsupportive relationships and feels that nurses should be more supportive of other nurses before they reach "the I-can't-cope-with-work-ever-again" situation.

Supportiveness: Atmosphere Context

Professionals influence the workplace atmosphere by their attitudes. "A professional gets up and goes to work with the idea that they're going to make changes and ...improve the process, improve ourselves, and have vision, and long term goals" (Lynn). "If you're working with positive people, then you will do the same thing. But if you're surrounded by negativism and nonchalant, blasé attitudes then you will, in time, develop that. You can see that in health care" (Joanne). Helen describes the potential of interpersonal interactions to influence the workplace atmosphere:

> Someone may say something in jest, and whether that's perceived in jest, as it was intended . . . or it may be taken to be disrespectful maybe or loud. It may even be

> an interaction between two people that they may have built a relationship where they may be comfortable with that interaction, but if you are a new person who's come in, it may seem totally inappropriate to any situation as a nurse/patient interaction.

Terri's example describes how acceptance, as part of the workplace atmosphere influences her practice.

> What I'm saying is that you learn [how much you can compromise technique] as you are working and as you are developing as a nurse and being able to think it through more. And then the culture also changes. Once you sort of feel that you are accepted then you have that confidence to say, "look, I'm not doing it that way anymore." But that acceptance rule, that culture, is really important at first. And once they've gained respect and acceptance of you, then you have more freedom.

Being accepted is also influenced by individual attitudes and behaviour.

> When I interviewed her, I thought, "I'm not sure how you're going to fit in" because she gave me the impression that she had been working for quite a while, and she knew a lot, and that she really wanted to be the boss. (Vera)

Spouse's (2000) work confirmed the importance of feeling accepted. "Much of the literature concerned with entry to unfamiliar settings, occupations, and socialization indicate that to be successful, newcomers have to engage at a deep level with the professional mores of their new community" (pp. 736-737). Kelly (1998) found that new nursing graduates who tried to fit in and to be liked coped better with the demands of the workplace. Similarly, Fessler and Christensen (1992) identified striving for acceptance as a major characteristic of teachers during the stage of induction into the workplace.

Supportive workplaces enhance opportunities to develop nursing reputations that show growing and striving to achieve. "You want to excel at what you're doing and become the best you can be" (Lynn). How available and willing experienced nurses are to act as mentors, the attitudes of others in the workplace, the pace of work, and the amount

of autonomy accorded to nurses all influence nurses' perceptions of workplace support. Elaine speaks of trying to keep pace with others in the workplace and wanting to "compete with others to be professional."

The workplace atmosphere can influence the process of *reworking professional identity* negatively. A closed atmosphere that hinders *becoming aware* is characterized by open criticism, a lack of supportive mentors, and unwillingness to help. In such atmospheres, nurses may choose to find a mentor but none may be available or potential mentors may not be willing to engage. When relationships in workplaces involve a disconcerting pattern in which newly graduated nurses or nurses new to a unit are observed, practice is watched, mistakes are expected, and actions are evaluated, these nurses are distracted from concentrating on accomplishing the practical tasks at hand. Such monitoring patterns create tension which can interfere with working relationships, limit asking appropriate questions, reduce reflection, and "bring new nurses down" (Debbie). And when workloads are too heavy, there is little time to establish effective relationships with other professionals. All in all, the broader process of *reworking professional identity* is then stifled.

Nurses are often critical of each other because they perceive it to be safer to criticize each other than to criticize directly physicians or other non-nurse professionals.

> Absolutely it's not safe [to criticize other professionals]. You wouldn't be supported in a million years. You have to learn how to [give feedback] in a manner that is professional, not hurtful, and it's not going to impact on your working relationship. (Joanne)

Millie is concerned that nurses do not always contribute to creating an accepting

atmosphere for others.

> That putting you in your place is the mechanism that nurses have used with other nurses. It's the autocratic system. "If you're not willing to co-operate the way I want you to, then I'm going to see that you hear me." It's under the thumb.

Summary of Contextual Influences

Three contextual influences operate on *reworking professional identity*. They are (a) the *expectations* impinging on nurses from five different contexts (society, professional socialization, workplaces, families, and personal), (b) the *perceived status* of nursing, and, (c) *supportiveness*. The reworking process is greatly facilitated when the nurses perceive all three contextual influences as positive or active. The process becomes inhibited when the nurses perceive the influences as negative or inactive. It is time to explain in the next chapter the process itself, in all its three stages.

CHAPTER 5

Findings: The Process of Reworking Professional Identity

Introduction

This chapter explains and illustrates the three-stage process of *reworking professional identity*. I present first the basic social problem and then the responses that nurses use to address, resolve, or manage that problem. These responses, taken as a whole, constitute the process of *reworking professional identity*. I present the process and its three stages sequentially with illustrative quotations from verbatim transcripts and relevant literature. The implications arising from these findings follow in chapter 6.

Briefly, the process of *reworking professional identity* occurs when nurses encounter the basic social problem of *dissonance*. Nurses in this study experience dissonance on three types of occasions related to their expectations and experiences with professional identity. The first occasion occurs when others respond to nurses in ways that indicate a denial of automatic professional status or competence and, consequently, respect. The second occasion occurs when nurses themselves discover that their practice is not meeting their own or others' professional expectations and standards. The third occasion occurs when nurses recognize that their work has become routine and they are no longer developing as professionals. *Dissonance* occurs at various stages of a nurse's career; it is not a once-only trigger for resolving issues of professional identity and reputation.

These *dissonance* experiences are addressed, resolved, or managed through an iterative, three-stage basic social process that I named *reworking professional identity*. In

grounded theory, a basic social process is "conceptually developed to account for the organization of social behavior as it occurs over time" (Bigus, Hadden, & Glaser, 1994, p. 38). I named the three stages of this basic social process of *reworking professional identity* as *assuming adequacy*, *realizing practice*, and *developing a reputation*. Briefly, *assuming adequacy* is a stage of diminished awareness of actual practice competency, respect, professional identity, and others' perceptions of those. *Realizing practice*, stage 2, is characterized by *becoming aware of discrepancies* and experiencing consequent *dissonance*, and *attempting to find a balance* between assumptions and new understandings. In *developing a reputation*, stage 3, nurses become known for a pattern and standard of practice and begin to contribute to the development of others. Each stage has a number of key processes and their attendant subprocesses which I also elaborate. The details of each stage now follow. Table 9 outlines the three stages of the reworking process, its processes, and its subprocesses, while Table 13 on page 161 provides the full detail.

Table 9

Reworking Professional Identity: Outline

Stages	Processes	Subprocesses
Assuming adequacy	neglecting reflection	little reflecting; acting knowledgeably; having to ask; becoming bored
	concentrating on technical tasks	emphasizing accomplishing required procedures and skills
Realizing practice	becoming aware of discrepancies	noticing and comparing patterns; reflecting on practice; gaining insight
	attempting balance	developing protective response patterns; making connections; attending to credibility
Developing a reputation	establishing practice patterns	addressing competence; seeking and responding to stimulation; pursuing learning and growth
	choosing standards	deciding personal relationship to work; determining how work is done
	helping to advance nursing	mentoring other nurses; influencing impressions; engaging and disengaging

Stage 1: Assuming Adequacy

Assuming adequacy occurs through the two processes of *neglecting reflection* on practice and *concentrating on technical nursing tasks* to the exclusion of interpersonal tasks. When nurses assume adequacy, they fail to notice that they are neither respected nor considered professional, they make limited connections with people, and have a diminished awareness of their own competence. A strong influence on this stage is the

contextual factor of professional socialization in nursing education; the programs teach that nursing is a profession and that professionals are competent and respected; consequently, the graduates of such programs unquestioningly expect to be considered professional, worthy of respect, and competent when they arrive in the workplace. Accepting such a view of professional identity is congruent with the concept of received knowledge that is, accepting others' authoritative knowledge as legitimate (Belenky et al., 1986). Table 10 displays key processes and consequences of stage 1, *assuming adequacy*.

Table 10

Assuming Adequacy: Processes and Consequences

Processes	Consequences
Neglecting reflection	diminished awareness of being respected and being competent failure to notice others' views varying levels of confidence having to ask for help unable to recognize boredom or becoming stuck
Concentrating on technical nursing tasks	emphasis on accomplishing technical skills and procedures maintenance and development of technical competence protection from interaction with others limited interactions with others

The Process of Neglecting Reflection

Neglecting reflection on practice diminishes nurses' perceptions of their actual levels of competence. *Neglecting reflection* means that nurses reflect very little, or perhaps not at all, on nursing practice. New graduate nurses, who are trying to apply school-learned values, skills, and behaviours in unfamiliar work environments, concentrate on meeting externally-set expectations and mastering tasks. Schön (1987; 1995) described processes of reflection-in-action and reflection-on-action that involve

consciously assessing one's own practice to gain new understandings and more skilled action. Reflection-on-action increases self-awareness and leads to identifying competence areas for further development. Neglecting such reflection at this stage limits the conscious awareness that promotes growth of practice.

Neglecting reflection occurs at many points in a career. Experienced nurses, practising for some time in familiar workplaces and being very comfortable with work requirements, can also neglect reflection and act "like a robot" (Nora). When nurses practice mechanically or by rote, they may not perceive that their current practice fails to meet their own former standards. Thus, they suffer from a diminished awareness of what "others notice before you do" (Nora). Further, if experienced nurses recognize that they are practising by rote but cannot see any ways to address this problem, they are no better off than if they had not recognized this problem in the first place.

Diminished awareness yields confidence without competence. "When you first graduate, you think you've finally made it and so you think that you haven't got anything to learn and you know everything" (Vera). *Assuming adequacy* both allows nurses to wear blinders (metaphorically speaking) that hide their practice limitations and also permit nurses to forge ahead without anticipating difficulties. Some new graduates can be very confident and "just outright cocky" (Vera). Terri mentions that "I always had confidence in myself but not necessarily competence." This finding contrasts with Kelly's (1992) finding that senior nursing students perceived themselves as competent but lacking in confidence. Perhaps this lack of congruence between confidence and competence is related to the fact that nurses in the current study had graduated and those

in Kelly's 1992 study had not yet graduated.

Experienced, competent nurses know that their practice must stay within boundaries defined by the professional scope and policies of the employing agency. For Patty, her confidence at first exceeded her awareness of her limited competence:

> I was really green. When I think back now, I should never have done a lot of things that, I think went, not really beyond my scope, because I was really scared to do anything beyond my scope, but maybe I should have known a little more than I did. (Patty)

When new nurses have some confidence and are aware of their limited competence, they ask for help. "I wasn't as confident. I was wise enough to know what my limitations were and I would say, I'm going to need help" (Joanne). Having to ask for help to find things, to discover procedures, and locate supplies may also diminish confidence, depending on responses of those asked. Sarah says, "It takes [new nurses]. . . a full year to gain their confidence . . . so [in that time] you're always going to be in that absolutely-having-to-ask-about-everything" [stage]. When nurses have moved to a new area to work, they can again experience having to ask.

Neglecting reflection later in a nursing career can result in practice becoming stagnant; meaning that nurses begin to stall in their professional identity development and become less able to recognize growing boredom. Becoming stagnant may also occur when nurses are unable to change work areas or move because jobs are unavailable, available jobs are in too-distant locations and families are unable to move, or nurses fear having to start over again. In this study, becoming stagnant is experienced as negative attitudes, poor peer relations, making comments that diminish colleagues, and the loss of

behaviours considered to be professional, such as improving skills, respecting confidentiality, and having a neat appearance (Nora, Sarah, Kristina). Professional stagnation shows up too when technical proficiency is no longer accompanied by proficiency in caring relationships. When nurses lose interest and just do the job, they can still meet minimum standards but do not feel challenged to improve. Sarah talks about the effects of *neglecting reflection* and explains how nurses may move back to *assuming adequacy* after *developing a reputation.*

> People become complacent by staying in the same place for a long time. It's very easy to stay in the same place because you know the work very well. It's easy to go to work when you're not really faced with great challenges. There's very few things that you haven't seen before, or have to learn how to deal with, instead of knowing exactly. You get to a point where you can anticipate the problems... which is very easy and the patients get good care as a result. But I don't think people are able to identify when they're burned out. Other people need to identify it for them, that they're burned out and that their attitudes have gone sour, that the quality of their work has deteriorated.

Both Connie and Anna indicate that the pace of work sometimes leads them to neglect reflection: "you have so few opportunities for reflection" (Connie), "We're so busy you don't . . . have time to really think of how you're working, or how you're acting, or reacting, because you just . . . have to do it" (Anna).

Neglecting reflection reduces awareness of issues beyond technical performance and limits nurses' ability to resolve becoming stagnant. They cannot see options or they cannot see the need to consider options.

The Process of Concentrating on Technical Tasks

Assuming adequacy also occurs through *concentrating on technical nursing tasks* and their competent performance. Ruth recalls being a new graduate:

> I was not sure of my own ability, therefore I portrayed to everybody else that that's exactly where I was, that I was not sure of myself and my abilities and my own sense of professionalism. I wasn't even there. I was still on the technical side, trying to get things together.

Cowin (2001) observed that the workplace was experienced as stressful, unsatisfying, and shocking to new graduates who often lacked self-confidence and a sense of themselves as professional.

Concentrating on technical tasks is a narrow focus. Nurses with diminished awareness of workplace practice can focus on developing and maintaining technical proficiency. Kral and Hines (1999) reported a similar focus on tasks and techniques until professional family therapists developed "a competent sense of professional identity" (p. 102). *Concentrating* on performing technical tasks restricts nurses' vision beyond those tasks, making it difficult to engage in interactions aimed at building relationships with people in the environment while doing tasks. Olivia says, "I think you have blinders on because you're so task-oriented, and you're new at the profession, and it's hard to see beyond that." Later, a deliberate focus restricted to tasks may signal impending stagnation when nurses may see practising by rote as an essential way to avoid engaging in personal relationships and to protect them from having to interact personally with others (Lynn, Helen). Irene, an experienced nurse, reflects that "stress has a lot to do with it . . . and as a means of coping, it's easier to do a task than to have to deal with the whole."

Consequences of Stage 1

Nurses focus in this stage on building their credibility and professional identity through becoming competent with technical tasks. Debbie says, "Initially when you start

out as a nurse, I think you are very focussed." These processes mask nurses' perceptions of others' levels of respect and allow nurses to assume, without justification, automatic respect from co-workers and other professionals. *Assuming adequacy* may also act as a protective function when work situations are too challenging and when nurses are stagnating and it is no longer possible to engage personally with people.

Another consequence of *neglecting reflection* and *concentrating on technical nursing tasks* is the nurses' limited questioning of nursing as a profession. Nurses graduate with a form of professional identity: they assume that nursing is a profession and their school socialization creates pride in being a nurse and creates an expectation that workplace colleagues will automatically respect new graduates. Therefore it is not surprising that new nurses have a diminished awareness of others' lack of validation of these professional qualities; and so they feel no need to do anything in the workplace to earn professional identity. They feel no need even to question their basic professionalism. Gradually, however, new graduates discover that feeling accepted and feeling professional are influenced by how others respond to them. "I think along with that experience and becoming more professional, or feeling more professional, might have been people's perceptions of you. How they treat you, too, would make you feel more like a professional or less like a professional" (Olivia). So nurses learn that they have to earn professional respect rather than assume it.

The meaning of professional identity enacted at the stage of *assuming adequacy*, for both beginning and experienced nurses, reflects "uncritically assimilated" assumptions (Brookfield, 1998a) about the qualities and characteristics of being

professional. Irene indicates that this lack of reflection is related to the need to focus elsewhere, "because initially . . . you are so keen to get your skills developed . . . that you're not really even thinking professionalism. That's not even in your mind." More experienced nurses who have already moved through this process and are re-experiencing the *assuming adequacy* stage believe they are sustaining a professional reputation; but they may not recognize that their practice has stagnated and that their assumption of professional identity is seen by others as faulty.

In this study, the nurses assume that nursing is indeed a profession: "I always thought of nursing as a profession" (Kristina); "There was a time when nursing was not considered a profession and I always thought it was even then" (Vera) and "When I first graduated, I never really thought too much about [being] professional" (Elaine). New graduates also carry such unchallenged assumptions but they have not had opportunities to examine these assumptions. "I always thought nursing was a profession but had no concept of what that meant" (Gail). This statement reflects a "received" position in nurses' knowing about being professional (Belenky et al., 1986); that is, uncritically accepting others' definitions without reference to one's own meanings or experiences.

Transition to Stage 2

The transition to the next stage is initiated by the nurses' beginning awareness both of their own practice and of others' views of them in the workplace. This awareness begins to expose the discrepancies between their own and their colleagues' opinions about their professional identity and competence.

Stage 2: Realizing Practice

This stage is the key to resolving the dissonance experience. *Realizing practice* occurs through the two processes of *becoming aware of discrepancies* and *attempting a balance* between old assumptions and new understandings. I use the word "*realizing*" because it refers to both recognizing actual practice and values (in relation to assumed practice and values) and accomplishing a direction for addressing practice. *Realizing practice* as a stage occurs early in practice or later when potential or actual stagnation in practice may be occurring. *Becoming aware of discrepancies* between one's own practice and values and those of others generates feelings of dissonance. *Dissonance* is the cognitive identification and affective experience of discomfort related to noted discrepancies.

The first process, *becoming aware of discrepancies*, is identified as "a rude awakening" by Millie and "losing the idealism" by Nora. Three subprocesses apply: *noticing and comparing persistent actual patterns* that differ from the expected patterns of workplace behaviour, *reflecting on practice*, and *gaining insight. Attempting balance* is the second process of stage two and is managed through the subprocesses of *developing protective response patterns*, *making connections*, and *attending to credibility*. Contextual factors influencing the whole stage of *realizing practice* include *expectations*, *perceived status*, and *supportiveness*. Feeling *dissonance* and seeking to reduce the causes of dissonance motivate the action of this stage. Table 11 displays the processes, subprocesses, and consequences of stage 2, *realizing practice*.

Table 11

Realizing Practice: Processes, Subprocesses, and Consequences

Processes	Subprocesses	Consequences
Becoming aware of discrepancies	noticing and comparing patterns reflecting on practice gaining insight	feel discrepancies begin to examine practice experience dissonance
Attempting balance	developing protective response patterns making connections attending to credibility	decide how to address dissonance and protect self find help when needed establish how wish to be known

The Process of Becoming Aware of Discrepancies

Becoming aware of discrepancies is the process of beginning to see differences between one's own perceptions of practice and others' perceptions of that same practice, and also one's own and others' values ascribed to that practice. Nurses thus recognize gaps that had not been seen before. Lynn says, "they didn't teach us anything about this." Irene says that nursing is not what she expected:

> It's not at all what I thought. . . . I guess I thought it was the bedside, like Florence Nightingale, you know? Where I think now it's so much more. It's just the total care, coordinating everything . . . dealing with everybody that's involved in their care, and the plans for . . . what's ahead, and the teaching. . . . And I'm not saying that that wasn't going on at that time [when I first graduated] too. But just, in my mind I wasn't aware of that. I was focussed on, you know, that one patient, and how to make them better.

Similar difficulties of this transition to actually working as a nurse have been identified in the literature. Duncan (1997) stated that "the transition from student to new staff nurses has been characterized by stress, conflict, and withdrawal, which results in high rates of turnover" (p. 223). Nursing students are usually protected from the intense workplace

pressures created by scarce time, inadequate staffing, and heavy workloads so, after graduation, they need time to notice such features. One perspective, articulated by Freidson (1999), placed responsibility for the difficult transition from school to work with education programs that allowed learning to be disconnected from the reality of practice. Educators

> teach the received body of knowledge and skill to practitioners and also lay down the standards by which practitioners can be authoritatively judged. The standards they promulgate are likely to be different from those of practitioners, who are compromised by the need to satisfy consumers and work within the fluctuating, practical limits of time and place. . . . Professional schooling thus creates a very sharp and problematic division between academic authorities and practitioners. (Freidson, 1999, p. 122)

Whether full responsibility for disjunctive transitions can be borne solely by educational programs is doubtful when the contextual influences of the workplaces in this study are considered.

Becoming aware of discrepancies may happen suddenly or gradually. Sudden awareness can be stimulated by specific encounters with others: a particular patient connects with a nurse (Terri) or flashes of insight just seem to happen, "Hello! I'm there!" (Nora). In the more gradual process of awareness, the appreciation of discrepancies is less easy to explain, "It just seemed to happen" (Helen). For nurses working in one area for too long, gradually becoming aware brings a focus on the issue of stagnation. Stagnation is recognized through experiencing slight boredom, lacking enthusiasm for work (Fred), needing a change (Elaine), losing the adrenalin rush (Lynn), acting like a robot (Nora), and feeling stagnant (Irene). A similar concern is reported in the education literature: "A lot of teachers are aware of the fact that they can and have to develop professionally. They

do not want to rust in their old habits" (Clement & Vandenberghe, 2000, p. 95). Irene finds that when she has a "focus on your one thing that you do day to day," when she feels the "frustration of not being able to cope," when "it's just getting that it is a job," and "when there's no 'oomph,'" she is becoming aware that she is growing "stagnant."

The discrepancies nurses recognize vary and may occur between the learned expectations and values and those observed in actual practice. Millie's insight into her process of *becoming aware* of professional discrepancies is relevant:

> So, when you start to see the discrepancies, then you make your mental assessment [of] that doctor or that nurse . . . they've just been reevaluated in my mind as to how much respect I will pay them. It's not a question of, just because we're a nurse, we have a title, we're going to be a professional.

Terri talks about discrepancies in standards and her response to them.

> You did your own little bit of work . . . and you might do a better job than the next person, or you might do a sloppy job that night, but certainly if you saw a different standard, you found that frustrating. . . . The standard has to be developed and has to be taught. [With] a standard, [nurses] can't question it . . . You can be an individual thinker, and can say "why" but . . . I think there has to be a standard.

Discrepancies are noticed in four areas: (a) concentrating on technical tasks, which limits interpersonal interactions rather than integrating them with doing tasks; (b) not being respected automatically, and having to earn respect; (c) not being accepted as part of the team, and having to learn to fit in; and (d) not being offered help, and having to seek it out when needed. Sarah explains that she learned that "there's not many places you get respect without earning it. It's not just given." Those who are stagnating professionally may experience discrepancies between routinized practice and new practice. Those nurses who have changed some perspectives through reflection may note discrepancies between

their newly developed lens for viewing their professional identity and their former lens.

Later in a career, *becoming aware of discrepancies* reveals that nurses are receiving inadequate stimulation from the work environment to keep practice "on the edge" as described by Nora in "knowing when you've passed your prime and it's time to move on." Work is no longer stimulating or satisfying. Nora says "this isn't cutting it for me anymore." Work is becoming routine, no longer challenging, slightly boring, and nurses lose "the adrenalin rush" (Lynn); they lose interest in the work or the people and their own capability for doing better work. The awareness of feeling comfortable with their skills signals that more stimulation is needed. When such awareness is not forthcoming, colleagues may become alert to the changes before and instead of the nurse. Fred says that without awareness of one's practice and attention to others' perceptions, "I suspect that maybe professional is a bit of a sham in that I think there are a lot of things that work against nurses' feeling professional." Fred sees nurses who do not follow their own advice to patients, for example are themselves obese or are smokers, and do not consider how they are perceived by their patients. His concerns with self-aware role modelling are echoed by Pratt and Rury's (1991) argument that:

> Becoming a skillful teacher . . . is not simply becoming able to skillfully teach. It is also becoming able to judge one's teaching performance by the standards of good teaching and judgement about what constitutes good teaching, what might be better, and what is inappropriate or unacceptable. (p. 64)

Subprocesses of becoming aware. Nurses become aware of discrepancies through three subprocesses: *noticing and comparing persistent patterns* that differ from the expected, *reflecting on practice*, and *gaining insight*. The first subprocess involves

making observations over time, *becoming aware* of colleagues' behavioural patterns and how those patterns differ from their own, and then examining the differences. Such comparisons facilitate the questioning of assumptions behind observed discrepancies. Such patterns remain invisible until they are noticed. Helen indicates the importance of making the assumed visible and becoming aware of differences in the practices of one's colleagues. She suggests watching

> all the other people that you see from the very beginning and see how they interact with other people, and how they even interact with you, as that very beginning person. . . just knowing, or watching the effect, or feeling the effects. . . . As a beginning nurse, to be working with other nurses who have been working for a long time, just the effects that they are having on the people that they're working with, um, whether they're being listened to or looked to from those clients because they're the authority figure or because they're offering something that they are looking for. . . . And I guess, just by observing these people, you try to avoid one set of behaviours, or certain behaviours, and try to build on other behaviours.

Nurses compare workplace standards, interactions, and values with those taught in nursing programs. Gerrish (2000) found that new graduates experienced "conflict between the professional values acquired during the student socialization period and the bureaucratic values encountered as qualified nurses working on wards" (p. 475). Nurses notice that patterns of anticipated collegiality do not materialize fully formed but must be negotiated, and that expectations of respect from others with due recognition of professionalism do not occur automatically, must be earned, and are not permanent conditions. "Through noticing, learners become aware of the milieu, of particular things within it, and use this for the focus of reflection" (Boud & Walker, 1991, p. 22). For example, when nurses compare and contrast their own expectations of professional

identity with their colleagues' lack of automatic accord of professional status, they have to accept responsibility to meet the external standards. "To be professional, we have to work at it. We just can't assume that it's going to be there. . . . You've got to work at it as you're doing your work" (Elaine).

The second subprocess of becoming aware, *reflecting on practice*, is the process of becoming a deliberately critical thinker about values and assumptions that underpin workplace events. Interactions with people may be key incidents that stimulate such critical reflection. Tisdell and Taylor (2000) observed that in adult learning "Critically examining our practice makes apparent some of the discrepancies between what we say and what we actually do" (p. 6). Helen's reflection leads to her beginning to question some of the usual patterns in nursing.

> I think I'm seeing more of a bigger picture of things and trying to get away just from the chores of work, but yet, at the same time, appreciating the need for some of these . . . things, that sometimes now with cutbacks, people are saying, "oh we don't have time, don't bother". . . but to see the importance of those little things, too. And, yes, it is busy, but those things are the basis of nursing, and why we're there, and if you're just doing the duties, but you're not there to provide the care and the comfort, then are the duties really worthwhile?

When nurses develop new or changed perspectives, they again have choice between different actions. For experienced nurses, *reflecting on practice* sometimes uncovers the need to change practice areas or to withdraw from working with a particular patient; but "it takes reflection to know when you're no longer helpful" (Connie).

> It's interesting because one tries to sort things out. I think that may be part of being professional, that you do sort of think about your position, critique it, and try to make sense out of it, and rationalize it, or whatever. (Fred)

Rolfe (1997a, 1997b) argued that nurses process their experience through reflection so

that it can be converted into personal knowledge. Richardson and Maltby (1995) reinforced the need for nurses to develop their practice and use skills of reflecting, as did Purdy (1997b): "requiring of the nurses abilities to think critically and reflectively about their practice" (p. 136) was important. "The actor reflects 'in action' in the sense that his thinking occurs in an action-present--a stretch of time within which it is still possible to make a difference in the outcomes of action" (Schön, 1995, p. 32). Critical thinking and questioning strategies spark reflection on incidents and begin the process of becoming aware. "Self-reflection and good thinking" are valuable (Debbie).

Encounters with people stimulate reflecting: "One boss in particular, boss for lack of a better word, very pro-nursing, supportive, promoted autonomy, promoted you to do things. I think that was a real key to get thinking" (Gail). Millie's experience with her peers prompts reflection on a negative aspect of nurses' behaviour: she expresses concern and "disappointment with nurses [because they] have always allowed other people to lead [them.]" Patty speaks of struggling in a strained relationship with a patient, "and finally, the day he threw his breakfast tray at me, did me in . . . And I said, 'you don't have to worry about me, because I'll not be taking care of you anymore.'" The outcome of this negative encounter surprises Patty when he asks for her to care for him the next day. As she reflects on her response and the patient's response, Patty realizes that it is important to control herself assertively and to act within her image of professional identity:

> So I thought . . . I'm glad I didn't lose it with him. I could have. . . . I didn't swear or anything, but . . . he was as nice as pie to me after that. . . . I think sometimes you have to [stand up for yourself].

Connie is concerned that there is so little time for *reflecting on practice* during her

busy workday. She finds that stepping aside and engaging in degree course study in the evenings gives her time to think about her practice, about being professional, and about changing her perspectives.

How these nurses reflect on practice is generally consistent with established theories of critical reflection. Brookfield's (1998b) concept of critical reflection identified a process of examining or "uncovering and investigating [causal, prescriptive, or paradigmatic] assumptions, and on appraising whether assumptions are accurate, valid, and truly grounded in the context from which they spring, or if they have been uncritically assimilated from external authority sources" (p. 5). Mezirow's (1995b) theory of transformative learning articulated that meaning perspectives are ways of viewing the world; are involved in shaping one's interpretations and influencing one's expectations. The process of critical reflection may result in broadened, revised, or confirmed meaning perspectives and in becoming more fully informed (Cranton, 1994, 2000; Mezirow, 1995b, 2000). The current study illustrates that nurses use critical reflection at different times to gain the perspective needed to become aware of discrepancies. Then they can decide whether to address those discrepancies. These findings are congruent with Berragan's (1998) finding that a "nurse's desire and ability to reflect on experience" (p. 210) varied with that experience.

> Reflective practice allows professionals to go beyond the routine application of rules, facts, and procedures and gives them the freedom to practice their craft more as a professional artistry where they create new ways of thinking and acting about problems of practice. (Merriam & Caffarella, 1999, p. 237)

Nurses' discoveries about their professionalism are often stimulated by challenges

to their use of terminology as it affects professional identity. Anna gives an example:

> Actually caring isn't a word that goes with professional, really . . . when I think of other professions that see themselves as a profession, I don't think caring is involved in the way they see their profession . . . [but in nursing] when you are caring, that makes it professional.

Frahm and Hyland (1995) found that RNs believed that, as professionals, "caring is central to nursing" (p. 4). Although Anna's comment is consistent with that perspective, she arrives at this view through her own critical reflection on the relationship between caring and the profession of nursing, rather than on received knowledge acquired during nursing school.

Critical reflection on professional identity is prompted by nursing practice incidents as well as terminology challenges and encounters with people. Fred illustrates how practice incidents prompt critical reflection: "how can nurses feel professional when you're continually running up against that sort of stupidity?" (such as needing a physician's order to change simple dressings). Anna illustrates how her exposure to learning opportunities stimulates critical reflection: "Starting this program [BN/RN] has certainly made me a lot more aware of who I am as a professional." Patty extends her critical reflection to consider whether nursing is indeed a profession:

> Teachers, that went to teachers' college . . . for 2 years were considered professional, and they didn't go 2 full years. And I often wondered, like, when all this talk about, is nursing really a profession or not, and I'm thinking, well, why wouldn't it be? [It] got me thinking, well, why, why do I need to have that, a degree, to be professional?

As Patty is engaged in studying toward her degree, she continues to reflect on her professional identity,

> I don't see how adding the BN to my list is going to make me more professional. It'll increase my knowledge. It already has increased some. It's given me a broader outlook on nursing. . . . I don't see where that's going to make me more professional but it'll enhance my knowledge and, in the end, I could be wrong, it may enhance my professionalism too.

Critical reflection on practice involves assessment of such factors as boredom, personal potential, workplace quality, responses to work, and levels of job satisfaction. Nurses use critical reflection to identify when it is time to examine a situation more closely, assess potential actions, and then act. Ghaye (2000) advocated the use of reflection as a strategy to improve practice.

> Arguably reflection marks a fundamental point of departure for those who continuously strive to improve what they do with and for others, regardless of profession and workplace. Through reflection we question thoughts and actions and the values that influence and give rise to them. (p. 147)

In their study of reflection with adult educators, Ferry and Ross-Gordon (1998) found that reflective educators "reframed the situation and quickly made adjustments in their problem definition" (p. 110). This action fits with nurses' way of reflecting on their practice. Being professional requires their reflective understanding of discrepancies they encounter so that their responses are not limited to prescriptive, automatic, and technical methods only. Johns' (1995) work promoted critical reflection as a way to improve practice.

> The essential purpose of reflective practice is to enable the practitioner to access, understand and learn through his or her lived experiences and as a consequence, to take congruent action towards developing increased effectiveness within the context of what is understood as desirable practice. (p. 226)

Reflecting on potential or actual boredom means that nurses are alert to personal responses to work and recognize that potential stagnation is caused by lack of interest,

little novelty, and inadequate stimulation. Lynn describes her beginning awareness of lack of interest in maintaining her role on the hospital's cardiac arrest team,

> You went to the code, and you did what you had to do, but there was no adrenalin rush. . . . I knew what to do; it was just chick, chick, chick but it had become a task. . . And I said "OK. I need something to bring that rush back to keep me interested."

In many workplaces, developing technology and new treatments are part of constant change in nursing care and these changes help prevent stagnation, according to Kristina. Elaine says that her workplace always contains opportunities for her to learn.

The third subprocess of becoming aware of discrepancies, *gaining insight,* is the dawning realization of the limits of one's own skills and attitudes, of the risks in managing interactions, and the differences between older and newer ways of doing things. *Gaining insight* is not a result of deliberate conscious thought. Flashes of insight bring sudden realization while other experiences take longer to bring insight over time. Ruth says she felt she was "being forced" into "seeing the bigger picture" because "it's in your face" through becoming able to observe "just little things," showing the illusive nature of *gaining insight.* Vera says, "It takes a while and you make a few mistakes, and you say a few things that you wish you had bitten your tongue instead. . . you realize that there's a lot that you don't know." Olivia adds that for her, *gaining insight* into her professional identity is enhanced through direct workplace experience:

> Working in different areas and gaining experience and . . . every new client or patient would contribute to my being professional, and how I deal with them and what I learn from them. Ten years ago I may have answered "it's only an educational aspect that made me professional," whereas now I think experience and a broader view of nursing and health care make me more of a professional. I think it's just having a broader view and experience.

Consequence of Becoming Aware

In this first process of the second stage, all three ways of *becoming aware of discrepancies* between expectations and reality lead to feelings of *dissonance*, which leads to further action in the second and third stages of *reworking professional identity*. Experiencing *dissonance* means becoming aware of feelings of discomfort, dissatisfaction, and disillusionment. Discrepancies between expectations do not, by themselves, create *dissonance*; discrepancies have to be felt and observed. In the face of dissonance, the nurses no longer consider habitual assumptions valid and so they seek strategies to manage, resolve, or reduce discrepancies. "Cognitive dissonance is a state of tension that occurs whenever an individual simultaneously holds two cognitions (ideas, attitudes, beliefs, opinions) that are psychologically inconsistent" (Aronson, 1992, pp. 174-175). As Nora says about the dissonance she experiences when she becomes aware of the discrepancies between expectation and reality, "I'm getting over my disillusionment with what I thought was nursing." Experiencing such dissonance is not unique to nursing. "A major theme that is repeated throughout the literature related to professionalization of school counseling relates to this dissonance or conflict between school counselor preparation and the realities of the work environment" (Brott & Myers, 1999, p. 339).

The Process of Attempting Balance

Attempting balance, the second process of stage 2, is the process used to address discrepancies between expectations and reality and to resolve the resulting *dissonance* by weighing discrepant perspectives and adopting a preferred perspective. The subprocesses for *attempting balance* are *developing protective response patterns*, *making connections*,

and *attending to credibility*. Before explaining these subprocesses, I outline the extent to which personal factors influence *attempting balance*.

Attempting balance is influenced by the personal factors of motivation and strength of values. When nurses have enough motivation, they can consider *attempting balance* via personal change that may incorporate some of their colleagues' expectations. When nurses have limited motivation, they may be less able to challenge colleagues' patterns and may accept uncritically colleagues' perspectives that they need to change their practice. To change practice, nurses need the desire to build credibility, seek support from others, listen to feedback, and conform to practice expectations. "When our old ways of meaning-making no longer suffice, it behooves us to engage with others in reflective discourse, assessing the assumptions and premises that guide our ways of constructing knowledge and revising those deemed inadequate" (Belenky & Stanton, 2000, p. 71). Millie is concerned about maintaining integrity, however, in choosing ways to attempt balance: "people have to be congruent as to who they are."

If nurses choose to meet some collegial practice expectations as a way of *attempting balance,* they may need to conform. Ruth calls this "revving up to par" and thinks it brings advantages--for example, beginning to be accepted as part of the team, receiving some help to manage the workload, and being given some respect (Wendy). The professional socialization in nursing programs has sometimes led nurses to regard conforming as a more expedient behaviour, and certainly less disruptive, than challenging expectations. Terri observes that

If you want to keep your job, and you want to, you have to sort of fit into the

> system. There is a system out there. And maybe a professional person realizes that you have to fit into the system a certain way.

Nurses see disadvantages of conforming completely: they may have concern about yielding a personal stand or being unable to following through on personal beliefs.

Nurses may not be able to contemplate personal change, or are able to consider only limited change, when they evaluate too great a risk to themselves, their strongly held values, or their professional integrity. Then they may choose to reject many of the others' practice perspectives and their credibility. While such rejections may sustain nurses' personal integrity, they may also create social isolation. Sometimes retaining personal perspectives means continuing to adhere to personal standards regardless of how adequate are those standards.

Nurses stagnating or burning out, after too long in one practice area, may retain their own practice patterns as a comfortable rut. Irene says that some nurses "have just not as broad a focus. But they're happy at what level they are . . . some [see nursing] as a job, you know? And those are the people who are probably burning out."

In most instances, nurses compromise: they accept neither perspective completely and they forge a middle road. The options identified in these data to attempt balance are congruent with those identified by Aronson (1992): dissonance can be resolved by seeking change in one or both discrepant perspectives to make them more compatible (more consonant) or by adding new ideas that help bridge the gap between discrepant perspectives (Aronson). Facing new understanding, nurses may maintain their usual framework in spite of its inadequacies and reject the possibility that the usual framework

does not fit (perhaps by redefining the situation). Or, nurses can accept the situational challenge, recognize the inadequacy of the usual framework, release previous perspectives, and explore possibilities for adopting a different situational framework. The latter choice presents opportunities for critical reflection and transformative learning. Relevant to this study is Blumenthal's (1998) finding that "a good resolution [of dissonance] should meet three criteria as fully as possible" (p. 96). These criteria were identified as: an intellectually coherent solution, a resolution that allows one to maintain one's sense of reality, and one can live with one's basic beliefs (Blumenthal). In this study, the process of *attempting balance* is managed through three subprocesses: *developing protective response patterns*, *making connections*, and *attending to credibility*. These subprocesses permit nurses to attempt balance and achieve the criteria described by Blumenthal.

The subprocesses of attempting balance. The first of three subprocesses of *attempting balance* is *developing protective response patterns* and the first of these patterns is *maintaining integrity and self-respect.* In this study, nurses need to protect themselves from dysfunctional situations such as critical encounters with peers, physicians, or patients, feeling put down for giving suggestions, and being publicly humiliated. "When you work with a doctor who obviously discounts everything you say or think, you think, what am I doing here?" (Ruth). "I've seen nurses do some terrible scoundrellous [*sic*] things . . . so some of my experiences have been really rude awakenings" (Millie). "I have recently been attacked [verbally] because of asking about a doctor's care and it really upset me . . . he was sarcastic . . . and almost degrading the way

he was talking to me" (Brenda). Kristina describes her discomfort when other nurses criticized one junior nurse: "The [other nurses] not only talked about [a junior nurse], and how she [worked], but her person, too . . . getting into her background." Nurses have to develop safe ways of responding; when they avoid, deflect, or adequately manage criticism, they are better able to protect their integrity and self-respect, become grounded, and move on. Nurses must balance action with astute observation to prevent overstepping professional boundaries, infringing on others, and being confrontational. Sometimes nurses inadvertently invite aggressive or opposing responses and then they need to protect themselves from repercussions. "We have to protect ourselves as well and that's another aspect of professional" (Brenda).

To protect integrity and maintain self-respect, the nurses use two strategies: not taking criticism personally and connecting with the criticizer. Not taking criticism personally is shown in various ways: (a) controlling responses: "I was shaking but I maintained a level voice and I thought, you're not going to get to me. . . . I just don that professional cloak for protection" (Brenda); (b) shrugging off attacks and comments that do not fit with personal perceptions: "I know who is saying that"(Vera), "I know where it's coming from"(Joanne); (c) seeking ways to avoid potential conflict and confrontation such as standing back and being silent or stepping aside: "You're getting yourself removed for a few minutes, away from that, the tough thing" (Patty). The second strategy is to connect with the criticiser and understand the source of concern. Nurses take two actions, seeking explanation: "So I get him to explain to me where he is going on this. . . . And we start discussing things and it just goes from there" (Ruth); "I'll say 'look can we

talk to each other and let's find out what's going on here?'" (Patty); and, trying to collaborate: "You have the problem-solving skills and you are able to challenge [the doctor] and say 'what about this? Does that work?' And, all of a sudden, it's a collaborative approach!" (Joanne). Having *protective response patterns* that maintain integrity and self-respect allows nurses to hold a belief congruent with a self-perception as a good person, sustains professional identity, and enables them to live with themselves (Millie). "I couldn't live with myself if I didn't do what I believe" (Brenda).

When nurses are unable to protect their integrity, they may lose a sense of self, become overwhelmed, lose self-respect, and give up. Millie calls this "losing congruence" with oneself. Richards (1998) indicated that maintaining self-respect was crucial to being professional but recognized the challenges of doing that. "Altruism is the price and the reward of professional self-respect" (Richards, p. 1149). Terri describes a personal response pattern that enables nurses to fit in.

> within that culture there's a level that you want to be accepted and. . . I'm thinking of the new grads . . . coming out. [They] were taught to do it a certain way but they, within a few weeks, they're all doing it as badly as everybody else. . . . Why do people move to poorer techniques instead of to better techniques? And I think a lot of it is, you want to be accepted within that environment. . . . It's a trade off, I suppose, isn't it?. . . You do need to be able to work with the people.

Getting grounded, the second protective response pattern, means making personal space, creating time for oneself, and making room for reflective thinking: "I can have that little bit of distance. You need that time for yourself to just get grounded" (Brenda). Strategies nurses use for *getting grounded* are gaining personal space, time, and distance from the workplace, maintaining a personal balance between work life and private life,

and ignoring others. Time and distance from the workplace are used to rest, do hobbies, be with families, volunteer in the community, and be alone. Maintaining the personal balance between work and private life provides a new view of work, retains enthusiasm, contributes to satisfaction and quality work, and permits reflection on practice and professionalism. Nurses find that ignoring others is an effective *getting grounded* strategy when no other adequate protective response is evident or available. Being unable to make necessary personal space limits *getting grounded* and contributes to both resentment of the workplace and its demands and a greater risk of burning out over time.

Moving on, the third protective response pattern, works toward staying stimulated and avoiding stagnation. The nurses move on, for example, by changing work areas or work loads, or seeking stimulation in formal learning. They feel the effects of *moving on* as reduced boredom, increased enthusiasm, renewed adrenalin rush, and reduced automatic, or even robotic, behaviour.

> I've always moved on when I got to the point in my career that I felt like "Oh God, here we go! Another day I don't want to do this anymore." It's either time for me to take a course or to move to a different area of work. (Ruth)

Moving on is influenced by several personal factors: recognizing the need to change, recognizing potential alternatives such as availability of jobs, accessibility of new education opportunities, flexibility in areas of practice interest, and having no fear of change. The consequences of *moving on* are re-entering a learning context or becoming a novice for a while and experiencing a lack of initial comfort, with the result that nurses feel re-stimulated and have renewed interest in the job. McNeese-Smith (2000), for example, found that "time in the same job seems to lead to boredom and indifference

toward the job" (p. 145). Earlier, McNeese-Smith (1999) found that many nurses reported experiencing a phase of burning out; "however, after going back to school or changing jobs, they were presently experiencing new appreciation and growth" (p. 1339). Callister and Kramer (1999) reported that moving to a new work unit may act as experience similar to that of beginning practice because those moving nurses "also experience uncertainty concerning their new locations and work groups but their adjustments may not be identical to those of organizational newcomers because they have a higher level of organizational knowledge" (p. 429). Sarah's experience is relevant here:

> I can anticipate being in that same cycle going to [a new unit]. . . . It's going to be at least 6 months before I see anything for the second time, so you're always going to be [asking] about everything which is difficult when you've been around for a while. But. . . I can remember what it felt like to be a brand new grad again.

Assessing their options for *moving on*, nurses examine possibilities for promotion, moving to a new specialty unit, moving to a different institution, furthering education, and adopting additional roles (for example, working two part-time jobs may limit commitment to a single workplace and also provide stimulation). When nurses choose to work in new part-time or short-term jobs, such as maternity leaves, or change specialty areas or institutions, they gain different perspectives and find they are energized. Olivia began a second part-time job and says it stimulated thinking about her practice.

> It is a nice change. So I still work half time on a surgical floor and then a few shifts a month in the pre-surgery clinic. . . . To me it has been useful. I find it has opened my eyes to things that I would do on the surgical floor.

Helen finds that working two part-time jobs provides "a varied experience. . . I really am enjoying that. I'm learning a lot of things that go on, a whole different aspect that I just

didn't have a good appreciation for."

How nurses assess the problem, the workplace contexts, the availability of other jobs and courses, and intrapersonal factors influences their choice of strategy for *moving on*. The choice of strategy is limited by hierarchical workplaces that are not controlled by nurses; advancement through promotion is difficult because there are few positions above the staff level. Irene is convinced that nurses need change but admits that moving up the hierarchy is unusual and limited.

> Everybody needs a change. . . [but] we're a profession where there isn't a lot of rising to the top. Like really, we can only go sideways, or change to a different area. And, if there are different [jobs], then sometimes they aren't even in the same union.

The time for change is sometimes reached when there are no new positions to be filled or they appear to be filled arbitrarily. Joanne elaborates the ensuing frustration in her workplace:

> Because of the way the hiring system is now, it's different than it was years ago. [Employers] basically have the power to wave the wand whatever way they want. They can say, because you're senior, you can be trainable to that area. Or they can say because you have experience, you can work on that unit. One minute they choose seniority and the next they chose experience. There's no consistency.

Personal factors, such as whether moving geographically is possible, whether working part-time is affordable, whether studying part-time is accessible, whether there are interests in other areas of nursing, and whether there is personal confidence in providing good care in a different area, influence options. Irene explains:

> The nurses that have come out, they've worked in a certain field, or a certain area, and they've stuck with that. If they haven't broadened and [gone] to different areas to work or that type of thing, then your focus is mainly on your one thing that you do day to day. . . . Even within the same institution, a change always

> gives you a different outlook . . . and the more knowledge that you have of that, I think, helps the professionalism.

Making connections is the second of the three subprocesses for *attempting balance*. Nurses try to connect with mentors, with patients, and with the public to gain support and strategic advice. A frequent example of a supportive peer connection is a more experienced nurse acts as a mentor or role model for a less experienced colleague. Cofer (2000) identified mentoring as an effective way of facilitating informal workplace learning and sharing knowledge and skills. In this study, a mentor is seen as a respected nurse who has the desired and admired ability and knowledge, who willingly helps mentees learn, and who helps mentees address practice discrepancies. Fred says that nurses he admires are "the most professional people. They've got a high skill level. They also see the whole picture and plus they're very, very good at things and [at] sort of tuning into things."

Making connections with mentors provides practical help, fosters development, promotes team membership, and stimulates professional growth. Washington (1997) argued that mentoring was one of the "systematic ways of enculturing young professionals and of setting up a network for career growth and development" (p. 22). Choosing a willing mentor ensures that nurses have someone to ask in times of uncertainty; and when they seek and get help, they are more likely to ask again. Having a mentor and a supportive work environment are positive influences on nurses' practice patterns:

> Her expectations were much higher than my own, so then, that's when part of the growing started because I had to measure up to her expectations. And then I found

> out myself that I was actually able to do that and it just rebounded from there! (Ruth)

When nurses make connections with mentors, they begin a pattern of action that facilitates their initial adjustment to the workplace and that continues to be useful when they change workplaces. Kristina benefited from a relationship with a mentor: "I . . . worked with her, . . . I gleaned her information, and it was really good." "Careful selection of a mentor to facilitate role development and job satisfaction is important" (Kelly & Mathews, 2001, p. 161). Mentees are often enticed to learn because they see mentors learning too and they see a level of desired competence in practice that they try to attain for themselves. Being part of the mentor's team gains a nurse support, credit for knowledge, help when needed, protection when possible, advice to avoid problems, and positive interactions.

If nurses do not have mentors, they will obtain help and be included in the team only if colleagues feel they have the time to help and the inclination to share that available time (Wendy). Nurses' levels of insight into their needs for professional development will influence connecting with mentors. *Making connections* helps nurses develop their practice, reduce discrepancies, and gain support of role models. Duncan (1997) argued that programs designed to ease the transition to work through mentoring were important to enhance competence, foster team development, and provide support.

Later, when nurses have achieved some measure of expertise and professional identity, they still need to find support from peers. As Nora puts it, "we chew together" at the change of shift report time and when away from patients. Sharing information

resolves issues, provides support, and shows nurses that they are not alone. Such collegial sharing and learning is important even for experienced nurses: "We try to encourage that here because ...when you're not down the hall, I might not be able to help you" (Connie); other nurses are "experts and we borrow from their experience" (Connie). Buckenham (1998) asserted that role models or mentors were essential to the interactive process of professional socialization.

Nurses also receive support through *making connections* with their patients, especially when patients support nurses who are publicly criticized. Patty relates:

> We've had trouble with a couple of doctors here that take a strip off you right in public but the public are more on the side of you than they are of the physicians. . . . One of the surgeons just ranted, and raved, and went on like a mad person, and then went down the hall. And then, after he left, the people all said to me, "You didn't deserve that. Why didn't you say something back to him?" And I said, "Well, I didn't want to encourage him, and if I did, I'd feel like I'm lowering myself to his level."

In other situations, patients support and value nurses' work by praising and showing appreciation.

Making connections with the public may involve building relationships and accepting positive comments from the public. A choice not to engage in such connections results in stunting professional identity development and limiting success in practice performance. *Concentrating on tasks*, either as a new graduate or as a nurse becoming stagnant, limits *making connections*. Some interactions with the public, however, indicate a lack of support. Wendy feels she is sometimes treated like a waitress while Elaine reports feeling taken for granted sometimes and denied courtesy from her patients. Such responses can diminish growth and increase frustration. Kristina believes that the level of

public support is influenced by the fact that nurses do not feel free to discuss pay and other work-life issues important to them because they are unaccustomed to advocating for themselves. She says that nurses:

> can't articulate their needs to say . . . "I'm doing this, this, this, and this. I need to be compensated in these areas." And it's more like they feel like they're looking for money and money's kind of like, well, "we don't talk about this, we're professionals." Well, it is very much a part of your profession [because it is] what you're able to give to them [patients]. They are consumers using the [services]. It is very important that is discussed on a very non-emotional level because it's factual.

Becoming aware reveals that the system in which nurses function, the pace of work, and their own behaviour may all contribute to available support. As Ruth says,

> Maybe a lot of that is how nurses perceive themselves and how they portray themselves to society in general. . . . In a larger area, you're more in the service role. You're there to do your job and "I really don't care what your name is, or where you're from, or if your kid is sick, I'm paying you." You do what you're supposed to do.

Clare (1993) presented a position consistent with these concerns: "Nurses often do not value their own legitimate professional concerns about nursing and wider social and health care issues, Neither do they present their ideas forcefully in a political forum" (Clare, p. 1033).

Attending to credibility, the third subprocess for *attempting balance*. Nurses define it as deciding if and how they choose to pursue professional development. The nurses decide whether and when to work with mentors to encourage positive interactions, attend workshops or in-service sessions to improve technical skills, and figure out how to practice capably. In *attending to credibility*, nurses recognize that their practice patterns both influence others' perceptions of their professional knowledge and skills and reflect

their actual use of such knowledge and skills. Irene believes that her practice and professionalism have improved through: "studying, for me . . . different workshops and work-related study as well. But certainly the formal part [BN] I think is the biggest factor for me." Kristina reflects about the influence of learning on her practice.

> I'm starting to look back [on a course in her BN program] and I'm thinking, I would never have thought of theories when I was doing a nursing assessment. . . . I'd just be doing that. Now, I'm thinking when I'm doing it. It's like, I can, you know!

Recognition occurs that the title "professional" and the respect that comes with it must be earned (Elaine). If strategies are not used to build professional credibility, only the existing level of credibility is sustained, leading to a tendency to stagnate; practice becomes repetitious rather than better. Olivia observes that when nurses do not consciously try as hard to build credibility, they "are not caring. They don't continue their education. They don't keep up with the changes." It is now time to summarize the consequences of this second stage of *reworking professional identity, realizing practice.*

Consequences of Stage 2

In this second stage of *reworking professional identity*, all three subprocesses of *attempting balance* lead to a resolution of the dissonance experienced earlier, to the acquisition of new knowledge, and to a raising of practice standards to meet a basic professional and institutional level. Sarah's comment is characteristic of the need for resolution of dissonance:

> You have to manage a few things well and not manage too many things poorly. . . at the same time, aside from your nursing skills, you have to be liked. . . . Eventually they'll say, "ah, so-and-so's doing all right" and . . . people stop identifying them as "new" and they start talking about the things that they did

well.

Nurse raise their practice to minimum external expectations in order to meet basic professional and institutional standards. They point out that it is essential to reach this level in order to be considered safe; otherwise, they may voluntarily or forcibly leave the profession. "You have to start somewhere and master the basic tasks" (Nora) whether nurses are new graduates or have moved to another area of nursing work.

A final consequence of *realizing practice* is that nurses have begun to think about their personal meaning of professional identity. They can recall many of the learned (or "received") characteristics of a profession and then begin to assess such qualities as they may or may not appear in their own and colleagues' practice. At this second stage of *reworking professional identity*, new graduates in particular "are kind of groping with the idea of what exactly is a professional" (Ruth).

Transition to Stage 3

The transition from *realizing practice* to *developing a reputation* is stimulated by reaching an acceptable level of practice adequacy, identifying the need to develop future plans for practice, and developing professional identity.

Stage 3: Developing a Reputation

Developing a reputation is defined in this study as establishing an individualized, habitual way of practising that becomes a recognizable professional identity. At any given point in time, reputations developed by nurses reflect varying degrees of professional expertise. The quality of the reputation depends upon the extent to which nurses intentionally and effectively strive toward a level of expertise which they and their

colleagues recognize to be professional, that is, having practice patterns that show high standards of competence, skill, and proficiency, and willingness to "help advance nursing" (Debbie). Reputational quality may vary during a career. Kristina identifies a range of reputations.

> [When] the person feels that it's their chosen profession, they seek, and want to build, and make it better, and refine it, and tune it, and shape it so that people look to it with respect. I think there's others that have some elements of that, but [for others], it serves their needs by giving them an annual salary.

Liaschenko's (1998) research highlighted the point that, when nurses saw work as only carrying out tasks and procedures, they became psychologically separated from patients and the work became meaningless except in terms of justifying an income.

Developing a reputation for professional expertise is intentional and is achieved through successful, directed actions toward that goal. "When you've gained that respect, and once you are included in that nucleus of expertise, then that's what you've aspired to all that time" (Sarah). *Developing a reputation* that reflects less-than-expert practice may not be intentional and may occur with failure to take directed actions, either because the nurse does not see or cannot meet the need for action. Wendy indicates the variety of approaches for *developing a reputation.*

> Like any profession, or like any job, there are nurses who are people who just go to work, and want to do their work, and they don't want anything else. They have that education component that was required to do it. They've learned, they do a good job at it, and that's all. And they are perfectly happy with doing what they're doing and that's fine. But there are others that there's always something on the go, and there's always a challenge . . . that certainly would help nursing to become a profession.

Developing a reputation involves three processes: *establishing practice patterns*;

choosing standards for decision making, clinical judgements, and practice; and *helping to advance nursing* as a profession. Table 12 displays these processes.

Table 12

Developing a Reputation: Processes, Subprocesses, and Consequences

Processes	Subprocesses	Consequences
establishing practice patterns	addressing competence	become known for consistency in practice become more skilled
	seeking, responding to stimulation	determine whether to develop practice
	pursuing learning and growth	change work areas or study
choosing standards	deciding personal relationship to work	interactions; presence; caring; follow through
	determining how work is done	vision; skill; priorities; responsibility
helping to advance nursing	mentoring other nurses	foster growth in self and others improve nursing provide support
	influencing impressions	public image views of other professionals
	engaging and disengaging	involvement with and distance from unions, professional associations, committees

The Process of Establishing Practice Patterns

Establishing practice patterns refers to a process of forming a customary manner of nursing characterized by consistently by three subprocesses: *addressing competence*, *seeking and responding to stimulation*, and *pursuing learning and growth*. The extent to which such patterns are professional varies, based on three salient factors: (a) the degree of learning and striving to address clinical competence, for example, the amount of

personal focus on improving practice; (b) the extent of seeking or responding to formal learning, for example, the degree of engagement in in-service programs; and, (c) the extent to which the nurses are alert to, recognize, and pursue informal opportunities for learning and growth, for example, the ability to recognize incidental learning in encounters with, and feedback from, patients, peers, and related professionals. Gail observes that examining her position in the workplace and developing leadership skills is part of developing her professional identity: "As a leader, when you're looking at where you fit -- nursing, the professionalism, the whole realm of nursing, what it means in a leadership context--unless you're seeing yourself at a certain point of professionalism it's really hard to lead nurses to that thought."

The subprocesses of establishing practice patterns. Addressing competence, the first of the three subprocesses, refers to the nurses' recognition that they can indeed change their capability for practising effectively. If they pay attention to personal feedback about practice and reflect on their practice they can clarify their competence levels. Such awareness, combined with the desire to be "included in the nucleus of expertise," develops professional competence and increases self-respect and self-esteem (Sarah). Ways to address competence range from striving to increase it through challenging oneself, feeling stimulated by change, needing "the adrenalin rush" (Lynn), seeking to avoid boring routine work, sustaining basic competence, avoiding change, and gaining comfort with practice.

Patients get excellent technical care from competent nurses. Fred recognizes peers who have competence: "On the floor where I work, the quality of nursing is pretty good

but there is a small group of people who, I find, are just above the rest. They are more skilled at doing things, more knowledgeable" (Fred). Striving for more expertise sometimes requires that a nurse changes work areas. "Knowing when it's time to go for something a little bit more difficult and challenging and be willing to do that" helps nurses apply these strategies to enhance their competence (Nora) and reputation. But one consequence of changing work areas is that nurses then need time to reach a new level of competence.

Seeking and responding to stimulation, the second subprocess, refers to the extent to which the nurses actively look for and engage in activities that prod their development. Such looking varies with the degree to which workplaces provide challenges and inspire informal development. For those working to develop their expertise, such workplaces are exciting: "It's always challenging . . . I'm always learning. You can never get it. It's not mundane. There's always going to be something new coming in the door and with the technological advances, you're continually upgrading yourself" (Joanne). The extent to which nurses seek and respond to stimuli depends upon what they experience as stimulating. Sometimes nurses do not see stimulation in the workplace; at other times they cannot engage in the stimuli available. Nurses feel it is necessary to balance *seeking and responding to stimulation* with enough practice consistency so that they develop competence and professional identity.

Pursuing learning and growth, the third subprocess, ranges from consistently seeking opportunities to learn, to occasional participation, to deliberate avoidance of such opportunities. When nurses actively pursue learning, they can see growth from it: "We

continue to learn. It's not like learning how to do a manual thing and then just staying there. There's a growth to this, a growing pattern" (Ruth). Recognizing the need to learn is part of being professional, "as we grow and mature as professionals, we realize there's more to learn" (Lynn); professionals are "always at a point [of] . . . learning something" (Connie), and "As part of my professionalism, I wanted to expand my knowledge or go into another aspect of nursing" (Elaine). Clement and Vandenberghe (2000) reported that the teachers characterized in their study as progressive professionals were "the ones who are always looking for learning experiences. And if they do not find them, they create them themselves" (p. 96). MacKeracher (2001) has argued that adult learners often seek learning experiences to meet their needs. "Since we know that an individual's concept and esteem are central factors in learning, we can assume that how learners describe and assess themselves becomes a crucial element in how they learn" (p. 209). This search for learning experiences sometimes takes nurses in this study to other workplaces, or to formal education, or informal learning in the workplace, or to incidental learning.

Pursuing learning and growth is influenced by workplace conditions, access to and availability of opportunities for learning, adequate personal finances, and recognizing available alternatives. A richly varied workplace can be a learning context in itself as Patty indicates: it is "all a part of it [being professional] because you learn, you grow, through every hour that you spend in nursing." If enough learning opportunities cannot be found, created in the workplace, or if workplaces are unsupportive of learning, nurses who "want to be current" (Brenda) can still pursue learning by looking beyond the workplace for workshops, short courses, and university degrees. Erickson and Ditomassi

(1998) advocated learning as a habit of nursing. "Each of us must . . . be willing to learn--continuously learn--because the environment in which we work is rapidly changing" (p. 16). Lange (2000) noted that participating in a formal course outside the workplace reduced stress reactions when it provided an affirming, restorative environment and space for reflection. Sometimes, however, family and social environments limit or facilitate opportunities for engaging in learning.

The Process of Choosing Standards

Choosing standards is the process of selecting the criteria to guide nurses' practice. Nurses may be more or less aware that they are actually choosing standards. With high awareness, they make deliberate choices. With diminished awareness, they may choose by defaulting on a conscious decision or without full consideration of alternatives. Nurses may choose from a range of standards; from continuing to meet only the basic, external, institutional, or unit, standards of practice to establishing standards that reflect internalized criteria that exceed but are congruent with basic institutional and professional criteria. One end of the range of standards reflects the status quo of practice that promotes acceptable care without extending practice capacity; the other end of the range reflects standards of excellence. Ruth looks to the higher standards:

> There is a minimum [standard] that is set by these other groups but, then as a professional, then you should be at least maintaining that and then trying to exceed that. . . . Part of [professionalism] is being willing to reach beyond what your actual scope, reaching beyond that umbrella a little bit, and anticipating, and searching for answers.

Vera agrees: "there's something about being a professional that makes you want to exceed the standard."

Two subprocesses apply to the choice of standards. The first sets standards determining one's individual relationship to work. The second sets standards determining how work is done. Standards within each subprocess vary. *Choosing standards* for the work relationship means that nurses figure out personally appropriate dimensions of commitment, presence, caring, and follow-through. The first dimension, commitment, relates to nurses' commitment to patients, to the work environment, and to peers; it ranges from passionate commitment to just being there and to absenteeism. The second dimension, presence, relates to how nurses connect with patients and family; it ranges from being fully present, to somewhat distant, to being too closely involved and infringing personally on patients. The third dimension, caring, is a complex one. It ranges widely: from nurses being intensely ethical to casually so; from respecting confidentiality to breaching confidentiality; from according respect to being disrespectful to overstepping boundaries; from showing empathy to not connecting well with others; from practising with deliberate skill to practising with less skill; and from sharing knowledge and information to sharing limited knowledge and information. The fourth dimension, follow-through with patient care issues; it ranges from high to low levels of obligation and advocacy for patient needs that nurses cannot meet by themselves. "But really what you're doing is advocating for your patient and if you let a need pass by that doesn't get met... then probably you've been more of a technician than a professional" (Sarah).

Regarding the second subprocess, determining how work is done, the nurses set their own standards using vision, skill, prioritizing, and accountability. Vision ranges from nurses' being able to see and address holistically the patient's situation, including all

the family and related social issues, to working only with a patient's specific, recognizable, and often physical, problems. Skill ranges from recognizable and respected expertise to working at a basic level of competence to sometimes incompetence. When nurses "don't treat patients very well, and they give sloppy care, always needing prodding to do their work, and don't take pride in their work," they are no longer meeting practice standards (Patty). Prioritizing ranges from actively assessing and meeting patient needs to doing tasks relevant only to what is observable and acting on generalizations that do not consider the specific needs of individual patients (Helen). Accountability ranges from taking full responsibility and mediating to taking more limited responsibility to avoiding basic responsibility.

The Process of Helping to Advance Nursing

Helping to advance nursing is the third and final process in *developing a reputation*. Now nurses decide whether, when, and how much to give back to the nursing profession. *Helping to advance nursing* has three sub-processes: *mentoring* other nurses, *influencing impressions of nursing*, and *engaging and disengaging with promotional activities*.

Subprocesses of helping to advance nursing. Mentoring other nurses is the first subprocess of *helping to advance nursing*. To mentor other nurses in the workplace is to intervene actively to answer their questions, show them how to do new procedures, act as formal preceptors or role models, and informally "pass on knowledge" (Debbie). In the field of adult education, Darwin (2000) described the role of mentors: "Mentors 'go to bat' for their proteges, provide access to scarce resources, help with visibility, protect

from harm, and promote and recommend for challenging assignments" (p. 201). Experience and confidence contribute to nurses' ability to mentor others, to use acquired knowledge, and to feel confident in allowing others to emulate their behaviour. *Mentoring other nurses* fulfills a felt obligation to be involved in improving the profession itself as well as current patients' lives and future patient care. "And once you have seen, or once it's opened for you to have advanced, you want to go around opening all the doors for everyone" (Kristina). Feeling professional, Terri supports such a future orientation:

> We could move the profession along, we could move ahead. It's just finding the way to do it. . . . I think one of the main things in professionalism is to be able to, especially as a group, make decisions and see where the whole profession is going. Not just doing the same old thing over and over. A future orientation with your own goals in mind and you can stand on your own and say this, we're doing this because of this and this is where we're going with it and that kind of thing. And we think it's better for everybody else coming up.

Mentoring other nurses provides nurses with satisfaction and leads to feeling good about their own further professional development. Olivia reinforces the importance of being a role model:

> There's a lot of younger nurses in the last few years, especially. There's been a big turnover and I think it's very important that they have good role models. It's part of who you are to pass things on. And I think that's an important part of professionalism.

Workplace factors that influence *mentoring* include the extent to which the work environment appears too busy for *mentoring*, superiors encourage the helping of others, and reciprocal support exists. Personal factors also influence; for example, how open nurses are, how willing they appear to assume responsibility for teaching others, and their

confidence level. Sometimes the presence of other skilled mentors on the unit makes it unnecessary for others to take on the task (Joanne). In such cases, nurses defer to more experienced mentors when questions are asked and that mentor acts as a role model for others. "As the seasoned nurse, you have a lot of experience to pass on to them. You have skills that they can observe". . . and you are "*helping to advance nursing*" (Debbie). Irene acts as a mentor for her co-workers:

> You have to show that professionalism in your work so . . . you're demonstrating how you even want them to work . . . because they're constantly coming to me for advice. . . . "What should we do in this situation?". . . Even at times, yes, I would have to say, you know, even doctors will too. You know, well, "what do you suggest we do?"

The extent to which nurses are tired of helping, do not try to make time to mentor, have pressing work schedules, and are fatigued influences their likelihood of *mentoring.* Nurses' personal lives beyond the workplace influence their available energy for mentoring because "when your children are small, you may just want to go to work, and come home, and put your energy there" (Wendy). The extent to which nurses engage in mentoring is influenced, then, by their confidence levels, their inclination and energy, their previous experience being mentored, workplace support, and their personal lives.

Influencing impressions of nursing, the second subprocess of *helping to advance nursing,* affects how the lay public and other professional groups understand nursing. Even though some members of the public have a generally positive image of nurses, widespread public expectations do not encompass all that nurses can do. This study shows uneven participant responses regarding informing and updating the public, and promoting nurses' full contributions within the health care system. Nurses vary in their

levels of commitment to the profession and in how they choose to influence the public impressions of nursing.

Nurses behaviours influence the creation of a range of impressions of nursing. Some of these tend to be more negative than positive because they originate in unsettling or demeaning interactions with nurses. Such interactions occur, for example, when a tired nurse responds quickly or sharply. Vera expresses concern about the public image of nursing: "There are some images that are hard to live down. And I think there are people within the profession who promote those images still. . . .[For example], years ago you were the handmaiden, but that is changing." Debbie agrees that nurses may influence negative public images of nursing. "When you're stagnant, it doesn't move your profession along any." Physical appearances of nurses that do not conform to stereotypical public expectations do not help image development; for example, being overweight or engaging in unhealthy habits:

> I know it's a personal choice what you eat and if people smoke but it really bothers me when a coronary care nurse smokes because here you're telling [patients] all this stuff . . . but people don't think it's important if you don't practice what you preach. (Anna)

Influencing impressions of nursing is shaped too by how far the nurses see themselves as members of public communities and carry educative roles outside those of work. "I think that I have a role in the community to educate as a professional. . . . I don't mind explaining to them. . . . I'm long past the days of coming home and saying this is OK" (Joanne). Public impressions are influenced positively as more nurses become "more involved in community events, more promoting charities, doing volunteer work.

They always say 'blah, blah, who is a nurse,'" explained Debbie positively. The degree of nurses' involvement generally in community and public education is influenced by their multiple role demands, stage of career, personal energy levels, and abilities to sustain commitment to nursing promotion after working hours. Beginning nurses sometimes inadvertently present a narrow impression of nursing to the public because their own vision is limited by their strong task focus and reduced understanding of the potential of nursing.

Anna notes that since the professional associations and unions influence collective impressions of nursing, image development need not entirely be an individual responsibility.

> I think they, all the time, have little things going on that are supportive. I think it's our union mostly, isn't it? Maybe it is the association. And sometimes you think maybe they're not doing anything for us as nurses but at least they are letting the public know . . . who we are and what we can do exactly. And I think it is changing that the public is seeing that we can do more than we used to. (Anna)

Engaging and disengaging, the third and final subprocess of *helping to advance nursing,* reflects the cyclical nature of deliberate involvement in and withdrawal from activities involving the advancement of nursing. Discussions, creating situations in which to make change, and working in organizations concerned with nursing welfare are examples of direct and active involvement. They necessarily vary over a nurse's career because of the multiple-role demands of family, work, and other community responsibilities. "Most [nurses] are women, many people have children of different ages, with different needs, different shifts, people have to have another life... not everybody has the energy all the time to give to [the professional association]" (Gail). The nurses in this

study appreciate the flexibility of being able to engage in and disengage from active participation in advancing the profession as their lives permit.

Engaging and disengaging with professional associations, unions, and professional practice committees in workplaces are influenced by several factors: stage of career, opportunity, amount of personal energy, time, family, and work schedules, concern for the future of the profession and newer nurses, vision for the future, and amount of professional pride. These factors are not necessarily present simultaneously. Gail recalls having time as a new nurse to become involved with the professional association but she feels she lacked then the necessary vision for that activity: "At one time, I was very interested in the [professional association] but didn't probably have the years under my belt to fully be able to promote it" (Gail). Others may have the concern and vision but have not yet become involved: "I owe it to myself to attend a [professional association] meeting" (Debbie). Even with interest and inclination, work schedules influence involvement: working part-time allows more opportunity to participate; working full-time or taking courses reduces time; and shift work and being called back to do extra shifts limit time. Family situations including the presence and ages of children and the presence and assistance of spouses also influence time for participation. Anna says that "unless you're willing to take the time and dedicate yourself, you're not going to have time for growth because . . . we're tired, and also young mothers, and have so many different roles."

Even when time, interest, and energy permit, access to professional activities is sometimes additionally influenced by transportation, weather, and distance from the

location of meetings. Local chapters of provincial organizations reduce geographic access problems but meetings are often held during shift hours or at times devoted to families (Nora). Consequently, engagement over a career is often sporadic. "All professional associations experience problems or operational snags . . . problems typical of many associations are the voluntary nature of participation and operation" (Imel, Brockett, & James, 2000, p. 637). In this study, encouragement by superiors and mentors tends to increase involvement in professional associations.

Engaging and disengaging with professional associations is also influenced by nurses' actual experiences with those associations. If their experiences are negative, nurses feel frustrated and reduce their expectations of future support from that source. They also experience disappointment because they still believe that professional promotion is a role that those groups are paid to implement.

> And, every time I just get really frustrated with them and end up saying, "look, you guys, again, you failed me." And they're frustrated with me, I know that, but I mean, I'm calling them for things that they should be able to help with. (Patty)

If interactions with professional associations are positive, nurses experience growth and increased engagement and they encourage the involvement of other nurses.

Engaging and disengaging with unions negotiating to improve working conditions varies with personal perceptions. *Disengaging* occurs when nurses believe that unions do not help to promote nursing as a profession when they use strong lobbying tactics perceived as unprofessional. There is also fear that such tactics will persuade others that nursing is not a profession. *Engaging* occurs when nurses believe that, as a predominantly female group, they would be paid even more poorly and have less

favourable working conditions without the advocacy intervention of unions: "Because I think if nurses didn't have the unions, because it's the majority of a female workforce, I don't think they'd be paid anything" (Patty). This opinion is also reflected in the nursing literature: for example, O'Neill (1992) indicated that gender influenced pay levels very strongly before the 1980s. "Nurses, a predominantly female occupation, were being paid less than city garbage collectors, a primarily male occupation" (O'Neill, p. 143).

Nurses also *engage and disengage* with professional practice committees in their workplaces. They engage when they see how such committees improve nursing directly and also influence relationships with other health disciplines. Nurses' involvement in these practice committees ranges from helping to do regular audits of nursing practice, evaluating nursing practice and other nurses, participating in meetings of complaints committees, and acting on interdisciplinary practice committees. Nurses often are involved too with community advisory boards or committees. "These positions of decision making offer the opportunity to demonstrate to society the positive behaviors of the professional nurse" (Miller, Adams, & Beck, 1993, p. 293).

Consequences of Stage 3

Developing a reputation establishes an habitual way of practising that is recognizably characteristic of a nurse at a point in time. In this third stage of *reworking professional identity*, all three processes lead to manifestations of professional identity that embody distinctive ways to address competence and learning, develop practice standards, and promote the nursing profession. The contextual influences identified in chapter 4 influence the variation in extent to which reputations are considered

professional over time.

Iterations of the Three-Stage Process

Iterations are triggered by changes to the nurses' actual practice or their affective responses to that practice. Each change sends the nurses into the stage of *assuming adequacy*. Each iteration produces an increasingly integrated, context-relevant, and deeper understanding of professional identity. Joanne's reflection on her professional identity points to this increasing depth and provides a fitting end to this chapter:

> I was excited to be a professional [when I graduated]. I was thrilled. I think it was more of a statement to me then than it is now. . . . Now it's part of me as a person. It's not the word per se. I've been able to incorporate that into me . . . because before, it was like, okay, now that I've graduated, I am a professional and I have to conduct myself, and be respectful, and dot, dot, dot. Now, I can do all that and still have me. I can be me because it's all one.

Table 13
Reworking Professional Identity

Stage	Processes	Subprocesses	Consequences
Assuming adequacy	neglecting reflection	little pondering acting knowledgeably having to ask for help becoming bored	diminished awareness of being respected and being competent; failure to notice others' views; stagnation
	concentrating on technical tasks	emphasizing and accomplishing required procedures and skills	diminished awareness; maintenance, development of competence; protection from, and limitation of interactions with, others
Realizing practice	becoming aware of discrepancies	noticing, comparing patterns; reflecting on practice; gaining insight	see discrepancies begin to examine practice experience dissonance
	attempting balance	developing protective response patterns making connections attending to credibility	decide how to address dissonance and protect self find help when needed sets how wish to be known
Developing a reputation	establishing practice patterns	addressing competence; seeking and responding to stimulation; pursuing learning and growth	become known for consistency in practice; become more skilled; determine whether to develop practice; change work areas; study
	choosing standards	deciding individual relationship to work determining how work is done	interactions; presence; caring follow through; vision; skill; priorities; responsibility
	helping to advance nursing	mentoring other nurses influencing impressions engaging and disengaging	foster growth in others and self improve nursing; provide support public image views of other professionals engagement and distance with unions, professional associations, committees

To review, Table 13 displays the substantive theory that emerged from the findings of this study as a three-stage process with the processes, subprocesses, and consequences for each stage. The contextual influences on the reworking process were discussed in chapter 4. Now I establish the significance of these findings by identifying and elaborating key implications.

CHAPTER 6

Implications of the Process of Reworking Professional Identity

Introduction

The findings of this grounded theory research into becoming and being professional reveal a process of *reworking professional identity* and how it is influenced contextually. Since becoming professional has not been conceptualized in this way before, these new findings have key implications for nursing practice and education, adult learning, and further research. I organize the implications according to the three central outcomes of this study: (a) becoming and being professional are managed through a three-stage process that I name *reworking professional identity*; (b) the process reveals certain influences of social structures on *reworking professional identity*; and (c) the process identifies intervention points for potential change and adult learning. I end the chapter with questions for further research.

Implications of the Process of Reworking Professional Identity

The first outcome--that becoming and being professional are managed through a three-stage process of *reworking professional identity*--brings important implications for the nursing profession as a whole and specifically for nursing education programs. The first implication is the need to question the conventional model of becoming professional. I place the discussion of this implication in the context of professional career models. The second implication is the apparent need to make three significant changes in nursing education programs: (a) to incorporate understanding of adult learners or adult learning principles in order to facilitate moving through the reworking process; (b) to apply

knowledge of the reworking process in the professional socialization of nurses within basic nursing education programs; and, (c) to facilitate moving through the subprocess of *pursuing learning and growth* by changing BN/RN programs. More specifically, under these three proposed changes I explain how incorporating four adult learning principles into nursing education would change how nurses enter *reworking professional identity*; I argue the need to increase awareness of the existence of *reworking professional identity* generally, and specifically, in *assuming adequacy* of actual competence and workplace-relevant practice competencies; and I elaborate on the need to ensure credibility of BN/RN programs, recognize prior learning, consider nurse-learners as developing professionals, and make formal learning relevant to workplace conditions.

The first implication--the need to question the conventional model of becoming professional--arises because the theory of *reworking professional identity* emerges as a three-stage process. According to the conventional model, nurses become professional by being educated into a socially-mandated, self-regulated, service discipline with its own body of knowledge and code of ethics. This model also assumes that professionalism and professional identity are learned adequately in formal education programs, are merely applied in workplaces, and are automatically accorded by others. These expectations of the conventional model are derived from the characteristics of professions initially generated by Flexner in 1915 and promoted since then by the profession of nursing (as discussed in chapter 2).

However, my theory of *reworking professional identity* indicates that becoming and being professional is an iterative process occurring over the course of a career. This

new perspective raises questions about the "uncritically assimilated" (Brookfield, 2000b) assumptions that underlie the conventional model for identifying professions. The reworking process indicates that earning the title "professional" requires more than earning the legal title "nurse"; it requires understanding the RNs' self-identified experiences with developing professional identity through a career-long process rather than through only once meeting external criteria endorsed by the profession. Nurse educators and practising nurses can be a strong force if they collaborate to question and influence the conventional theory of being professional. Nurse educators need to help nursing students to anticipate *reworking professional identity* and help prepare them for active involvement in this process; but how this task is done is another matter.

The identification of this process of *reworking professional identity* is significant. It presents a new theory for understanding the development of professional identity, provides a context within which both individual nurses and the profession as a whole can examine existing assumptions about professional identity, and facilitates nurses' redefinition of their own meanings of professional identity. As individuals, nurses can locate themselves within the process of *reworking professional identity*, anticipate or review their progress, recognize career possibilities, and see previously-invisible opportunities for professional change. As a profession, nurses collectively can benefit by examining and questioning the now-visible process and contextual influences on the development of their professional identity. Such constructivist approaches are lacking when nurses and the profession passively accept criteria established by others for conferring professional identity. The reworking process promotes a new understanding of

professional identity, validates nurses' experiences, legitimizes nurses' perspectives on professional identity, raises awareness of the process, and facilitates action. The process also accounts for diversity across nursing careers, workplaces, geographical regions, and societal contexts.

Context of Professional Career Models

The nursing profession needs to follow the example of other professional disciplines that have identified useful theories for developing professional identity. For example, research by Kral and Hines (1999) validated a developmental process experienced by professional family therapists and indicated how understanding that process

> may help normalize the experience of growth and empower inexperienced family therapists. Without some knowledge about the process of achieving a competent sense of self as family therapists, inexperienced therapists may be in danger of being left isolated and possibly wondering if they should leave the field. (p. 110)

Research with teachers by Beijaard, Verloop, and Vermunt (2000) articulated insights for promoting teacher development that included:

> similarities and differences among teachers' perceptions of their professional identity, including changes in identity and relevant learning experiences throughout their careers. These insights are not only useful for understanding their self-image and helping them to reflect on themselves as teachers, they are also useful for student teachers as part of their orientation on becoming a teacher. (p. 762)

The process of *reworking professional identity* could serve similar functions for developing professional nursing identity.

In the field of teacher education, career models have explained changes in career interest over time but they did not articulate a relationship to professionalism. Steffy

(1989), Lyons (1981), and Fessler and Christensen (1992) have each proposed developmental models that articulate teachers' movement through career paths. For example, Steffy, observing that most models were based upon age, thus limiting how career development could be viewed, based her model upon attitude with "an overlay of the age component" (p. 19). Steffy described a linear five-stage model, beginning with entry into the teaching profession and ending with exit from the profession. Between these two points were progressive stages of self-actualization, withdrawal, and renewal. Fessler and Christensen developed a model that placed an eight component career cycle into "the context of influences from personal and organizational factors" (p. 35), thus creating a more dynamic cycle.

The process of *reworking professional identity* expands upon the existing knowledge about career models in three ways. First, the process shows that nurses attend to their own professional identity development throughout their careers. Second, nurses experience the stages of the process several times over a career before exiting the profession, in contrast with the linearity portrayed by the above career models. Third, the process identifies significant contextual influences that promote or inhibit movement from stage to stage. My articulation of this process provides a starting point for change: prepare beginning nurses for managing discrepancies, promoting their careers, and understanding their professional identity by incorporating the process of *reworking professional identity* into learning activities. This educators help the students gain skills for the self-management of who they are as professionals.

Changes in Nursing Education Programs

The second implication related to the process aspects of *reworking professional identity* is the need for significant changes in the content and activities of nursing education programs. Since the reworking process indicates that graduating nurses are not well prepared for the experience of developing professional identity, I recommend that learners in basic nursing programs be considered as adult learners, leading to learning strategies to enhance nurses' capacities to engage in relevant learning throughout the process, to reflect critically on their practice, particularly as they are *becoming aware*, and to develop the skills for career-long learning.

Basic diploma nursing education has traditionally relied on didactic strategies to teach concrete knowledge for the production of skilled technical practitioners. Such programs have rarely illustrated adult learning principles and have often supported the use of the 1915 Flexner criteria for assessing professions. In Canada, 4-year generic baccalaureate programs are beginning to supplant these diploma programs so the time is ideal to recommend greater adoption of adult learning approaches. I recommend that nurse educators structure these programs based upon four interconnected general thoughts about adult learners, often referred to as adult learning principles: adults are motivated to learn when they experience a real need to learn (Baskett & Marsick, 1992), past learning influences current learning (Knox, 1992), adult learners are self-responsible learners (Candy, 1991), and critical reflection skills help adult learners adopt new perspectives (Kolb, 1984; Schön, 1987). I elaborate on each separately; of course, in practice these principles interact.

The process of *reworking professional identity* discloses discrepancies between expectations of formal education and workplace realities. With this in mind, nurse educators can enhance the relevance of practice-based learning and reduce these perceived discrepancies. First, adults are motivated to learn when they experience a learning need they want to satisfy (Baskett & Marsick, 1992). The basis for planning learning experiences, then, becomes helping learners to identify what they need to learn in order to cope safely with workplace conditions. If nurse educators and learners together carefully assessed learners' needs, they could use constructivist learning environments to better meet those needs (Land & Hannafin, 2000). Although beginning nursing students are adults, they will need help to identify learning needs because they do not yet "know" nursing as it actually happens. Nurse educators could, for example, have student nurses observe an unfamiliar clinical environment for several hours, followed by them articulating their observations and questions. Within small groups, they could discuss: how to identify adequate care, what and how they need to learn in order to provide such care, what assumptions underlie their observations and the identified learning needs, and what questions are raised by observing that workplace. Such activity would identify relevant learning needs, provide a context for learning, and promote critical reflection about that learning--in contrast with pre-planned clinical and classroom experiences based upon students receiving delivery of educators' expert knowledge of what is needed. Such a proactive strategy would validate learners' competence in determining their own learning needs and in selecting how to meet them, build self-confidence, and promote a learning pattern that could be used skilfully throughout the stages of the process of

reworking professional identity.

Second, learners build upon past learning and experience, which, in turn, influences their current learning (Knox, 1992; Merriam & Caffarella, 1999). Nurse educators could build upon learners' identification of their current knowledge, learning styles, and preferences rather than assume that beginning nursing students bring no life experience, knowledge, and values that could be used in education. Nurse educators could help learners articulate what is often tacit knowledge and build connections to new learning. Beginning students may be unaccustomed to class participation, informal learning seminars, and sharing ideas so educators also need to help learners acquire learning to learn skills. Nurses who have learned to construct their own knowledge pro-actively will more easily *establish practice patterns* that reflect such learning. As an educator, I will work more with students to establish supportive learning environments demonstrating genuine interest, trust, uncritical acceptance, and constructive validation of ideas. When nursing students graduate, they could apply their knowledge of how to learn later within *reworking professional identity*.

Third, adult learners generally want to feel self-responsible in the role of learner (Candy, 1991). By self-responsible learners I mean that adults prefer some autonomy in decisions about what and how to learn. In *establishing practice patterns*, nurses who have learned to exercise responsibility for their learning would be more involved in identifying learning needs and planning, implementing, and evaluating their learning. Nurse educators who perceive themselves as experts may struggle with students' autonomy if they believe that only they know best what and how to teach nursing. However, students

need to be considered as experts in managing their own learning. Beginning nursing students may need time, patience, and help from their educators to develop skills for self-responsibility that they may apply throughout *reworking professional identity*.

Critical reflection is essential to *reworking professional identity*, and yet there is evidence that nurses in the stage of *assuming adequacy* neglect reflection. Therefore, fourth, I recommend promoting the use of critical reflection. Fostering these skills ought to enable nurses to move beyond their current perspectives (Kolb, 1984; Schön, 1987). Critical reflection skills are developed and enhanced in interactive, open-minded classroom settings through strategies such as introducing and discussing a real problem or controversy, asking stimulating, guided questions, creating opportunities to examine assumptions and consider implications, and educators' willingness to hear views that may threaten their own assumptions. Such strategies will promote acquisition of learning strategies useful for the whole process of *reworking professional identity*.

Changes in Professional Socialization

The second significant change needed in nursing education programs concerns their embedded professional socialization process. The practice discrepancies associated with *assuming adequacy* imply a need to change initial professional socialization from promoting the passive acceptance of the traditional criteria to facilitating new graduates' increased awareness of their competence, developing strategies to enhance relevant their practice skills, and recognizing the iterative nature of their thinking about professional identity. Since this proposed change brings significant sub-implications, I discuss them as they relate separately to basic nursing education programs and then BN/RN programs.

The process of *reworking professional identity* shows how many basic nursing graduates *assume adequacy.* As nurse educators, we need to facilitate graduates' more accurate awareness of their levels of competence so that they will be less likely to assume adequacy and experience reality shock when they begin work. Nurse educators also ought to facilitate students' awareness of practice realities; however, this strategy risks reducing numbers of students who would want to become nurses at the current time! In any case, graduates need to anticipate a period of adjustment to practice. The reality gap between experiences in education programs and actual workplaces has been described in adult learning arenas by Wilson and Hayes (2000) who expanded the discussion of Schön's (1983) "depiction of the often deep crevasses between how we think professionals carry out their work and what working conditions are really like" (p. 18).

Assuming adequacy also implies that nurse educators need to develop strategies to enhance graduates' actual, workplace-relevant practice competencies. If nurse educators and practising nurses collaborated more closely to articulate essential competencies for beginning nurses, nursing students could focus on mastering those essential workplace-relevant competencies. Closer partnerships between educators and employers would have many advantages: it would facilitate graduate adjustment, reduce the dissonance they experience, and limit the potential for the kind of unhelpful divisions described by the sociologist, Freidson (1999).

> While the traditional craft form of training does divide members of crafts into masters, journeymen, and apprentices, the division is much sharper in professions, for some members occupy an institutionalized position of cognitive authority without engaging in everyday practice. They teach the received body of knowledge and skill to practitioners and also lay down the standards by which

practitioners can be authoritatively judged. (p.122)

In *assuming adequacy*, new graduates assume that they are professional because they learned to believe it in nursing school. In comparison with experienced nurses, however, they perform skills less competently, work less confidently, and interact more tentatively; such behaviours are not congruent with the accepted views of being professional. The reworking process indicates that new nurses need time to develop such observable behaviours and qualities of professional identity. Therefore, nurse educators need to teach that there is a process by which nurses develop and earn professional identity as distinct from its happening via unquestioned acquisition in nursing programs. New nursing graduates expect to achieve, almost automatically, the status of being recognized and respected as professional because they have learned that professional identity is static, automatic, accorded by others, and achieved upon graduation. Because *reworking professional identity* counters that view, nursing education programs need to help students understand that being professional means earning professional recognition with almost constant attention over a whole career. Nursing students need to learn to be proactive in *reworking professional identity*. Nurse educators need to design more opportunities to disclose the tentative status of being professional.

> In education the values and attitudes of the sub-culture are more likely to be openly stated as they are passed on to the next generation, than out in practice where they are taken as so natural that they are seldom commented upon. (Greed, 1990, p. 147)

Turning now to experienced nurses who choose to engage as adult learners in BN/RN programs, *reworking professional identity* brings additional implications. These

implications arise from the subprocess of *pursuing learning and growth* and relate to ensuring the credibility of that education, recognizing nurses' prior learning, viewing these nurses as developing professionals, and making their learning relevant to their workplaces. I currently teach in such a program and I consider these implications appropriate for myself as well as for other nurse educators.

RNs perceive BN/RN education as one effective way to change their practice when, *neglecting reflection*, they have reached or are trying to prevent stagnation. In effect, they are nursing experts who now need course facilitators who are experts in adult learning practises. Confident and competent facilitators could well abandon the concept of RNs as students, reduce their control of classrooms, leave their prescriptive learning approaches, and regard RNs as peers engaged in a mutual ongoing process of *reworking professional identity*. When such a perspective change is achieved, the nurse educators would recognize the value of nurses' experiential learning ad give it appropriate credit, share decision-making, and build on self-responsibility. Increased professional development for nurse educators would enhance our abilities to become such facilitators.

RNs in the stage of *developing a reputation* often have years of nursing experience. It is important, therefore, to recognize and value that accumulation of learning. Programs need to construct more ways for nurses to articulate and evaluate their prior learning, and to be given formal credit for such learning. Nurse educators need to develop time-efficient and effective strategies to assess prior learning and to legitimize it in the classroom.

Kolb's (1984) experiential learning cycle articulates why RNs' reflection on their

prior experiences should be useful. Kolb's cycle begins with "concrete experience"--the daily realities of nursing practice. Using this experience, learners take time to deliberately analyze that experience in order to understand it (the "reflective observation" stage). Nurses in some stages of *reworking professional identity* engage in such reflection and it certainly is required for examining prior learning. Next in Kolb's cycle, learners use the preliminary results of their analysis to form tentative abstract concepts and emerging theories ("abstract conceptualization"); nurses formulate new perspectives on their practice and their own professional identity. The fourth stage of Kolb's experiential learning cycle shows learners developing ways to test out these new perspectives in practice using "active experimentation" strategies and new ways of approaching *reworking professional identity* (in "concrete experience"). With each iteration of Kolb's cycle, learners develop increasingly complex levels of affective, perceptual, symbolic, and behavioural activities. Kolb's experiential learning cycle explains how nurses might learn from reflection on experience given appropriate conditions; however, for reasons described earlier, they cannot engage in reflection during the stage of *assuming adequacy*.

Nurse educators who understand the process of *reworking professional identity* in terms of Kolb's experiential learning cycle would see that BN/RN learners need time and iterative activity for continuing their professional development. RNs do not enter BN/RN programs as non-professionals and exit as professionals. Nurse educators who respect nurse-learners as professional colleagues can enhance the learners' possibilities for learning and developing self-esteem and can increase their potential for initiating change. We must avoid prescriptive or oppressive teaching methods that reduce such possibilities,

increase learner resistance to new ideas or entrench them in old ones. As a nurse eductor with RNs, I have tried to demonstrate my respect for learners by listening, accepting learners as peers, affirming their ideas, fostering class participation, and hearing challenges. However, I think I need to try harder to succeed with these approaches and to identify additional adult learner-development approaches (as in Taylor, Marienau, & Fiddler, 2000, for example). As an adult educator, I also need to facilitate more opportunities to surface, analyze, and reflect upon inequalities related to gender, power, status, and workload, since these contextual influences are so strong on *reworking professional identity*. I may need, too, to listen more closely to RNs' specific concerns about their learning needs and check the accuracy of my understanding.

Implications Related to Influences of Social Structures

The second outcome of the whole study--that the process reveals certain influences of social structures on *reworking professional identity*--brings three pressing implications. They are: (a) to increase awareness of and reduce the limitations imposed by gender-related socialization at both individual and collective levels; (b) to increase the support for nurses as they juggle multiple roles related to paid and unpaid work (not to mention the longer-term, more political need to examine why so many nurses must juggle multiple roles); and (c) to create workplace atmospheres that deliberately and overtly support the kinds of learning needed to facilitate nurses' movement through the three-stage process.

Gender-Related Socialization

I believe there is a pressing need, at both individual and collective levels, to

increase awareness of and reduce limitations imposed by gender-related socialization. If nurses are to become proactive, they must, in my judgement, build their critical awareness of how gender-socialization works and how it may negatively influence the status of the nursing profession and themselves. The critical question becomes how to do this. I believe that we need to target our efforts at nurses in the subprocess of *developing protective response patterns*, when they are more aware of various contextual influences on their interactions and are beginning to develop ways to respond. Both basic nursing education programs and workplace education sessions can apply strategies such as encouraging open discussions about gender-related and power influences, facilitating critical examination of assumptions underlying gender-related beliefs, moving from the safer examination of external assumptions to personally-held assumptions, and role-playing various strategies for responding to gender-related communication styles. Discussion of institutional structures is also essential according to Dahlberg (1994) who found that the relative importance of male-dominated medicine influenced even the structure of ward routines implemented largely by female nurses.

Building personal capacity for *developing protective response patterns* can happen when nurses feel that they are relatively low in the status hierarchy and are diminished by gender-related frames of reference, when they recognize gender-related influences on communication, and when they increase their skill for communicating effectively, assertively, and appropriately in gender-related situations. Both Dehli (1992) and Hughes (1995) articulated their concerns that women move beyond understanding gender-related behaviour and increase their understanding of power-related behaviours so

that they might begin to influence them. Delhi, for example, asserted that even women's relationships with other women needed critical examination for influences of power. In the reworking process, nurses identify that it is more acceptable to criticize other nurses than other professionals, behaviour that is influenced by their awareness of power differences.

Nurses could use more skills to manage gender-related influences throughout *reworking professional identity*; particularly during the third stage process of *helping to advance nursing*. The contextual influences on *reworking professional identity* imply that when nurses' workplaces are dominated and controlled by others, nurses do not feel valued for their caring work. Too often nurses subordinate their ideas to those of other health professionals and, despite their own skilled observations of patients, are reluctant to challenge them. Nurses with better gender-focussed skills would be more effective in *helping to advance nursing* because they would feel more confident and assertive in speaking with professional in other disciplines. With strategic attention to context, nurses may be more able to influence changing the respect accorded to nursing within workplaces. Dahlberg (1994) attributed nurses' tendencies to subordinate themselves to the domination of the largely female caring profession by predominantly male physicians. More assertive nurses could help increase society's awareness of gender-related expectations of nursing, increase the acceptance of men in nursing, promote broader roles for nurses, increase the status of nursing, and address the management of nurses' multiple roles. More communicatively-skilled nurses could help ensure valuing and hearing nurses' voices, expose verbal abuse of nurses, and establish credible partnerships between

nurses and other health professionals. However, I recognize that these strategies are difficult to achieve: nurses with such assertive tendencies will need to be risk-takers because these new initiatives will likely create ripples of resistance.

Development of nurses' gender-aware skills as part of their professional identity construction can be enhanced also by supportive workplaces. Significant changes are therefore required within nursing workplaces to foster acceptance of this new theory of *reworking professional identity* and permit time for nurses to pursue their development. Miehls and Moffatt (2000) argued how identity is constituted through social relationships and so becomes a social reality. Clark and Dirkx (2000) observed that "the self is an ongoing construction that is both social and personal" (p. 109) and "how we think about ourselves is shaped dramatically by society and culture" (p. 115). Such views reinforce the importance of what MacKeracher (2001) and others name as relational learning. Fenwick (2000) portrayed a flexible concept of identity as an adaptable, reflexive sense of self and indicated that such a view was liberating "for those who feel oppressed by the limited, conventional options defining self in the workplace according to hierarchies, competencies, and job descriptions" (p. 299). *Reworking professional identity* is congruent with such a flexible concept of identity but the two key challenges for educators, nurses, and their workplace colleagues are how to promote flexibility and adaptability without apparent loss of ascribed professional status and how to manage this within the oppression of existing gender-influenced hierarchies.

Juggling Multiple Roles

The second implication of the influence of social structures is the need to increase

support to nurses as they juggle multiple roles related to their paid and unpaid work. It may also be timely to raise questions about why many women, disproportionately to men, juggle multiple roles related to work and family responsibilities. The reworking process reveals that nurses' roles in families often involve the stressful experience of juggling child care, homemaking, transportation, and organization. Crawford's (1999) research found that women juggling work with motherhood often required great flexibility to accommodate the needs of those multiple roles. For nurses *reworking professional identity*, these challenges are increased by meeting unpredictable demands in very busy, sometimes unsupportive work environments, responding to problems of inadequate staffing, and feeling torn between family and work responsibilities. Nurses have limited options for addressing workplace stress: they can change workplaces if that is possible, reduce hours of work, or decide to stay at home with children but often economic demands influence their choices. These nurses who are parents face a dilemma: if they choose family priorities, this slows their movement through the process of *reworking professional identity*; if they continue to work, they often feel that their families are negatively influenced. Sarah calls this feeling "trapped." Family responsibilities are therefore a powerful influence on the reworking process. Nurses with children would be greatly assisted by employer strategies that offer child care arrangements or facilitate child care on or near workplace premises for shift-working parents. The larger question of how nurses came to be so responsible for both working and child care needs examination within a wider socio-political and gender context. I currently lack the essential knowledge and skills for such an analysis and this issue is beyond the bounds of this particular study.

Changes in Workplace Atmosphere

The third implication of the influences of social structures is the urgent need to create workplace atmospheres that deliberately and overtly support learning to facilitate nurses' movement through the three-stage process. Nurses experience *reworking professional identity* within the context of their workplaces. Owen (2001) provided a critique of how people generally interpreted context "as a preset environment that influences behaviour, rather than as a set of resources people use as they create cognition and culture in ways that are constantly shifting and dynamic" (p. 599). The process of *reworking professional identity* has implications for change within both preset environments and resources. Here I expand on the changes needed to provide adequate resources, improve workplace environments, and provide learning opportunities.

Regarding resources: adequate staffing would reduce the extremely heavy nursing workloads, increase nurses' available reflection time, reduce overtime, pace the work to allow meal breaks and vacations, reduce nurses' struggle to meet their own and others' professional expectations, and increase possibilities for contributing to the profession. Time is another resource issue operating at many levels of the health care hierarchy, so for example, nurse managers must also have the time and skills to facilitate growth and professional development of staff nurses and promote supportive work environments.

Improved workplace environments result from increased relational openness and interpersonal support, opportunities to enhance learning, protection of new nurses, and fostering the growth of all nurses. Currently, nursing workplaces cannot make such changes because many cannot afford to hire enough staff; and even if they could afford it,

they could not find staff because of the serious shortage of nurses: "The growing concern about the worldwide shortage of nurses will necessitate more attention to recruitment and retention issues ... work environment factors such as autonomy, control over practice, collaborative relationships with physicians, and ultimately job satisfaction are essential" (Laschinger, Shamian, & Thomson, 2001, p. 218).

More effective, accessible, and frequent workplace learning opportunities are also needed. Nurses in the *assuming adequacy* stage need help to adjust to new practice, learn to reflect, gain confidence, and increase practice competence. Ideally, experienced nurses would understand and accept the task concentration of these nurses and schedule opportunities for new nurses to develop technical skills before carrying a typical workload of direct patient-care assignments. Ideally, workplace conditions would enable changing areas of work and facilitate engagement with stimulating organizations and committees. Ideally, nurses would support each other, allow time to develop competence, advocate for better working conditions, manage their dissonance, say "no", and work with unions to improve negotiated conditions such as salaries and working conditions. However, current workplace realities preclude implementation of most of these ideals.

To facilitate workplace learning opportunities for new graduates, I recommend the following strategies based on the reworking process. Provide new nurses with longer scheduled orientation periods to ensure security in technical skills before assigning large patient loads. Currently, I understand that some nurses receive no orientation while others have brief ones confined to reading policy and procedure manuals but with little focus on honing essential skills. If hospitals provided a small skills room where nurses could

practice new skills until they felt comfortable, and if orientation periods built in diminishing time periods over several weeks beginning with about one hour a day, new nurses could attend there as part of their designated work. If nurse-managers articulated their unit's expectations of new graduates, those expectations would be more visible to nurse educators, nursing students, and new graduates. Any potential incongruence should become obvious and therefore be addressed. Workplace needs change rapidly related to funding and staffing challenges so this needs to be done regularly. Securing adequate funding to ensure enough staff to replace nurses for required meal and coffee breaks and vacations is essential to improve patient and nurse safety. In the process of *reworking professional identity*, Joanne's experience highlights the destructiveness of the current pattern. My own frustration with identifying problem-solving strategies is based on knowing that financial and organizational resources cannot support them.

Workplace learning opportunities would also benefit experienced nurses. Nursing has long been recognized as a low-status profession with low-level rewards and demanding work characterized by little upward mobility, long hours, and shift work. Such conditions persist in some workplaces even after 20 years of experience (Kelly, 1998; McNeese-Smith, 1999). The contextual influences in my study include those factors identified by Kelly and McNeese-Smith. They act to influence the reworking process in one of two ways: they may impede the process by creating frustration and blocking nurses' development or they may support the process by facilitating nurses' movement into more interesting workplaces. Such positive movement increases portability of skills, enlarges the pool of skilled nurses who can safely "float" to other units, promotes nurses'

self-esteem and growth, and connects learning more closely to nursing work; all helping nurses to learn constantly. But, the reworking process also reveals that timing is important: nurses should not be moved before they have achieved competence and confidence in one area.

The workplace learning literature is relevant to the need for increased learning opportunities in workplaces. I outline the forms and definitions of workplace learning, and the relationship of workplace learning to this study. Watkins and Marsick (1992; and later Marsick & Watkins, 2001) identified the three forms of workplace learning as formal learning as in goal-directed training, informal learning as in mentoring, and incidental learning as in unintended development. "Formal workplace learning is defined as that which occurs as part of an organized workplace-accredited program, embedded within the organisation's authority and accountability structure" (Owen, 2001, p. 598). Beckett and Morris (2000) observed in research with nursing home staff that informal learning was grounded in immediate needs to address situations with residents and staff. "The intention of incidental learning is task accomplishment, but it serendipitously increases particular knowledge, skills, or understanding" (Rowden & Ahmad, 2000, p. 310). Merriam and Caffarella (1999) categorized arenas for adult learning as formal as in institutions, nonformal as in community-based organizations, and informal as in self-directed learning within natural settings. It appears that all three forms and arenas of learning could be connected with the process of *reworking professional identity*.

Many nurses in the subprocess of *pursuing learning and growth* perceive that workplaces provide numerous opportunities for professional learning. This learning could

be construed as workplace learning by the above definitions, but I believe that there is a significant distinction between the construal of workplace learning in the current literature and in this study. Most literature analyzing and promoting workplace learning, as I understand it, has addressed learning designed to create creating learning organizations (Barnett, 1999; Garrick, 1999; Hager, 1999; Marsick & Watkins, 1999; McCormack, 2000). In this view, the system rather than the individual was the focus and employees were seen as learners receptive to education that can change the way they work so as to improve the productivity of both themselves and the organization. This view anticipated that employees would change work behaviour by conforming to new workplace expectations.

Workplace learning in this study is construed by nurses in a way that is more congruent with Mezirow's (1991, 2000) and Cranton's (1994) view of transformative learning. In this view, the focus is more individual, and learners examine assumptions that, in turn, may alter their perspectives on their work, for example, and how they conduct themselves within it. This examination is done at a more personal level and may even create conflict with workplace values and practices rather than conformity with them. For example, when nurses transform their perspectives, they may begin to see the need to challenge the status quo of their practice and may activate their energies to address this new perspective. "Nurses might be understood as problem-makers by some, but they are true to the caring ideals, which means they have a problem-solving caring consciousness" (Dahlberg, 1994, p. 400). Such behaviour contrasts with the view of workplace learning in which employees were expected to accept other's arguments that

learning and change were necessary and beneficial for the organization. The discussion of workplace learning in the literature could be expanded by including the concept of workplace learning as it is construed in this study; that is, learning that meets personal professional goals as distinct from corporate goals.

With this distinction in mind, nurses who become aware of discrepancies and experience the subsequent related dissonance find increased opportunities for workplace learning. Whether and how nurses choose to address these discrepancies influence their engagement in workplace learning. Nurses who choose consciously to conform may see a need to learn. Nurses who choose to confirm their own ideas or who adopt external perspectives without examination (these become "uncritically assimilated," Brookfield 1998b, 2000b; Mezirow, 1991), may not see a need to learn. Nurses may choose to *establish practice patterns* by developing new skills, taking courses, or *moving on*. When moving on, Brookfield (2000a) cautions against uncritically transferring learning to different situations: "One cannot take techniques and methods used in one context and simply transfer or apply them to another" (p. 47). We may need to consider further how we expect nursing students to transfer learning.

On the whole, this section identifies implications of the social structures such as workplaces, nursing education programs, families, and gender-related socialization expectations and how they intentionally or inadvertently, influence the movement of nurses through the process of reworking professional identity.

Implications of Identified Intervention Points

The third outcome of this study is that *reworking professional identity* identifies five specific intervention points to enhance workplace change and adult learning. Nurses would move through the three-stage process more effectively if nurse educators and practising nurses paid attention to these actions and intervention points: foster nurses' critical reflection during the process of *becoming aware of discrepancies*; influence the framework connecting mentors and mentees during the process of *attempting balance*; facilitate nurses' job mobility during the process of *establishing practice patterns*; acknowledge nurses' growth potential during the subprocess of *pursuing learning and growth*; recognize how nurses can promote the growth of the profession during the process of *helping to advance nursing.*

Regarding the intervention of fostering critical reflection: relevant here is King and Kitchener's (1994) process of developing reflective judgement in which people moved from pre-reflective through quasi-reflective to reflective thinking. The *assuming adequacy* stage shows no reflection, which in King and Kitchener's terms would be pre-reflective. As nurses develop competence in technical skills, become aware of discrepancies between expectations and experiences, and begin to recognize that reality is uncertain, they begin to develop reflective judgement and use it to examine their practice and professional identity. However, in contrast to King and Kitchener's arguments, *assuming adequacy* reveals that nurses sometimes are unable to, or cease to, use reflective judgement. Workplaces that actively and overtly promote the use of reflective judgment and critical reflection skills may assist nurses to move through that stage of the process.

Nurses can benefit by developing critical reflection skills when co-workers are supportive, encourage questioning the status quo of practice, encourage creative thinking, engage in dialogue about practice, and promote informal learning. Again, such strategies may be quite unrealistic in many workplaces.

Regarding the mentoring interventions: nurses identify that mentoring is an important part of the process of *reworking professional identity*. The literature reported various models of mentoring. For example, seen from a functionalist framework, mentoring acts as a rational and hierarchical process; while from a humanist framework, mentoring acts to expose exploitive power relationships (Darwin, 2000). Most often, nurses experience mentoring within a functionalist framework, but I believe that this framework is too limiting. Darwin asserted that "if mentoring is viewed less as a role and more as the character of the relationship, it has the capacity to transform workplace relationships" (p.112). Ideally, rather than arbitrarily matching nurses in the stage of *assuming adequacy* (who need mentors) and nurses in the process of *helping to advance nursing* (who are willing and interested in being mentors), nurse managers would be better advised to foster workplace atmospheres in which all nurses can develop meaningful working and learning relationships (English, 2001).

While current financial and organizational challenges of many nursing workplaces prevent such possibilities, there are some opportunities. I suggest that workplace policies could formalize mentoring strategies, clarify expectations of mentors and mentees, and articulate the value of mentoring. Policies could specify the expected duration and nature of supportive mentoring strategies and relationships, alter workload assignments to allow

time to mentor, add mentoring to job descriptions and performance appraisal systems, and recognize mentoring in incentive and reward systems such as awards, time off, or different staffing patterns. Some of these suggestions would have to be negotiated within union contracts. Formal professional development programs designed to improve mentoring skills and strategies would ensure that experienced mentors reap their own benefits such as increased recognition, confidence, self-esteem, and job satisfaction. Legitimizing mentoring activities through promoting working relationships should increase personal and professional connections. Buddying new nurses with more experienced nurses as mentors would facilitate learning the culture and norms of the unit and facilitate faster adjustment.

"Knowledge needs to be viewed as an active process in which curiosity is encouraged and learning becomes a dynamic, reciprocal, and participatory process" (Darwin, 2000, p. 101). Effective mentoring relationships can promote such qualities of learning. Baxter Magolda's (1992) definition of learning as a relational activity is appropriate here. She asserted that the relational aspects of knowing are key to developing the complex forms of knowing such as that demanded by professional workplace behaviour. I believe that her work on relational learning reinforces the importance of mentoring relationships to facilitate nurses' movement through the three stages of the process of *reworking professional identity*. If nurses and managers can identify the reasons for fluctuating levels of support (perhaps limited time, work pressures, limited vision), they can work toward promoting opportunities for relational learning from other professionals and peers; all employees can be seen as life-long learners.

Regarding job mobility interventions: in the process of *attempting balance*, one way in which nurses develop the protective response pattern of *moving on* is to change jobs. Nurse administrators who understand this need for *moving on* could be more proactive in facilitating the movement of nurses from job to job; for example, in negotiating replacement of the traditional criterion of seniority for filling jobs with the more learning-relevant criterion of a felt need for self-development. Nurse administrators also could legitimize *moving on* as a key part of the process of *reworking professional identity* rather than demeaning it as a weakness. Job mobility also produces workplace benefits such as increased staff enthusiasm, versatility, and broadened expertise. In this study, the nurses who are more interested in their work become more willing to learn, are more satisfied with their jobs, and provide improved care.

Facilitating job mobility also requires addressing policy issues: for example, collaboration between employers and nurses' unions to ensure that pension credits are maintained or transferred, that changing workplaces does not impose waiting periods for benefits programs, and that available jobs are publicly posted. Because other patterns for *moving on* include beginning formal studying, it would be useful for workplace administrators to enhance the pursuit of learning opportunities by reimbursing course tuition, providing time off to attend classes, enable changing shifts, and providing moral support for nurses studying. Such strategies are considered beyond the capacities of most workplaces.

Regarding acknowledging nurses growth potential: if the subprocess of *pursuing learning and growth* is seen through an adult learning lens, workplace administrators and

nurse colleagues have to consider additional general thoughts about adult learners. Earlier I discussed several principles of adult learning so there is no need to repeat them here. What is pertinent now, in thinking about proactive interventions, is for nurse administrators and practising nurses to intervene carefully and deliberately to promote the conditions for transformative learning during the whole process of *reworking professional identity.*

Merriam and Caffarella (1991) asserted that "learning in adulthood [according to Mezirow and Freire] is a transformative rather than an additive process. It requires ability to reflect critically upon one's thoughts and assumptions" (p. 313). During the stage of *realizing practice*, nurses experience this kind of transformative adult learning. When nurses use critical reflection to increase their awareness of practice and assumptions about practice, and compare expectations to experiences, and examine underlying assumptions of those expectations, they create potential for transformative learning. During the stages of *assuming adequacy*, stifled or limited critical reflection reduces transformative potential. Nurse administrators and practising nurse can collaborate to create conditions that promote critical reflection.

The process of *reworking professional identity* has the potential to be transformative when nurses' examination of underlying assumptions leads to changing meaning perspectives, such as occurs in the stage of *realizing practice*. Nurses may decide to accept external perspectives after critical reflection on assumptions that underlie discrepancies or after deciding to forge a compromise position between perspectives. The workplace influences the potential for significant learning to occur when nurses become

aware of discrepancies through critical reflection. I use Mezirow's (1991) criteria to assert that the process of *reworking professional identity* is a transformative experience. The experience of dissonance that occurs upon noticing discrepancies is closely related to Mezirow's experience of a "disorienting dilemma" (1991), providing the opportunity to examine underlying assumptions, schema, and meaning perspectives that can change practice and personal perspectives on that practice. Dissonance provides opportunities to examine one's position and to consider alternate perspectives. Examining, identifying, and choosing perspectives to adopt may involve questioning observations, underlying assumptions, and systemic factors that may lead to a new practice perspective and changed professional identity. Nurses may choose the more external perspective by coming to accept the understanding that practice needs improving. On the whole, transformation occurs over the course of the process of *reworking professional identity* in areas of understanding professional identity, personal assessment of practice, and ability to reflect critically.

Nurse administrators and practising nurses can create workplace relationships and atmospheres to promote transformative learning by encouraging nurses themselves and their colleagues to examine their assumptions and be open to change their meaning perspectives. The process of *reworking professional identity* is grounded in accepting that change is possible and is likely over time. Nurses begin the process in the stage of *assuming adequacy* without reflecting on their assumptions about nursing practice and professional identity. Some initial assumptions influencing their practice were promoted by their early socialization; others arose through their professional socialization in

nursing education programs that taught that nursing is a profession and that nurses are respected and respectable professionals by virtue of their education. Early socialization may have promoted acceptance of the assumption that personal care work is not valued. Many workplace assumptions are congruent with this prevailing societal assumption of low value on personal care work done by nurses and relatively higher value on the curing work done by other health professionals. "The greater status accorded these professions [medicine, psychology, and business administration] within the health care hierarchy has provided the basis for their influence on nursing practice" (Dahlberg, 1994, p. 395). However, the professional socialization of nurses within education programs has promoted higher value on providing comfort and healing through giving such care skilfully and expertly. *Becoming aware* of these discrepant assumptions creates additional opportunities for transformative learning. Indeed, most nurses in this study critically reflect upon those assumptions and move beyond the societally-defined values related to caring.

When workplaces are conducive to promoting awareness of discrepancies in practice between what nurses were taught to do and what they find they can do (for whatever reasons, either current ability or workplace constraints), they increase awareness of opportunities for change. Nurses need the essential skill of critical reflection to facilitate examining assumptions underlying practice and determine approaches for resolution. Sometimes this process is conscious; at other times, it appears spontaneous, through insight or sudden realization. In any case, when nurses critically examine what underlies their current practice and beliefs and what options exist for seeing or doing

things differently, they may transform their perspectives. Transformative learning does not occur for all nurses at all stages of the reworking process: sometimes nurses cannot take opportunities to examine assumptions; they cannot engage in critical reflection, or when they do, they do not see possible or acceptable options for change, and change does not occur. When nurses are stagnating, for example, they are unable to seize opportunities for transformative learning (for a variety of reasons) and become stuck in routines of practice that do not include critical reflection. These same nurses may, however, at a different stage of the process, engage in critical reflection that could lead to transformative learning. Over the course of the *reworking professional identity* process, nurses' professional identities change significantly from the accepted characteristics they learned in nursing education to their own personally-crafted professional identity that varies with contextual influences.

Regarding the promoting intervention: key here is recognizing that nurses in different stages of the reworking process are differently positioned to promote the growth of the profession. Nurses in the process of *helping to advance nursing* are particularly well-prepared to influence positively the impressions of nursing. Experienced nurses could create opportunities to promote realistic images and accurate information about what professional nurses actually do without creating negative results. Nurses in the process of *helping to advance nursing* are better able to speak with tactful frankness and reflective wisdom, and handle public audience questions than are nurses in the stage of *assuming adequacy*. Workshop designers need therefore to choose workshop leaders or speakers with particular care.

Nurses are capable of filling broader roles within health care delivery but the public is not fully aware of this potential. Nurses in the process of *helping to advance nursing* can promote awareness of their professional abilities through increased involvement in political, community, and professional activities. In general, nurses must be vigilant in promoting a positive image and respect for nursing to other professions, the public, physicians, and other nurses particularly at this time of health care reform. Tisdell (1998) recommended that feminist adult educators explore connections between who they are and the influencing systems that privilege and oppress. Such examination and understanding would be appropriate for nurses when they engage in promoting the profession to others.

Understanding the subprocess of *engaging and disengaging* explains nurses' apparent sporadic involvement with professional activities and such understanding of the complex factors that influence participation could prevent judging nurses inappropriately. Professional associations can use the knowledge of *engaging and disengaging* to adjust their expectations for nurses' participation. They can also help to adopt and promote the process of *reworking professional identity* and encourage nurses to question traditional criteria for recognizing professions and professionals.

Implications for Further Research

I now see many researchable questions about this three-stage process of *reworking professional identity*. Is this process congruent with experiences of nurses graduating from basic baccalaureate education in nursing where stages one and three of professional socialization are combined? Does this process fit for other practice professions who are

educated in universities and enter practice with little actual experience? Does the process apply for nurses in other than this particular eastern Canadian and western world culture? What factors and issues will help this study claim the attention of both nurse educators and practising nurses? What strategies must be implemented to critique and refine our understanding of this process across the whole profession and nursing education programs? How could nurse educators, who should be very interested in whether current professional socialization of nurses leads to discrepant expectations about practice and professional identity, be helped to critique and connect with these findings? What nursing education strategies can be devised to better prepare nurses for the shock of reality, for earning respect, and for seeking acceptance within new working groups? How can the first months of employment better facilitate getting established, perfecting skills, and applying learned knowledge? What strategies can be developed for teaching essential skills for fluent practice in chaotically busy workplaces and how can the success of these approaches be evaluated? To answer such questions will require various research projects to refine conceptual frameworks, especially ones that better link adult learning and nursing practice. Indeed, future research could focus on any of the stages, processes, subprocesses, or contextual influences listed above.

In conclusion, the process of *reworking professional identity* has significant implications for nurses, nursing education and practice settings, and for adult education, and raises many questions for future research. Not to conduct such essential research would, in my opinion, further constrain the growth of the nursing profession.

References

Adams, A., & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing, 32*(3), 536-543.

Allen, D. G. (1990). Critical social theory. In National League for Nursing, *Curriculum revolution: Redefining the student-teacher relationship* (pp. 68-83). New York: National League for Nursing.

Appleton, J. V., & King, L. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advances in Nursing Science, 20*(2), 13-22.

Aronson, E. (1992). *The social animal* (6th ed.). New York: W. H. Freeman.

Artinian, B. M. (1998). Grounded theory research: Its value for nursing. *Nursing Science Quarterly, 11*(1), 5-6.

Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (pp. 248-261). Thousand Oaks, CA: Sage.

Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: The grounded theory/ phenomenology example. *Journal of Advanced Nursing, 17*, 1355-1360.

Bannerji, H. (1992). But who speaks for us? Experience and agency in conventional feminist paradigms. In H. Bannerji, L. Carty, K. Dehli, S. Heald, & K. McKenna. *Unsettling relations: The university as a site of feminist struggles* (pp. 67-107). Boston: South End Press.

Barnett, R. (1999). Learning to work and working to learn. In D. Boud & J. Garrick (Eds.), *Understanding learning at work* (pp. 29-43). New York: Routledge.

Baskett, H. K. M., & Marsick, V. J. (1992). Confronting new understandings about professional learning and change (pp. 7-15). *New Directions for Adult and Continuing Education, no. 55*. San Francisco: Jossey-Bass.

Baskett, H. K. M., Marsick, V. J., & Cervero, R. M. (1992). Putting theory to practice and practice to theory (pp. 109-118). *New Directions for Adult and Continuing Education, no. 55*. San Francisco: Jossey-Bass.

Baumgart, A. J., & Larsen J. (1988). *Canadian nursing faces the future.* St. Louis, MO: C. V. Mosby.

Baxter Magolda, M. B. (1992). *Knowing and reasoning in college. Gender-related patterns in students' intellectual development.* San Francisco: Jossey-Bass.

Beagan, B. L. (2001). "Even if I don't know what I'm doing I can make it look like I know what I'm doing": Becoming a doctor in the 1990s. *Canadian Review of Sociology and Anthropology, 38*(3), 275-292.

Beck, C. T. (1999). Grounded theory research. In J. A. Fain (Ed.), *Reading, understanding, and applying nursing research* (pp. 205-225). Philadelphia: F. A. Davis.

Beckett, D., & Morris, G. (2000, June). *Ontology at work: Constructing the learner/worker.* Paper presented at Adult Education Research Conference 2000. Retrieved November 9, 2001 from http://www.edst.educ.ubc.ca/aerc/2000/ab2000.htm#sectB

Beeman, P. B. (1990). Brief: RN students in baccalaureate programs - faculty's role and responsibility. *The Journal of Continuing Education in Nursing, 21*(1), 42-45.

Beijaard, D., Verloop, N., & Vermunt, J. D. (2000). Teachers' perceptions of professional identity: An exploratory study from a personal knowledge perspective. *Teaching and Teacher Education, 16*, 749-764.

Belenky, M. F., Clinchy, B. M.., Goldberger, N. R., & Tarule, J. M. (1986). *Women's ways of knowing: The development of self, voice, and mind.* New York: Basic Books.

Belenky, M. F., & Stanton, A. V. (2000). Inequality, development, and connected knowing. In J. Mezirow and Associates, *Learning as transformation: Critical perspectives on a theory in progress* (pp. 71-102). San Francisco: Jossey-Bass.

Benner, P. (1984). *From novice to expert.* Menlo Park, CA: Addison-Wesley.

Benner, P. (1995). A response by P. Benner to K. Cash, "Benner and expertise in nursing: A critique." *International Journal of Nursing Studies, 33*(6), 669-674.

Bennett, J., & Kingham, M. (1993). Learning diaries. In J. Reed & S. Procter (Eds.), *Nurse education: A reflective approach* (pp. 144-156). London: Edward Arnold.

Benson, P. (1991). Autonomy and oppressive socialization. *Social Theory and Practice, 17*(3), 385-404.

Berragan, L. (1998). Nursing practice draws upon several different ways of knowing. *Journal of Clinical Nursing, 7*(3), 209-217.

Bigus, O. E., Hadden, S. C., & Glaser, B. G. (1994). The study of basic social processes. In B. G. Glaser (Ed.), *More grounded theory methodology: A reader* (pp. 38-64). Mill Valley, CA: Sociology Press.

Birx, E. C. (1993). Critical thinking and theory-based practice. *Holistic Nursing Practice, 7*(3), 21-27.

Björnsdottir, K. (1998). Language, ideology, and nursing practice. *Scholarly Inquiry for Nursing Practice, 12*(4), 347-361.

Blumenthal, D. R. (1998). Theodicity: Dissonance in theory and praxis. In H. Häring & D. Tracy (Eds.), *The fascination of evil* (pp. 95-106). London: SCM Press.

Boud, D., & Walker, D. (1991). *Experience and learning: Reflection at work.* East Lansing, MI: National Center for Research on Teacher Learning. (ERIC Document Reproduction Service No. ED384696)

Boud, D., & Walker, D. (1998). Promoting reflection in professional courses: The challenge of context. *Studies in Higher Education, 23*(2), 191-207.

Britten, N. (1995). Qualitative interviews in medical research. *British Medical Journal, 311*(6999), 251-254.

Brookfield, S. (1998a, June). *Contesting criticality: Epistemological and practical contradictions in critical reflection.* Paper presented at Adult Education Research Conference 2000. Retrieved November 9, 2001 from http://www.edst.educ.ubc.ca/aerc/2000/ab2000.htm#sectB

Brookfield, S. (1998b, April). *The critical reflection dimension.* Paper presented at The First National Conference on Transformative Learning, Teachers College, Columbia University.

Brookfield, S. D. (2000a). The concept of critically reflective practice. In A. L. Wilson & E. R. Hayes (Eds.), *Handbook of adult and continuing education* (pp. 33-49). San Francisco: Jossey-Bass.

Brookfield, S. (2000b). Transformative learning as ideology critique. In J. Mezirow and Associates, *Learning as transformation: Critical perspectives on a theory in progress* (pp. 125-148). San Francisco: Jossey-Bass.

Brooks, K. L., & Shepherd, J. M. (1992). Professionalism versus general critical thinking abilities of senior nursing students in four types of nursing curricula. *Journal of Professional Nursing, 8*(2), 87-95.

Brott, P. E., & Myers, J. E. (1999). Development of professional school counsellor identity: A grounded theory. *Professional School Counseling, 2*(5), 339-349.

Buchanan, J., & MacIntosh, J. (1997). Trust: A process and an outcome in an audio-teleconferencing learning environment. *Canadian Journal of University Continuing Education, 23*(1), 49-60.

Buckenham, M. A. (1998). Socialization and personal change: A personal construct psychology approach. *Journal of Advanced Nursing, 28*(4), 874-881.

Burge, L., & Haughey, M. (1993). Transformative learning in reflective practice. In T. Evans & D. Nation (Eds.), *Reforming Open and Distance Education: Critical reflections from practice* (pp. 88-112). London: Kogan Page.

Caffarella, R. S., & Barnett, B. G. (1994). Characteristics of adult learners and foundations of experiential learning (pp. 29-42). *New Directions for Adult and Continuing Education, no. 62*. San Francisco: Jossey-Bass.

Caffo, B. J. (1992). *Factors influencing role conception and perceived autonomy among RN students in a baccalaureate nursing program.* Widener University School of Nursing. Retrieved November 1998 from UMI ProQuest Digital Dissertations. http://www.lib.umi.com/dissertations/fullcit?385179

Callin, M. (1996). From RN to BSN: Seeing familiar situations in different ways. *The Journal of Continuing Education in Nursing, 27*(1), 28-33.

Callister, R. R., & Kramer, M. W. (1999). Feedback seeking following career transitions. *Academy of Management Journal, 42*(4), 429-439.

Campbell, J. C., & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science, 13*(3), 1-15.

Canadian Nurses Association. (1997). *Code of ethics for Registered Nurses.* Ottawa, ON, Canada: Author.

Candy, P. C. (1991). *Self-direction for lifelong learning: A comprehensive guide to theory and practice*. San Francisco: Jossey-Bass.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23.

Cash, K. (1995). Benner and expertise in nursing: A critique. *International Journal of Nursing Studies, 32*(6), 527-534.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.

Chenitz, W. C. (1986). Getting started: The research proposal for a grounded theory study. In W. C. Chenitz & J. M. Swanson (Eds.), *From practice to grounded theory: Qualitative research in nursing* (pp. 39-47). Menlo Park, CA: Addison-Wesley.

Chiantera, P. (1996). A space of one's own: The self and the construction of the other - she. *International Review of Sociology, 6*(3), 443-452.

Chitty, K. K. (2001). *Professional nursing: Concepts and challenges* (3rd ed.). Philadelphia: W. B. Saunders.

Chornick, N. L. (1992). A comparison of RN-to-BSN completion graduates to generic BSN graduates: Is there a difference? *Journal of Nursing Education, 31*(5), 203-209.

Clandinin, D. J., & Connelly, F. M. (1995). *Teachers' professional knowledge landscapes*. New York: Teachers College Press.

Clandinin, D. J., & Connelly, F. M. (1996). Teachers' professional knowledge landscapes: Teacher stories - stories of teachers- school stories- stories of schools. *Educational Researcher, 25*(3), 24-30.

Clare, J. (1993). A challenge to the rhetoric of emancipation: Recreating professional culture. *Journal of Advanced Nursing, 18*, 1033-1038.

Clark, M. C., & Dirkx, J. M. (2000). Moving beyond a unitary self: a reflective dialogue. In A. L. Wilson & E. R. Hayes (Eds.), *Handbook of adult and continuing education. New edition* (pp. 101-116). San Francisco: Jossey-Bass.

Clement, M., & Vandenberghe, R. (2000). Teachers' professional development: A solitary or collegial (ad)venture? *Teaching and Teacher Education, 16*, 81-101.

Clinchy, B. (1989). On critical thinking & connected knowing. *Liberal Education, 75*(5), 14-19.

Cofer, D. A. (2000). *Informal learning in the workplace: A brief review of practice and application.* (Report No. CE 080 194). East Lansing, MI: National Center for Research on Teacher Learning. (ERIC Document Reproduction Service No. ED441160)

Cohen, H. A. (1981). *The nurse's quest for a professional identity.* Menlo Park, CA: Addison-Wesley.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48-71). New York: Oxford University Press.

Collins, M. (1996). Current trends in adult education. From self-directed learning to critical theory. In G. D. Benson & B. E. Griffith (Eds.), *Process, epistemology and education* (pp. 69-86). Toronto, ON, Canada: Canadian Scholars' Press.

Connelly, F. M., & Clandinin, D. J. (1988). *Teachers as curriculum planners: Narratives of experience.* Toronto, ON, Canada: The Ontario Institute for Studies in Education.

Cowin, L. (2001). Measuring nurses' self-concept. *Western Journal of Nursing Research, 23*(3), 313-325.

Cragg, C. E. (1991). Professional resocialization of Post-RN baccalaureate students by distance education. *Journal of Nursing Education, 30*(6), 256-260.

Cranton, P. (1994). *Understanding and promoting transformative learning.* San Francisco: Jossey-Bass.

Cranton, P. (1997). Higher education: A global community (pp. 5-9). *New Directions for Teaching and Learning, no. 72.* San Francisco: Jossey-Bass.

Cranton, P. (1998a, April). *Fostering transformative learning.* Paper presented at The First National Conference on Transformative Learning: Changing Adult Frames of Reference. New York: Teachers College, Columbia University,

Cranton, P. (1998b). *No one way.* Toronto, ON, Canada: Wall & Emerson.

Cranton, P. (2000). Individual differences and transformative learning. In J. Mezirow and Associates, *Learning as transformation: Critical perspectives on a theory in progress* (pp. 181-204). San Francisco: Jossey-Bass.

Crawford, V. M. (1999, April). *Semiotic processes in women's coordination of work and family.* Paper presented at the Biennial Conference of the Society for Research in Child Development, Albuquerque, NM. (ERIC Document Reproduction Service No. ED429730)

Creasia, J. L., & Parker, B. (2001). *Conceptual foundations: The bridge to professional nursing practice* (3rd ed.). St. Louis, MO: Mosby.

Dahlberg, K. (1994). The collision between caring theory and caring practice as a collision between feminine and masculine cognitive style. *Journal of Holistic Nursing, 12*(4), 391-401.

Daley, B. L. (2000). Learning in professional practice (pp. 33-42). *New Directions for Adult and Continuing Education, no. 86.* San Francisco: Jossey-Bass.

Dannels, D. P. (2000). Learning to be professional. Technical classroom discourse, practice, and professional identity construction. *Journal of Business and Technical Communication, 14*(1), 5-37.

Darwin, A. (2000). Critical reflections on mentoring in work settings. *Adult Education Quarterly, 50*(3), 197-211.

Davies, E. (1995). Reflective practice: A focus for caring. *Journal of Nursing Education, 34*(4), 167-174.

Deems, T. A. (1998). Vital work: Adult development within the natural workplace. In J. C. Kimmel (Comp.), *Annual Adult Education Research Conference Proceedings* (pp. 127-132). San Antonio: Texas A & M University.

Dehli, K. (1992). Leaving the comfort of the home: Working through feminisms. In H. Bannerji, L. Carty, K. Dehli, S. Heald, & K. McKenna. *Unsettling relations: The university as a site of feminist struggles* (pp. 145-165). Boston: South End Press.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2000). A model of burnout and life satisfaction amongst nurses. *Journal of Advanced Nursing, 32*(2), 454-464.

Denzin, N. K., & Lincoln, Y. S. (1994). Major paradigms and perspectives. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 99-104). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (1995). New ethnographies. *Journal of Contemporary Ethnography, 24*(3), 349-359.

Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 1-28). Thousand Oaks, CA: Sage.

Dick, M., & Anderson, S. E. (1993). Job burnout in RN-to-BSN students: Relationships to life stress, time commitments, and support for returning to school. *The Journal of Continuing Education in Nursing, 24*(3), 105-109.

Dirkx, J. M. (1997). Nurturing soul in adult learning (pp. 79-88). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Doheny, M., Cook, C., & Stopper, C. (1992). *The discipline of nursing: An introduction* (3rd ed.). Norwalk, CT: Appleton & Lange.

Donald, J. G. (1995). Disciplinary differences in knowledge validation (pp. 7-17). *New Directions for Teaching and Learning, no. 64*. San Francisco: Jossey-Bass.

Duff, V. (1989). Perspective transformation: The challenge for the RN in the baccalaureate program. *Journal of Nursing Education, 28*(1), 38-39.

Duff, V. M. (1997). Returning to school to a baccalaureate program: Is there an easy way to learn? *Journal of Nursing Education, 36*(8), 390-392.

Duncan, K. (1997). Student pre-entry experience and first year employment. *Journal of Continuing Education in Nursing, 28*(5), 223-230.

du Toit, D. (1995). A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing, 21*, 164-171.

Eisenhauer, L. A. (1998). The reconstruction of professional knowledge. *Journal of Nursing Education, 37*(2), 51-52.

Eisner, E. W. (1997). The new frontier in qualitative research methodology. *Qualitative Inquiry, 3*(3), 259-274.

Ellis, J. R., & Hartley, C. L. (2001). *Nursing in today's world: Challenges, issues, and trends* (7th ed.). New York: J. B. Lippincott.

Ely, M. (with Anzul, M., Friedman, T., Garner, D., & Steinmetz, A. M.). (1991). *Doing qualitative research: Circles within circles*. London: The Falmer Press.

Ely, M., Vinz, R., Downing, M., & Anzul, M. (1997). *On writing qualitative research*. London: The Falmer Press.

English, L. M. (2001). Mentorship. In T. B. Stein & M. Kompf (Eds.), *The craft of teaching adults* (3rd ed, pp. 261-272). Toronto, ON, Canada: Culture Concepts.

Erickson, J. I., & Ditomassi, M. (1998). The professional practice model: A tool for articulating nursing practice. *Creative Nursing*, (4), 12-15.

Ettling, D., & Hayes, N. (1997a). *Learning to learn: Creating models of transformative education with economically disadvantaged women*. 27th Annual Standing Conference on University Teaching and Research in the Education of Adults (SCUTREA) Proceedings 1997. Retrieved August 15, 1997 from: http://www.leeds.ac.uk/educol/documents/000000226.htm

Ettling, D., & Hayes, N. (1997b). Learning to learn. Women creating learning communities. *ReVision, 20(1),* 28-31.

Fagerhaugh, S. Y. (1995). Analyzing data for basic social processes. In B. G. Glaser (Ed.), *Grounded theory 1984-1994* (pp. 173-187). Mill Valley, CA: Sociology Press.

Fawcett, J. (1984). The metaparadigm of nursing: Present status and future refinements. *Image: The Journal of Nursing Scholarship, 16*(3), 84-89.

Fenwick, T. J. (2000). Putting meaning into workplace learning. In A. L. Wilson & E. R. Hayes (Eds.), *Handbook of adult and continuing education* (pp. 294-311). San Francisco: Jossey-Bass.

Ferry, N. M., & Ross-Gordon, J. M. (1998). An inquiry into Schön's epistemology of practice: Exploring links between experience and reflective practice. *Adult Education Quarterly, 48*(2), 98-112.

Fessler, R., & Christensen, J. C. (Lead authors and Eds). (1992). *The teacher career cycle: Understanding and guiding the professional development of teachers*. Boston: Allyn and Bacon.

Flexner, A. (1915). Is social work a profession? *School and Society, 1*(26), 901-911.

Flexner, A. (1930). *Universities. American English German*. London: Oxford University Press.

Frahm, L., & Hyland, S. (1995). Professional self–concept among registered nurses in Minnesota. *Minnesota Nurse Accent, 67*(5), 4.

Freidson, E. (1999). Theory of professionalism: Method and substance. *International Review of Sociology, 9*(1), 117-129.

Galbraith, M. W. (Ed.). (1991). *Facilitating adult learning*. Malabar, FL: Krieger.

Garrick, J. (1999). The dominant discourses of learning at work. In D. Boud & J. Garrick (Eds.), *Understanding learning at work* (pp. 216-231). New York: Routledge.

Garrison, D. R. (1997). Self-directed learning: Toward a comprehensive model. *Adult Education Quarterly, 48*(1), 18-33.

Gerrish, K. (2000). Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing, 32*(2), 473-380.

Ghaye, T. (2000). Making a difference through reflective practices: Values and actions. *Reflective Practice, 1*(2), 141-148.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Gillis, A., & Jackson, W. (2002). *Research for nurses: Methods and interpretation.* Philadelphia: F. A. Davis.

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G. (Ed). (1994). *More grounded theory methodology: A reader*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (Ed.). (1995). *Grounded theory 1984-1994.* Mill Valley, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing.

Grabove, V. (1997). The many facets of transformative learning theory and practice (pp. 89-95). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Greed, C. (1990). The professional and the personal: A study of women quantity surveyors. In L. Stanley (Ed.), *Feminist praxis: Research, theory and epistemology in feminist sociology* (pp. 145-155). London: Routledge.

Greenawalt, W. W. (1996). *Professional socialization of baccalaureate nursing students: A study of the meaning of selected concepts related to nursing professionalism.* UMI ProQuest Digital Dissertations. Retrieved November 1998 from http://wwwlib.umi.com/dissertations/fullcit?96466

Greenwood, J. (1998). The role of reflection and double loop learning. *Journal of Advanced Nursing, 27*(5), 1048-1053.

Group for Collaborative Inquiry. (1997). *Rewriting the boundaries of practice: Storying the work of a transformative pedagogy*. 27th Annual Standing Conference on University Teaching and Research in the Education of Adults (SCUTREA) Conference Proceedings 1997. Retrieved August 15, 1997 from http://www.leeds.ac.uk/educol/documents/000000236.htm

Grunfeld, E., Whelan, T. J., Zitzelsberger, L., Willan, A. R., Montesanto, B., & Evans, W. K. (2000). Cancer care workers in Ontario: Prevalence of burnout, job stress, and job satisfaction. *Canadian Medical Association Journal, 163*(2), 166-170.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (pp. 105-117). Thousand Oaks, CA: Sage.

Guba, E. G., & Lincoln, Y. S. (1998). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research. Theories and issues* (pp. 195-220). Thousand Oaks: Sage.

Hager, P. (1999). Finding a good theory of workplace learning. In D. Boud & J. Garrick (Eds.), *Understanding learning at work* (pp. 65-81). New York: Routledge.

Hammersley, M. (1990). *Reading ethnographic research: A critical guide.* London: Longman.

Harding, S. (1991). *Whose science? Whose knowledge? Thinking from women's lives.* Ithaca, NY: Cornell University Press.

Heath, H. (1998). Reflection and patterns of knowing in nursing. *Journal of Advanced Nursing, 27*, 1054-1059.

Hickman, J. S. (1995). An introduction to nursing theory. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 1-14). Norwalk, CT: Appleton & Lange.

Hogsett, C. (1993). Women's ways of knowing Bloom's taxonomy. *Feminist Teacher, 7*(3), 27-32.

Holstein, J. A., & Gubrium, J. F. (1998). Phenomenology, ethnomethodology, and interpretive practice. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 137-157). Thousand Oaks, CA: Sage.

Hughes, K. P. (1995). Feminist pedagogy and feminist epistemology: An overview. *International Journal of Lifelong Education, 14*(3), 214-230.

Imel, S., Brockett, R. G., & James, W. B. (2000). Defining the profession: A critical appraisal. In A. L. Wilson & E. R. Hayes (Eds.), *Handbook of adult and continuing education* (pp. 629-642). San Francisco: Jossey-Bass.

Jacobs-Kramer, M. K., & Chinn, P. L. (1988). Perspectives on knowing: A model of nursing knowledge. *Scholarly Inquiry for Nursing Practice: An International Journal, 2*(2), 129-139.

Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing, 22*(2), 226-234.

Johnson-Bailey, J., & Cervero, R. M. (1997). *Beyond facilitation in adult education: Power dynamics in teaching and learning practices*. 27th Annual Standing Conference on University Teaching and Research in the Education of Adults (SCUTREA) Proceedings 1997. Retrieved August, 15, 1997 from http://www.leeds.ac.uk/educol/documents/000000248.htm

Jones, S. A., & Brown, L. N. (1991). Critical thinking: Impact on nursing education. *Journal of Advanced Nursing, 16*, 529-533.

Kelly, B. (1992). The professional self-concepts of nursing undergraduates and their perceptions of influential forces. *Journal of Nursing Education, 31*(3), 121-125.

Kelly. B. (1996). Hospital nursing: 'It's a battle!' A follow-up study of English graduate nurses. *Journal of Advanced Nursing, 24*, 1063-1069.

Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing, 28*(5), 1134-1145.

Kelly, N. R., & Mathews, M. (2001). The transition to first position as nurse practitioner. *Journal of Nursing Education, 40*(4), 156-162.

Kemmis, S., & McTaggart, R. (2000). Participatory action research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 567-606). Thousand Oaks, CA: Sage.

Kincheloe, J. L. (1991). *Teachers as researchers: Qualitative inquiry as a path to empowerment.* London: Falmer Press.

Kincheloe, J. L., & McLaren, P. L. (1998). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 260–299). Thousand Oaks, CA: Sage.

King, K. P. (1996). *Identifying factors that promote perspective transformation in higher education: A model.* East Lansing, MI: National Center for Research on teacher Learning. (ERIC Document Reproduction Service No. ED407596).

King, P. M., & Kitchener, K. S. (1994). *Developing reflective judgement. Understanding and promoting intellectual growth and critical thinking in adolescents and adults.* San Francisco: Jossey-Bass.

Kintgen-Andrews, J. (1991). Critical thinking and nursing education: Perplexities and insights. *Journal of Nursing Education, 30*(4), 152-157.

Knox, A. B. (1992). Comparative perspectives on professionals' ways of learning (pp. 97-108). *New Directions for Adult and Continuing Education, no. 55.* San Francisco: Jossey-Bass.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development.* Englewood Cliffs, NJ: Prentice-Hall.

Kools, S., McCarthy, M., Durham, R., & Robrecht, L. (1996). Dimensional analysis: Broadening the conception of grounded theory. *Qualitative Health Research, 6*(3), 312-331.

Kozier, B., Erb, G., & Blais, K. (1997). *Professional nursing practice: Concepts and perspectives* (3rd ed.). Menlo Park, CA: Addison-Wesley.

Kral, R., & Hines, M. (1999). A survey on developmental stages in achieving a competent sense of self as a family therapist. *The Family Journal: Counseling and Therapy for Couples and Families, 7*(2), 102-111.

Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage.

Kvale, S. (1995). The social construction of reality. *Qualitative Inquiry, 1*(1), 19-41.

Land, S. M., & Hannafin, M. J. (2000). Student-centered learning environments. In D. H. Jonassen & S. M. Land (Eds.), *Theoretical foundations of learning environments* (pp. 1-23). London: Lawrence Erlbaum Associates.

Lange, E. (2000, June). *Beyond transformative learning: Work, ethical space and adult education.* Paper presented at Adult Education Research Conference 2000. Retrieved November 9, 2001 from http://www.edst.educ.ubc.ca/aerc/2000/ab2000.htm#sectB

Laschinger, H. S., Shamian, J., & Thomson, D. (2001). Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care, and work satisfaction. *Nursing Economic$, 19*(5), 209-219.

Lawler, T. G., & Rose, M. A. (1987). Professionalization: A comparison among generic baccalaureate, ADN, and RN/BSN nurses. *Nurse Educator, 12*(3), 19-23.

Liaschenko, J. (1998). Response to "Language, ideology, and nursing practice." *Scholarly Inquiry for Nursing Practice, 12*(4), 363-366.

Liaschenko, J., & Fisher, A. (1999). Theorizing the knowledge that nurses use in the conduct of their work. *Scholarly Inquiry for Nursing Practice, 13*(1), 29-41.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lindberg, J. B., Hunter, M. L., & Kruszewski, A. Z. (1998). *Introduction to nursing* (3rd ed.). Philadelphia: J. B. Lippincott.

Loughlin, K. A., & Mott, V. W. (1992). Models of women's learning: Implications for continuing professional education (pp. 79-88). *New Directions for Adult and Continuing Education, no. 55*. San Francisco: Jossey-Bass.

Loustau, A. (1993). Evaluating the academic experience for returning Registered Nurses. In N. Diekelmann & M. Rather (Eds.), *Transforming RN education: Dialogue and debate* (pp. 198-210). New York: National League for Nursing.

Lynn, M. R., McCain, N. L., & Boss, B. J. (1989). Socialization of R. N. to B. S. N. *Image: Journal of Nursing Scholarship, 21*(4), 232-237.

Lyons, G. (1981). *Teacher careers and career perceptions*. Windsor, UK: Nelson Publishing.

MacDonald, M., & Schreiber, R. S. (2001). Constructing and deconstructing: Grounded theory in a postmodern world. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 35-54). New York: Springer Publishing.

MacIntosh, J. (1996, May). *Experiences of university students with learning through distance education technologies*. Paper presented at the Twelfth Annual Canadian Association for Distance Education Conference, Moncton, NB.

MacIntosh, J. (2001). Learner concerns and teaching strategies for video-conferencing. *Journal of Continuing Education in Nursing, 32*(6), 260-265.

MacIntosh, J., MacKay, E., Mallet-Boucher, M., & Wiggins, N. (1998, June). *Listening to voices of distance co-learners in the process of becoming nurses*. Paper presented at the Society for Teaching and Learning in Higher Education Conference, Sackville, NB.

MacIntosh, J., MacKay, E., Mallet-Boucher, M., & Wiggins, N. (in press). Discovering co-learning with students in distance education sites. *Nurse Educator*.

MacIntosh, J., & Wiggins, N. (1998). Venturing through the looking glass: An instance of transformative learning in adult education. *Canadian Journal of University Continuing Education, 24*(2), 11-19.

MacKeracher, D. (1996). *Making sense of adult learning*. Toronto, ON, Canada: Culture Concepts.

MacKeracher, D. (2001). Processes of adult learning. In T. B. Stein & M. Kompf (Eds.), *The craft of teaching adults* (3rd ed., pp. 199-224). Toronto, ON, Canada: Culture Concepts.

Maltby, H. J., & Andrusyszyn, M. A. (1997). Perspective transformation: Challenging the resocialization concept of degree-seeking registered nurses. *Nurse Educator, 22*(2), 9-11.

Marks-Maran, D. (1999). Reconstructing nursing: Evidence, artistry and the curriculum. *Nurse Education Today, 19*, 3-11.

Marsick, V. J., & Watkins, K. E. (1999). Envisioning new organisations for learning. In D. Boud & J. Garrick (Eds.), *Understanding learning at work* (pp. 199-215). New York: Routledge.

Marsick, V. J., & Watkins, K. E. (2001). Informal and incidental learning (pp. 35-24). In *New Directions for Adult and Continuing Education, no. 89*. San Francisco: Jossey-Bass.

Mathews, M. B., & Travis, L. (1994). Research on the baccalaureate completion process for RNs. In J. J. Fitzpatrick & J. S. Stevenson (Eds.), *Annual review of nursing research, 12* (pp. 147-172). New York: Springer Publishing.

McBride, A. B. (1999). Breakthrough in nursing education: Looking back, looking forward. *Nursing Outlook, 47*(3), 114-119.

McCormack, B. (2000). Workplace learning: A unifying concept? *Human Resource Development International, 3*(3), 397-404.

McNeese-Smith, D. K. (1999). A content analysis of staff nurse descriptions of job satisfaction and dissatisfaction. *Journal of Advanced Nursing, 29*(6), 1332-1341.

McNeese-Smith, D. K. (2000). Job stages of entry, mastery, and disengagement among nurses. *Journal of Nursing Administration, 30*(3), 140-147.

Merriam, S. B., & Caffarella, R. S. (1991). *Learning in adulthood*. San Francisco: Jossey-Bass.

Merriam, S. B., & Caffarella, R. S. (1999). *Learning in adulthood. A comprehensive guide* (2nd ed.). San Francisco: Jossey-Bass.

Mezirow, J. (1989). Transformation theory and social action: A response to Collard and Law. *Adult Education Quarterly, 39*(3), 169-175.

Mezirow, J. (1991). *Transformative dimensions of adult learning*. San Francisco: Jossey-Bass.

Mezirow, J. (1995a). Conclusion: Toward transformative learning and emancipatory education. In S. B. Merriam (Ed.), *Selected writings on philosophy and adult education* (pp. 123-136). Malabar, FL: Krieger.

Mezirow, J. (1995b). Transformation theory of adult learning. In M. R. Welton (Ed.), *In defense of the lifeworld* (pp. 39-70). New York: State University of New York Press.

Mezirow, J. (1996). Contemporary paradigms of learning. *Adult Education Quarterly, 46*(3), 158-172.

Mezirow, J. (1997a). Transformation learning: Theory to practice (pp. 5-12). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Mezirow, J. (1997b). Transformation theory out of context. *Adult Education Quarterly, 48*(1), 60-62.

Mezirow, J. (1998a). On critical reflection. *Adult Education Quarterly, 48*(3), 185-198.

Mezirow, J. (1998b, April). *Transformation theory of adult learning: Core propositions*. Paper presented at The First National Conference on Transformative Learning, Columbia University, New York.

Mezirow, J. (1998c). Transformative learning and social action: A response to Inglis. *Adult Education Quarterly, 49*(1), 70-73.

Mezirow, J. (2000). Learning to think like an adult: Core concepts of transformation theory. In J. Mezirow and Associates. *Learning as transformation: Critical perspectives on a theory in progress* (pp. 3-33). San Francisco: Jossey-Bass.

Miehls, D., & Moffatt, K. (2000). Constructing social work identity based on the reflexive self. *British Journal of Social Work, 30*, 339-348.

Miller, B. K., Adams, D., & Beck, L. (1993). A behavioral inventory for professionalism in nursing. *Journal of Professional Nursing, 9*(5), 290-295.

Milliken, P. J., & Schreiber, R. S. (2001). Can you "do" grounded theory without symbolic interactionism? In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 177-190). New York: Springer Publishing.

Morse, J. M. (Ed.). (1991). *Qualitative nursing research: A contemporary dialogue* (Rev. ed.). Newbury Park: Sage.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147-150.

Morse, J. M. (1998). Validity by committee. *Qualitative Health Research, 8*(4), 443-8.

Morse, J. M. (1999). Qualitative generalizability. *Qualitative Health Research, 9*(1), 5-7.

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Munhall, P. L. (1993). 'Unknowing': Toward another patten of knowing in nursing. *Nursing Outlook, 41*(3), 125-128.

Nurses Association of New Brunswick. (1984, Amended 1996). *Nurses Act.* Fredericton, NB, Canada: Author.

Oermann, M. H. (1991). *Professional nursing practice: A conceptual approach.* New York: J. B. Lippincott.

Olesen, V. (1994). Feminisms and models of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (pp. 158-174). Thousand Oaks, CA: Sage.

Olesen, V. (1998). Feminisms and models of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (2nd ed., pp. 300-332). Thousand Oaks, CA: Sage.

O'Neill, S. (1992). The drive for professionalism in nursing: A reflection of classism and racism. In J. L. Thompson, D. G. Allen, & L. Rodrigues-Fisher (Eds.), *Critique, resistance, and action* (pp. 137-148). New York: National League for Nursing.

Owen, C. A. (2001). The role of organisational context in mediating workplace learning and performance. *Computers in Human Behavior, 17*, 597-614.

Pennell, J., & Flaherty, M. (1993). Feminist social work education in mainstream and nonmainstream classrooms. *Affilia: Journal of Women & Social Work, 8*(3), 317-339.

Periard, M. E., Bell, E. A., Knecht, L., & Woodman, E. A. (1991). Measuring affective factors in RN/BSN programs. *Nurse Educator, 16*(6), 14-17.

Philpin, S. M. (1999). The impact of 'Project 2000' educational reforms on the occupational socialization of nurses: An exploratory study. *Journal of Advanced Nursing, 29*(6), 1326-1331.

Pilhammar Andersson, E. (1993). The perspective of student nurses and their perceptions of professional nursing during the nurse training programme. *Journal of Advanced Nursing, 18,* 808-815.

Poland, B. D. (1995). Transcription quality as an aspect of rigor in research. *Qualitative Inquiry, 1*(3), 290-311.

Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essentials of nursing research: Methods, appraisal, and utilization* (5th ed.). Philadelphia: Lippincott.

Post, P., Carusetta, E., Maher, E., & MacIntosh, J. (1998). Not the wand but the wizard. *Canadian Journal of University Continuing Education, 24*(2), 21-36.

Pratte, R., & Rury, J. L. (1991). Teachers, professionalism, and craft. *Teachers College Record, 93*(1), 59-63.

Purdy, M. (1997a). Humanist ideology and nurse education. 2. Limitations of humanist educational theory in nurse education. *Nurse Education Today, 17*(3), 196-202.

Purdy, M. (1997b). The problem of self-assessment in nurse education. *Nurse Education Today, 17*(3), 135-139.

Queen, P. S. (1984). Resocializing the degree-seeking RN: A curriculum thread. *Journal of Nursing Education, 23*(8), 351-353.

Rather, M. L. (1992). "Nursing as a way of thinking"- Heideggerian hermeneutical analysis of the lived experience of the returning RN. *Research in Nursing and Health, 15*, 47-55.

Rather, M. L. (1993). "Harbingers of entry to practice": The lived experience of returning RN students. In N. L. Diekelmann & M. L. Rather (Eds.), *Transforming RN education: Dialogue and debate* (pp. 97-120). New York: National League for Nursing Press.

Rather, M. L. (1994). Schooling for oppression: A critical hermeneutical analysis of the lived experience of the returning RN student. *Journal of Nursing Education, 33*(6), 263-271.

Reason, P. (1994). Three approaches to participative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 324-339). Thousand Oaks, CA: Sage.

Reed, J., & Procter, S. (1993a). Nursing knowledge: A critical examination. In J. Reed & S. Procter (Eds.), *Nurse education: A reflective approach* (pp. 14-29). London: Edward Arnold.

Reed, J., & Procter, S. (1993b). Teaching reflective practice: Possibilities and constraints. In J. Reed & S. Procter (Eds.), *Nurse education: A reflective approach* (pp. 30-44). London: Edward Arnold.

Rice, C. P. (1992). Strategies and faculty roles for teaching RN students. *Nurse Educator, 17*(1), 33-37.

Richards, P. (1998). Professional self-respect: Rights and responsibilities in the new NHS. *British Medical Journal, 317*(7166), 1146-1149.

Richardson, G., & Maltby, H. (1995). Reflection-on-practice: Enhancing student learning. *Journal of Advanced Nursing, 22*(2), 235-242.

Rolfe, G. (1997a). Beyond expertise: Theory, practice and the reflexive practitioner. *Journal of Clinical Nursing, 6*(2), 93-97.

Rolfe, G. (1997b). Science, abduction and the fuzzy nurse: An exploration of expertise. *Journal of Advanced Nursing, 25*(5), 1070-1075.

Rowden, R. W., & Ahmad, S. (2000). The relationship between workplace learning and job satisfaction in small to mid-sized businesses in Malaysia. *Human Resources Development International, 3*(3), 307-322.

Rutty, J. E. (1998). The nature of philosophy of science, theory and knowledge relating to nursing and professionalism. *Journal of Advanced Nursing, 28*(2), 243-250.

Schamberger, M. (1997). Elements of quality in a qualitative research interview. *South African Archives Journal, 39*, 25-35.

Schön, D. A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

Schön, D. A. (1995). The new scholarship requires a new epistemology. *Change, 27*(6), 26-35.

Schratz, M. (Ed.). (1993). *Qualitative voices in educational research.* London: Falmer Press.

Schreiber, R. S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-83). New York: Springer Publishing.

Schutzenhofer, K. K., & Musser, D. B. (1994). Nurse characteristics and professional autonomy. *Image: Journal of Nursing Scholarship, 26*(3), 201-205.

Scott, S. M. (1997). The grieving soul in the transformation process (pp. 41-50). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Scribner, J. P. (1999). Professional development: Untangling the influence of work context on teacher learning. *Educational Administration Quarterly, 35*(2), 238-266.

Seidel, J., Friese, S., & Leonard, D. C. (1996). *The Ethnograph v4.0*. Amherst, MA: Qualis Research Associates.

Severiens, S., & ten Dam, G. (1997). Gender and gender identity differences in learning styles. *Educational Psychology, 17*(1/2), 79-94.

Silva, M. C., Sorrell, J. M., & Sorrell, C. D. (1995). From Carper's patterns of knowing to ways of being: An ontological philosophical shift in nursing. *Advances in Nursing Science, 18*(1), 1-13.

Smith, A. (1998). Learning about reflection. *Journal of Advanced Nursing, 28*(4), 891-898.

Spouse, J. (2000). An impossible dream? Images of nursing held by pre-registration students and their effect on sustaining motivation to become nurses. *Journal of Advanced Nursing, 32*(3), 730-739.

Stake, R. E. (2000). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (2nd ed., pp. 435-454). Thousand Oaks, CA: Sage.

Stange, S. (1995). Lifelong learning: A phenomenology of meaning and value transformation in postmodern adult education. In S. B. Merriam (Ed.), *Selected writings on philosophy and adult education* (2nd ed., pp. 269-281). Malabar, FL: Krieger.

Steffy, B. E. (1989). *Career stages of classroom teachers*. Lancaster, PA: Technomic Publishing.

Stein, K. F., Corte, C., Colling, K. B., & Whall, A. (1998). A theoretical analysis of Carper's ways of knowing using a model of social cognition. *Scholarly Inquiry for Nursing Practice: An International Journal, 12*(1), 43-58.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research. Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing* (2nd ed). Philadelphia: Lippincott, Williams, & Wilkins.

Strong-Boag, V. (1979). Canada's women doctors: Feminism constrained. In L. Kealey (Ed.), *A not unreasonable claim* (pp. 109-129). Toronto, ON, Canada: The Women's Press.

Sullivan, E., Brye, C., Koch, C., Olson, J., & Shabel, W. (1984). RN to BSN: A quality alternative program. *Journal of Nursing Education, 23*(4), 156-158.

Taylor, E. W. (1997). Building upon the theoretical debate: A critical review of the empirical studies of Mezirow's transformative learning theory. *Adult Education Quarterly, 48*(1), 34-59.

Taylor, K., Marienau, C., & Fiddler, M. (2000). *Developing adult learners*. San Francisco: Jossey-Bass.

Tedlock, B. (2000). Ethnography and ethnographic representation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 455-486). Thousand Oaks, CA: Sage.

Throwe, A. N., & Fought, S. G. (1987). Landmarks in the socialization process from RN to BSN. *Nurse Educator, 12*(6), 15-18.

Thurber, F. W. (1988). A comparison of RN students in two types of baccalaureate completion programs. *Journal of Nursing Education, 27*(6), 266-273.

Tisdell, E. J. (1998). Poststructural feminist pedagogies: The possibilities and limitations of feminist emancipatory adult learning theory and practice. *Adult Education Quarterly, 48*(3), 139-156.

Tisdell, E. J., & Taylor, E. W. (2000). Adult education philosophy informs practice. *Adult Learning, 11*(2), 6-10.

Tonuma, M., & Winbolt, M. (2000). From rituals to reason: Creating an environment that allows nurses to nurse. *International Journal of Nursing Practice, 4*, 214-218.

Tucker, B., Foreman, C. W., & Buchanan, P. (1996). *What is reflection? Process evaluation in three disciplines.* East Lansing, MI: National Center for Research on Teacher Learning. (ERIC Document Reproduction Service No. ED404933)

van den Hoonaard, W. C. (1997). *Working with sensitizing concepts: Analytical field research.* Thousand Oaks, CA: Sage.

van Manen, M. (1997). From meaning to method. *Qualitative Health Research, 7*(3), 345-369.

Wade, G. H. (1999). Professional nurse autonomy: Concept analysis and application to nursing education. *Journal of Advanced Nursing, 30*(2), 310-318.

Washington, C. C. (1997). Mentoring: A necessity for professional growth. *Washington Nurse, 27*(3), 22-23.

Watkins, K., & Marsick, V. (1992). Toward a theory of informal and incidental learning in organizations. *International Journal of Lifelong Learning, 11*(4), 287-300.

Weiss, S. (1984). Educating the nursing profession for role transformation. *Journal of Nursing Education, 23*(1), 9-14.

Welton, M. R. (1995a). The contribution of critical theory to our understanding of adult learning. In S. B. Merriam (Ed.), *Selected writings on philosophy and adult education* (pp. 173-185). Malabar, FL: Krieger.

Welton, M. R. (1995b). The critical turn in adult education theory. In M. R. Welton, (Ed.), *In defense of the lifeworld* (pp. 11-38). New York: State University of New York Press.

White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science, 17*(4), 73-86.

Wilson, A. L., & Hayes, E. R. (2000). On thought and action in adult and continuing education. In A. L. Wilson & E. R. Hayes (Eds.), *Handbook of adult and continuing education.* (New edition, pp. 15-32). San Francisco: Jossey-Bass.

Wilson, C. S. (1995). *The perception of values and the process of professional socialization through classroom experiences among baccalaureate nursing students.* UMI ProQuest Digital Dissertations. Retrieved November 1998 from http://www.lib.umi.com/dissertations/fullcit?305698

Witt, B. S. (1992). The liberating effects of RN to BSN education. *Journal of Nursing Education, 31*(4), 149-159.

Wong, F. K. Y., Kember, D., Chung, L. Y. F., & Yan, L. (1995). Assessing levels of student reflection from reflective journals. *Journal of Advanced Nursing, 22*, 48-57.

Wong, F. K. Y., Loke, A. Y., Wong, M., Tse, H., Kan, E., & Kember, D. (1997). An action research study into the development of nurses as reflective practitioners. *Journal of Nursing Education, 36*(10), 476-481.

Woodman, E. A., Knecht, L., Periard, M. E., & Bell, E. A. (1991). Assessment of affective outcomes in RN/BSN programs: Advancing toward professionalism. In M. Garbin (Ed.), *Assessing educational outcomes* (pp. 79-89). New York: National League for Nursing.

World Health Organization. (1998). Burnout. In *Primary prevention of mental, neurological and psychosocial disorders* (pp. 91-111). Geneva: Author.

Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Health Research, 5*(1), 125-137.

Wuest, J., & Merritt-Gray, M. (2001). Feminist grounded theory revisited: Practical issues and new understandings. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 159-176). New York: Springer Publishing.

Zerwekh, J., & Claborn, J. C. (1997). *Nursing today: Transition and trends* (2nd ed.). Philadelphia: W. B. Saunders.

APPENDIX A

SUPPLEMENTARY LITERATURE

Patterns of Knowing in Nursing

Concepts of the Nursing Paradigm within Nursing Theories

Depth Psychology Perspective of Transformative Learning

References

Patterns of Knowing in Nursing

The first pattern, ethical knowledge, concerns moral decisions and clinical judgements required by those whose role is to care for people (Carper, 1978; Jacobs-Kramer & Chinn, 1988; Johns, 1995; Silva et al., 1995; Stein et al., 1998). Professional nursing behaviour is guided by a written Code of Ethics for Registered Nurses that is intended to assist nurses in making decisions in situations where conflicting ethical principles are active (Canadian Nurses Association, 1997). Also guiding nursing action are standards of practice that are developed and enforced by provincial bodies responsible for regulating nursing (see for example, Nurses Association of New Brunswick, 1998). These documents establish minimal requirements for acceptable nursing practice across a variety of settings and contexts and indicate what ought to be done (White, 1995). Standards are developed pursuant to acts of provincial legislatures, granting self-regulatory powers to the profession (for example, Nurses Act, 1984, amended 1996). These documents are important because, across disciplines, "'professionals' actions are never value-neutral; they must be judged as wise with respect to an ethical framework" (Cervero, 1992, p. 93).

When members of a profession share an ethical framework for decision making, there is greater awareness of, and agreement upon, acceptable professional behaviour. In the first stage of professional socialization, nursing students developed an awareness of nursing as a profession which requires morally and ethically constructed decisions and behaviour. In the second stage of professional socialization, Registered Nurses experienced actual situations requiring them to make ethical decisions related to caring

for clients. The third, or baccalaureate, stage of professional socialization enables learners to develop beyond awareness and use of ethical strategies to an epistemological stance, that is, to examine and reflect upon the assumptions underlying the ethical pattern of knowing and its relevant action strategies.

The second pattern identified by Carper, esthetic knowing, concerns the art of nursing (Carper, 1978; Jacobs-Kramer & Chinn, 1988; Johns, 1995; Silva et al., 1995; Stein et al., 1998). The concept of professional artistry includes such skills and attributes as perception, understanding, communication, experience, and interpersonal engagement (White, 1995). Within this knowledge pattern, the key process is empathy, defined as "the capacity for participating in or vicariously experiencing another's feelings" (Carper, p. 17). The esthetic pattern of knowing fits well with a constructivist paradigm in that this pattern developed from the idea that multiple realities are possible, was based on individually different understandings of a single situation, and it dealt with knowledge that is not confirmable by empirical observation, that is, it does not arise from facts. Other authors have labelled the knowledge which fits within Carper's esthetic pattern as negotiating skills (Adams et al., 1997), strategic knowledge (Le Maistre, 1998), implicit or informal theories of knowledge (Williams, 1998), and communicative knowledge (Cranton, 1994).

Carper's third pattern, empirical knowing, outlines the 'science' of nursing consisting of factual or content knowledge, observations, concepts, principles, formal theories, and practical skills (Carper, 1978; Jacobs-Kramer & Chinn, 1988; Johns, 1995; Silva et al., 1995; Stein et al., 1998). The empirical pattern of knowing fits well with the

positivist paradigm of how knowledge is created, tested, and generally regarded as a detached thing to be acquired and applied. Empirical knowledge has also been called declarative knowledge (Le Maistre, 1998); "knowing that" (Rolfe, 1997a, 1997b); propositional knowledge (Cash, 1995), and instrumental knowledge (Cranton, 1994).

Carper's fourth pattern, personal knowledge, refers to knowledge created by nurses through self-awareness and critical reflection (Carper, 1978; Jacobs-Kramer & Chinn, 1988; Johns, 1995; Silva et al., 1995; Stein et al., 1998). Berragan (1998) further broke this pattern of knowing into three kinds: intuitive, experiential, and interpersonal knowing. It is within this overall pattern of knowing that personal meaning is made of other patterns of knowledge. Rolfe called this pattern "knowing how" (1997a). Reflection-in-action, critical thinking, reflective judgement, and reframing situations are processes used by nurses to examine and adapt factual or passively accepted knowledge into their own pattern of personal knowing.

Schön's (1987) processes of reflection-in practice and reflection-on-practice are useful in a practice profession such as nursing. Within programs, educators design reflective practica and use facilitators as coaches to encourage learner reflection and enable new understanding and action (Schön). Nurses engage in knowing-in-action (Berliner, 1986) after they have processed relatively passive experiences and made meaning of them. Personal knowing is characteristic of experienced or reflective practitioners and RNs are encouraged to examine this pattern of knowing as experienced practitioners. The notion of expert involves practitioners who use reflexive practice (Rolfe, 1997a).

Unknowing is the fifth pattern of knowing included by Munhall (1993) and Heath (1998). The unknowing pattern describes a condition of being open and acknowledging that one does not yet know something or understand someone. "To engage in an authentic encounter, one must stand in one's socially constructed world and unearth the other's world by admitting, 'I don't know you. I do not know your subjective world.'" (Munhall, p. 125). The unknowing pattern allows clients to be themselves and nurses to begin to understand the meaning of the health experience for them. Heath considers this pattern closely linked to the pattern of personal knowing. Learners discover the apparent paradox in the label of this pattern of knowing when exploring it.

White (1995) considers a sixth pattern, sociopolitical knowing, essential to understanding the previous five patterns. Sociopolitical knowing describes the broader context within which the other patterns occur. The sociopolitical pattern involves looking more broadly beyond individual relationships to consider the assumptions underlying the health care system, culture, and society and their influences on client's and nurses' lives (White). This pattern fits well within the critical social theory paradigm (Allen, 1990; Berragan, 1998; Candy, 1991; Collins, 1996; Welton, 1995a, 1995b). This pattern enables learners to understand better, and practice, a view which includes seeking systemic origins of health problems rather than treating symptoms only (Butterfield, 1990).

Concepts of the Nursing Paradigm within Nursing Theories

I have selected several theoretical orientations from the nursing literature to illustrate the scope of acceptable ways in which each of the concepts central to the nursing paradigm is interpreted. Learners entering BN/RN programs are often unfamiliar with the concept of a paradigm, formal theoretical interpretations of the concepts central to it, and the notion that nursing knowledge is structured within a paradigm. These nurses have learned essential knowledge for practice through their basic education and, by working, have often developed eclectic views of nursing's knowledge base. I have also incorporated opportunities for exploring learners' eclectic views into the courses I teach.

The concept of nursing is used to refer both to the profession itself, including professional attributes and characteristics of the profession, and also to the art and science of the practice of the profession. Watson considered that nursing is concerned with promoting and restoring health, preventing illness, and caring for the ill (Talento, 1995, p. 325) while Peplau defined nursing as an interpersonal process involving human relationships (Belcher & Fish, 1995, p.57) and Hall defined nursing as participation in the "care, core, and cure aspects of patient care" (George, 1995c, p. 92). Very different parameters for nursing practice are delineated by each of these views.

The concept of person refers to the personhood of the nurse, or the self, and also to the personhood of the recipient of nursing care with whom the nurse interacts, or the other. Person is understood as meaning different levels of recipient depending on the context of care. That is, person can mean an individual, a family, a group of clients, or a community. Hall used the notion of person to refer to adults requiring long-term care

(George, 1995c, p. 92) while Rogers used person to mean unified beings who are in continuous energy exchange with the environment (Falco & Lobo, 1995, p. 237) and Leininger defined person so as to include institutions, communities, and cultures (George, 1995d, p. 380). Nurses using these different theories to guide their practice would expect to work with very different clients.

The concept of health refers to the state of well-being, or wellness, as defined and experienced by clients and may include the experience of illness. Henderson defined health as related to human functioning and ability to function independently (Furukawa & Howe, 1995, p.74) while Orem defined health by using the definition provided by the World Health Organization as the state of physical, mental, and social well-being and not merely the absence of disease (Foster & Bennett, 1995, p. 107). King defined health as a dynamic life experience (George, 1995b, p. 221) and Parse as a process of becoming (Hickman, 1995b, p. 345) while Rogers considered it a value term (Falco & Lobo, 1995, p. 237). Nurses are in the business of health and what they do in relation to health is influenced by the theory they use to guide their practice.

The concept of environment is used to refer to the client's external surroundings which include other persons, events, and settings and also to the client's internal factors such as genetics, emotional responses, and stress (Creasia & Parker, 2001; Hickman, 1995a; Lindberg et al., 1998). One of the earliest theorists, Nightingale, interpreted the environment as the physical surroundings of patients, paying particular attention to light, ventilation, noise, and cleanliness (Lobo, 1995, p. 36-7) while Roy considered environment as both internal and external stimuli (Galbreath, 1995, p. 261) and Neuman

added a third dimension, the created environment which is a protective coping shield developed unconsciously by clients (George, 1995a, p. 287).

The Depth Psychology Perspective of Transformative Learning

In the depth psychology perspective[1] of transformative learning, learners hold personal beliefs, values, and assumptions that influence and constrain their lives whether or not learners are aware of the existence of these (Clark, 1997; Cohen, 1997; Wilcox, 1997). Transformative learning is a process in which the learner becomes aware of, and is freed from, constraining internal forces. The learning processes involved are intuitive and result in profound emotional experiences often marked by recognizing and relating both to the individual and collective unconscious (Clark; Dirkx, 1997; Grabove, 1997; Scott, 1997).

In the analytical depth psychology perspective, the learner experiences a personal journey that requires recognizing symbolic images as they surface into the conscious mind through dreams or other brief unconscious connections. The learner does not analyze these images logically but responds more generally to the whole experience. Through this responsive process, possibilities of renewal, restoration, and rebirth exist for the learner (Grabove, 1997). The private nature of this process may mean that it is not used, or sometimes not even recognized, within formal education programs.

In this perspective, the adult learner is seen as an individual whose experience of transformative learning is unique. Learners are freed from internal constraining forces

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1 The term depth psychology perspective is also used with the term "analytical" referring to the analytical psychology proposed by Carl Jung.

(Clark, 1997; Cohen, 1997; Dirkx, 1997; Ettling & Hayes, 1997; Grabove, 1997; Scott, 1997). Learning in this perspective is a personal, internal, individual process. Learners may not involve others at first so that the experience may be less visible to others.

In this perspective, others may facilitate transformative learning by assisting learners: to relate to internal images, fantasies, and dreams; recognize the quality of experience through soul work (Dirkx, 1997); to use metaphor, release ego controls, and contemplate the holistic experience (Clark, 1997; Wilcox, 1997). Learners make meaning through intuitive, creative, passionate, and holistic processes that lead to self-knowledge (Grabove, 1997; Scott, 1997; Wilcox).

In this perspective, the anticipated process is that learners develop altered meaning perspectives, expand their personal consciousness, and experience a personal change (Clark, 1997; Scott, 1997). This perspective is grounded in the field of analytical depth psychology developed by Carl Jung (Clark; Grabove, 1997; Scott).

Features of the Two Perspectives of Transformative Learning

This table shows the characteristic features of both views of transformative learning and those features that are present in baccalaureate nursing programs for these learners are marked with an asterisk.

Appendix A Table 1

Features of Two Perspectives of Transformative Learning

Common places	Rational Perspective	Depth Perspective
Learning Process	*Involves critical reflection on assumptions underlying internal and external forces; occurs across domains; process involves: 1. Elaborating points of view 2. Establishing new points of view 3. Transforming points of view 4. Transforming habits of mind	Involves critical reflection on assumptions underlying internal forces; process is: intuitive, creative, passionate, individual, internal, relates to the unconscious, emotional experience
Learner	*Social and internal contexts constrain learners; need social interaction, rational discourse, group discussion to examine assumptions	Learners recognize symbolic images, respond to these images personally and privately; experience is unique, personal
Facilitator Roles	*Creating disorienting dilemmas, encouraging examining assumptions, challenging assumptions, creating supportive environment	Assisting learners to: relate to internal images, dreams, recognize soul work; using metaphor, contemplating holistic experience
Learning Outcomes	*Autonomous, socially responsible thinker, freed from constraining meaning perspectives	Altered meaning perspectives of learner, expanded personal consciousness, possibly changed personality
Foundation	Critical social theory	Analytical depth psychology

Summary

Grabove (1997) identified nine common characteristics found in both the rational and the analytical depth psychology perspectives of transformative learning: "humanism,

emancipation, autonomy, critical reflection, equity, self-knowledge, participation, communication, and discourse" (p. 90). Both perspectives link closely to the characteristics of adulthood. Both use cognition and emotional processes although their emphasis, sequence, and use is different. Scott contrasted the two facilitative approaches: the rational perspective begins with talk and dialogue to sort out external meanings whereas the analytical depth psychology perspective begins by sharing internal experiences (1997, p. 46). Both perspectives involve transformations but the analytical depth psychology perspective involves an internal, individual transformation exclusively while the rational perspective involves both an internal and an external, socially-based transformation. The rational perspective is the approach more commonly found in baccalaureate programs for RNs.

References

Adams, A., Pelletier, D., Duffield, C., Nagy, S., Crisp, J., Mitten-Lewis, S., & Murphy, J. (1997). Determining and discerning expert practice: A review of the literature. *Clinical Nurse Specialist, 11*(5), 217-222.

Allen, D. G. (1990). Critical social theory. In *Curriculum revolution: Redefining the student-teacher relationship* (pp. 68-83). New York: National League for Nursing.

Belcher, J. R., & Fish, L. J. B. (1995). Hildegard Peplau. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 49-66). Norwalk, CT: Appleton & Lange.

Berliner, D. C. (1986). In pursuit of the expert pedagogue. *Educational Researcher, 15*(7), 5-13.

Berragan, L. (1998). Nursing practice draws upon several different ways of knowing. *Journal of Clinical Nursing, 7*(3), 209-217.

Butterfield, P. G. (1990). Thinking upstream: Nurturing a conceptual understanding of the societal context of health behaviour. *Advances in Nursing Science, 12*(2), 1-8.

Canadian Nurses Association. (1997). *Code of Ethics for Registered Nurses.* Ottawa, ON: Author.

Candy, P. C. (1991). *Self-direction for lifelong learning: A comprehensive guide to theory and practice*. San Francisco: Jossey-Bass.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23.

Cash, K. (1995). Benner and expertise in nursing : A critique. *International Journal of Nursing Studies, 32*(6), 527-534.

Cervero, R. M. (1992). Professional practice, learning, and continuing education: An integrated perspective. *International Journal of Lifelong Education, 11*(2), 91-101.

Clark, J. E. (1997). Of writing, imagination, and dialogue: A transformative experience (pp.13-21). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Cohen, L. R. (1997). I ain't so smart and you ain't so dumb: Personal reassessment in transformative learning (pp.61-68). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Collins, M. (1996). Current trends in adult education. From self-directed learning to critical theory. In G. D. Benson & B. E. Griffith (Eds.), *Process, epistemology and education* (pp. 69-86). Toronto, ON, Canada: Canadian Scholars' Press.

Cranton, P. (1994). *Understanding and promoting transformative learning*. San Francisco: Jossey-Bass.

Creasia, J. L., & Parker, B. (2001).*Conceptual foundations: The bridge to professional nursing practice* (3rd ed.). St. Louis: Mosby.

Dirkx, J. M. (1997). Nurturing soul in adult learning (pp.79-88). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Ettling, D., & Hayes. N. (1997). Learning to learn. Women creating learning communities. *ReVision, 20(1), 28-31.*

Grabove, V. (1997). The many facets of transformative learning theory and practice (pp.89-95). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass..

Falco, S.M., & Lobo, M. L. (1995). Martha E. Rogers. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 229-248). Norwalk, CT: Appleton & Lange.

Foster, P. C., & Bennett, A. M. (1995). Dorothea Orem. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 99-124). Norwalk, CT: Appleton & Lange.

Furukawa, C. Y., & Howe, J. K. (1995). Virginia Henderson. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 67-85). Norwalk, CT: Appleton & Lange.

Galbreath, J. G. (1995). Callista Roy. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 251-280). Norwalk, CT: Appleton & Lange.

George, J. B. (1995a). Betty Neuman. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 281-300). Norwalk, CT: Appleton & Lange.

George, J. B. (1995b). Imogene King. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 209-228). Norwalk, CT: Appleton & Lange.

George, J. B. (1995c). Lydia E. Hall. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 87-98). Norwalk, CT: Appleton & Lange.

George, J. B. (1995d). Madeleine Leininger. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 373-390). Norwalk, CT: Appleton & Lange.

Heath, H. (1998). Reflection and patterns of knowing in nursing. *Journal of Advanced Nursing, 27*, 1054-1059.

Hickman, J. S. (1995a). An introduction to nursing theory. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 1-14). Norwalk, CT: Appleton & Lange.

Hickman, J. S. (1995b). Rosemarie Rizzo Parse. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 335-254). Norwalk, CT: Appleton & Lange.

Jacobs-Kramer, M. K., & Chinn, P. L. (1988). Perspectives on knowing: A model of nursing knowledge. *Scholarly Inquiry for Nursing Practice: An International Journal, 2*(2), 129-139.

Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing, 22*(2), 226-234.

Le Maistre, C. (1998). What is an expert instructional designer? Evidence of expert performance during formative evaluation. *Educational Technology Research and Development, 46*(3), 21-36.

Lindberg, J. B., Hunter, M. L., & Kruszewski, A. Z. (1998). *Introduction to nursing* (3rd ed.). Philadelphia: J. B. Lippincott.

Lobo, M. L. (1995). Florence Nightingale. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 33-48). Norwalk, CT: Appleton & Lange.

Munhall, P. L. (1993). 'Unknowing': Toward another patten of knowing in nursing. *Nursing Outlook, 41*(3), 125-128.

Nurses Association of New Brunswick. (1984, Amended 1996). *Nurses Act*. Fredericton, NB: Author.

Nurses Association of New Brunswick. (1998). *Revised standards of practice*. Fredericton, NB: Author.

Rolfe, G. (1997a). Beyond expertise: Theory, practice and the reflexive practitioner. *Journal of Clinical Nursing, 6*(2), 93-97.

Rolfe, G. (1997b). Science, abduction and the fuzzy nurse: An exploration of expertise. *Journal of Advanced Nursing, 25*(5), 1070-1075.

Schön, D. A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

Scott, S. M. (1997). The grieving soul in the transformation process. (pp.41-50). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Silva, M. C., Sorrell, J. M., & Sorrell, C. D. (1995). From Carper's patterns of knowing to ways of being: An ontological philosophical shift in nursing. *Advances in Nursing Science, 18*(1), 1-13.

Stein, K. F., Corte, C., Colling, K. B., & Whall, A. (1998). A theoretical analysis of Carper's ways of knowing using a model of social cognition. *Scholarly Inquiry for Nursing Practice: An International Journal, 12*(1), 43-58.

Stevens Barnum, B. J. (1994). *Nursing theory: Analysis, application, evaluation.* Philadelphia: J. B. Lippincott.

Talento, B. (1995). Jean Watson. In J. B. George (Ed.), *Nursing theories* (4th ed., pp. 317-334). Norwalk, CT: Appleton & Lange.

Welton, M. R. (1995a). The contribution of critical theory to our understanding of adult learning. In S. B. Merriam (Ed.), *Selected writings on philosophy and adult education* (pp. 173-185). Malabar, FL: Kreiger.

Welton, M. R. (1995b). The critical turn in adult education theory. In M. R. Welton (Ed.) *In defense of the lifeworld* (pp. 11-38). New York: State University of New York Press.

White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science, 17*(4), 73-86.

Wilcox, S. (1997). Becoming a faculty developer. (pp.23-31). *New Directions for Adult and Continuing Education, no. 74*. San Francisco: Jossey-Bass.

Williams, P. L. (1998). Using theories of professional knowledge and reflective practice to influence educational change. *Medical Teacher, 20*(1), 28-35.

APPENDIX B

PARTICIPANT INTERVIEW INFORMATION

Letter of Invitation to Participants

Statement of Consent

Initial Interview Guide

Letter of Invitation to Participants

93 Wetmore Road
Fredericton, NB, E3B 6Y2
Date

Dear

I am a nurse and a graduate student in the Faculty of Education. I am conducting research as part of the requirements for my doctoral degree. My dissertation supervisor is Dr. Elizabeth Burge.

I am interested in how nurses enrolled in baccalaureate programs describe the meaning of being professional. I would like to know, from learners' perspectives, how they describe being professional, generally and in nursing; how they think they developed this meaning of being professional; whether the meaning changes over time; and, if so, what the change process is like.

If you agree, you will be asked to participate in an initial audio-tape-recorded interview at a convenient time and location. I expect that this interview will last between 60 and 90 minutes but more time can be made available should we both think it is needed. I will tape record the interview so that no information is lost and so that I can pay attention to what you are saying. Later, you may be invited to participate in a second interview when I will share my understanding of the data and ask how it fits with your meaning of being professional..

Your anonymity will be protected. Your identity, responses, and personal information will remain confidential to me. Should presentations or publications result from the study, no participants will be named. You may withdraw from the study, or

refuse to answer a question, at any time. There will be no academic rewards for participating and no academic penalties for not participating. Your participation is voluntary. The BN/RN Program office sent out these letters but they will not know who returns them to me nor who participates. No evaluative comments about the BN/RN program will be solicited nor accepted.

I do not anticipate any risks to you given the nature of the interviews and the subject matter. It will require at least 60 to 90 minutes of your time. Often participants in this kind of study find that reflecting on their past experiences is positive. Outcomes may influence baccalaureate nursing education and the notion of being professional.

If you agree to participate in this study as described, please sign and return to me by mail the second copy of this letter, or respond by e-mail to macintsh@unb.ca, or telephone 458-7638.

Thank you for considering my request. I look forward to having the opportunity to meet with you. Should you have questions or concerns, please feel free to direct them to me.

Sincerely,

Judy MacIntosh, BN, MSc(A)

I agree to participate in this study. Please contact me at the following telephone numbers to arrange an interview.

_____ _____

Name Phone Numbers

A time convenient to contact me to set up an interview is:

Statement of Consent

Experienced Nurses' Perceptions of Being Professional

I have read the above description of the project and the researcher has answered my questions to my satisfaction. I, _____, agree to participate in this study.

_____ _____

Participant (signature) Date

To the best of my ability, I, Judith MacIntosh, have explained the purposes, benefits, risks, and inconvenience of this study to _____, and I have answered all questions/concerns related to this research.

_____ _____

Researcher (signature) Date

Initial Interview Guide

The overall research interest guiding this study was how participants understand the meaning of being professional. Actual questions asked were determined by research conversations as they occurred. The initial areas explored were:

How do participants describe being professional, generally, and in nursing?

How did participants think they developed their meaning about being professional?

Have participants had opportunities to explore or examine their meaning of being professional?

> If so, how do they describe their experience with those opportunities exploring or examining their meaning?
>
> What were the outcomes of the process of exploring or examining their meaning of being professional?

How do they describe the influence of educational experiences, and their experiences in other contexts, on being professional?

Are there other aspects of being professional they would like to add?

APPENDIX C

AUDIT TRAIL

Sample Audit Trail

Sample Entries into Audit Trail

Summer 1999 Decided that I needed to telephone to follow up after sending out letters because few were calling me back. I felt concerned and frustrated by this. I didn't expect everyone to reply but I had only two of the six letters come back. I need more than that! I spoke with Judy and Liz and they agreed that I could phone to follow up on my letters without going back to the Ethics Committee. This was much more effective because most nurses said they had received the letter and had intended to respond but hadn't got around to it. Then most agreed to an interview.

Fall 1999 One male nurse responded to the letter the program sent out. Should I include one male participant or keep it to all women? I have no reason to believe that gender plays a role that would influence here so I think I should include him since he replied to my letter...

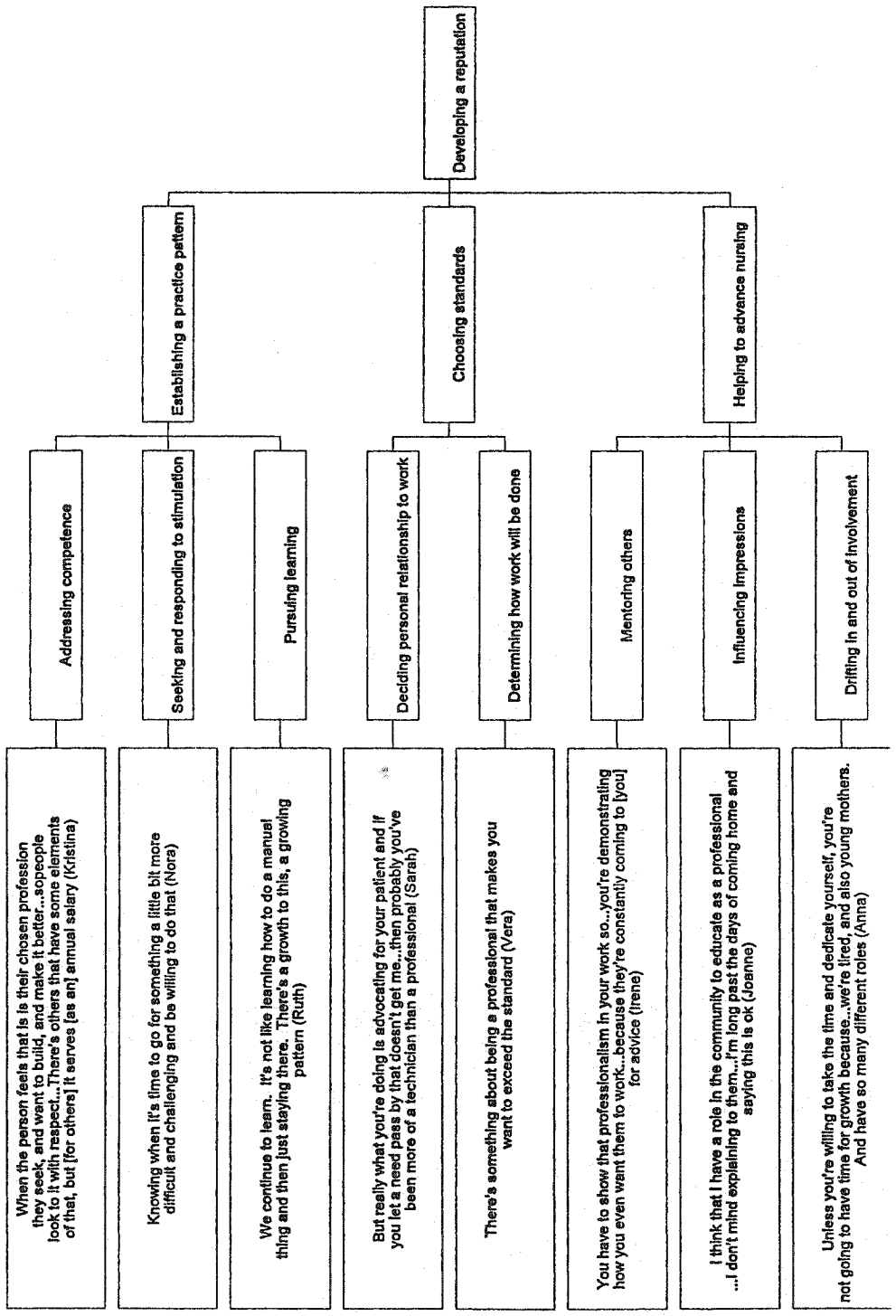
When I call to set up the interviews or to further explain the study, it's interesting that so many nurses say they hadn't thought about what being professional means. They say they are concerned that they won't be able to help me very much. During the interviews, they talk about learning the characteristics and can repeat some of those but doing that doesn't seem to reflect being professional for them. I wonder what else influences this?...

Fall 1999 I've been surprised by the presence of the concept of moving on in the few interviews I have done until now. I need to pursue this further is other interviews if it doesn't come up....

The workplace seems to be a hostile environment for so many nurses. It's a wonder they survive there! I think some work very hard to give the kind of care they believe they should and they seem to be aware of all the factors that challenge them in doing this. Of course, they also talk about mentors and other positives.

Winter 2000 I'm in a bit of a dilemma. My proposal indicated that I would gather data from nurses in NB but I've run out of participants that I haven't taught and think I need to continue to interview. I plan to invite participation from some of the group in PEI taught by the instructor there. I know that isn't NB but it's the same program and I haven't taught them and I have no reason to believe that they are any different. They only thing will be that I'll have to wait until the end of term to go there to interview and I'd like to set up a few while I'm there to make the trip worth it. I hope people show up!

Sample Category Audit Trail from Raw Data to Stage Label



VITA

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MacIntosh, J. (in press). Gender-related issues in nursing education. Accepted for publication in *Journal of Professional Nursing*.

Davidson, P., MacIntosh, J., McCormack, D., & Morrison, E. (in press). Primary health care: A framework for policy development. Accepted for publication in *Holistic Nursing Practice, 16*(4).

MacIntosh, J., MacKay, E., Mallet-Boucher, M., & Wiggins, N. (in press). Facilitating co-learning for students at distance education sites. Accepted for publication in *Nurse Educator.*

MacIntosh, J. (2001). Learner concerns and teaching strategies for video-conferencing. *Journal of Continuing Education in Nursing, 32*(6), 260-265.

MacIntosh, J., & McCormack, D. (2001). Research with homeless people uncovers a model of health. *Western Journal of Nursing Research, 23*(7), 679-697.

MacIntosh, J., & McCormack, D. (2001). Partnerships identified within primary health care literature. *International Journal of Nursing Studies, 38*(4), 547-555.

MacIntosh, J., & McCormack, D. (2000). An integrative review illuminates curricular applications of primary health care. *Journal of Nursing Education, 39*(3),116-123.

MacIntosh, J., & Wiggins, N. (1998). Venturing through the Looking Glass: An instance of transformative learning in adult education. *Canadian Journal of University Continuing Education, 24*(2), 11-20. And available on-line at: http://www.extension.usask.ca/cjuce/articles/2421.htm

Post, P., Carusetta, E., Maher, E., & MacIntosh, J. (1998). Not the wand but the wizard. *Canadian Journal of University Continuing Education, 24*(2), 21-36. And available on line at: http://www.extension.usask.ca/cjuce/articles/2422.htm

Buchanan, J., & MacIntosh, J. (1997). Trust: A process and an outcome in an audio-teleconferencing learning environment. *Canadian Journal of University Continuing Education, 23*(1), 49-60. And available on-line at: http://www.extension.usask.ca/cjuce/articles/2313.htm

MacIntosh, J., & McGinnis, E. M. (1997). Teaching becomes learning: Our lived experience. *Nurse Educator, 22*(1), 45-49.

MacIntosh, J. A., & McCormack, S. D. (1995). Primary health care progress in nursing citations. *International Nursing Review, 42*(4), 115-120.

MacIntosh, J. (1995). Fashioning facilitators: Nursing education for primary healthcare. *Nurse Educator, 20*(3), 25-27.

MacIntosh, J. (1993). Focus groups in distance nursing education. *Journal of Advanced Nursing, 18*, 1981-1985.

Research Reports

MacIntosh, J., MacKay, E., Mallet-Boucher, M., & Wiggins, N. (2001). *Becoming nurses: Experiences of co-learners in three distant sites. Report of the phenomenological study.* Fredericton, NB: Authors.

MacIntosh, J., & McCormack, D. (1998). *Social process of health experienced by homeless persons.*(New Brunswick Collection #362.5 m 131 NBC). Fredericton: New Brunswick: Legislative Library, Government of New Brunswick.

MacIntosh, J., & McCormack, D. (1996). *Nursing Services: The cost saving choice in quality health care.* Report commissioned by the New Brunswick Nurses Union, Fredericton, New Brunswick.

MacIntosh, J. (1988). *Nursing Education Needs on Prince Edward Island.* Charlottetown, PEI: Hospital and Health Services Commission.