Violation of Personal and Professional Nursing Values: Six Case Studies of Nurses who have Left Nursing

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Dedication

This dissertation is dedicated to all nurses and to all those whose work is aimed at enabling nurses to practice their science and art to the fullest, for the benefit of all those we serve.

Abstract

Background: Registered Nurses (RNs) comprise the largest group of health care providers in the US. The shortage of RNs is expected to worsen to 29% by 2020. Many nurses depart practice prior to retirement. Previous research has linked professional turnover to various aspects of job satisfaction. **Purpose:** This study sought to understand and describe the decision to leave nursing. **Design/Methods**: This Case Study examined the experience of nurses who had allowed their license to lapse. Potential participants had been licensed RNs, registered in the State of Minnesota younger than age 59 at the time of recruitment. All six potential informants who responded agreed to participate. All participants were white, all but one were female. Participants' ages ranged from 35 – 55. Each was interviewed once. Each interview was audio taped and transcribed. Field notes were documented by the researcher after each interview. A reflexive journal was maintained during the analysis of the data. **Findings**: Analysis of participants' stories revealed that they had departed practice following an overall experience of professional disillusionment. Three major themes were discovered. The first was *challenges to personal and professional values* which was supported by subthemes of *inability to provide quality care*, *clinical nursing competes with life and family*, and *lack of professional self-fulfillment*. The second major theme was *workplace stressors* which was supported by subthemes of *disrespect from the public and other health care professionals* and *stress, workload, and unsafe practices*. The third major theme was *life after nursing: reconstituting the caring passion*. This theme was supported by subthemes of *nurse as identity – a nurse is who I am*, *caring as a way of being in the world*, and *transfer of*

knowledge, skills, and work ethic. **Conclusions:** It is clear from the stories shared by the former nurses that many of the factors driving the choice to leave are amenable to intervention. Workplace policies must be developed and enforced to ensure a professional working environment in which nurses are expected and able to provide the highest quality of care. Nursing must continue to support workplace environments and policies that foster respectful communication and behavior.

Table of Contents

List of Figures

List of Appendices

Chapter One: Introduction to the Study

Registered Nurses (RNs) comprise the largest group of health care providers in the United States (Bureau of Labor Statistics, 2009). The shortage of RNs relative to anticipated demand will reach 285,000 by 2020 and is expected to reach 500,000 by 2025 (Buerhaus, 2008). Failure to retain RNs in both individual positions and the profession itself continues to contribute to difficulties in meeting the nursing care needs of the nation. The severity of this situation is such that it "threatens the health of the entire healthcare system." (Black, Spetz, & Harrington, 2008, p. 143). It is widely accepted that the current shortage of practicing RNs in the United States is severe, and that it is worsening, (Brewer, Zayas, Kahn, & Sienkiewicz, 2006; Rambur, McIntosh, Palumbo, & Reiner, 2005) with an anticipated shortage of 29% by 2020 (U.S. Department of Health and Human Services, 2002). Retention of currently employed nurses both in their positions and in the profession is of great importance to the health of citizens and to health care facilities (Strachota, Normandin, O'Brien, Clary, Krukow, 2003).

The estimated cost of replacing one nurse is high, with reported costs ranging from $44,000 (Baggot, Hensinger, Parry, Valdes, & Zaim, 2005) - $145,000 (Atencio, Cohen, & Gorenberg, 2003). Additional costs beyond monetary are well documented for nurse turnover. As the workload of the nurses who remain on the unit rises owing to the loss of the experienced colleague and orientation of the replacement, unit morale and nurse job satisfaction decrease (Goode, Lynn, Krsek, & Bednash, 2009; Rondeau, Williams, & Wagar, 2009) increasing the likelihood of further turnover of experienced staff (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Palumbo, McIntosh, Rambur,

& Naud, 2009; Raup, 2008). Nurse turnover creates a threat to patient safety as well. Research affirms that positive patient outcomes are associated with the provision of care by sufficient numbers of registered nurses (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Clarke, Sloane, Lake, & Cheney, 2009). Facilities with insufficient numbers owing to turnover may deliver suboptimal care to their patients. Benefits associated with decreasing nurse turnover include decreased expenditures for recruitment and orientation, improved patient satisfaction and outcomes, and an increasing depth of organizational knowledge (Drenkard, 2010).

The vacancies created by turnover are often covered by temporary nurses. One study reports that as much as 5% of nursing hours were provided by temporary nurses in the facilities managed by the executives responding to the survey. The same report estimates that each increase of 1% in turnover costs a facility $300,000 annually ("*What works*", 2007).

In the literature there are many references to nurses leaving nursing positions for a variety of reasons. This can create confusion when writing about retention issues. For the purpose of clarifying this work, there are five nuanced concepts that relate to nurses leaving their employment positions. The first is nurses who choose to leave their current position for another position in nursing; the second is nurses who stop practicing nursing temporarily for alternate pursuits such as raising a family; the third concept is nurses who choose to practice in areas indirectly related to nursing such as academics; the fourth concept is nurses who elect to leave their employing organization for another

organization. The fifth and final concept, and the focus of this study is those nurses who choose to leave nursing as a profession altogether, and let their licenses lapse.

Little is known about why nurses actually leave the profession of nursing, thus, the overall questions that guided the boundaries of the case study were *"Why did these nurses choose to leave nursing and what is the experience of leaving nursing as a profession and what if any experiences contribute to the decision to leave?"*

This chapter presents a general overview of literature pertaining to the need for this study, the research question, a description of the research approach, and the significance of the research for the discipline of nursing.

Literature Review Overview

There are three studies exploring the factors that had influenced the decisions of RNs to leave the profession of nursing.

MacKusick and Minick (2010) performed a hermeneutic study with ten participants using semi-structured interviews. Participants were recruited by telephone and then scheduled for one on one interviews that were audio taped and transcribed. The primary theme discovered in that research was an unfriendly workplace. Other themes included emotional distress, lack of collaboration, and fatigue and exhaustion. Much research has been done exploring factors that contribute to the intent of nurses to leave their current positions, as well as nurse job satisfaction and nurse job dissatisfaction. There are related factors that have been found to contribute to all of these issues (Aiken et al., 2009; Bowles & Candela, 2005; Letvak & Buck, 2008; Nedd, 2006; Park & Kim, 2009).

Skillman, Palazzo, Hart, and Keepnews (2010) utilized a descriptive survey to query nurses with expired licenses regarding the reasons they had let their licenses lapse. The survey also included questions regarding their attitudes toward the profession of nursing, and which, if any circumstances might bring them back to practice. The survey response rate was 21.5% when adjusted for the number of survey recipients who were deceased. Among the nurses who responded to the survey, the most common reason for leaving was illness or disability, closely followed by job-related stress or exhaustion. Fewer than half of the participants who had left reported moderate or extreme satisfaction with their last nursing job (the authors report that among practicing nurses, 78% report their satisfaction as moderate to extreme). Among those respondents physically capable of returning to practice, fewer than one third identified any of the provided options as having the power to entice them back into practice. When asked to rank them as the most powerful (if still not convincing) they suggested that "availability of more flexible hours", "responsibility for fewer patients", "change in personal situation, and "higher pay." More than two thirds of the group able to return to practice said there was nothing that would persuade them to return. These researchers report that it is likely that few if any of their participants would rejoin the nursing workforce.

Flinkman, Leino-Kilpi, and Salanterä (2010) presented an integrated review of the literature on nurses' intent to leave the profession in order to synthesize cross-study findings. Common demographic findings related to nurses intending to leave the profession included youth, being highly qualified, and being male. Work related variables contributing to increased likelihood of leaving the profession included low occupational

commitment, low affective commitment to the profession, and low professional commitment. Other variables with high correlation to intent to leave were low job satisfaction, dissatisfaction with pay, few possibilities for development, the experiences of burnout or work-family stress, or being in a family not dependent on the nurse's salary. It is posited that the intent to leave nursing may begin as a withdrawal process with a trajectory initiated by leaving the unit and then extending to leaving the profession.

Research Question

The general inquiry posed to the participants of this study was "Tell me about your decision to leave the nursing profession."

Research Approach

The goal of the research was to understand why nurses choose to leave nursing. Stake (1995) asserts that case study design is focused on achieving a contextual understanding of a particular case or cases. Yin (2009) identifies case study methods as ideal for examining complex social phenomena. The set of six people who had made the choice to leave nursing as a profession comprised the case. Because the case directly reflects the phenomenon under study rather than an associated issue, the most appropriate inquiry is an intrinsic case study. The complex social phenomenon of choosing to leave nursing as a profession varies by individual within the context of each individual. Inquiry utilizing case study interviews made available through words and interaction the knowledge of the phenomenon possessed by those who had experienced the complex social phenomenon. Qualitative methods such as case study value the richness and detail

of the individual experience and recognize and tolerate the ambiguity and social existence incumbent in human experience (Dahlberg, Drew, & Nyström, 2001). Accessing the knowledge of participants through interviews made available to the researcher the data that was needed to understand the experience. The understanding of the meaning of this human experience could not be accomplished through quantitative methods as there are no tools for measuring individual meanings of the experience of choosing to leave nursing.

Significance for Nursing

This study was clearly needed to provide context to the limited existing research on why nurses leave nursing as a profession. Much is being done with the intention of retaining nurses both positionally and professionally. The addition of the knowledge and context yielded by this study may allow those efforts to be more precisely developed and implemented. Understanding why this group of nurses left nursing may enlighten the design of nurse retention strategy. The results of this study may be utilized by those who design nursing curriculum, environments, retention interventions, and programs to increase the likelihood of nurses' choosing to remain in their employment positions. Desired patient outcomes are clearly linked with the presence and practice of sufficient numbers of qualified registered nursing staff (Aiken et al., 2002; Aiken et al., 2009; Aiken, 2010).

Chapter Two: Review of the Related Literature

This chapter will explore the literature related to why RNs leave the profession of nursing, RN retention, and job satisfaction. Three studies are known about nurses' decisions to leave nursing and these are presented first. The next portion of the chapter will focus on studies related to nurse job satisfaction and positional retention. A summary and synthesis conclude the chapter.

An integrated review of the literature was undertaken to explore and describe phenomena which impact retention of nurses in the United States. The review included both research and empirical literature with the goal of encompassing successful strategies used to increase retention of both new and experienced RNs.

Utilizing the strategy suggested by Garrard (2004), CINAHL, MEDLINE, and PsycINFO databases were searched using the terms personnel retention, retention, turnover, and nursing shortage. Articles were not included if the focus of the article was nurses in another country or if they were not available in English. The resulting pool of articles was 157. Titles and abstracts were hand reviewed for indication of meeting the inclusion criteria below.

For inclusion, articles had to be in English and the focus needed to be RN turnover, satisfaction, or retention. Both quantitative and qualitative articles were discovered, as were anecdotal reports of successful retention strategies utilized. Anecdotal reports were included as the focus of this review was to explore and report not only research related to RN retention but also what has worked to increase RN retention. Papers were not included if they were opinion/editorial articles, not in the English

language, focused on nurses in other countries, or focused on job classes other than staff nurse. The final pool was 55 articles.

Nurses Who Left the Nursing Profession

Three articles featured similar research questions and those articles are presented first. The remainder of the included literature fell easily into the categories of nurses' intent to leave or stay, nurses' job satisfaction, recruitment and retention, and innovative orientation programs.

Flinkman, Leino-Kilpi, and Salanterä (2010) presented an integrated review of the literature on nurses' intent to leave the profession in order to synthesize cross-study findings. Common demographic findings related to nurses intending to leave the profession included youth, being highly qualified, and being male. Work related variables contributing to increased likelihood of leaving the profession included low occupational commitment, low affective commitment to the profession, and low professional commitment. Other variables with high correlation to intent to leave were low job satisfaction, dissatisfaction with pay, few possibilities for development, the experiences of burnout or work-family stress, or being in a family not dependent on the nurse's salary. It is posited that the intent to leave nursing may begin as a withdrawal process with a trajectory initiated by leaving the unit and then extending to leaving the profession. These authors note that integrating the literature on nurses' intent to leave was challenging owing to varying definitions of "leaving intention" (p. 1432) which was further complicated by the near exclusive reliance on survey methods. Among their

recommendations was further research in which nurses who have left explain the reasons for their departures in their own words.

MacKusick and Minick (2010) utilized Hermeneutic Phenomenology to explore the factors that influenced the decisions of RNs to stop practicing clinical nursing. Informants participated in semi structured interviews. Recruitment was accomplished through snowball sampling beginning with requests to practicing nurses for nomination. Participants (n=10) were recruited by telephone and had a minimum of one full year of clinical practice with none of that practice having occurred in the six months preceding the interview. These researchers excluded nurses who had allowed their licenses to lapse, positing that those nurses might no longer identify as nurses. The primary theme discovered related to leaving was unfriendly workplace. The theme unfriendly workplace included subthemes of severe bullying, being deliberately left alone with multiple critically ill and crashing patients, and sexual abuse by MDs. The second theme was emotional distress related to patient care that included overly aggressive treatment of patients by physicians such as running codes 'just as learning instruments,' lack of collaboration between MDs and staff, and lack of respect for family and patient wishes by the physicians. The final theme was fatigue and exhaustion. The summary quote shared by the authors is included here.

> If you are doing a good job, it is mentally as well as physically exhausting, demanding… you are going to burn out, as no one supports you, stands by you…you are always working, always on your feet, always thinking. It doesn't end…ever…your brain is always in overtime. (p. 339)

Skillman, Palazzo, Hart, and Keepnews (2010) utilized a descriptive survey to query nurses with expired licenses regarding the reasons they had let their licenses lapse. Also included were questions regarding their attitudes toward the profession of nursing, and which, if any circumstances might bring them back to practice. The pool of potential respondents were members of the group who had allowed their licenses to expire in 2002 or 2003 who were younger than age 69 at that time. Surveys were sent to half of that group who were randomly selected. The survey response rate was 21.5% when adjusted for the number of survey recipients who were deceased. Among the nurses who responded to the survey, the most common reason for leaving was illness or disability, closely followed by job-related stress or exhaustion. Fewer than half of the participants who had left reported moderate or extreme satisfaction with their last nursing job (the authors report that among practicing nurses, 78% report their satisfaction as moderate to extreme). Among those respondents physically capable of returning to practice, fewer than one third identified any of the provided options as having the power to entice them back into practice. When asked to rank them as the most powerful (if still not convincing) they suggested that "availability of more flexible hours", "responsibility for fewer patients", "change in personal situation," and "higher pay." More than two thirds of the group able to return to practice said there was nothing that would persuade them to return. These researchers report that it is likely that few if any of their participants would rejoin the nursing workforce, though they note an "enduring self-identification with nursing" (p. 188) that might be leveraged to convince them to return to practice. These authors suggested increasing the family friendliness of the workplace and making flexible

hours available might incentivize nurses absent from the nursing workforce to return. Increasing pay was not clearly identified as likely to impact the decision to return.

Literature Related to Nurse Retention and Job Satisfaction

Nurses' intent to leave or stay in their current position.

Intent to leave is a common variable measured in researching nurse job satisfaction, turnover and retention. While none of the 15 included articles examining intent to leave or intent to stay defined 'intent to leave,' the variable was typically measured with a direct question such as "How likely are you to leave your principal RN position in the next 12 months?" (Zurmehly, Martin, & Fitzpatrick, 2009, p. 386).

Alexander, Lichtenstein, Oh, and Ullman, (1988) utilized structural equation modeling to develop and test a causal model of personnel turnover among workers on a psychiatric unit. While their sample included LPNs and NAs, they used a large number of participants (N=1106) 444 of whom were RNs. Other participants included 152 LPNs, and 510 NAs. Participants in this sample had remained in their positions for a mean of 7.82 years. The intervening variables between demographic factors (age, gender, and education) and intention to quit were work hazards, professional growth opportunities, role clarity, workload, autonomy, and relationship with coworkers. Theoretical variables thought to relate to intent to quit that were not included in the final model included tenure (both with the institution and in the position), marital status, satisfaction with pay and benefits, satisfaction with material resources, and satisfaction with relationship with patients. The final model contained no discrimination between differing job classes and

thus is not presented here. The authors noted that the "model is better at accounting for variation in intention to quit and job satisfaction than actual turnover" (p. 425).

Boyle, Bott, Hansen, Woods, and Taunton (1999) examined the relationship of the nurse manager characteristics of power, influence, and leadership style on RNs' intent to stay in their positions. Using structural equation modeling the authors specified a model with a strong relationship between manager characteristics of position power and influence, structuring expectations, and consideration on critical care RNs intent to stay in their position. Consideration refers to the "degree to which the manager regards the comfort, well-being status, and contribution of staff" (p. 365). Also significant in this study was RN job satisfaction that was influenced by instrumental communication, autonomy, and group cohesion, through decreasing job stress.

Taunton, Boyle, Woods, Hansen, & Bott (1997) sought to specify a model of the impact of manager characteristics on hospital RNs' intent to stay. These researchers utilized structural equation modeling. Two variables were primarily responsible for the explained variance in retention: manager consideration and RN intent to stay. Manager consideration was measured with two items that reflected "fairness and helping work group members develop their skills" (p. 211). These authors used Price and Mueller's (1981) definition of intent to stay which was "the estimated likelihood of continued membership in an organization." (p. 546). Other significant variables impacting retention were characteristics of manager, organization, work, and nurse, and job satisfaction (enjoyment, administration) and commitment (see Figure 1).

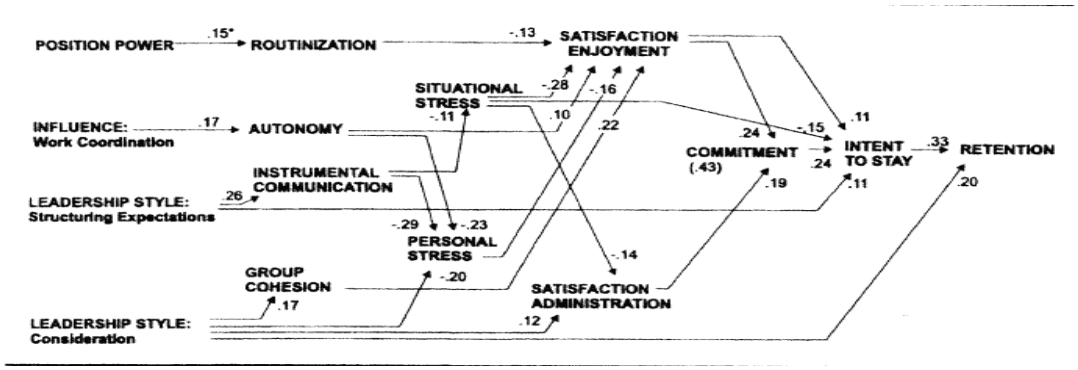


Figure 1: Causal model of retention: Modified sample. [1]

Miller (2008) sought in a descriptive-correlational survey to determine the relationship between three types of job satisfaction (extrinsic, intrinsic, and general) and intent to leave. This author defined 'intrinsic' factors as the work itself, achievement, and responsibility. Extrinsic factors were advancement, company policies and practices, implementation of company policies and practices, salary, and work quantity. General factors were not defined. The sample for this research was hospice nurses in a for profit corporation. Hospice nurses (N=302) were surveyed with items measuring factors of job satisfaction and intent to leave along with demographic items. In this study, intent to leave was significantly and negatively related to 'general satisfaction,' 'intrinsic satisfaction,' and 'extrinsic satisfaction.' There was a large relationship between intent to leave and 'general satisfaction' and 'extrinsic satisfaction,' while there was a moderate relationship between 'intrinsic satisfaction' and intent to leave.

[1] From "Manager leadership and retention of hospital staff nurses," by R. L. Taunton, D. K. Boyle, C.Q. Woods, H. E. Hansen, and M. J. Bott, 1997, *Western Journal of Nursing Research, 19*(2), p. 217. Copyright 1997 by SAGE Publications. Reprinted with permission.

Nedd (2006) sought to determine if perceptions of formal power, informal power, and access to work empowerment structures related to RNs self-reported intent to stay in their positions. In a correlational study, the researcher administered the Job Activities Scale, Organizational Relationships Scale, and the Conditions for Work Effectiveness Questionnaire to a small sample of Florida nurses (N=206). Nedd suggested that there is a significantly positive relationship between perceptions of access to opportunity, information, support, and resources with intent to stay. Another finding was that individual nurse characteristics such as gender, age, education, and clinical practice area were not significantly related to intent to stay. The majority of the participants (76%) were prepared with an Associate Degree (40%) or a Baccalaureate Degree (36%). This report of no significant correlation between educational level and intent to stay is contrary to Rambur et al. (2005) who reported a significant relationship between educational level and intent to turn over, finding that baccalaureate prepared nurses were more likely to intend to stay.

Palumbo et al. (2009) utilized a convenience sample and a mailed survey to explore RNs perceptions of intent to stay in current position, with their current employer, and employed as a nurse (self-report measure), the organizational and unit-level culture regarding older nurses in the work environment, the importance of specific HR policies to their intents to stay in the workplace, and the extent to which those HR practices are implemented in their workplaces. Surveys were sent to nurses employed in one of 12 institutions (four hospitals, seven home health agencies and one long term care facility). Responses to the survey were received from 583 RNs which represented a 53% response

rate. Nurses in this sample reported that they were intending to work beyond the "traditional retirement age of hospital nurses" of 55. These authors credit the identification of this retirement age to Minnick (2000).

Six areas were identified by Palumbo et al. (2009) that require consideration in the retention and recruitment of older nurses. First among them is the recruitment attitude toward older nurses and whether or not they are targeted by HR for recruitment and retention. Beyond that is the question of whether or not the institution encourages older nurses to update their job skills and further develop their careers. Work design is important to older nurses. To this end, are jobs designed for maximum efficiency and effectiveness? Feedback to older nurses needs to be offered regularly and recognition for achievements needs to be provided. A competitive rewards system is important to older nurses and finally, how is the work culture integrating older nurses? Do they have a voice and are they recognized and valued? Organizations that are able to respond thoughtfully to the needs of aging nurses will gain an increasingly competitive advantage.

Parsons and Stonestreet (2004) researched what had attracted nurses to the health care system, what was contributing to their continued presence in the system, and what would enhance the likelihood of their staying in the system. Focus groups consisting of staff nurses from one health system in Texas were conducted using open ended data-generating questions, guided interview, and comment. The primary theme that emerged for retention was pay. Included in that theme was resentment of hiring bonuses paid to newly employed nurses in the absence of longevity pay for nurses who continued in their positions. The second theme was staffing: maintaining staffing levels, realistic charge

nurse roles, and sufficient time for precepting new staff. Other themes included positive relationships with physicians, manager support and advocacy, positive relations on the unit, participation in problem solving and decision making. Two additional themes involved management and retention. The management theme encompassed administration listening and responding, and upper management being visible. The retention theme described uncertainty regarding retention in the hospital.

Rambur, Palumbo, McIntosh, & Mongeon (2003) explored the effect of gender, age, educational preparation, setting, position, clinical practice area, and population density on the intention of nurses' to leave their nursing position within 12 months for career advancement, situational, or job satisfaction reasons. They examined RNs' intentions to leave their current positions in a secondary analysis of a statewide survey by the Board of Nursing in Vermont. They reported that approximately 20% of the survey respondents stated they were intending to quit their current position, and that BS nurses were more satisfied than AD nurses. In addition to these findings, the authors posited that the total rewards of nursing (emotional and financial) are not sufficient to retain large numbers of nurses. Evidence cited for this assertion was their finding that male participants intending to leave listed salary as the reason to leave and the female participants intending to leave listed personal or other "neutral" reasons. Though multiple interpretations are possible, because of these differing responses, the authors suggest that females are less likely to voice dissatisfaction with salary and instead offer a neutral reason for their intention to leave.

Raupp (2008) identified the leadership styles of nurse managers in academic health center hospital emergency departments and examined their influence on patient satisfaction and nurse turnover. An online survey comprised of the Multifactor Leadership Questionnaire and 10 researcher developed items was conducted with the population of interest to which 15 managers and 30 staff nurses responded. Although 98 sites agreed to participate, only 15 sites had complete survey responses. Of the sites with complete responses, 80% of managers identified their leadership style as transformational versus non-transformational, which was validated by 20% of the nurses reporting to them. A trend but not statistical significance was identified in the retention rates of units managed by leaders who asserted the use of transformational leadership. The turnover rate among the units managed by these leaders was 13% while the turnover rate among the other group was 29%. There was no impact noted on patient satisfaction.

Sofield and Salmond (2003) sought to both describe the experience of verbal abuse and to determine the relationship between the experience of verbal abuse and intent to leave the organization. Verbal abuse is defined as "communicated through words, tone, or manner that disparages, intimidates, patronizes, threatens, accuses or disrespects" (p 274) and is described as a form of workplace violence that leaves no physical scarring. The study reports that verbal abuse can result in devastating emotional damage to the inner core of the victim. In a study utilizing a descriptive correlational design, these researchers mailed questionnaires to 1000 nurses. The final pool of useable surveys was 461. In those responses they found that 91% of respondents had experienced verbal abuse in the previous month and 24% of respondents had experienced more than five incidents

of verbal abuse in the previous month. They also report that 50% of respondents did not feel able to respond competently to verbal abuse. The verbal abuse came primarily from physicians (35%) followed closely by patient's families (22%) with other sources being patients, peers, immediate supervisor and subordinates. Fourteen percent of respondents had left a previous position because of verbal abuse and 62% felt that verbal abuse contributed to increased staff turnover. The authors found a weak but significant correlation between verbal abuse and seeking a new position.

Zurmehly et al. (2009) explored the relationship between the empowerment of RNs and their intent to leave their position or the profession of nursing. Empowerment stems from Kanter's theory of structural power in organizations and includes facets of both formal and informal systems of power. Empowered nurses have access to opportunity (growth, mobility, and opportunities to increase knowledge and skills), power (ability to mobilize resources and complete the job), and information (data, expertise, and technical knowledge to perform one's job). Surveys were distributed to 3000 nurses in 16 counties in West Central Ohio. Of these, 1,231 returned surveys were complete enough for inclusion. Perceptions of empowerment significantly and negatively correlated with both intent to leave current position and intent to leave the profession of nursing. Variation was noted by demographic as well. Of note was that baccalaureate prepared nurses reported the most empowerment and the least likelihood to leave their position. Older nurses were also less likely to be planning to leave their current position.

Nurses' job satisfaction.

Atencio et al. (2003) explored the perceptions of staff RNs regarding autonomy, task orientation, and work pressure in the acute care hospital work environment. In this longitudinal study, they measured nurses' perceptions every six months for two years. In their report of the initial baseline survey, they affirmed previous findings regarding RN's perceptions of the listed concepts. They noted that newer nurses (<5 years of experience) perceived greater autonomy and had a more positive view of their tasks than did more experienced RNs. Nurses perceived an increase in work pressure over time.

Bowles and Candela (2005) sought to determine what choices new nurses made in their first positions and, if they had left them, why. They received 352 completed surveys from Nevada licensed nurses who had graduated in the previous five years. Findings included that 57% of respondents had left their first position in the first two years. New graduates were most satisfied if they worked in not-for-profit facilities and on units with fewer than 20 beds. Reasons for leaving included patient care issues, increased stress with high acuity patients, management issues, and a lack of support and guidance.

Corley, Minick, Elswick, & Jacobs (2005) examined the relationship of moral distress and ethical work environment. In a descriptive-correlational study, they correlated the frequency and intensity of moral distress with work environment and demographic factors. They reported that the incidents which cause the most intense moral distress occur infrequently. There was a negative correlation between age and moral distress intensity which the authors interpreted as the impact of experience in dealing with ethical problems. The issue which incited the highest moral distress intensity

and frequency was the nurses' perception of unsafe staffing. These authors note that as early as the 1990's 15% of nurses in one study reported leaving a previous position because of moral distress and that some nurses stop practicing nursing as a result of moral distress.

Cox et al. (2006) sought to identify factors that triggered negative perceptions related to workload among nurses. Additionally this study intended to develop and validate an instrument for the evaluation of pediatric nursing perceptions of correlations between workload and job satisfaction. Surveys were completed over a one year period by 879 nurses. These surveys utilized elements of widely accepted tools as well as items developed specifically for the tool. The most positive perceptions of manager performance were held by the most satisfied nurses. That correlation supports the findings of Taunton et al. (1997) that manager behaviors influence nurse satisfaction. Also significant was that the most highly satisfied nurses were those with less than one year in the unit.

Hart (2005) investigated the impact of hospital ethical climates on RNs' professional and positional intent to leave. A cross-sectional study of randomly selected nurses (N=463) was conducted. Among Hart's findings were that RNs who had been nurses longer were more likely to report an intent to stay in their current position, and that the hospital ethical climate exerted the strongest pressure on intent to turn over professionally or positionally when compared to control over practice, educational reimbursement as a retention strategy, gender, and staff sufficiency. Hospital ethical climate explained 25.4% of the variance in positional turnover intent. Together, hospital

ethical climate, patient load, and control over practice explained 15.8% of the variance in professional turnover intention.

Hauck, Quinn Griffin, and Fitzpatrick (2011) examined the relationship between anticipated turnover and perceptions of structural empowerment among critical care nurses. A survey comprised of items from multiple standard measures was distributed to 257 critical care nurses. The response rate was 38% with 98 completed surveys returned. This study utilized Laschinger's structural empowerment framework which builds on Kanter's theory on workplace performance within an organization. Laschinger's framework holds that having access to formal and informal power systems results in an increased sense of autonomy, increased self-efficacy, and in greater organizational commitment. In this study, critical care nurses perceived themselves to be moderately empowered. Results of this study included an inverse relationship between the nurses' perception of access to opportunity information, support, and resources, and their potential for leaving (measured by stated intent to leave). Nurses in this study with greater perceptions of empowerment had an increased sense of autonomy, job satisfaction, and organizational commitment.

Larrabee, Janney, Ostrow, Withrow, Hobbs, Jr., and Burant (2003) investigated the relative influence of nurse attitudes, context of care, and structure of care on job satisfaction and intent to leave. These researchers implemented a nonexperimental, predictive design utilizing a questionnaire distributed to a convenience sample. The findings supported job dissatisfaction as a major predictor of intent to leave and described the contributing forces of job dissatisfaction. In this small study (N=90) the researchers

compared responses on measures of job satisfaction, intent to leave, nurse manager leadership style, unit turbulence, staffing, autonomy and control of practice, nurse/physician collaboration, support services, group cohesion, psychological empowerment, and hardiness. They concluded that the main predictor of job satisfaction was psychological empowerment, which was in turn predicted by hardiness, transformational leadership style of managers, nurse/physician collaboration, and group cohesion.

Morgan and Lynn (2009) sought to explore what nurses identify as important to their evaluation of their work and to describe the central themes. Twenty informants participated in semi-structured interviews in this phenomenological exploration. Participants described both intrinsic and extrinsic dimensions of work satisfaction. The authors organized the emerged themes by dimensions of job satisfaction. Included intrinsic themes were humanizing care work (comforting patients, making a difference, educating patients, and patient advocacy), professional ideals (professional pride, autonomy, mentoring, respect for nursing, and professional boundary maintenance). Extrinsic themes identified were financial, convenience, career opportunities, relationships with coworkers and resource adequacy. The definitions of these themes were self evident with the exception of "convenience." This theme described the pressure to accomplish more than is possible within one's shift and was described as "…but if I work as hard and as fast as I can and I still can't get it all done, that's a bad day." (p. 405)

Rosenstein (2002) explored how nurses, physicians, and executives viewed nurse-physician relationships, disruptive physician behavior, and institutional response to such

behavior and how that behavior affected nurse satisfaction, morale, and retention. A convenience sample was utilized including 1200 survey responses. Of the respondents, 720 identified themselves as nurses, 173 identified themselves as physicians, and 26 identified as administrative executives. Rosenstein found that physicians viewed nurse-physician relationships as less important than did the nurses and that physicians felt the existing relationships were better than did the nurses. Ninety-two percent of respondents reported witnessing disruptive physician behavior and that it had contributed to nurses leaving their jobs with the hospital. When asked to estimate how many nurses left each year because of disruptive physician behavior, the average response was 2.6 nurses leaving each year. Twenty-four percent of respondents who knew nurses who had left because of this behavior reported that still other nurses who had experienced disruptive physician behavior made different changes: changing schedules, switching shifts, or changing departments. Work relationships are essential to nurses' job satisfaction and intent to stay or leave.

Strachota et al. (2003) sought to determine why 84 nurses who had resigned or cut their hours in a Midwestern hospital within one nine month period had done so. These researchers utilized a telephone survey strategy involving open-ended questions and probing follow up questions. The primary reason cited by 50% of participants for leaving or cutting hours was the type of hours worked. They discussed holidays, weekends, nights, long shifts, and overtime. Other reasons included staffing levels and lack of management support. Almost half of the respondents were frustrated with the quality of

care they could deliver with the staffing levels utilized and 76% cited low staffing levels as part of the reason they left or cut hours.

Williams, Stotts, Jacob, Stegbauer, Roussel, & Carter (2006) investigated why inactive nurses made the choice to leave nursing and questioned them regarding what would encourage them to return to practice. Using a mailed survey, they polled nurses younger than 60 years licensed and residing in the state of Mississippi who were not practicing. Seventy-one percent of eligible participants responded to their surveys. Nurses who would be willing to return to practice if they could work part-time comprised 48% of the sample. Of the disabled nurses, 26% were willing to do light-duty work, and 41% were willing to work if it didn't involve patient care. The three most often cited reasons for having left the nursing workforce cited by participants were parenting duties (28%), shift length (14%), and salary (13%).

Wyatt and Harrison (2010) utilized a researcher developed tool to determine the perceptions of certified pediatric nurses (CPNs) regarding job satisfaction. Additionally these researchers measured the influence of certification on job-related factors and to identify the factors that motivate pediatric nurses to become certified. A 22 item survey was sent to 6,912 certified pediatric nurses. The survey was returned by 1,354 participants which represented a 19.6% return rate. Of the respondents, 30.3% reported excellent job satisfaction and 57.7% reported good satisfaction. Poor job satisfaction was reported by 1.4% of participants. Items important to job satisfaction were relationships with colleagues (82%), supportive work environment (79.9%). Among CPNs, the most common reason for pursuing certification was a personal sense of achievement (93.5%)

and the next most common reason cited was professional recognition (63.4%). Other CPNs cited validation of clinical competency (57.1%).. The researchers were the CEO and the Executive VP of the Pediatric Nursing Certification Board.

Recruitment and retention of nurses.

Bassi and Polifroni (2005) described learning communities as a link to recruitment and retention. They suggested that the implementation of learning communities in healthcare would decrease professional turnover and increase positional retention. The authors defined a learning community as "any group of people having as their common interest to gain knowledge, comprehension, or mastery through experience and study." (p. 105) and described steps to be taken in transforming the organization into a learning community. Time and space must be devoted to meetings at which learning should be the goal. This time and space must be away from the interruptions of clinical duty. These writers asserted that the creation of a learning community will create a supportive environment that reduces feelings of isolation, support professional growth and mutual respect.

Brewer and Nauenberg (2003) researched the impact of demographic, economic, and attitudinal factors on intent to leave and workforce participation among RNs in western New York. Surveys were sent to 1,482 RNs and usable responses were received from 776. These researchers defined economic factors as wages, benefits, and unionization, and attitudinal factors as organizational commitment, job perception, and job satisfaction. They found that full time RNs were less likely to be married and were more likely to attach significance to benefit packages than were part time RNs. Most of

the RNs in their sample (N=776) were satisfied with their jobs, but the group most likely to be moderately or extremely dissatisfied were full time hospital RNs. The level of dissatisfaction was additionally reported to have increased in this group over the previous year. As expected, the nurses with the most years of experience were the most likely to be planning on leaving permanently. The group most likely to be seeking a change of position was the group with the least years of experience.

Brewer et al. (2006) sought to use the wisdom of practicing nurses, nurse managers and health care administrators with the goal of prioritizing nursing recruitment and retention programs and resources. Multiple focus groups were conducted with participants' representative of the above groups. These groups identified recruitment challenges included the aging of the workforce, media and gender stereotypes of nurses, public misunderstanding of nursing, high school pipeline barriers (guidance counselors promoting medicine at the expense of nursing), and nursing faculty shortages. Identified retention challenges were work intensity in the healthcare setting, staffing and scheduling, lack of empowerment, the use of traveling nurses, workforce compensation, barriers to continuing education and work culture. The findings of this study were the basis for the New York State Health Education Center's nursing strategic plan which committed to improve access to education and enhance program capacities, address the faculty shortage and develop strategies to remediate it, promote workplace best practices, promote a positive nursing image, provide pre-professional exposure to nursing careers, and to provide nursing support for displaced and or downsized workers.

Duvall and Andrews (2010) sought to identify the factors associated with the nursing shortage. Following a structured literature review they report that reasons nurses leave hospital practice were related to management issues, job design, job stress, physical demands, and non-nurturance of new nurses. Also contributing to the nursing shortage was the shortage of nursing faculty. Members of the nursing faculty are expected to retire in numbers far exceeding those entering the faculty for a number of reasons included the disparity of income between practice and teaching.

Ellenbecker, Samia, Cushman, and Porell (2007) described the effect of implemented retention strategies on nurse job satisfaction and intent to leave. Data was sought from 149 randomly selected provider organizations. Participation was offered by 123 of them. Most of the agencies included reported the implementation of multiple retention strategies including offering competitive benefits, enhancing workplace safety, sharing decision making, employee recognition programs, flexible work schedules, offering opportunities for control over work or professional growth, and reducing agency job demands. The implementation of a shared governance model was the only strategy that resulted in a significant impact on job satisfaction. None of the reported strategies yielded a significant impact on intent to stay. The primary influence on intent to stay was job satisfaction.

Gambino (2010) examined the relationship between RN's motivation for entering the profession, their occupational commitment, and their intent to remain with their employer until retirement. While 2050 invitations to participate were sent by email, only 206 surveys were completed and of those, only 150 were included in the study. The

author did not find a significant relationship between motivation for entering the profession and intent to remain with their current employer until retirement. Significant relationship between age and intent to remain, and normative commitment and intent to remain were reported. Normative commitment is described as a feeling or sensation of an obligation to continue employment. Other types of commitment explored in this study included affective commitment which was defined as the employee's sense of attachment to and identification with the organization, and continuance commitment which was defined as a sense of needing to continue with the organization because of the costs of leaving.

Hayhurst, Saylor, and Stuenkel (2005) investigated factors associated with nurse job satisfaction in the work environment and their relationship to actual retention rates. These researchers utilized a sample of 240 northern California nurses. This research used a descriptive-correlational design to compare the perceptions of work environments of nurses who stayed in their position over 18 months with those who changed positions during those 18 months. The nurses who did not change position reported less pressure from work, greater peer cohesion, and greater supervisor support and autonomy than those who did change position.

Holtom and O'Neill (2004) examined the predictive validity of the job embeddedness concept. To this end, they employed a longitudinal design with two measures one year apart. Job embeddedness encompasses three dimensions which generally include how well the employee's job and community fit the employee, how thoroughly the employee is linked to people in the local community, and how easily and

what it would cost the employee to break those links. These dimensions are labeled “fit,” “links,” and “sacrifice.” Fit describes the level at which the employee feels comfortable at the organization and his or her environment. Links describe the individual ties between the employee and other persons and organizations in the area and may include family, finances, and non work activities such as clubs, hobbies, and community organizations. Sacrifice encompasses the costs to the employee of leaving the position and may include personal losses such as relationships with friends or departing a highly functional work team. Embeddedness was negatively correlated with intent to leave. These researchers reported that job embeddedness was superior to other predictors, such as job satisfaction, organizational commitment, and perceived ease of movement in predicting turnover.

Karlowicz and Ternus (2009) utilized grounded theory in an effort to increase understanding of nurse retention practices in the first year. These authors collected data using structured telephone interviews with 14 nurses. The participants were psychiatric nurses in one for profit organization. Participants identified the practice model as "infirmary" which utilized nurses as medication givers and discouraged leaving the desk to interact with patients. This model is task driven and stations the nurses away from the patients in their care. The researchers suggested a number of interventions to increase first year retention of psychiatric nurses in this organization which included: focused interviews of nurse applicants, shadowing of an employed nurse by potential hires prior to the hiring decision, the development of a mentoring program, and establishing competency based job descriptions that would expand the role of the RN leading to an increased level of nursing professionalism.

Letvak and Buck (2008) sought to determine how multiple factors including individual characteristics, workplace characteristics, and health related to work productivity and intent to stay in nursing. The individual factors included were demographic characteristics, years of nursing, and body mass index. The included workplace factors were hours worked, shifts worked, and unit type. The health factors were perceived overall health, health problems, and job-related injuries. A descriptive correlational survey design was utilized. It was reported that nurses found that 12.7% of them they were unable to meet patient care needs and reported moderate stress. Despite these findings, 93% of the nurses in the sample also reported that they were satisfied with their jobs. More than 50% of the sample was overweight but body mass index was associated with neither decreased work productivity nor intent to stay in nursing. In this report, years worked as an RN was associated with decreased productivity.

Manion (2004) sought to determine best practices associated with retention of RNs, which in this study was represented by creating "a positive work environment and a culture of retention" (p. 29). Using a mixed methods qualitative research design, individual interviews were conducted initially with participants who were "successful" nurse managers, and those individual interviews were followed by focus groups comprised of the supervisors and employees of the initial informants. The focus groups were used to validate what the managers had shared. Success of managers was defined with a combination of low turnover rates of staff, high satisfaction of patients, employees, and providers, good patient outcomes, and positive working relationships among staff members. The overall question for the focus groups was "What makes a culture of

retention?" Findings included putting the staff first, forging authentic connections with staff, coaching for and expecting competence, focusing on results, and partnering with staff.

Manion and Bartholomew (2004) discussed the concept of community in the workplace as a strategy to retain nurses. They described the defining characteristics of community in the workplace and suggested interventions that nurse leaders can implement in order to create an environment in which community can flourish. The recommendations included holding a clear vision of the possibility of the community and nurturing relationships. Suggestions also included providing support for community formation that requires the nurse leader to balance the need for social capital with productivity, and seeking opportunities to strengthen the sense of connection. They also recommended a shared governance model to foster community in the workplace.

Rambur et al. (2005) investigated the comparative job satisfaction and career retention between associate degree (AD) and bachelor's degree (BS) RNs. Using survey research, they compared responses on a career satisfaction scale and components of the US Health and Retirement survey. Their final sample included 379 AD nurses and 499 BS nurses. All participants were RNs in the State of Vermont. Of significance were the findings that BS nurses were more satisfied with opportunities for autonomy and growth, amount of job stress and physical demands, and job and organizational security. They found no difference in the number of years that the nurses had held their current position, but that BS nurses had held more nursing jobs. Another significant finding included the identification of a longer career for baccalaureate prepared nurses than for associate

degree nurses. AD nurses were older when they began their career and consequently practiced for a shorter length of time.

Salt, Cummings, and Profetto-McGrath (2008) performed a systematic literature review to determine the effectiveness of strategies utilized in efforts to improve the retention of new graduate nurses. These researchers categorized the reviewed efforts into four basic groups. Two groups utilized preceptors, one with a focus on the preceptors and one with the focus on the new graduates. The programs that focused on the preceptors were aimed at developing existing staff into excellent preceptors. The programs that focused on the new graduates generally aligned the new graduate with one or more preceptors for specific clinical experiences. A second type of strategy focused on a needs-based model and/or specialty training. This type of program was utilized for specific skills unique or commonly used in the specific area into which the new graduate was hired. The final group of strategies utilized pre-graduation/pre-licensure externships. The largest increases in the retention rates of new graduates were seen in the strategies that included a three to six month orientation with preceptorships. The one year retention rates among that group climbed to 86-90% from the 60-63% of the control group.

Ulrich et al. (2010) aimed to improve the retention rate of new graduate RNs in Vermont. To meet this aim they instituted a competency based new graduate curriculum that took an average of 716 hours. Prior to the implementation, participating Vermont hospitals generally turned over 50% of new grads within the first two years. Following implementation, turnover at five years was 40%.

Unique needs and retention of aging nurses.

Hader, Saver, and Steltzer (2006) examined the presence of comprehensive strategies to retain aging nurses. This report used the results of the *Nursing Management* Aging Workforce Survey that reported the responses of 978 participants. Respondents were nursing supervisors from a variety of health care settings. Respondents identified many strategies implemented to help nurses in their work but the strategies were inconsistently utilized. Among the strategies was the implementation of special shift lengths of four, eight, ten, and twelve hours. Other strategies involved the acquisition and use of electric beds, mechanical patient lifts, ergonomic training, and bariatric equipment or accommodations. One facility offered reduced cost bariatric surgery to their nurses. In addition to the special bariatric equipment, many hospitals utilized lift teams that reduce the burden on mature nurses. Magnet hospitals consistently implemented more strategies aimed at retention of the mature nurse. This article focused on what strategies had been implemented and did not address the success or lack of success of any individual strategy. Recommendations endorsed by the authors include splitting 12 hour shifts into two 6 hour shifts, consideration of innovative programs supporting nurses with functional limitations, and the provision of health insurance to nurses working less than full time.

In a study offering descriptive results, Letvak (2002) sought to explore the plans for utilization of aging RNs and to discover what was known about this group. This researcher reported on what was being done administratively at the time to retain older nurses in North Carolina. The researcher utilized a descriptive survey distributed to hospitals, nursing homes, and institutions combining hospital and nursing home services,

as well as four institutions describing themselves as continuous care facilities regarding their RN demographics and their attitudes and policies relating to older RNs. When asked if they wanted to retain older nurses, 22% of facility administrators selected "yes, at all costs" and 77% selected "yes, if they can meet job requirements." Only 10% of administrators stated that they had policies in place regarding the older RN at the time of the survey. Existing policies described were benefit packages geared toward senior employees, eight hour shifts available if requested, reduced or part-time hours with continuation of benefits, part-time hours and flexible shifts encouraged for older workers, the ability to start retirement benefits after age 60 to supplement part-time work, appreciation gestures, older RNs being placed in administrative roles when possible and being used to orient younger RNs, and the provision of seminars and scholarships. The researcher did not define "older RNs."

Innovative orientation strategies for nurses.

In an anecdotal report, Almada, Carafoli, Flattery, French, and McNamara (2004) reported on an education based preceptor program implemented at a community hospital with 40 new graduates oriented with the new program. The purpose of the implemented changes to the orientation plan was to increase retention of the newly hired staff. The implemented program included one week in the classroom with professional development staff (PD), two week rotations to other departments including OR, recovery, endoscopy, radiology, stress testing, and the ED, and an eight week minimum preceptorship with extensions possible. The preceptors were educated about the program and paired with a preceptee and PD staff was available on all shifts and followed the preceptee for one

year. The preceptee worked each shift during the eight week preceptorship with the preceptor. Quantitative findings included 100% of the new hires having had their choice of facility influenced by the expanded orientation program, and an increased retention rate in this group of 93%, up from their baseline of 25%. Of note, those who left did so for "uncontrollable situations." Qualitative findings included three themes of what could be done to provide more support and preparation for new graduates: hands-on learning, instructions on systems/paperwork, and education/support from PD staff.

Baggot et al. (2005) shared a cost-benefit analysis of a retention strategy. This strategy entailed formally training RN preceptors to ensure strong teaching skills and awareness of techniques of teaching. To achieve this, RN preceptors were trained with a mixture of content using the ZingTrain method for training trainers, concepts of teaching during action, and role playing with a professional theater troupe. Through investing in preceptors in this fashion, this institution hoped to increase retention of both preceptors and new hires. Following this investment, the RN vacancy rate dropped 68% over two years and the all-nurse turnover rate decreased to 9.4%. Turnover of new nurses was 24% during their first year of employment while the national average was 55% – 61%. These researchers followed the turnover rates of both the new graduates and the preceptors. The preceptors themselves had less than 0.5% turnover in the three years following implementation. All participants reported high satisfaction with their training and 96% reported a willingness to recommend it to others. The authors stated that the investment in training and increased orientation more than paid for itself in decreased turnover and recruitment costs.

Cavanaugh and Huse (2004) wrote of an implemented program designed to increase the nursing staff in a neonatal intensive care unit. The program prepared 20 expert nurses to be assigned as preceptors. Each new hire was assigned two preceptors in order to avoid preceptor fatigue as well as to ensure that all shifts with the new hires were covered by consistent preceptors. Evaluations were completed every two weeks and further orientation was designed individually for each new nurse. The length of orientation varied from three to five months and was followed by four weeks of being buddied with the preceptors on each shift. Buddying involved the preceptee carrying a full load and the preceptor being given a light assignment. All participants reported satisfaction with the program, activities, and outcomes. The authors reported that following the implementation of this program further new hires chose their hospital because of the reputation of the orientation program and that of the 27 nurses hired into the program only two had left during the first two years. Neither of them had departed because of job dissatisfaction; one had health issues and the other had personal issues. The two year retention rate of new hires was 93%.

Graling and Rusynko (2001) documented the implementation of a nurse fellowship program which they credited with reducing their operating room (OR) nurse vacancy rate from 27% to 15%. Their fellowship program was based on adult learning theory and encompassed the cognitive, affective, and psychomotor domains. The program was eight months long and entailed classroom and practice sessions. The designers sought college credit for the program and George Mason University granted three credits toward the B.S. in Nursing at that university. The report covered two years

of fellows. The retention rate in June of 2000 for the 1998 classes was 73% and for the 1999 group, 83%. The authors reported that the cost of the program was offset by the savings on agency staffing personnel.

Halfer, Graf, and Sullivan (2008) reported on the implementation of a new pediatric nurse internship program. These researchers compared job satisfaction and retention rates of new graduate nurses who had started before and after the implementation of a new program. The report omitted specific components of the Pediatric New Graduate Nurse Orientation Program but asserted that job satisfaction was significantly higher in the post internship nurses. Nurses who had participated in the new program who worked the night shift reported higher ability to identify work resources, and a higher ability to manage the demands of the job. One year voluntary turnover was 12% in the Internship group and had been 20% in the group of orientees who preceded the implementation of the internship program.

An exploration of the impact of mentoring relationships on socialization, satisfaction, and intent to stay was reported by Prevosto (2001). In this correlational research study, 100 questionnaires were mailed to each of three groups of stratified, randomly selected military nurses. With a final pool of 171 completed and returned questionnaires, the researcher compared responses from the three organizational groups of nurses within the military on three measures: Intent to Stay Scale, an investigator developed mentoring survey, and Hoppock's job satisfaction survey. In this research, mentoring was defined as "a process of sharing experience with and providing advice to those who have less experience, rather than forcing those less knowledgeable to go it

alone" (p. 22). Mentored nurses reported higher job satisfaction and a greater intent to stay. There was no significant difference among the three groups of nurses on job satisfaction or intent to stay. The researcher posited that mentoring relationships are beneficial for "all nurses in all organizational assignments" (p. 26).

Roche, Lamoureux, & Teehan (2004) described a partnership between the University of Massachusetts School of Nursing and Baystate Health System (BHS) to increase the number of nursing graduates and to address cuts in educational funding. To the effort, BHS contributed funding for two full-time clinical faculty positions and two part-time clinical faculty for three years, which enabled the University to accept 16 additional students for each of the three years. At the beginning of the partnership, BHS had recently hired 67 new graduates and 23 experienced nurses. The BHS professors utilized Chandler's empowerment model to design an orientation and socialization program. One part of this program was support groups for the new graduates and support groups for the preceptors. Other activities were performed to enhance individual support, relationships, and opportunity. The retention outcome of the intervention was a six month retention rate of new graduates of 92.5% and an overall retention rate of 90% of all new hires.

Strauss (1997) described an internship program for new operating room (OR) nurses which was implemented in response to high nurse turnover. The program ran once per year and had run five times when the article was written. In those five years the author found that the retention rate of participants was twice that of nurses who had come with previous OR experience. The average length of stay in the department of nurses

hired with OR experience was 13 months and the average length of stay in the department of new graduates was three years. There were three sections of the internship program: classroom instruction, OR learning, and working with a preceptor. The program began with six weeks of classroom instruction, labs, and clinical opportunities. This was followed by ten months of working with preceptors. During the first year, interns worked with preceptors about 50% of the time and in the second year, they worked independently approximately 90% of the time and started functioning as preceptors themselves. At the time the article was written, 60% of the interns were still with the department and three of them had achieved movement up the clinical ladder.

Theory and Conceptual Models

Taunton et al. (1997) utilized an investigator-designed framework labeled Organizational Dynamics Paradigm. This framework suggests that RN retention is related to four sets of predictor variables: manager characteristics, organizational characteristics, work characteristics and nurse characteristics. Manager characteristics encompassed type of power (reward, coercive, legitimate, referent, and expert), influence, and leadership style. Organizational characteristics related to control over nursing practice and included control over practice, access to ideas, interpersonal influence, evaluation and modification, personal resources, and research utilization. Work characteristics centered around job stress and included competence, physical work environment, staffing, team respect, and time priorities. Nurse characteristics included job satisfaction and enjoyment. The interactions of these four sets of variables combine to predict retention of RNs.

Boyle et al. (1999) utilized this framework in their research on critical care nurses' intent to stay in their positions.

Alexander et al. (1998) offered a theoretical perspective on turnover based on two earlier theories of job attitudes and behavior. The Alexander et al. framework is a blending of the needs-satisfaction view that suggests that jobs have specific characteristics that will or will not match with individuals' unique needs and the opposing framework of social information processing perspective which holds that individuals' needs and wants are determined by their situations and that attitudes are shaped by social contexts and the results of past behaviors. The blend of these perspectives offered by the researchers is that staff nurses attitudes toward work and workplace are a function of their training, experience, and social network. These frameworks suggest that there is not one solution to increase the satisfaction of all nurses, but that different groups of nurses will require differing satisfiers.

Sofield and Salmond (2003) employed the framework of Oppressed Group Behavior in their investigation of the impact verbal abuse and nurses' intent to leave. This model suggests that individuals in subordinate groups learn behavior patterns that are necessary for survival. These behaviors then perpetuate the cycle of subordination and oppression (Roberts, 1996). According to the researchers, one of the oppressing behaviors learned in nursing is verbal abuse which is then adopted and utilized between nurses and toward perceived subordinates. Increased incidents of witnessed verbal abuse were correlated with more intense intent to leave.

Larrabee et al. (2003) utilized a blend of Nursing Systems Outcomes Research (NSOR) model and the cognitive model of empowerment in their research into the prediction of RN job satisfaction and intent to leave. NSOR is based on structural contingency theory which contends that with differing structural contingencies, identical inputs will lead to differing outcomes. The cognitive empowerment model holds that there are four cognitions which are products of individuals past experiences. They cognitions are meaning, competence, self-determination, and impact. The authors contend that empowerment and disempowerment can come from within and that job satisfaction as a major predictor of intent to leave is heavily influenced from within the individual nurse.

Almada et al. (2004) described a new preceptorship program which was based on Benner's Novice to Expert theory. This theory suggests that an expert responds to situations without reductionist thinking and is able to perform because of experience which has been reflected upon, bringing an embodied or tacit knowing. The novice cannot have this embodied knowing because that person does not have the experience as a resource on which to draw. The goal of the writer was to bring each orientee to the advanced beginner level during the preceptorship. This preceptorship involved one week in the classroom followed by a two week rotation that included the OR, recovery room, endoscopy, radiology, stress testing and the ED. Subsequent to that the new graduates were paired with experienced nurses for at least 24 hours per week for at least 11 weeks. Friedman, Cooper, Click, and Fitzpatrick (2011) also utilized Benner's theory in an exploration of retention of new graduate critical care RNs.

Zurmehly et al. (2009) employed Kanter's theory of structural power in organizations. Kanter defines power as the capability of getting things done in the organization and that power derives from the structural conditions under which an employee group operates. Laschinger in 2001 extended Kanter's work with her Structural empowerment framework that was used by Hauck et al. (2011). Laschinger's theory asserts that the power structures identified by Kanter contribute to employees' perception of workplace empowerment. The experience of having access to these structures results in employees' increased perception of autonomy, self-efficacy, and organizational commitment (Hauck et al., 2011).

Summary of Findings

Nurses' intentions and job satisfaction.

Nurses' intent to leave or stay and Nurses' job satisfaction have been thoroughly researched and validated as components of nurse turnover (Boyle et al., 1999; Larrabee et al., 2003; Miller, 2008; Rambur et al., 2003; Zurmehly et al., 2009) and also with intent to leave the profession (Zurmehly et al., 2009). The opposite concept of intent to stay has been significantly related to staying in one's position (Boyle et al., 1999; Nedd, 2006; Palumbo et al., 2009; Parsons & Stonestreet, 2004). Nurses' intent to leave or stay and nurses' job satisfaction are tightly linked conceptually, and nurse job dissatisfaction is the primary predictor of nurses' intent to leave (Larrabee et al., 2003). Nurse job satisfaction is a product of a number of components including management and leadership (Atencio et al., 2003; Boyle et al., 1999; Larabee et al., 2003, Raup, 2008; Taunton et al., 1997), moral distress and ethical climate (Corley et al., 2005; Hart, 2005). Other components of

nurse job satisfaction include autonomy (Antencio et al., 2003; Larabee et al., 2003), work load and pressure (Antencio et al., 2003; Larabee et al., 2003) and organizational commitment (Lynn & Redman, 2005). Another significant contributor to nurse job satisfaction is the quality of the relationships between nurses and physicians (Rosenstein, 2002).

Recruitment and retention of nurses.

It is widely accepted that the current shortage of practicing RNs in the United States is severe, and that it is worsening, (Brewer et al., 2006; Rambur et al., 2005) with an anticipated shortage of 29% by 2020 (U.S. Department of Health and Human Services, 2002). Retention of currently employed nurses both in their positions and in the profession is of great importance to the health of citizens and to health care facilities (Strachota et al., 2003). The estimated cost of replacing one nurse is high with reported costs ranging from $44,000 (Baggot et al., 2005) - $145,000 (Atencio et al., 2003).

Components of nurse job satisfaction and manager behaviors which predispose nurses to remaining in their positions have been included in the criteria for Magnet Hospital status (Albaugh, 2003; Atencio et al., 2003; Kelly, McHugh, & Aiken, 2011) and indeed, facilities which have achieved this designation have retention rates twice those than do facilities which have not (The American Nurse, 2002, Kelly et al., 2011).

Less research has been focused on retaining nurses nearing the end of their careers (Letvak, 2002) and attracting those who have left to return to nursing (United States Department of Health and Human Services, 2002). There have been strategies published to accomplish both of those ends (Albaugh, 2003). Benefit packages can be

arranged to encourage nurses nearing retirement to continue working part time or in limited positions (Letvak, 2002) though research confirming the efficacy of these programs was not discovered in this review.

Unique needs and retention of aging nurses.

Managers consistently report that they want to retain older nurses (Letvak, 2002). Various strategies have been implemented in efforts to retain aging nurses (Hader et al., 2006; Barr, 2010). Altered shift lengths, advanced assistive equipment, and lifting personnel have all been utilized in this effort. Magnet hospitals consistently implemented more strategies aimed at retention of the mature nurse.

Innovative orientation strategies for nurses.

Multiple reports of new orientation model implementation were discovered. All of the reports indicated that the model discussed was implemented in an effort to address turnover rates. Most of the reports included a longer period of orientation (Almada et al., 2004; Cavanaugh & Huse, 2004; Halfer et al., 2008). Other alterations that reportedly decreased turnover included developing the relationship with the new graduate the summer before their senior year of nursing school (Wittman-Price & Kuplen, 2003), and buddy systems of orientation (Cavanaugh & Huse, 2004).

Chapter Three: Methodology

This chapter provides an overview of the study methodology. The basic research principles and philosophical foundations of case study research will be discussed with a particular focus on the approach of Stake (1995). Discussion then follows regarding participant recruitment, data collection procedures, data analysis, ethical issues, and the protection of human subjects.

The focus of this research was to develop an understanding of why nurses who have chosen to leave nursing as a profession have done so. Case study methodology can be appropriate for both naturalistic and positivistic enquiry but is the preferred method when the study seeks to answer 'how' or 'why' questions and the focus of inquiry is a specific phenomenon that is contextually based (Yin, 2009). Stake (1995) identifies case study as the method of choice for enquiring why people do what they do.

Case study methodology is based in a constructivist paradigm (Stake, 1995; Yin, 2009), "which assumes a relativist ontology, a subjectivist epistemology, and a naturalistic set of methodological procedures" (Denzin & Lincoln, 2000, p 21). Relativism assumes that there exists more than one reality (Baxter & Jack, 2008). Subjectivism holds that truth is a product by and of the interaction between the "knower and the known" (Kraus, 2005, p. 761), that the knowledge and experience of each individual develops through social interaction (Costantino, 2008). Naturalistic procedures are aimed at the understanding of phenomena rather than the knowing of facts (Owen, 2008). Constructivism developed in the 19th and 20th century as the interest of philosophers grew to concepts beyond the limits of positivism. Through the work of

philosophers such as Dilthey, Husserl, Weber, and others, acceptance of ontologically and epistemologically different inquiry developed (Denzin & Lincoln, 2000).

Stake (2009) identifies two types of case study research. Intrinsic case studies, such as this study, that seek understanding of specific phenomena or behaviors simply to understand the phenomenon or behavior. Instrumental case studies are the other type that is identified by Stake and those studies seek to understand the behavior or experience of an individual in order to gain knowledge about something else.

Case study is a qualitative method that seeks the 'how' and 'why' information regarding human choices and experiences (Stake, 2009). The focus of case study research is on understanding the whole of the experience, and a distinct advantage of this type of research is that some evolution of technique is anticipated through the research process; the researcher is not locked into a set of procedural steps, any breach of which will invalidate the enquiry. Rather the technique for asking the questions will evolve as the research progresses. "…the conversational interview method may serve either to mainly *gather* lived experience material or serve as an occasion to *reflect* with the partner (interviewee) of the conversational relation on the topic at hand." (van Manen, 1990, p. 63, italics and parens in original). The implementation of the research activities occur with the aim of fully understanding the whole. Accessing the knowledge of participants through interviews makes available to the researcher the data that is needed to understand the experience. Stake (1999) describes case study research as casting nets and collecting specimens. Continuing with Stake's metaphor, in this study the net was cast over nurses who had made the choice to leave nursing and the interview responses of each participant

nurse (the transcript) served as a 'specimen.' Each 'specimen' was compared to the others in order to derive the commonalties of the experience. The findings of this case study are contained in the informants' responses to the interview questions that became meaningful through reflection, analysis, writing, and re-representation by the researcher.

Sampling and Inclusion and Exclusion Criteria

To be included in the study, individuals must have been an English speaking, licensed, registered nurse in the State of Minnesota and have been younger than 59 years of age at the time of recruitment. The participants must not have been practicing nursing at the time of recruitment and must have let their nursing license lapse.

Participants were excluded if they were unlicensed as a result of adverse action against their license, or older than 59 years of age.

The sample targeted for this research was that group of Minnesota nurses who had let their licenses lapse. Nurses who had self-selected to leave the profession and who had intentionally let their licenses lapse were targeted as potential informants for the study. The assumption was made that nurses over the age of 59 years with inactive licenses were retired without having experienced the phenomenon of interest for this study (the decision to leave nursing prior to the completion of their nursing career).

Purposeful (criterion) sampling was used in this research. Criterion sampling is an appropriate method for qualitative inquiry (Creswell, 1998) and includes only participants who have experienced the phenomenon of interest as data sources. All individual informants met the criterion and as such were expert and knowledgeable in their grasp of the phenomenon.

Recruitment

The Minnesota Board of Nursing (MBN) maintains a list of Minnesota nurses and their license statuses as well as their practice statuses. The MBN provided the researcher with names and contact information of nurses who had let their license lapse and were not practicing. Letters of invitation to participate were sent to all 384 nurses who comprised the list provided by the MBN (see Appendix A for recruitment letter). Enclosed with the letter was a postcard addressed to the researcher that the participant returned if their intent was to indicate interest in participation. Sixty-two invitation letters were returned after delivery had failed. Seven response letters were mailed back to the researcher by family members of the addressees sharing that they had left owing to death or catastrophic injury (four) or that they had moved out of state and were continuing their nursing practice in their new locations (three). Six responses were received from individuals indicating that they were willing to participate in the research.

Face to face interviews were scheduled by telephone with these interested informants at sites of their choosing. They were asked to select a site and space that would be comfortable for them and free of interruption during the interview. All questions about the research that the potential participants had were answered during the scheduling telephone call. All six interviews resulted in useful transcripts.

Participant Demographics

The six nurses included in the study had allowed their Minnesota nursing license to lapse in 2007. Participants ranged in age from 35 – 55 years with a mean of 38.2 years. The sample included five women and one man. Three had stopped practicing within two

years and had not moved into other careers. Among the participants were one attorney, one speech pathologist, and one research administrator. Four of the participants were involved in long term relationships where the partner was gainfully employed. Two of the participants were divorced. Of those who responded to the invitation and who met inclusion criteria, all agreed to participate after hearing the detail of the study. Interviews lasted between 40-120 minutes with interview times averaging 74 minutes.

Data Collection

Stake (1995) asserts that there is not a defined moment when data collection commences. The data collection begins when the decision to undertake the study begins and continues as the researcher familiarizes him or herself with the background information. While there is no defined moment of beginning, there are critical components of data collection. Specifically they are "definition of case, list of research questions, identification of helpers, data sources, allocation of time, expenses, intended reporting" (p. 51).

For this study, case was defined as nurses who have chosen to leave nursing as a profession. Each participant provided through the interview his or her experience to the researcher and that experience became a component of the case. The list of research questions included "Tell me about your decision to leave nursing," as well as various open ended clarifying questions intended to ensure understanding of the response. These clarifying questions took the form of "What does it mean when you say…," and "Can you tell me more about…?" Data sources included the literature review covering nurse turnover, transcripts of the interviews with people who had experienced the phenomenon

of interest, as well as the field notes documenting the thoughts and impressions of the researcher composed immediately after the interviews. Time planned for data collection was one year. Expenses included two digital voice recorders for the audio taping of interviews and transportation costs to the appointments for the interviews, as well as transcription fees for the recordings. The intended reporting of the case study was the dissertation.

Unstructured interviews were conducted by the researcher with informants until the point of data saturation was reached. It was anticipated that 6 – 12 interviews would be required for the completion of the research, but interviews were planned to be continued until the point of data saturation. Data saturation occurs when no new data is coming out of successive interviews and data previously obtained is being repeated (Polit, 1996). Interviews were conducted to the point of data saturation. For this study, saturation occurred at the sixth interview. All persons meeting the inclusion criteria were invited to participate and all who accepted the invitation were interviewed.

The interviews were audio-taped and transcribed verbatim for data analysis. Following each interview, the researcher composed field notes containing impressions, thoughts, and researcher reactions to the interview. The transcriptions of the interviews were read by the researcher and compared to the audiotape to ensure complete accuracy.

Structure of the Interview

Following greetings and putting the participant at ease (explaining the recording instruments and ensuring a comfortable environment free from interruption, interviews commenced with a request to "Tell me about your decision to leave nursing and allowing

your nursing license to lapse." Clarification of meaning was sought with various follow-up questions such as "Can you tell me more about this?" or "When you say _____, what does that mean to you?" The researcher utilized the communication technique of restating both to elicit more information and to assure comprehension on the part of the researcher.

Data Analysis

Stake (1995) asserts that "Analysis is a matter of giving meaning to first impressions as well as to final compilations" (p. 71). The analysis of case study data involves taking apart the impressions of the researcher and assessing and finding meaning for the parts of the impressions. With observations and data gathered, the researcher searches for patterns and relationships between multiple parts. This process is iterative and occurs throughout the research process. Stake identifies two strategies common to the analysis of case study data: direct interpretation of the individual instance, and categorical aggregation. Direct interpretation is described as gathering the meaning of an event or instance from the observation of that event or meaning. Categorical aggregation refers to reviewing the data and seeking repetitions of ideas or concepts, coding them and then reviewing for further examples. The analysis of data for this case study was guided by specific questions focused on understanding the reports of the participants on their experience of choosing to leave nursing.

Both of the strategies were utilized in the analysis of this data. Multiple readings of the transcripts preceded the initial direct interpretation of the individual instance. Individual accounts of the experiences of participants were generated which revealed the

unique nature and characteristics of each individual experience. Each participant's story was reconstructed from the interview data and laid out as part of the findings.

Categorical aggregation was accomplished using Van Manen's (1990) detailed reading approach. Each sentence or sentence cluster was examined for what it might be revealing about the experience of choosing to leave nursing. The single statements or phrases were grouped into categories that were examined for common meaning. The categories were then reflected upon and a process of leaving nursing was apparent. Three themes were revealed from the meaning of the common categories and descriptions were written. The three themes became the second part of the findings of the study.

Rigor

Lincoln and Guba (1985) write extensively on the development and presence of quality in qualitative research. Validity of qualitative research is represented in "trustworthiness." They posit that there are four components of trustworthiness: credibility, transferability, dependability, and confirmability.

Credibility is the degree to which the write up of the research is such that participants would instantly recognize it and that others could understand it (Lincoln & Guba, 1985). Credibility may be established through multiple methods: prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy, or member checking (Lincoln & Guba, 1985). In this research, enhancement of credibility was achieved through clear descriptions of the data collection and analysis procedures (Mays & Pope, 2000). Further bolstering of the credibility was achieved through the care that was taken in the development of the coding scheme to

ensure that particular categories were not based on unique or rare events described by only one or two participants. Categories were developed based on consistent reports from multiple or all participants. The description of the genesis of early simpler classification of text evolved and refined into more complex coding structures and then into themes. The inclusion of this in the findings allows the reader of the research to make his or her own determination of credibility. Credibility was enriched by the comprehensive field journal created and maintained by the researcher as the data gathering progressed. The interview techniques themselves contributed to the credibility of the research. Interviews were scheduled in locations where each individual participant identified that they would feel comfortable and open.

Transferability is akin to the positivist notion of generalizability and refers to the applicability of the findings outside of the context of the study. Lincoln and Guba (1985) note that for any study the researcher cannot know to what population or situation any reader might want to transfer the findings. Because of this, the responsibility for assessing transferability lies with the reader. In this study, transferability is supported with the thick description of the experience. This research employed purposive sampling. This sampling methodology ensures that only experts in the experience will provide data for analysis. (Lincoln & Guba; Patton, 1999). From the expert-provided data, rich descriptions were developed which can be judged by those who may wish to apply them on their transferability. Within the thick description is sufficient detail to enable the reader to determine transferability to other contexts (Mays & Pope, 2000).

The construct of confirmability speaks to the extent to which the research results can be verified or corroborated by experts not associated with the research. Techniques targeted at increasing confirmability include confirmability audits, triangulation, and maintenance of a reflexive journal (Lincoln & Guba, 1985). Polit and Beck (2008) support clear explanation of how decisions were made in the analysis process as contributing to confirmability. Polit and Beck assert that the level of clarity in the communication of the thought processes underlying the analysis of the data represents confirmability of the findings. Maintaining the reflexive journal supported confirmability during data collection in this study. During the analysis and writing, confirmability was supported through clear communication of how decisions were made and conclusions were drawn.

Dependability is the manifestation in qualitative research of the quality labeled 'reliability' in quantitative research. The presence of credibility is sufficient to establish dependability as the relationship of validity to reliability mirrors that of dependability to credibility (Lincoln & Guba, 1985). Beyond that relationship, in this research the credibility was strengthened with clear descriptions of the data collection and analysis procedures.

Ethical Issues

Gender and minority subjects.

Hart (2004) reports that 6% of registered nurses in the US are male. Because of this, it was anticipated that the majority of the participants would be female. Minority

subjects were not targeted for oversampling as the vast majority (86.6%) of registered nurses are Caucasian (United States Department of Health and Human Services, 2002).

Human subjects.

This project was reviewed by the Institutional Review Board of the University of Minnesota for the protection of human subjects and permission was granted by that body to conduct the research (see Appendix B for the approval letter).

Each participant was advised both verbally and in writing of the purpose, risks, and potential benefits of the study. Written consent for participation was obtained from each participant after the primary investigator was confident that understanding of the purpose, risks, and potential benefits had been achieved (see Appendix C for consent form). Confidence in participants' understanding was achieved by questioning each participant about the purpose, risks, and potential benefits of the study and assessing their responses. Included in both the oral discussion of the study and on the written consent from was the stipulation that each participant was able to withdraw her or his consent to participate at any time without jeopardizing her or his relationship with any of the University of Minnesota, the principal investigator, or the principal investigator's advisor. Audio recordings were destroyed immediately following the completion of analysis. There were no incentives (monetary or otherwise) offered to potential participants or given to the informants of the study. No identifying data were collected from the informants and interview transcripts and audio recordings were kept in a locked file in the researcher's office at the University of Minnesota. Access to transcripts and

audio recordings was restricted to the principal investigator and his advisor, Dr. Cynthia Peden-McAlpine.

Chapter Four: Findings

Chapter Four will present the findings of the study and describe the experience of six participants who left the profession of nursing. Direct interpretations of the individual experiences are presented first, followed by the findings of categorical aggregation. Direct interpretation and categorical aggregation revealed an overall experience of professional disillusionment. Three themes comprise this phenomenon, challenges to personal and professional values, workplace stressors, and life after nursing: reconstituting the caring passion. Each theme will be described and will be followed by excerpts from the text highlighting the central ideas for the theme. Finally a diagram (Figure 2) will be presented that illustrates the essence of the experience. The names used to identify individual informants are pseudonyms.

Direct Interpretation

Lucy.

"*The thing that nursing brought to my practice of law is that nursing taught me critical thinking that has been very helpful in my practice of law.*"

The researcher met with "Lucy" in one of the meeting rooms of Lucy's law firm. The ambiance was very dignified and professional; the firm was located in a prestigious area of a large Mid-western city and the offices offered sweeping views of the city. Lucy was well spoken and friendly, and had clearly spent time contemplating her experience in order to share it with me.

Lucy began her nursing career upon graduation from a baccalaureate program in nursing. She started in a pediatric unit and soon moved into public health nursing. After three years of public health she moved her focus to patient education until she elected to take time off from her career to raise a family. She returned to practice working with disabled children and their families. She moved into an entrepreneurial position of assisting her friend to start a home care agency. At that time Lucy began a serious assessment of her career, noting that while she had accomplished much there was clearly something missing. She had changed positions every three or four years and her interpretation of this was that she had mastered everything she needed to do in those positions and needed to find something else that would provide challenge to her. She found that she was bored with the jobs she had held. Lucy contemplated returning to school to pursue an advanced degree in nursing. Her experience of hearing "Well, what do you know? You're just a nurse" carried weight in her decision not to pursue an advanced degree in nursing. She tells of realizing that she could not be happy or satisfied in any field in which practice was viewed with such disrespect.

Some of her work in administrative positions had involved collaboration with hospital administrators, physicians, and attorneys. In that work she had noted that attorneys seemed to have little understanding of the practices of medicine and nursing. Because of that, Lucy felt that she could build on her experience in healthcare by pursuing a degree in law. At age 40, Lucy returned to school to study law, finding employment at her current firm upon graduation and working there ever since. At the time of our visit, that had been fifteen years and she noted proudly that fifteen years was

the longest she'd ever stayed in one position. She shared that she'd never been bored in the practice of law, noting that every day is different and that there is always something new to learn. Lucy shared that while there was always something new to learn in nursing, her ability to apply that new knowledge in the practice of nursing was limited and that had contributed to her dissatisfaction with nursing. Lucy reiterated that she was frankly bored with nursing when she was practicing; sharing that she found her roles to be task oriented.

In her work as an attorney, Lucy notes that there she still deals with egos similar to those found in some physician staff, but that the level of respect with which she is treated is entirely different than it was in nursing.

> …My ability to do critical thinking and to take that critical thinking and transcribe it into a plan to assist my clients is respected whereas I didn't feel that was respected when I was practicing as a nurse.

Lucy kept her registration up to the year prior to the interview and she credits nursing with having taught her the critical thinking that has been critical to her practice of law. She shared that she maintained the license for as long as she did because nursing contributed to her self-image "That had been part of my identity since I graduated from college. So I kept my nursing registration up until this year."

Looking back at her career trajectory, Lucy recalls that she wanted to pursue a career other than nursing that would be perceived as more prestigious and yield higher compensation. She also notes that with the change she experienced an increase in

autonomy. She greatly enjoys the autonomy associated with her law practice and remembers that she had very little autonomy in her nursing practice.

When she graduated from law school, Lucy discovered an entire community of attorneys who were former nurses. They organized for a while as "Minnesota Nurse Attorneys" and were a group of about 90. Her interpretation of this phenomenon was that none of them were willing to give up 'being a nurse' as part of their identities. Even with the differences in careers, Lucy's practice of law mirrors her practice of nursing in many ways. She notes that as a nurse she helped individual patients by providing competent and professional nursing care to them. As a lawyer, she helps individual clients by providing competent and professional legal assistance to them

Delores.

"*And it became harder and harder. You know, it was really sad for me to leave because I loved the patients.*"

Delores was interviewed in her upscale suburban home and was gracious and expressive in relating her experience of leaving nursing. Obviously intelligent, she shared her story with grace and humor. She had always wanted to be a nurse when she was a child. She grew up during the Vietnam War and thought she would become a nurse and go into the military. That did not happen. After marrying at 18, she and her husband worked on getting him through school and into a good career. Delores began her nursing career with a baccalaureate degree from a private college when she was 31. The changes in the health care system included an increased level of acuity among hospitalized patients, shorter lengths of stays, and increased record keeping burdens for nurses. These

changes eventually created a situation in which Delores felt unable to provide the type and quality of care that she believed they deserved. Delores' nursing practice was incompatible with the realities of nursing in an institution.

Delores spent her entire career in one facility working on an orthopedics unit and eventually specialized in spinal injuries. She greatly enjoyed her role as charge nurse because in that role she was able to maintain an overview of what was happening with all of the patients on the nursing unit as well as functioning as an admissions nurse for patients who were admitted on her shift. She relates the pride that she felt in participating in her patients' accomplishments "I was proud when I came home and I knew that I had gotten someone to stand."

She described advocacy as the framework of her practice. She was good at nursing because she knew what needed to be done for her patients in order for them to get better and be discharged. During her career, the lengths of stay for patients with various injuries diminished until they were no longer sufficient to achieve the appropriate level of teaching and pain control prior to discharge.

> …It became difficult because the discharges were coming sooner and sooner. When I first started for an anterior/posterior surgical surgery they were on our unit between 10 and 13 days. By the time I left, that same surgery was five to seven days.

She felt strongly that these changes occurred for financial reasons and were implemented by people without connection to the patients.

> (Administrators) could bypass the whole hospital. They didn't even have to walk into the hospital to get to the admin area... So they don't even walk through the hospital. They don't see anything that's going on. They don't walk through the area where the ER is. Of course there were many, many different ways to access that admin building but they always chose the one that came through the back way. And they never even saw a patient.

Delores was also disillusioned by the reduction in post discharge care that insurance companies would cover for her patients. She described this here:

> She was elderly…her husband was there and they said, we can't get home health care to go look at her incision. I said "She needs someone to look at her incision"… No, she has a husband. I said "yeah, he's walking down the hall with a walker and he just bumped into a wall."

Relationships with physicians were a source of satisfaction for Delores. She expressed great respect and admiration for physicians responsive to the needs of the patients and respectful of the nursing staff. However she was distressed by problems that arose with residents and physicians who did not respond to the reports of patients in trouble reported by nursing.

While Delores enjoyed her career, experiences of disrespect and violence toward nurses were a part of it. "And he (the physician) got mad at this nurse and you know, back then (the patient's record) was a three ring notebook chart, and he threw it at her and hit her in the head." To add insult to injury, management's response to the situation was breathtakingly ineffective in her eyes.

Like Delores' entry into the practice of nursing, her departure was carefully thought out, planned, and implemented. When she was no longer comfortable providing the kind of quality care possible, she stopped depositing her paychecks. After a sufficient period of time had passed indicating that her family would not suffer from the absence of her financial contribution, Delores resigned her position.

Delores' commitment to others continues and is lived out in volunteer service at a long- term care facility in her neighborhood. She serves on the board of directors of the nursing home. She is also politically active supporting changes in the health care system that she believes will improve health care for all residents of the United States.

Marilyn.

"*It's taken a lot of years to get to the point where I feel good about what I do because it's not nursing.*"

Marilyn is a vivacious, healthy woman in her early forties. We met at a coffee shop in her historic hometown overlooking a large lake popular with sail boaters and other water enthusiasts. She was articulate, well educated, and demonstrated a quick wit during the interview. As a young girl Marilyn experienced a strong calling to be a nurse. She found her work as a nurse very rewarding and built a life around her profession. Helping her patients and participating as a strong team member contributed to her satisfaction with nursing. She had a son and it became difficult to meet the requirements of all of her roles. Marilyn's son lived with chronic illness and she felt she was not able to hold up her end of the teamwork in her position when she had to stay home with her son. Marilyn described her experience of guilt for letting her patients and her teammates

down. As the discomfort of being unable to meet all of her obligations grew, she began to search for a new career path in which there would be more flexibility. A friend who had experienced the same issues with the rigidity of the work schedule suggested she look for work with a pharmaceutical company.

Marilyn began working with the research arm of a pharmaceutical company and immediately enjoyed it both for the work and for the freedom to schedule her own work time. She found that she used her nursing knowledge and many of the skills she learned in nursing in accomplishing the work of her new role. Her ability to both prioritize and to anticipate the future with regard to multiple possible plans of action was essential to her success and these are skills that she learned as a nurse. When asked if she misses nursing practice she appears conflicted:

> No, I do sometimes, but I always go back to the feeling that I had a calling. My son is now eight, but when he was two he had a chronic illness, and that feeling at 7:30 in the morning, negotiating with my husband who was going to call in… That call – that feeling that there were all those patients…the other NPs would have a crappy day because they were covering not only their patients but mine too. All I have to do is think about that feeling. It's a trade-off.

Marilyn still experiences some of the rewards of nursing by volunteering at a teen clinic, not as a nurse, but doing intakes and providing reassurance for frightened teen-age clients experiencing symptoms of sexually transmitted infections. She notes that in this volunteer role, she has a large influence in how

their experience of the clinic will be. By providing reassurance that they are safe in the environment, their health needs are private, and that no one will judge them here, she sets them up for the least stressful and most productive outcome possible. Marilyn shares that the "thank yous" received for her nursing work and her volunteer work are of a deeper and more meaningful nature than those in her new professional environment. She describes this below:

> I thought you were going to ask me if I get that in my current job. Absolutely not, and that's the part that if I didn't have that volunteer part that I would definitely miss, that intangible. Sometimes there is a tangible thank you and feedback that what you did helped somebody. You don't get that in the business world very often I think, or not the same sort of sincerity to it. With back rubs the patient says the next day, oh that was so great. You get that immediate feedback loop that you did something helpful.

In her new role, Marilyn supervises a large team of well-educated people and travels extensively ensuring that work outcomes are met and that patient safety is maintained. The satisfaction she derives from the work is related to but different from the satisfaction she experienced with the practice of nursing. The activities in which she engages are different from those in nursing practice. While she could have actively sought to give presentations in her nursing role, in her current role, it is a part of her work. In her practice of nursing, Marilyn made a positive impact on patients one at a time. Her new career allows her to have a positive impact on populations rather than

individuals “I’m still making an impact, given my background, although it’s not on a person-to-person basis; it’s more on a population basis.”

Marilyn derived part of her self-esteem from identifying as a nurse and it took a long time for her to feel good about her post-nursing career. She identifies that part of the difficulty is that the public has such an overwhelmingly positive opinion about nurses and such a low opinion about biotech companies. “It’s almost like being a lawyer.”

Marilyn relates that she perceives a difference in her current coworkers from her nursing colleagues in that the evaluation of pressure is different and the level of discomfort required to elicit a complaint is lower among her non-nurse colleagues.

> It’s funny, the people I manage now complain a lot about their workload and nurses never do. I’ve finally had it with the complaints, what’s the difference between your workload and his workload. I used to work in a hospital where I couldn’t pee all day. I literally couldn’t go to the bathroom because I was so busy. I can even get lunch now, which I never could before, so it’s all in what they compare it to. Anyone who’s had a hospital background, it’s not that every day was like that, but you know those days where it’s just crazy. It’s so funny that the nurses are the non-complainers.

Allen.

"*I started off in ICU as a new grad; I did trauma surgery to neurosurgery as a new grad. I walked back to my car in tears every day.*"

Allen is a man in his mid-thirties who spoke to me in his suburban home. He appeared unhappy during most of the interview. Allen was friendly and very proud of being a nurse. He was proud in particular of being a critical care nurse and expressed a great deal of frustration and anger at the US Army's lack of recognition of his nursing education and skills because of his associate degree preparation.

Allen did not share why he had become a nurse, instead beginning his story with his notice that he was to deploy to a war zone on five days notice. He talked of his pride in being a critical care nurse.

He spoke at length about his time in the war zone and told frightening stories of his time there. He sustained an injury to his back a few days prior to his discharge home and because of that injury he was not able immediately to resume the position he had held at the time of his deployment.

Upon his return to the US, Allen needed to take a break from nursing, describing his relationship to the profession as "love/hate." Allen spoke fondly of the camaraderie he experienced being a member of the ICU staff in his hospital and shared the level of pride he felt having the knowledge and skills required for successful critical care nursing practice "you can't get much higher than ICU."

Allen discussed stressors associated with clinical practice that contributed to his ambivalence regarding the career. Primary among them was the requirement of floating to units without orientation. He describes his dissatisfaction with the disrespect he received below:

> I'm an RN and I'm from ICU—oh, here's our worst patients and your office is in the toilet, and if you want something to eat, go scrape something off the curb, but we're going to have a buffet in the back and you're not allowed to go.

The other aspect of practice that Al found problematic was mandatory overtime. He devoted so much energy to his practice that at the end of his shift he was exhausted "I only have so much in me and once it's up, it's up."

Doris.

"*Doctors are only concerned about the cure; nurses are concerned about the care, so that's what it was for me.*"

The interview with Doris occurred in a coffee shop in her hometown in the middle of a blizzard. She was a fit and energetic woman appearing to be in her mid-50s, and an engaging conversationalist who had clearly spent time thinking about how to share her experience of letting her nursing license lapse. Being a nurse was an essential part of Doris' life. Allowing her license to lapse was painful despite the fact that she had not practiced for six years. She had enjoyed her long career as a nurse but had set it aside to concentrate on her four children three of whom were living at home.

Doris began her career with a baccalaureate degree in nursing and immediately moved to the East coast where she began practice on a medical/surgical floor in an acute care facility covering all three shifts. After gaining a few years' seniority she was able to rotate days and evenings. The medical surgical unit on which she worked gradually converted into an oncology/hospice unit and that development inspired her keen interest in oncology nursing. She began moving out of acute care by taking a position in an oncology clinic and maintaining her acute care practice only on the weekends. Doris also practiced as clinical nursing faculty that brought great rewards that were different than those she received from clinical practice. She found joy in the students' enthusiasm for learning and retelling of their experiences. She describes this below:

> The excitement that I would hear—it was so great, "I had to give my first suppository today"—"oh really, darn, I never get to do anything like that"—that kind of thing. Just being there with a student, talking them through, letting them know it's okay, especially that first injection. You remember what that was like—your hands were shaking.

Responding to a request to share a story highlighting the rewards of her clinical nursing practice, Doris related the following:

> There was one couple who were probably in their late sixties he had cancer, and we took care of him for probably eighteen months to two years, and I grew close to his wife. They never had any children, and he eventually did pass away. Six months after he died, his wife was admitted and was also diagnosed with cancer. I haven't thought about this in

> forever. She was part of the family; she already knew everybody and we knew her. We knew what was going to happen and she just kept saying you're my only family, so there was that connection. We didn't have any extended family living out there, so you grew your own extended family and you were able to be there, either for people who had a big family and you could just be part of it, or you were there for people during the difficult times, and then finally at the end.

Doris cherished the close relationships that she was able to develop and valued the reality that as an "acquired family member" she could function in therapeutic ways impossible for others; she could act as a sounding board for her patient's ideas and a safe person to whom to vent frustration.

Frustrations with the practice of nursing that Doris experienced were related to the behaviors of colleagues whose work practices did not measure up to hers: "fellow staff workers either not doing the kind of job that I thought they needed to do, or skimping on care."

Ellen.

"*… I started as a speech pathologist, and I don't miss nursing at all. I don't at all. I thought I would miss the adrenaline rush that you get in the trauma ICU, but I really don't.*"

Ellen is a young woman who appears to be in her thirties. She has come to the interviewer's residence for the conversation. She is cheerful and articulate and communicates that she is happy with her choice to leave nursing. She is also candid about

a learning disability for which she has always compensated. Ellen is well dressed and appears very comfortable with the interview. Ellen chose nursing as a first career because of her enchantment with medical dramas on television while she was growing up. Her favorites were St. Elsewhere, Trapper John, M.D., and Quincy. She would have preferred to go to veterinary school but felt she would not be admitted.

She began her nursing career with a baccalaureate degree directly after high school. She took the only position she was offered which was on a medical floor in a major metropolitan hospital. Ellen enjoyed that for about five years and then felt she needed a change. She moved out of state and began practicing in a children's hospital but returned to her original job after nine months. She followed her friend to a surgical intensive care unit [SICU] where she worked nine years. Ellen began thinking of doing something else two to three years before she left the SICU. She discusses this below:

> So I did it. I ended up being in SICU for nine years, and it was probably six or seven years before I started thinking of doing something else, so I don't know if it's really nursing itself, or if it was me just not being sure of what I'm happy doing, and thinking a change is going to make everything better.

As Ellen's career in the SICU progressed, a number of changes brought her to the place where she began looking for a new career. She was developing a personal interest in learning more about how the brain works at the same time identifying and recognizing a growing sensation that something was missing from her life. More concrete things that drove the consideration of a career change was

tiring of working different shifts and working every other weekend. As a single woman Ellen felt that the work schedule severely and negatively impacted her personal life. Her commitment to her pet dogs prevented her from changing to a schedule incorporating twelve-hour shifts every third weekend.

> I don't know what it was that made me make that final decision. I think it was just overall my interest in brain injury patients, and thinking maybe I would like to work in cognitive rehab as a therapist. So I began my lovely journey. I went to grad school full-time, and I still worked part-time. I had dropped my hours a little bit each year, and worked when I accepted my first speech job as a speech pathologist.

Ellen is very happy with her new career although she misses the higher salary that she earned as a nurse. She enjoyed the intimate involvement with her patients as a nurse and taking the extra time to make sure that they experienced exceptional care. She shared that many times her practice was very stressful.

Ellen enjoys being an expert in three areas rather than being expected to be an expert in every aspect of every patient to whom she was assigned as a nurse. That expectation – to be an expert in everything – contributed to Ellen's discontent as a nurse. She enjoys bringing her experience in critical care to her team of speech pathologists and enjoys the respect of her teammates. "Even amongst my colleagues, they'll ask me things because of my background—medical questions." She also enjoys the more global view of the hospital that she gets in her current role.

Categorical Aggregation

Overall themes.

The specific aim of this study was to describe and interpret the meaning of the experience of choosing to leave the nursing profession. Participants openly and generously discussed their experiences and related their stories. Many of the journeys shared began with the passionate desire to be a nurse. Participants had worked hard to become nurses and then practiced in various environments, delivering excellent care to many patients. The journeys concluded with a departure from the practice of nursing because of their overall experience of ***professional disillusionment***.

Themes emerging from the participant interviews to describe the essence of professional disillusionment were: challenges to personal and professional values, workplace stressors, and life after nursing: reconstituting the caring passion. Each main theme was supported by multiple subthemes. The subthemes of challenges to personal and professional values were the inability to provide quality care, clinical nursing competes with life and family, and lack of professional self-fulfillment. Supporting the workplace stressors theme were disrespect from the public and other health care professionals, and stress, workload, and unsafe practices. The subthemes of life after nursing: reconstituting the caring passion were nurse as identity - a nurse is who I am, caring as a way of being in the world, and transfer of knowledge, skills and work ethic. Figure 2 presents a conceptual diagram of the major themes and overall findings of the study.

Challenges to personal and professional values.

All of the participants described their decision to leave nursing as a profession as a process. This process began dramatically for some and more insidiously for others. All participants described competing priorities in their lives as practicing nurses. Among the priorities were time, personal responsibilities, deeply held ethical values, and respect for self and others. With the passage of time, the relative weight of these priorities changed until the decision was made to leave nursing.

A tension was described from the conflict of having been 'called' to nursing and then not being able to practice in a reality that enabled them to deliver the care that they felt was the essence of nursing. The calling to nursing was described by this participant:

> I had always wanted to be a nurse growing up. In fact, that was during the Viet Nam war and I thought about becoming a nurse and then going into the military. So I always wanted to be a nurse.

The inability to provide quality care.

The inability to provide quality of care because of institutional barriers was a major factor in the nurses' decisions to leave nursing. A participant summed up the reality of practice:

> But it also came about primarily from the fact that I just felt that we couldn't be the advocates that we needed to be for the patients. And that was... that was distressing for me. I was disillusioned, I just I remember seeing patients and knowing they weren't getting the best care. I just I

knew and as the years wore on I knew that it was getting less and less. We did the absolute best that we could [under the institutional circumstances].

This was insufficient to meet the need of the nurses to deliver the level of quality care they valued. Another participant shared:

> So. Everyone's hands are tied in the healthcare industry because of the insurance industry. And that was very difficult for me. And you know I mean we all know we called it [an HMO] group death. We all had our little sayings. I felt that it was just going the wrong way. We weren't going the right way. And that was difficult for me. I did see patients that yes we could have done more. Not that they left the hospital in a bad way but they left and you knew they were leaving the hospital and they weren't where they were supposed to be.

Compounding that struggle was the reality that not all of their colleagues both nurses and physicians shared their commitment to high quality care. The nurses also perceived that administration cared more for the profit generating aspects of health care than the delivery of quality health care. The chasm between their deeply held convictions regarding nursing care and the reality of practice weighed heavily on these nurses and was a large factor in their decisions to leave nursing. None of the participants thought they made the wrong decision in entering the profession, however, for each of them, a time came when it was no longer right for them personally. The actual decision to leave was difficult for all of the participants. Whether dramatic or insidious in onset,

participants struggled with their reality of truly enjoying nursing, yet needing to leave because their values were compromised.

One participant discussed the tension involved in working with fellow staff members who had poor work standards. She felt she was diligent and hard working and to see others give poor quality care to their patients disturbed her. She relates this experience below:

> It'd probably be my fellow staff workers either not doing the kind of job that I thought they needed to do, or skimping on care… It didn't matter whether they were RN's, LPN's, or nurses' aides; I worked with some wonderful people, but I also worked with some careless people and it was hard. … It was difficult to see people not being as careful with the patients as I wanted.

Another nurse discussed a distressing situation that had a bad outcome because of poor staffing issues and physician neglect.

> A man had fallen from a tree and he came into the hospital. He had fallen very high, crawled to the side of the road someone finally found him - he came to our floor and we were waiting to see what was going to happen. They gave him pain meds but no one really checked on him the way they should have and we kept trying and trying and trying. They [physicians] didn't follow up and then we found him getting confused, all these issues... so we knew that there was pulmonary embolisms going on. It's like this guy is confused… we've got a big issue here. He died. Mid

> thirties and they stopped count at 105 clots. That was so difficult. We didn't do the best we should've for this guy…we knew there were times patients weren't getting what they needed but they should've gotten more.

When asked if this death had occurred because of substandard nursing care, the nurse responded: "No. That occurred because the doctors refused to do anything. We kept calling and calling."

Each participant mentioned ethical issues during their interviews. Multiple issues were identified ranging from the ethical implications of the national nursing shortage to the unit level issues of dealing with the discrepancies between their own ethical codes and those demonstrated by colleagues.

The impact of the nursing shortage on the workload of individual nurses was seen as an ethical issue along with the increasing workload stemming from the increasing levels of acuity in acute care. Contributing also to the ethical problems of health care at the national level is the profit motive of health care and the insurance industry. Cost cutting and denial of care was at odds with the ethical codes described by the participants and it became untenable for this participant to continue in the system.

> …But as time went on I did start to feel like golly these patients just aren't getting what they need and that's why I'd become politically involved with making sure the politicians we have are looking at universal healthcare. There was a time when we had to put the patient out on the street knowing she and her husband were homeless. That was very difficult. We gave them the telephone numbers but that was all we could do. That was

healthcare. We need to do more but you know hospitals can only do so much. Nurses can't do everything.

Clinical nursing competes with life and family.

Many participants found that professional time commitments were in conflict with family responsibilities. The nurses described many instances where either family commitments or work commitments had to be chosen as they could not be met simultaneously. Contributing to the problem of meeting family responsibilities was the necessity of working at days and times that are more traditionally thought of as family time. The necessity of, and inability to, meet personal and/or professional obligations caused anxiety and contributed to the nurses' feelings of inadequacy.

The reality of practicing nursing often necessitates working rotating shifts, weekends, and holidays. Multiple participants' spoke at length of feeling like nursing was competing with their family, religious, and social lives. The culture's social norm of working Monday through Friday during the day was seen as much more compatible with meeting responsibilities to friends, families, and spiritual communities. One participant shared that her scheduling prevented her from spending sufficient time with her child who suffered from a chronic illness. She was frustrated because of her need to be with her child during many of her shifts. She also acknowledged that her split priorities created an undue burden on her colleagues. Another participant explained that as her parents aged and required more attention, she was unable to meet the demands of her family obligation. The commonality shared by these participants is that the work pattern

of many nurses is in direct competition with their ability to meet all perceived obligations.

The necessity of working various shift patterns contributed to participants' frustration with competing priorities. The shifts themselves were often prolonged as mandatory overtime extended as long as sixteen hours. One nurse shared the frustration of long shifts: "I knew I couldn't do twelve hours and every third weekend because of the dogs, because I couldn't leave them alone that long." Mandatory overtime caused nurses to omit basic self-care activities such as fitness endeavors and relaxation. The experience of not knowing when your shift was going to be over was unsettling and led to a feeling of life being 'out of balance'. In addition, rotating shifts led to altered sleep patterns which disrupted individual nurses' commitments to self-care. Two participants noted that disrupted sleep patterns as a result of rotating shifts and chaotic patterns of days off led to never feeling well rested. Chronic exhaustion greatly diminished the nurses' quality of life.

Lack of professional self-fulfillment.

Some participants found that they experienced their lives as being incomplete. They assessed their personal and professional lives and determined that pursuit of work other than nursing might contribute to a longed for sense of self-fulfillment. This ultimately led to the decision to change careers in an effort to experience life without the sense of "missing something." These nurses discovered new directions that were seen to be pathways to self-fulfillment. One nurse explained. "I just wasn't getting *something* from nursing. I was missing *something* from my life, and I thought changing careers

might make things better, or I would feel more fulfilled, or happier." Another participant described feeling that nursing was not a challenging profession and that she moved from position to position about every two years after having mastered all of the skills needed in each position. She shared her feelings below:

> And when I started to look at why I was changing positions it was I had pretty much mastered what I needed to do to keep those positions, I was bored, and wanted to move on with my education. I thought, Wow! If I look back on the number of positions that I've held and how long I've held them, something just isn't satisfying me here.

These participants slowly took stock of their options and eventually made the decision to pursue alternate professional avenues.

Workplace stressors.

Each of the participants identified multiple negative experiences in the workplace that contributed to their actual decision to leave the profession. Again, no one single problem could be identified as the motivation to leave nursing, but combinations of the problems over time led them to the decision.

Disrespect from the public and other health care professionals.

Despite the public perception of the nurses being among the most respected professionals, this perception does not translate into the clinical practice arena. All participants were told: "what do you know, you're just a nurse" by physicians or other members of the health care community and this perception of disrespect contributed significantly to their decision to leave nursing. This phrase was so powerful and so

devaluing that for most it was the first thought shared after asking of the initial question: "Tell me about your decision to leave nursing." For the participants, the respect of their colleagues in health care was of pivotal importance. As one participant noted:

> Probably the kick start to my decision [to leave nursing] was one of the physicians, as we were discussing quality care and how we were going to measure quality care in a joint venture said to me 'Well what do you know? You're just a nurse' to which I thought: Really? Is that how nursing is perceived?

A closely related concept "prestige" was important as well. Many of the participants shared their belief that nursing lacked prestige in the larger community. They perceived respect from community members but that respect did not translate into prestige, which was important to them. Many of the participants experienced others' perceptions of nursing as low prestige or a non-challenging profession. One of the participants shared that she just couldn't be happy if others' perceptions of nursing were not positive. Another participant shared "I actually saw it almost as a failure compared to the people I grew up with, like it's not good enough.

Each participant shared experiences with arrogant physicians who verbally expressed their disrespect for nurses and displayed this disrespect in their attitudes toward nurses and nursing. One nurse told of trying to contact a medical provider to relate a change in patient condition:

> … and he said "you know you kept beeping me. Me and my wife were trying to watch Shindler's List." And I said "well I'm sorry, if I beeped you

during Shindler's List but we were just trying to get a hold of you because blah, blah" and he started to yell at me...

Most of these displays of disrespect were verbal and attitudinal but some were physically abusive. One nurse shared an episode of physical violence: "And he (physician) got mad at this nurse and you know, back then (the patient's record) was a three ring notebook chart, and he threw it at her and hit her in the head."

Incidents of disrespect for nurses as individuals by other nurses and nurse managers were also shared. While bedside nurses providing care to patients hold themselves to the highest possible ethical principles, some nurse managers do not always treat nurses in the same way. One participant reported being mistreated by managers who made decisions that were incongruent with both state law and union contract. This was disillusioning for this informant:

> She just didn't even blink an eye; she (the manager) even told me she was going to give away my job. She wasn't supposed to do that. I just said oh, well, if you want to give away my job, I'm not going to work here anyway. That was illegal. They don't follow the rules; they don't know the rules. The upper management just makes it up as they go and when they get in trouble, then they go look it up and say oh yeah; [the nurse] is right.

Stress, workload and unsafe practices.

The amount of work that a nurse is expected to accomplish during the workday has steadily increased. This workload has become unachievable and compromises the nurse's responsibility to maintain a safe environment while providing required care and

documentation. The increasing levels of acuity and workload lead to an overall increase in the stress level experienced by nurses. One nurse describes this here:

> You're kind of screwed [sic] covering for breaks. I remember one time I had to call a code when I was covering. I was the only one in the unit (six bed ICU) because there were only three or four patients and the other nurse went to lunch or dinner, and one of the staff physicians was at the desk…but I was working on a patient and he was standing behind the desk right across from me, and things were just starting to slowly go downhill, and he was watching, and it got to the point where he was like "do you need some help?", and I was like, "yeah." We ended up calling a code just to get the people there, and coded the patient, so that was rather stressful.

Staffing at levels sufficient to provide safe, high quality care was important to the respondents. Many nurses expressed concern that increasingly tight staffing matrices brought their practice to the point of being unable to provide the care needed. One participant who had worked frequently in the role of charge nurse spoke of needing to 'game the system' to get enough help to provide safe care. She shared the following:

> Staffing issues that was... I became very disillusioned with that because it came down to as you know they staff by... Fill out the little sheet of paper for acuity levels and if they just had a little bandage on their hand you wrote that down that it looked like a bigger bandage so that you can give more care to these patients.

Another nurse shared that the staffing matrix was so tight that it did not allow for any of the patients to experience a decline in condition:

> And sometimes we'd you know they allow four and a half nurses you know and that was always so odd to me. And staffing had to go by what they were told. But there were times that you felt 'This isn't the proper staffing.' I remember saying... We are stretched so tight if one of these patients starts to fail... What happens is you have to concentrate on that patient so what happens to the other ones? It was just the absolute basic minimum care that you can give them.

The acuity of patients requiring care has gone up and this increase contributes to the stress and workload of nurses. One participant who had practiced in Iraq during the war shared the following:

> In Iraq, you saw some nasty stuff. It looked like they put some of these kids in a blender and turned it on puree for a second. It was like, oooh, man. It's the number one trauma hospital in the world. … but wow, you're working three twelve-hour shifts and then you get a day off and then three twelves on, so they work the bone out of you. I had six to eight patients; I've had up to ten patients before working up in Baghdad. When I got back down to [military hospital in Iraq] we'd have mass casualties. Thirty was our biggest one. You can't run fast enough. They're big bombs, these guys are ripped apart; it's just like damn. I've seen trauma before—car

accidents—and this tops it. I did my job over there and I think I need a little break.

The experience of stress was compounded by work issues such as 'floating' or being reassigned to an unfamiliar unit in the institution. One participant shared that often the patient assignment included very difficult patients from whom the staff needed a break: "I floated down and they'd give you the worst patients. I didn't know where anything was." All participants shared that the experience of floating was a major source of stress. Participants described stressful and unsafe experiences including unfamiliarity with the environment (where to find needed supplies), unfamiliar patient illness trajectories, procedures, medications, and treatments as well as unfriendly or unhelpful staff in the area to which they floated leading to extreme stress.

The necessity of working extended shifts and working on weekends was included as a source of work stress. The experience of never knowing for certain when a shift would end led to a constant worry that other plans would be disrupted or other commitments would go unmet.

Life after nursing: Reconstituting the caring passion.

All participants felt very strongly that being a nurse was an integral component of their self-concept and part of their self worth.

Nurse as identity - A nurse is who I am.

All participants had completely separated the concept of 'being a nurse' from possessing a valid license to practice nursing. After having allowed their licenses to

lapse, all participants continued to refer to themselves as nurses and expressed this as: "once a nurse, always a nurse".

The participants discussed experiences of being called to nursing, completing their nursing education, and then practicing as a nurse that brought about an existential change in their lives. One participant explained: "I was called to nursing. I have always been a nurse and I will always be a nurse. Whether or not I have a license to practice is irrelevant." Another participant had maintained her license for 25 years (before letting it lapse) despite not practicing and not intending to practice nursing again because it was important to her to "be a nurse." For her, the license was a powerful symbol of her identification as a nurse. Moving beyond their nursing career, participants actively sought new ways to continue caring for others. One of the participants who had entered the practice of law after clinical nursing shared the story of many of her contemporaries who felt that their futures in nursing were limited:

> Even if I'd gotten a master's degree in nursing I had better upstart potential being an attorney than I did with advanced education in nursing. Then I discovered when I did graduate from law school that there were a number of other nurses who were out there practicing law. And we actually had an organization for a while called Minnesota Nurse Attorneys. There were about 90 nurses that participated in that group. And they were in a variety of practices. Not just doing medical malpractice either from the defense or the plaintiff side. They were in corporate, they were in securities, some of them were in-house counsel for

> some of the hospitals. … Some of them were doing labor type things. A variety of practice areas but, we all called ourselves Nurse Attorneys. To me that says we weren't willing to give up nurse as part of our identity.

Another participant discussed how integral being a nurse was to her:

> Part of it is self-esteem. I worked very hard for it and I was a very good nurse. It was part of who I am. It's part of my identity. I always expected to go back and practice nursing in some manner. I still have one child at home, but I do a lot of volunteer work in the community, and I'm involved in a lot of things where they say oh, you're a nurse, that's great, we have somebody here just in case something happens. My family participates in a triathlon and I'm the medical team. It's just cabins around our little lake, and everybody goes up and has a good time. Two big things: number one is self-esteem, it's part of who I am, and I could still say I'm a registered nurse. I can't say that anymore.

Caring as a way of being in the world.

Each of the participants had been drawn to nursing as a profession because of a desire or need to care for others, and continuing this care for individuals, community, and even country was important to this group of participants. Some discussed it as a way of continuing a caring practice in one way or another and others just discussed it as a part of who they are as human beings. All described one or more things that they did to give back or contribute to the health of others. Some volunteered at nursing homes or teen clinics and one sees her current career as contributing on a national scale to the health of

all individuals in the nation, and by extension of these benefits, to the global community. One participant explained: "…that's the way I justify continuing to do what I do because I feel like I'm still making an impact, given my background, although it's not on a person-to-person basis; it's more on a population basis."

All discussed being their family's health interpreter and coach. This role ranged from attending clinic appointments with elderly relatives with little health care knowledge, assisting in communication between providers and family members, to supporting health decisions that other family members had made. One participant describes this below:

> …The last part of it was my mother-in-law. She has numerous health issues, and part of the reason for wanting to hang onto my license and why I would not have let it go sooner is that I seem to have more credibility with the healthcare professionals than my husband does. He doesn't always understand what they're saying, or they won't tell him the full story and then he says: "why don't you talk to my wife". Then I explain that I'm an RN and they give a more complete picture.

Transfer of knowledge, skills, and work ethic.

The participants in this study all found the knowledge, experience, and skills obtained as nurses to be useful in their new careers. They identified nursing knowledge itself as valuable, and the critical thinking and prioritization skills that are developed as nurses as being most useful in their new careers. A participant shared the following:

> …I think it has to do with people skills and following SOPs (standard operating procedures). The physicians I work with, there's one that works for me who doesn't have the worldview to do the job. He doesn't prioritize well. It's just a set of skills that I think nurses, especially if they've had a hospital background, where you're constantly thinking of what's the next ten things I have to get done, what's the first ten things, I mean there's critical things that you do. It's not like they're life and death situations these protocols, but they're trained what has to happen first, and they get how to prioritize and how to bump something up when something is more immediate. Nurses are way better at the job than [people with] other backgrounds.

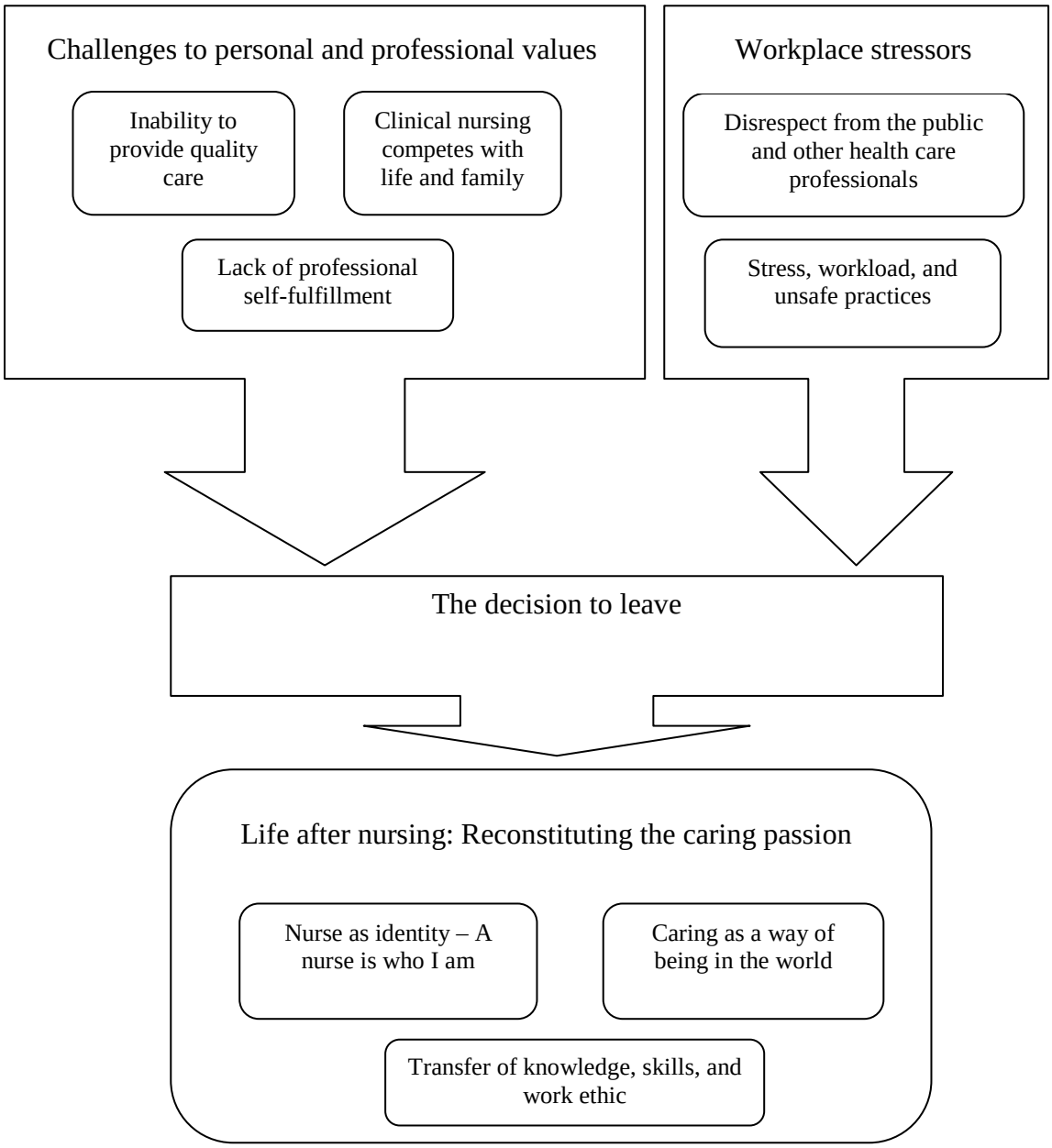
Each participant shared instances of how they were experiencing life after nursing. Many participants were having common experiences following their departure from nursing. The participants now in business reported fewer thank yous and more complaints about work than when they were in nursing. It was felt that expressions of appreciation and gratitude were more heartfelt and immediate in clinical nursing. Some participants were not immediately pleased with the changes made in their career. One participant explained: "It's taken a lot of years to get to the point where I feel good about what I do because it's not nursing."

Most participants began volunteering in various capacities and felt that they received some of the positives that they had been accustomed to receiving from nursing. Participants who were pursuing new careers all valued their experiences in nursing and

reported bringing nursing knowledge into their new careers. Many continue serving others directly and place high value on their ongoing contributions. One participant describes this below:

> Our elderly are not treated the way they should be. I mean they are at the bottom - bottom of this whole health... They just don't see them as productive. We have an adult daycare and child daycare and we have everyone doing everything together. And we have art therapy. We set up an art program for them and these elderly residents are doing beautiful artwork and all of this is still nursing.

Figure 2. Choosing to leave nursing



Chapter Five: Discussion of Findings and Implications for Nursing

Overall findings will be discussed in this chapter and reviewed in light of the literature review in Chapter Two and new literature that supports the themes. Theoretical implications will be included that support the findings of this study. Strengths and limitations of the study will be explored. Implications for nursing practice and future research will also be discussed.

Overall Findings

In this sample of Midwesterners who chose to let their nursing licenses lapse, the choice was framed in the context of multiple personal and professional crises common to the experience of practicing nursing in an institution. The major contribution of this study is that it provides ***context*** to describe why nurses leave nursing that is not found in the literature. The experiences of these former nurses shared many common characteristics with regard to their practice of nursing and their decision to leave. Each of the participants identified multiple negative experiences that contributed to their actual decisions to leave nursing. No one single problem could be identified as the motivation to leave, but combinations of the problems over time led them to the decision.

The overall finding from the study was the experience of professional disillusionment. Descriptions of themes followed by exemplars from the text illustrate the process of professional disillusionment. Three themes comprised this phenomenon; challenges to personal and professional values, workplace stressors, and life after nursing; reconstituting the caring passion. Contained within each main theme were multiple subthemes. The theme of challenges to personal and professional values was

supported by the inability to provide quality care, clinical nursing competes with life and family, and lack of professional self-fulfillment.

The inability to provide quality of care because of institutional barriers was a major factor in the nurses' decisions to leave nursing. Specific reasons for the inability to provide quality care included inability to advocate for patients because of lack of staffing. The nurses also expressed frustration because other nursing staff and physicians provided less than quality care. Nurses discussed that their personal and professional ethical codes were being violated because of these dilemmas. Multiple participants' spoke at length of feeling like nursing was competing with their family, religious, and social lives because of scheduling issues. The nurses also discussed problems associated with shift work that led to altered sleep patterns, which disrupted individual nurses' commitments to self-care and caused chronic exhaustion that affected their quality of life.

Workplace stress was another significant theme that led to professional disillusionment. Workplace stressors included disrespect from the public and other health care professionals and stress, workload, and unsafe practices. All participants reported being told: "what do you know, you're just a nurse" by physicians or other members of the health care community. Verbal and attitudinal displays of disrespect as well as physical assaults were described and this lack of respect over time significantly affected the nurses' decision to leave nursing. Situations of unsafe staffing levels and increased acuity were described in detail as were unsafe situations where nurses were sent to other specialty units where they did not have the specialized skills to safely care for patients.

The participants shared an experience of increasing disillusionment and dissatisfaction with the profession of nursing which led to their choosing to follow non-nursing career paths. While many aspects of the decision were common to most if not all participants, each participant had aspects of their own unique experience.

The theme of life after nursing; reconstituting the caring passion has not been identified in previous literature. The theme of life after nursing; reconstituting the caring passion contained subthemes of nurse as identity-a nurse is who I am, caring as a way of being in the world, and transfer of knowledge, skills, and work ethic. All participants felt very strongly that being a nurse was an integral component of their self-concept and part of their self worth after leaving the profession. The nurses reported they had completely separated the concept of 'being a nurse' from possessing a valid license to practice nursing. After having allowed their licenses to lapse, all participants continued to refer to themselves as nurses.

The participants in this study all found the knowledge, experience, and skills obtained as nurses to be useful in their lives. They identified nursing knowledge itself as valuable, the critical thinking and prioritization skills and work ethic that they developed as nurses as being most useful in their new careers.

Most participants began volunteering in various capacities and reported bringing nursing knowledge into their new careers. Many continue serving others directly and place high value on their ongoing contributions. Some discussed it as a way of continuing a caring practice in one way or another and others just discussed it as a part of who they are as human beings. All described one or more things that they did to give back or

contribute to the health of others. Some volunteered at nursing homes or teen clinics and one sees her current career as contributing on a national scale to the health of all individuals in the nation, and by extension of these benefits, to the global community.

Links with Existing Research on Nursing Satisfaction, Dissatisfaction, and Retention.

In this section each theme and subtheme will be reviewed in light of the literature reviewed in Chapter 2 that lends support or does not lend support to the theme or subtheme. If there is no literature that is related to the theme or subtheme, this will be noted.

Challenges to personal and professional values.

The theme of challenges to personal and professional values, universal among the participants, encompassed the gradual changes in perspective that eventually led to the decision to leave nursing as a profession. For many of the participants, issues of job dissatisfaction were rooted in an inability to provide a high quality of care. Support for this relationship has been widely reported in the literature (Bowles & Candela, 2005; Corley et al., 2005; Morgan & Lynn, 2009; MacKusick & Minick, 2010). Bowles and Candela (2005) found that 26% of new graduate nurses identified a theme of "stress associated with the acuity of patients, unacceptable nurse-to-patient ratios, and feeling patient care was unsafe." (p. 134). Morgan and Lynn (2009) reported that the negative impact on quality of care related to resources both staffing and environmental was a major dissatisfier to the participants in their study. Many participants in MacKusick and Minick's (2010) study of nurses who had left nursing shared stories of not being able to

provide high quality patient care and connected that situation with their decision to leave nursing. Informants in that study spoke at length regarding the emotional distress associated with being able to provide only limited care or providing extraordinary care in situations where the outcome was virtually assured to be negative.

Inability to provide quality care.

A primary concern of the participants in this study was the inability to reconcile the level of care they were able to provide in the institutional environment with the level of care that they felt compelled by their work ethic to provide. This dichotomy was viewed through an ethical lens and strongly contributed to their dissatisfaction. Other experiences of ethical issues were as broad as concerns with the national shortage of registered nurses and the impact of that on the quality of patient care to specific and narrow experiences in their personal practices compared to those of colleagues whose practices were viewed in a negative enough light to warrant their consideration as ethical issues rather than just differences in practice. The existence of ethical issues in practice is supported in the literature both as an issue impacting the quality of care (Corley et al., 2005) and as a contributor to job dissatisfaction and intent to leave (Hart, 2005). Indeed, Hart (2005) concluded that "…the hospital ethical climate was most important in explaining nurses' positional and professional turnover intentions" (p. 173). Hart describes the ethical climate as the organizational conditions and policies affecting how complex patient care issues with ethical implications are talked about and resolved. Contributing to ethical climate are power, inclusion, trust, and role flexibility (p. 174).

Concerns regarding ethical issues at the most broad level were shared by some of the participants both as the impact of the national shortage of registered nursing on patient load and acuity and as an issue with a profit motive in the delivery of health care. These situations create a deleterious effect on quality of nursing care. Participants experienced concern as the number of patients for whom they were required to care increased and as the acuity level of those patients increased. These concerns were intensified by the presence of fewer nurses among whom to divide the care. Also contributing to moral distress among the participants was the profit motive in health care lived as seeing patients turned away for lack of money or insurance. For one of the participants this was the indentified experience triggering the decision to leave nursing and this is consistent with the literature. Another participant described a parallel progression of her impression that hospital administration's major interest was profits and her increasing dissatisfaction with nursing. Corley (2005) reported that "… the treatment of patients as objects in order to meet institutional objectives" (p. 382) contributed to moral distress and even professional turnover. Ethical climates of employing facilities and experiences of moral distress significantly impact nurses' job satisfaction and intent to leave (Corley et al., 2005; Hart, 2005). These findings are affirmed by the experiences of most of the participants in this study.

One participant identified unit level ethical issues. The disparity between the care provided by the participant and the care provided by colleagues was experienced as an ethical issue. This disparity led to distress on the part of the participant and contributed to the decision to leave nursing.

Participants in this study viewed manager practices through an ethical lens rather than a management skill lens, and manager practices directly impacted one informant's decision to pursue a career outside of nursing. Decisions implemented by managers that were felt to be unfair to the participants were described by the participants as ethical violations. Hart (2005) discussed the impact of managerial decisions which had a negative impact on the delivery of patient care as a contributor to moral distress experienced by nurses. That moral distress contributes to intent to leave is affirmed by the experience of these informants.

Management style was the focus of two of the included research works. Both Boyle et al. (1999) and Taunton et al. (1997) found that manager style was a significant contributor to nurses' intent to stay. This was supported in the experience of some, though not all of the participants of this study. One nurse shared a story involving a staff meeting subsequent to a physician throwing a chart and hitting one of the nurses in the head with it. At the meeting, the manager suggested that the staff should look at the physician disapprovingly in response to this violence. This same manager expressed surprise that the informant stated she would not have picked up the chart and given it back to the throwing physician as he ordered.

Clinical nursing competes with life and family.

The subtheme of clinical nursing competes with life and family was experienced by participants as the unmanageable competition between the needs of their patients, the needs of their families, and even their own needs. Many informants shared stories of being so busy in the workplace that they did not have time to meet their own basic human

needs. Others discussed work schedules that precluded taking responsible and sufficient care of their children and families. In some cases it involved being scheduled to work during times that the informants felt an obligation to be present with children (recitals, plays) or aging parents (clinic visits). This inability to meet perceived obligations generated negative feelings toward self and contributed to the decision to leave nursing. Williams et al. (2006) surveyed licensed but non-practicing nurses in Mississippi and found that the primary reason offered for not practicing was conflict with parenting duties (28% of respondents) followed by shift length (14%). Other authors found that autonomy was a primary component of job satisfaction which has been shown to predict intent to leave (Alexander et al. 1988; Atencio et al. 2003; Larrabee et al. 2003). Many of the informants perceived diminished autonomy with being forced to choose which obligations they could fulfill.

Lack of professional self-fulfillment.

No literature directly supports this subtheme which was experienced by participants as a vague dissatisfaction with career. While intent to leave has been shown to be influenced by a nurse's perception of opportunities available elsewhere (Brewer & Nauenberg, 2003), their participants were considering other *nursing* employment opportunities available to them and thus this subtheme is a new addition to the literature.

Workplace stressors.

None of the participants indicated that a single issue could be identified as the motivation to change careers indicating instead that the decision was multifactorial. The experience described by the participants in the current study affirms that as dissatisfaction

grows in multiple areas of satisfaction variables, the impetus to leave nursing becomes stronger until the decision to leave is taken.

For some of these participants the changes began dramatically and suddenly and for others they were slower and more insidious. The notion that multiple factors supported nurse dissatisfaction and intent to leave was widely supported in the reviewed literature (Alexander et al., 1998; Boyle et al., 1997; Atencio et al., 2003; Bowles & Candela, 2005; Cavanaugh & Coffin, 2002; Corley et al., 2005; Hart, 2005; Hayhurst et al., 2005; Larrabee et al., 2003; Rambur et al., 2005; Taunton et al., 1997). Both Boyle et al. (1999) and Taunton et al. (1997) described several factors which led to nurses' intent to leave which had additive effects on the likelihood of the nurse leaving. Alexander et al. (1998) discussed specifically how increasing dissatisfaction on various scales such as relationships with patients, relationships with coworkers, workload, etc. increased nurses' intentions to leave. As dissatisfaction grows, the intent to leave becomes stronger. Multiple components of intent to leave are identified in the literature (Boyle et al; Taunton et al.; Alexander et al.). A primary constituent of intent to leave is job satisfaction, which is predicted by hardiness, management style, nurse physician relationships (Larrabee et al., 2003), and group cohesion (Larrabee et al., 2003; DiMeglio et al., 2005). Also included are communication, autonomy, and job stress (Boyle et al.), and perceived ease of finding another job (Holtum & O'Neill (2004).

Disrespect from the public and other health care professionals.

The subtheme of disrespect was experienced by almost all of the participants. Many described incidents in which they experienced disrespect from others; patients,

patient families, physicians. Most of the disrespect was expressed verbally or attitudinally, but some informants related stories of disrespect expressed as physical abuse. Almost all of the participants had experienced disrespect by hearing the phrase "Well, what do you know? You're just a nurse." Nurse physician collaboration and communication is important to nurse job satisfaction (Rosenstein, 2002; Apker & Propp, 2009) as well as how others interact with nurses (Sofield & Salmond, 2003). Stein-Parbury and Liaschenko (2007) reported on three types of knowledge used by providers in critical care using the example of confused patients. These authors noted that nurse-physician collaboration breaks down when neither is confident in a solution to the presenting problem. They describe *case knowledge* which is medical-model information based on diagnoses. The other types of knowledge they label are *patient knowledge* and *person knowledge.* Patient knowledge encompasses the knowing of an individual patient and how they respond to various stimuli and person knowledge speaks to knowing the patient as an individual human being with unique history. While both physicians and nurses use all three types of knowledge, case knowledge is often valued more highly than the others. When the physicians in the study were unable to resolve the issue of confusion using case knowledge, they became dismissive and disrespectful of nurses instructing them to "handle the patient as best you can" or "just hold their hand and give them a kiss." (p. 475).

It is through interaction that respect or disrespect is conveyed. The experience of choosing to leave nursing as a profession among this group of informants was heavily influenced by the lack of respect perceived from others. Practicing RNs indicate that

nursing is not a good career choice for students who want respect (Buerhaus et al., 2005). Disrespect and abuse have been linked in the literature with nurses choosing to leave nursing positions (Sofield & Salmond, 2003). These authors found that 14% of respondents had left previous positions because of abuse. The abuse came primarily from physicians (35%) followed closely by patients' families (22%) with other sources being patients, peers, immediate supervisors, and subordinates.

Stress, workload, and unsafe practices.

This subtheme was experienced as an array of characteristics of working as a nurse that were essentially unpleasant and which contributed to overall dissatisfaction. Workload and stress had increased over the years for the participants as the acuity of the patients had risen and staffing levels had ebbed leaving the informants to take care of more and sicker patients, frequently for longer shifts. The increasing level of patient acuity and the decreased staffing levels were experienced by the participants as unsafe. Beyond this, the majority of participants shared that floating was a major part of their dissatisfaction as they experienced various unpleasant interactions and experiences while floating. Some of their experiences included being rebuffed from a shared meal in the float unit, being expected to function in the unfamiliar unit without an orientation or with an inadequate orientation, and unwillingness on the part of the regularly assigned staff to answer questions. An additional stressor associated with floating was the necessity of administering pharmaceutical agents with which the participants were unfamiliar. These experiences while floating increased stress for the participants as they felt it was unsafe. The subtheme of stress, workload, and unsafe practices was richly supported in the

literature. Workload and stress are typically presented as components of job satisfaction and intent to leave or intent to stay (Alexander et al., 1998; Brannon et al., 2007; Boyle et al., 1997; Atencio et al., 2003; Bowles & Candela, 2005; Corley et al., 2005; Hart, 2005; Hayhurst et al., 2005; Larrabee et al., 2003; Rambur et al., 2005). Commonly reported stressors include workload, job hazards, relationships with coworkers, moral distress, patient care issues, and a lack of support or guidance. Unsafe practices enjoy less robust support in the literature (Corley et al. 2005) but are supported by the participants in this study. The included literature did not address floating as a component of nurse job dissatisfaction, intent to stay, or intent to leave.

Life after nursing: Reconstituting the caring passion.

All participants constructed their lives after leaving nursing to allow for a continuation of giving back, or caring for others. Various changes in life experiences were common among these participants. Those in business noticed that the communication of gratitude from others was given in a shallower manner than that received from providing nursing care. Many of the participants experienced a time during which they could not feel good about their new careers *because* they were no longer practicing nursing. A number of participants sought intangible rewards by volunteering. One of the differences noted by participants between themselves and the non-nursing people with whom they currently work was that their new coworkers complained more insistently about lesser issues than did their colleagues in nursing. Life after nursing; reconstituting the caring passion is not evident in the literature. The discovery of this theme is an addition to the literature.

Nurse as identity – A nurse is who I am.

Without exception all participants experienced nurse as their identity after leaving nursing. Each informant, though they had allowed their nursing license to lapse continued to identify themselves as nurses. Being a nurse was foundational to their self concept and their self worth and each of them referred to themselves as a nurse on multiple occasions during their interview. One nurse put it succinctly: "I was called to nursing. I have always been a nurse and I will always be a nurse. Whether or not I have a license to practice is irrelevant." This subtheme is also an addition to the literature.

Caring as a way of being in the world.

The subtheme of caring as a way of being in the world was experienced universally in this group as a part of who they are as human beings. Each of them continued to express this subtheme through either volunteer work at a facility such as a nursing home or a teen clinic, or professionally through service to country or subsequent careers in which they sought to help other individuals or groups. This subtheme is an addition to the literature.

Transfer of knowledge, skills, and work ethic.

This subtheme captures the utility of nursing knowledge in other career endeavors. All participants experienced this and described specifically the advanced ability to prioritize and think critically that was gained by practicing nursing. This skill, along with specific health knowledge was experienced as valuable and a specific outcome of having been a practicing nurse. The subtheme transfer of knowledge, skills, and work ethic is new and was not evident in the previous literature reviewed.

Links to New Literature Supporting Themes

The identified theme of *challenges to personal and professional values* in the current study enjoyed robust support in the new literature. Untenable levels of moral distress cause nurses to leave the profession (Peter & Liashenko, 2004; Schluter, Winch, Holzhauser, & Henderson, 2008). Nurses experience greater amounts of moral distress than do physicians (Schluter et al., 2008). This increased level of moral distress is rooted in the nature of nursing that requires the nurse to be continuously exposed to patients and the ethical issues associated with the patients (Peter & Liashenko, 2004). Peter and Liashenko (2004) state that "leaving nursing can be viewed as an ethically and socially acceptable mechanism to escape from the demands of proximity." (p. 223). Powerlessness and helplessness contributed to feelings of moral distress and can further lead to nurses disengaging from family and not wanting to return to work. (Schluter et al. 2008). Pellico, Djukic, Kovner, & Brewer (2010) identified a theme of "The Reality of Being a Nurse is Nothing Like the Dream" which encompassed the experience of management's uncaring attitude toward nurses and patients that was communicated through overburdening, equipment shortages, and supply shortages. These experiences were seen as a result of the organization's commitment to the profit motive rather than the provision of excellent care.

Many of the supporting themes of complexity compression (CC) (Krichbaum et al., 2007; Krichbaum et al, 2011) are reflected in the experiences of the participants in the current study. "Complexity compression is the phenomenon that nurses experience when asked to assume additional, unplanned responsibilities while simultaneously conducting

their multiple responsibilities in a compressed time frame." (Krichbaum et al., 2007, p. 86). In later work, Krichbaum et al., (2011) identified three factors that explained a total of 51.4% of the variance on an assessment survey designed to measure complexity compression. These were the work of nursing, systems, and personal factors. The work of nursing factor encompasses unexpected occurrences in the workplace that interfere with the nurse's work and includes issues such as delegation, floating, and others. The systems factor is comprised of issues stemming from the structure of the organization or administration issues that interfere with the nurse's work. The major themes (2007) of CC contain multiple subthemes which have clear relation to the current study. The subtheme clinical nursing competes with life and family in the current study is similar to the sub theme of *family/individual issues* in CC. That subtheme is comprised of "conflicts between demands of work and family/personal requirements" (p. 90). It is also closely related to the CC subtheme *conflicting responsibilities*, which encompass the existence of dilemmas created by equally important demands, both of which are impossible to meet. The subtheme of disrespect from the public and other health care professionals is closely related to the CC subtheme *psychosocial* which addresses the issues of conflict verbal and physical with others in the care environment. The subtheme of stress, workload, and unsafe practices encompasses experiences described in the CC subtheme of *floating/cross training/ unfamiliar tasks/needs* which addresses the safety implications of floating and being responsible for unfamiliar tasks/roles in an unfamiliar environment. Other CC subthemes that are related to the subtheme of stress, workload, and safety issues are: *lack of safety net, staffing, and ineffective administration and management*.

The individual decisions of nurses to leave the profession continue to have a significant impact on the practice and profession of nursing in the United States. New projections indicate the shortage of RNs will be 260,000 by 2025 (Buerhaus, Auerbach, & Staiger, 2009). Research continues to be performed primarily aimed at determining the reasons that nurses turn over positionally. Nemcek and James (2007) relate self nurturance and perceptions of magnet features of the employing facility with life satisfaction which contributes to job satisfaction. Job satisfaction is a significant component of nurses' intents to leave and intents to stay. Nemcek and James concluded that magnet characteristics and frequent self nurturance supported increased life satisfaction. The current research supports their findings in the subtheme *clinical nursing competes with life and family.* This subtheme contains the frustrations that participants experience in attempting to meet their own and their family's physical and emotional needs.

Parry (2008) notes that efforts to reduce turnover ought to be addressed both at reducing positional turnover as well as at professional turnover. Parry's research found that while affective occupational commitment (an individual's desire to remain in the professional role) and organizational commitment are related, the impact of diminishing organizational commitment is significantly related to diminishing affective occupational commitment among nurses. These findings are consistent with the sensation of the subtheme of *lack of professional self-fulfillment* included in the theme of *challenges to personal and professional values* identified in the current study. Pellico et al. (2010) identified a theme of "Getting Out" in their qualitative secondary data analysis study of

responses to an open ended question at the end of a work experience survey distributed to newly licensed nurses and then repeated one year later. These researchers found that the participants who responded had very different experiences of work in their first and second years of nursing. At the second measure, participants were looking to "get out" of the hospital because of "the burdensome physical work, strain on their family life, and fear for patient safety" (p. 13). These participants were seeking nursing employment elsewhere, and as Parry noted, seeking employment elsewhere is positively and significantly related to intent to leave the profession. Schluter et al. (2008) noted that the moral distress experienced by nurses is significantly related to job satisfaction and highlighted that low job satisfaction is a precursor to intent to leave both the position and the profession. In discussing the genesis of intent to leave the profession, Schluter et al. asserted that "poor self esteem and feeling overwhelmed and powerless, are emotions experienced by nurses close to making the choice to leave nursing." (p. 317). Figure 3 details the model Schluter et al. developed.

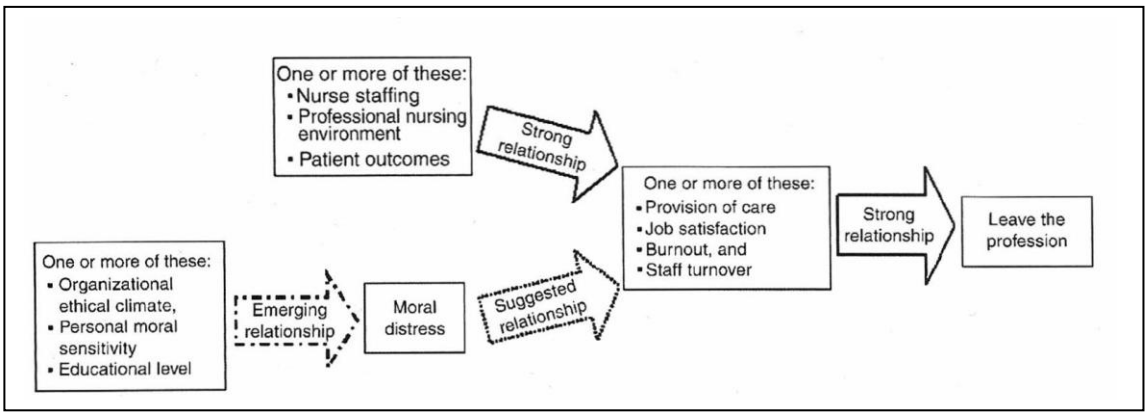


Figure 3. Influences and effects of moral distress on nurses' intention to leave the profession[2]

These findings are supported in the subtheme of *challenges to personal and professional values* in the current research.

In a study of newly registered nurses' positional commitment Kovner, Brewer, Greene, and Fairchild (2009) noted that the contribution of mandatory overtime and high patient load have a great impact on new nurses' intentions to remain in their positions. This is an important finding in light of Parry (2008) and the connection between nurses' organizational commitment and affective occupational commitment. That relationship is reflected in the discovered theme of *workplace stressors* in the current study. Participants in this study shared stories of high work stress, high patient loads, and forced overtime as contributing to their decisions to leave nursing. Pellico et al. (2010) identified two themes that are consistent with the current study's *stress, workload, and unsafe practices.* Their theme of "Pressured Time" encompassed participants' experience of struggling to completed their work within their assigned shift and finding that goal to be unattainable

[2] From "Nurses' Moral Sensitivity and Hospital Ethical Climate: a Literature Review," by J. Schluter, S. Winch, K Holzhauser, & A. Henderson, 2008, *Nursing Ethics,15*(3), p. 318. Copyright 2008, SAGE Publications. Reprinted with permission.

owing to the array of pressing issues with which they must cope as they get their work done. A further theme of "Growing Weary" in which informants shared stories of ill-behaved physicians berating nurses and other issues of disrespect is consistent with the subtheme *disrespect from the public and other health care professionals* in the current study. The participants in the Pellico et al. study grew "weary of verbal abuse by colleagues, the onerous work of bedside nursing, the consistent lack of equipment, poor management, inordinate levels of paperwork/computer work, and strain of the profession that creeps into their family life." (p. 10). The issue of work hours which was a part of the theme of *stress, workload, and unsafe practices* in the current study was reflected in Rajapaksa and Rothstein's (2009) report that 46% of their sample found the hours better in their new job. Rajapaksa and Rothstein performed a secondary data analysis on the responses by nurses who had left nursing for other occupations on the National Sample Survey of Registered Nurses from 2000. Lavoei-Tremblay, O'Brien-Pallas, Gelinas, Desforges, and Marchionni (2008) queried newly licensed French speaking Canadian nurses younger than 24 years of age who had received their nursing education in Quebec regarding their perceptions of nursing. Of their respondents (N=309), 190 intended to leave their current position and more than 10% intended to quit the profession. Those intending to quit the profession cited difficult working conditions and job instability as their reasons. This is consistent with the subtheme of *stress, workload, and unsafe practices* identified in the current study.

There exists a paucity of research encompassing the experience of nurses after they have left the profession of nursing. This study contributes to the literature by

bringing forward a new theme of life after nursing: reconstituting the caring passion as well as its subthemes of nurse as identity – a nurse is who I am, caring as a way of being in the world, and transfer of knowledge, skills, and work ethic.

Theoretical Considerations

The findings of this work are consistent with and lend support to the investigator-designed Organizational Dynamics Paradigm (Taunton et al, 1997). The paradigm was visible in the stories of leaving nursing. The framework suggests that RN retention is related to four sets of predictor variables: manager characteristics, organizational characteristics, work characteristics and nurse characteristics, and that the interactions of these four sets of variables combine to predict retention of RNs. The stories of the experience of departure shared by the participants contained many examples of dissatisfaction with the four included variables. One participant, discussing the genesis of her disillusionment with nursing, stated, "The disillusionment came from administration who I don't think were looking at the best for the patient. They were looking at the bottom line... the dollar." This is consistent with the framework component of organizational characteristics. As hypothesized in Taunton et al.'s Organizational Dynamics Paradigm (1997), dissatisfaction with manager characteristics contributed to participants' decisions to leave. One participant shared a story of managerial support following a violent outburst from a physician in the workplace. The manager's suggestion for handling the situation was: "We'll tell you what we think you should... You should just look at him like oh you shouldn't do that. And that'll put him in his place." As Taunton et al. have proposed in the model, work characteristics contribute

significantly to nurses' intentions to stay in their positions. Many of the participants in this study spontaneously offered support for this notion. One participant shared while discussing floating that it was the worst part of the job:

> Oh, here are our worst patients and your office is in the toilet, and if you want something to eat, go scrape something off the curb, but we're going to have a buffet in the back and you're not allowed to go.

Another participant, sharing the unacceptable stress level of nursing told the following story,

> You're kind of screwed [sic] covering for breaks. I remember one time I had to call a code when I was covering. I was the only one in the unit because there were only three or four patients and the other nurse went to lunch or dinner, I don't remember what shift it was, but one of the staff physicians was at the desk… but I was working on a patient and he was standing behind the desk right across from me, and things were just starting to slowly go downhill, and I think he was kind of watching, and it got to the point where he was like "do you need some help?", and I was like, "yeah." We ended up calling a code just to get the people there, and coded the patient, so that was rather stressful.

In this study, aspects of the participants Taunton et al. (1997) would label "nurse characteristics" were present in the decisions of the participants to leave nursing. One former nurse identified that she didn't possess the energy to practice as a nurse "I didn't

have the strength for it." And another participant shared that "quite frankly I got bored with it."

Findings from this study also support the theoretical perspective from Alexander et al. (1998) which blends the needs-satisfaction view suggesting that jobs have specific characteristics that will or will not match with individuals' unique needs and the opposing framework of social information processing perspective which holds that individuals' needs and wants are determined by their situations and that attitudes are shaped by social contexts and the results of past behaviors. The revealed subtheme of *lack of professional self-fulfillment* illuminates the experience of realizing that something was missing for the participants or that they had a basic need to change careers. This experience was universal for the participants and is consistent with the assertion by Alexander et al. that job characteristics will or will not match an individual's requirements from a job. The variety of participants' experience with the initiation of *lack of professional self-fulfillment* speaks to the concept that each individual's needs for job satisfaction are unique, suggesting that there is no single intervention that will achieve satisfaction in all practicing nurses.

Strengths and Limitations of the Study

Strengths of the study include utilization of a qualitative research approach that allows those who have experienced the phenomenon of interest to use their own words to communicate the experience to the researcher. Through direct and specific examination of the case and the descriptions as related by persons who have lived it, a better understanding of the experience may be gained (Miles & Huberman, 1994). The case

study design and method as described by Stake (1995) and Yin (2009) was suited to the question being posed. Participants had the opportunity to reflect on and prepare their thoughts about the question prior to the interview which enabled them to provide rich descriptions of the experience. Invitations to participate were sent to the entire population eligible by inclusion criteria to participate.

Transferability in this study can be related only to those nurses' experiences of leaving nursing that exhibit the same themes. Guest, Bunce, and Johnson (2006) report in their method exploration paper that 12 interviews yielded 100% of the content-driven codes used for analysis in their study, 80% of which were identified after the first six interviews. Because of the sample size (N=6) it is possible that only 80% of the content-driven codes were identified during the analysis. Homogeneous characteristics were noted among the sample, all but one was female, all were Caucasian and all were residents of a Midwestern state. This homogeneity also limits the transferability of the results.

There may be additional inherent bias related to the purposive selection process (Isaac & Michael, 1995). Through the process of requesting volunteers to participate, bias can be introduced based on who chooses to share their experience of the phenomenon in question. Those too introverted, or those too emotional about the experience are less likely to volunteer to participate. This reticence can negatively impact the researcher's comprehension of the full spectrum of the experience, which in turn can decrease the reliability of the results.

Future Research

This study examined the experience of choosing to leave nursing. Understanding of this experience yields insight into both the experience and the trajectory of the decision. Significant insight may also be found in understanding the experience of loving nursing and future research should seek to understand the experience of living a passion for nursing that would preclude the notion of changing professions. This research supports the thoughtful consideration of changes in the workplace of the nurse. Further research is warranted regarding the impact of implemented policy changes.

Implications for Nursing

Multiple researchers have documented the correlation between job satisfaction and intent to leave a position or employer (Alexander et al., 1988; Atencio et al.,2003; Bowles & Candela, 2005; Corley et al., 2005; Boyle et al., 1999; Taunton et al., 1997; Holtom & O'Neill, 2004; Hart, 2005; Larrabee et al., 2003; Lavoei-Tremblay et al, 2008; Marchionni & Ritchie, 2008; Parry, 2008; Pellico et al, 2010; Prevosto, 2001; Rambur et al., 2005; Rosenstein, 2002; Schluter et al., 2008), and many have documented the correlation between job satisfaction or intent to leave with intent to leave the profession (Hart, 2005; Parry, 2008; Lavoei-Tremblay et al, 2008; Peter & Liashenko, 2004; Schluter et al, 2008). The nation and indeed the world are in the midst of a nursing shortage that is predicted to continue worsening (Buerhaus, Staiger, & Auerbach, 2000; Buerhaus et al., 2009). It is imperative to understand the experience of choosing to leave nursing in order to address the issues facing practicing nurses that contribute to the consideration of professional exit. Nursing must continue its active role in designing the

environments in which nursing is practiced. The physical, interactional, and ethical environments must be developed intentionally to support nurses in the provision of high quality care.

The curriculum of nurse education programs needs to reflect knowledge of the trajectory of nurses who cease practice so that newly graduated nurses may be proactively aware of threats to their job satisfaction and take an active role in reshaping nursing environments to decrease the threat of dissatisfaction. High school counseling needs to combat stereotypes and inaccurate knowledge of what nursing is and is not. Accurate information regarding nursing disseminated to career searching high school students will increase the number of nursing students who will experience nursing as more what they expected.

The shortage of nurse faculty in nurse education programs magnifies the impact of each nurse's premature departure from practice. Because there are far more qualified students than there are seats in educational programs it is of increased importance that each graduate practice as long as possible.

There are multiple aspects of nursing practice that contribute to a multi-factorial experience culminating in a nurse's decision to stop practicing. These aspects are robustly supported in the nurse job satisfaction literature and their contribution to the decision to stop practicing is supported in this study. Many of these aspects are amenable to change through thoughtful and considered policy intervention. It is critical that these interventions be developed and implemented in order to retain as many nurses in the profession as possible. The investment in the education of each nurse, and the limited

resources required to educate nurses, warrant the best possible effort to retain each nurse in the profession. Once awarded to a student nurse, a seat in the academic preparation program cannot be reclaimed and reassigned following the departure of the nurse.

Quality care and safe practices in institutions demand that nurses be well educated and confident that their knowledge and skills are valued and respected. Respectful collaboration must become the norm in all practice areas and policy must be implemented to support that goal. Beyond policy implementation, the academic preparation of nurses must include leadership, communication, and assertiveness skills in order to prepare them to participate as a fully equal member of the healthcare community. The Institute of Medicine's 2011 report on the future of nursing identifies as its third key message out of four: "Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States." (p. 1). It is incumbent on both employers and educators to fully embrace this goal and support progress toward it.

Closing

The experience of these participants affirms much of what has been assumed and asserted regarding nursing job satisfaction, organizational commitment, and affective professional commitment. This study strove to describe and interpret the experience of choosing to leave the profession. It is clear from the experiences shared by the participants that many of the factors driving the choice to leave would be amenable to intervention. The participants in this study did not enter the profession with the intent to leave. They entered with commitment to serve their patients and to practice as professionals. Life events, workplace issues, and social interaction led them to points at

which they considered and subsequently decided to leave the profession. Life events cannot be controlled by workplace policies and thus cannot yield a solution to the issue of nurse attrition. Workplace policies can and should contribute to an environment in which nurses are expected and able to deliver the highest quality of care. Workplace policies can positively impact social interaction in the work environment and create and support an environment in which communication and behavior is respectful and collaborative. Multiple studies have been published which assess nursing job satisfaction with multiple instruments and methodologies. Consistent findings indicate that job satisfaction and dissatisfaction contribute to individual nurses' intent to leave the position/organization/profession. Understanding the experience of choosing to leave nursing as a profession affirms those findings and underscores the urgency of responding to nurse dissatisfiers. Nursing must continue supporting programs aimed at increasing respectful communication between health care professionals and to address more aggressively the workplace issues that contribute to nurse professional disillusionment.

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Appendix A: Recruitment Letter

110 West Grant St. #21J
Minneapolis, MN 55403

October 3, 2008

Name
Address
City, State, ZIP

Salutation,

I am writing to you to make you aware of a research project I am doing. I am interested in understanding the phenomenon of choosing to leave nursing as a profession. This research involves interviewing people who have chosen to leave nursing.

The Minnesota Board of Nursing maintains a list of Registered Nurses who have not renewed their licenses and I am writing to randomly selected people on that list and will arrange interviews with those people who are interested in participating.

There is no benefit to participants for participating other than the satisfaction of assisting in the understanding of the choice to leave nursing.

I have enclosed a card for you to return with a phone number at which I can reach you. If you would be more comfortable calling me, I would welcome your call at 612.708.0864. If you return the card to me in the enclosed stamped envelope, I will call you to discuss the research further and if you are willing, to set up a time for an interview at a time and place convenient to you.

Thank you very much for reading this and I hope we will talk further.

Sincerely,

Robert J. Muster, PhD(c), RN

Appendix B: IRB Approval Letter

07/29/2008

Robert J Muster
School of Nursing
5-140 WDH
Minneapolis Campus

RE: "The Experience of Choosing to Leave Nursing as a Profession"
IRB Code Number: 0806P37002

Dear Mr. Muster

The Institutional Review Board (IRB) received your response to its stipulations. Since this information satisfies the federal criteria for approval at 45CFR46.111 and the requirements set by the IRB, final approval for the project is noted in our files. Upon receipt of this letter, you may begin your research.

IRB approval of this study includes the consent form received July 21, 2008 and recruitment materials received June 17, 2008.

Please note that the following items are now required on each page of the consent form: IRB code number and consent form version date (the date the consent form specific to this study revised). This will be required at the time of continuing review.

The IRB would like to stress that subjects who go through the consent process are considered enrolled participants and are counted toward the total number of subjects, even if they have no further participation in the study. Please keep this in mind when calculating the number of subjects you request. This study is currently approved for 12 subjects. If you desire an increase in the number of approved subjects, you will need to make a formal request to the IRB.

For your records and for grant certification purposes, the approval date for the referenced project is July 1, 2008 and the Assurance of Compliance number is FWA00000312 (Fairview Health Systems Research FWA00000325, Gillette Children's Specialty Healthcare FWA00004003). Research projects are subject to continuing review and renewal; approval will expire one year from that date. You will receive a report form two months before the expiration date. If you would like us to send certification of approval to a funding agency, please tell us the name and address of your contact person at the agency.

As Principal Investigator of this project, you are required by federal regulations to inform the IRB of any proposed changes in your research that will affect human subjects. Changes should not be initiated until written IRB approval is received. Unanticipated problems or serious unexpected adverse events should be reported to the IRB as they occur. The IRB wishes you success with this research. If you have questions, please call the IRB office at 612-626-5654.

Sincerely,

Felicia Mroczkowski, CIP
Research Compliance Supervisor
FM/egk
CC: Cynthia Peden-McAlpine

Appendix C: Consent Form

CONSENT FORM

The Experience of Choosing to Leave Nursing as a Profession

You are invited to be in a research study of the experience of choosing to leave nursing as a profession. You were selected as a possible participant because records at the Minnesota Board of Nursing indicate that your license has not been renewed. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Robert J. Muster, a doctoral candidate in nursing at the University of Minnesota.

Background Information

The purpose of this study is to develop an understanding of how the decision is made to leave nursing and to describe the experience of choosing to leave.

Procedures:

If you agree to be in this study, we would ask you to do the following things:

Schedule an audio taped interview at your convenience with the researcher at a place and time of your choosing which is predicted to last between 90 minutes and two hours. During the interview the researcher would ask you to share your experience of choosing to leave nursing.

Risks and Benefits of being in the Study

This study has a small risk of emotional discomfort depending on your individual experience of choosing to leave nursing. If your experience leaving was painful for you, then sharing that experience with the researcher might be painful as well.

There is no direct benefit to the participant in the study.

Compensation:

You will receive no payment; there is no compensation or payment for participation in this study.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. No identifying data will be collected from the informants and interview transcripts and audio recordings will be kept in a locked file in the researcher's office at the University of Minnesota. Access to transcripts and audio recordings will be restricted to the researcher and the researcher's adviser, Dr. Cynthia Peden-McAlpine. Audio recordings will be destroyed immediately following the completion of analysis. Written transcripts of interviews (without participant identifiers) will be retained by the researcher for 15 years and may be used for educational purposes.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is Robert J. Muster. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at the University of Minnesota, 612.708.0864, must00132@umn.edu. You may also contact Dr. Cynthia Peden-McAlpine, PhD, RN at 612.624.0449, peden001@umn.edu who is this researcher's advisor.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature:_____ Date: _____

Signature of Investigator:_____ Date: _____