

# *Out in the Real World*

## *Newly Graduated Nurses in Acute-care Speak Out*

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Resources are being spent to develop and implement strategies to attract and retain staff. To further our understanding of work environment factors that affect these issues, the author asked five nurses to reflect on their first 6 months as professional nurses. The author's study provides insight into, and enhances understanding of, recruitment and retention issues for nursing administrators who serve as gatekeepers to the practice orientations and ongoing workplace environments of new nursing graduates.

These are challenging times for professional nursing practice. Although they purport a shortage of qualified and committed nurses, healthcare communities continue to fall short in their attempts to provide a quality work life that attracts and embraces both novice and seasoned nurses.<sup>1-4</sup> Vast healthcare dollars are being invested in strategies aimed at recruiting and retaining an energized, well-educated, critically thinking, motivated, and dedicated nursing work force.<sup>5-8</sup> Yet, there is minimal qualitative evidence to inform what constitutes an optimal work environment for the acute-care, hospital-based practicing nurse and even less evidence to detail the factors that exhaust, alienate, and discourage those professionally competent and caring nurses we most need to attract and retain.

### **Research Methods**

This study employed a phenomenological qualitative research approach, exploring how five nurses perceived their first 6 months as professional nurses. This research provided insight into, and enhanced the understanding of, the socialization and professionalization processes of new nursing graduates, establishing its usefulness as a guide for nursing administrators who serve as gatekeepers to the practice orientations and ongoing workplace environments of new nursing graduates. The study was approved by an advisory committee on ethics in behavior sciences research at a large Canadian univer-

sity and consents were signed by all participants well in advance of the first interview. Using purposive sampling, five women were selected; they ranged in age from 23 years to 25 years of age and had graduated from a 4-year baccalaureate degree nursing program within 2 months after the study began. All were employed in full-time equivalent positions within three acute-care hospitals in a mid-sized Canadian city.

### **Study Limitations**

This study explored the perceptions of nursing practice in five newly graduated nurses. Though small, this sample size provided an opportunity for in-depth interviewing, reinterviewing, and constant journal reflection, all of which enriched the study. Data were collected using a nonstandardized, semi-structured interview schedule and technique. Questions were constructed by the interviewer, and should be recognized as coming from within this author's personal and professional paradigm of thought. This subjectivity indirectly instilled conceptual bias into the interview process, although rigorous attempts were made to ensure that participants directed the course of the interview once the questions had been posed.

All data were collected and interpreted by a single researcher. At the time of this study, the author had been a practicing acute care nurse for 18 years and had prior involvement as a nursing educator for two of the five participants. Congruent with all qualitative research, the practice experience of the author necessarily influenced the research in both process and content. In this context, the author found herself aware of, and sympathetic to, the

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plight of the acute care bedside nurse, and had struggled with similar political, social, and cultural environments within which the participants also appeared to be struggling. This practice empathy, and the historical teacher-learner relationship that existed with two of the participants, must be considered as having potentially influenced the depth and candor with which the participants approached their disclosure.

### **Data Collection and Analysis**

Data were collected through the use of two in-depth interviews; the initial semistructured interview was audiotaped within 2 months of the new graduates commencing practice as registered nurses, and the final interview was audiotaped 6 months later. All participants engaged in monthly reflective journaling throughout the 6-month study period; journaling methods were determined by the individual participants and consisted of various methods that ranged from audiotaping and informal notetaking, to a collage of magazine photos that conceptually embodied one participant's feelings and experiences during a 1-month journaling period; this participant also provided an extensive literal description of her interpretation of these pictorial symbols. The volume of journaling varied from half a page to 40 pages of transcribed recordings per participant; the completed data encompassed approximately 700 pages of transcription.

Data were analyzed using a constant comparative approach to identify major themes and to categorize collective data, with significant involvement of the participants in member checking the interpretations of the data. The data collected through interviews and reflective journaling were analyzed and synthesized, revealing a core process entitled "The Journey." This journey was a process of searching during which the participants came to know themselves as professional nurses and as individuals separate from the student role. The three major themes that evolved sequentially (in time) from this process were:

1. Doing nursing;
2. The meaning of nursing; and
3. Being a nurse.

#### **Theme 1: Doing Nursing**

I might as well start by telling you what I felt like when I first started because I've kind of come to

the conclusion that it's the hardest thing I've ever had to do to make the transition from going to school to practicing in the real world. Everyone told me everything is going to come together. But that's something that I have learned; no one could tell me what was going to happen. It's something that I had to experience for myself and there's a lot of things that I've had to experience for myself that I couldn't have been taught.

### **Dependency on Others**

All participants experienced an enormous level of frustration during the initial several months of their introduction into clinical nursing practice. Much of the frustration originated from issues that conflicted with one another, perhaps explaining the degree of effect on the participants. There was a desire to deliver quality nursing care, but participants had neither the knowledge, focus, time, nor energy to do so. The participants felt a great need to be accepted as contributing members of their healthcare teams, but consistently found themselves requesting assistance from their nursing peers for issues relatively basic to the functioning of their new nursing unit. They could not establish the fundamental independence that would give them a sense of themselves as professionals. Many of the participants could not at this point accept this dependence on others.

XX was always looking over my shoulder. I was suctioning my patient's ET [endotracheal] tube by myself since with this patient it was ordered to suction with one person. XX walks in with this look on her face that said, "What in the world do you think you're doing?" I told her that I was suctioning him by myself because I was told I could. She says, "Well, I'm here now and you don't have to." So she helped me and I felt incompetent.

"Not knowing" was perceived as weakness, rather than as an expected state of their professional orientation. The participants drew relationships between the frequency and quality of their questions, and their sense of dependency on others. They feared not being accepted by the nursing staff, and the need to stop questioning and manage on their own was strong.

I wanted to be independent and I think that sort of isolated me from everybody; I didn't want to go ask for help and I think that's why I felt alone

. . . . But if you just don't know then you can't really think things through. If you have no knowledge of anything, then you can't really think things through. I think that's why I felt alone; because I didn't have the knowledge and I was trying to think it through but it wasn't working. I think the need for independence stifled my thinking because I was trying to be independent, and that was sort of stopping me from gaining more knowledge from other people; I think wanting to be independent stopped me from asking more questions.

### *Fear of Physicians*

The one person who's intimidating is the doctor, that's up there, he's pretty frightening sometimes . . . . It's just that he wants things done certain ways and if it's not done that way he gets mad, well not screaming at people; well sometimes he does sort of scream, but he's got a short temper and sometimes he can blow up at you. He blows up more at the residents than the nurses, but I've seen him blow up at the nurses too and I'm just waiting for the day when that happens to me . . . . He gets what's best for that patient but I don't know if the way he goes about getting that is right; sometimes he doesn't treat people like I would think to treat them. It makes me nervous when he's around just cause I might do something wrong, so I just sit there and think "what would he want?"

It was most remarkable to uncover the level of participant anxiety about their interactions with physicians. They universally described verbally abusive behavior directed toward themselves and others by senior staff physicians, and at no time during this study did they actively challenge this behavior either with the physician, the nursing unit manager, or even with themselves. The participants simply adjusted to the behavior, learning new ways to manipulate the situation so they could get what they needed, while least antagonizing the physician.

Today I was nervous for a different reason. The doctor just returned from holidays. On my student practicum, I found him very intimidating. He is overbearing and sometimes is mean and rude. He has made nurses cry and has made residents feel like nothing. So, I get to work and the night RN [registered nurse] tells me that she made a huge mistake and this patient received

130% fluid maintenance when it was ordered at 90%. As soon as I heard this I thought, "I AM DEAD! Dr. X will kill me." I think this was in the back of my mind the whole time, so I was asking myself each time I did something, "Would Dr. X freak out about this?" He gets angry if the patient's bed is messy and cluttered, so I tried to keep it as neat as I could.

One participant provided an unsettling comparison of nurses to worker ants; "tiny, little hard-working creatures that people often ruthlessly step on. You can tear down what they've accomplished, and they'll only respond by building things back up."

### *Self-absorption*

In circumstances of clinical significance, participants at this initial stage in the study had a tendency to focus on themselves rather than on their patients; there was a strong propensity to visualize patient outcomes in terms of their effect on the new nurse rather than on the patient. This deep sense of egocentricity, although not altogether unexpected, was impressive.

He had lice, he was filthy and that kind of blocked what I was looking at really, which was massive injuries on his arm and leg. But the lice was a problem. Once I got over that, I [could] look at the rest and I felt bad about that. I felt guilty. I thought, "my goodness, I'm not a prejudiced person, but here I am freaking out cause someone has lice." So I was worried about myself, I was worried about bringing it home with me and I [couldn't] look at the situation objectively and critically think about it because my judgment was clouded by the fact that he had lice.

Congruent with egocentricity, participants felt a need to uphold the time-honored traditions of the nursing unit to which they were assigned, rather than to address the needs of their patient population. Completing tasks on time allowed the nurse to blend into the fabric of the nursing unit, rather than be exposed as new and perhaps less capable. Only when the safety of the patient was compromised did the new nurse step out, in risk taking behavior, to address the patient needs.

I just felt so flustered that I really didn't take any time to think about it. I thought, "okay, we have to send this guy within the hour, there's all this paperwork that has to be done, all these arrange-

ments that have to be made for transportation and what not.” I just got all this in my head and I didn’t really take the time to think about something as simple as Heparin running. And I don’t know what to do about that . . . I was worried that being a new nurse, that I could hold things up by not being finished fast enough, by not making the arrangements quickly enough, by not doing the paperwork quickly enough. I was so worried that I would possibly hold things up that I didn’t take the time to stop and think.

### *Leaving the Nest*

Making the transition from a world of sheltered academia to that of the reality of nursing practice was traumatic for all participants.

In school I had the interaction and the feedback and whatever from everybody and suddenly that’s taken away; that can be a really big shock. There was like a cushion around me before and I could bump into it every once in a while and that was okay. And I know I can still make mistakes out here, but there’s not as much cushion; you have to own up to things and say “yes, I made a mistake and yes this is wrong, and you know I have done that, and I’m sorry I did this wrong, could you tell me how to do it better or could you help me with this.” In some ways that was hard for me to do initially because there was always that cushioning there and once it’s ripped away it’s hard.

So much of what the participants had learned during their education seemed unavailable to them now. They attempted to rigidly apply context-free concepts to clinical situations and were naturally confused when they discovered that this did not work. They could not modify or manipulate their knowledge, and thus frequently met with disappointment and disillusionment about the relationship between their nursing education and practicing in the *real* world of nursing.

The sense of responsibility inherent in their new nursing practice was absolutely overwhelming to the participants and they afforded accountability for this disparity in the lack of preparation by their nursing education. They believed they had never been conferred with the full weight of responsibility for patient care as students, and therefore could not cope with such responsibility as nurses.

As a new grad, the organization is just overwhelming and now we have to put together

everything, we have to put together the organization, we have to put together just dealing with the patient, we have to mix in with that the dealing with the doctors, everything has to come together. Whereas if you’re a student, you get bits and pieces, manageable bits and pieces.

This criticism of their foundational knowledge and clinical experience seemed natural and almost necessary for them to gain a sense of professionalism separate from the student role.

### *The Unwelcome Wagon*

All participants assumed that practice makes perfect; they equated experience with expertise. They entered their practice world perceiving their more senior nursing colleagues with a sense of wonder, attempting to understand “when did you know that, like how did you know that?” They tended not to question authority, but accepted the opinions and actions of senior nursing and medical colleagues as valid.

I’m sure she wouldn’t tell me to do something that wouldn’t be right cause she knows the routine, she’s been there for a long time and knows what can be done and what can’t. I just did it cause she’s been around. . . . I guess if I’ve seen somebody else do it maybe in a similar way, I think it’s the right way. Like if I’ve never seen it before and they teach me I just assume that it’s right because why would they teach me the wrong thing. . . . I think I just assume that they teach me that way because that’s the way they know is best; like, they wouldn’t teach me the wrong thing otherwise that would be pointless. That would be defeating.

This was significant in light of their evolving perception that they were being viewed with criticism rather than acceptance.

Some nurses aren’t too nice, they’re not too helpful. There’s some that are really great and they understand that you’re new and when you have questions they’re like teachers. Other ones, they just kind of make a list of everything you didn’t do or didn’t do correctly.

### *Focus on Doing*

During this initial stage of the study, the participants applied a linear model of thinking to their practice, looking for what was right and wrong, believing that

they could set their practice boundaries by these perceived limits. This was a time to do what was needed to keep up to the pace of the nursing unit and not display their obvious naivete; thinking about why they were doing it this way was not given importance.

When I'm doing my meds, I focus on doing my meds. That night I just felt like I had to do everything all at once. I mean there's no way I could have anyway, it was so I had the blinders on. I guess I was sort of blind to all outside information cause I was so focused on getting my work done and even when the patient said to me, "Wow, that's a [lot] of insulin," I didn't even click.

Meaning was associated with doing and completing the task with efficiency was their overall goal. They sought out assistance from people or resources that would give them practical guidance, as opposed to encouraging them to reason through their skill performance.

Just to get the routine down, the routine of the ward was a feat in itself, just to know what I should be doing at what time of day, what doctor's orders I needed, what patient symptoms I should be calling about. All that stuff is just extra on top of you know the general routine of the ward. So once I started to become at least a little bit familiar with getting back into practice I felt a lot better about being up there, but at first it's everything's coming at you at once and I just felt totally overwhelmed. . . . I hung up the phone and didn't really know what to do after that, so I asked if there was any procedure for when a patient has to go for angioplasty; is it in a manual and can I look it up?

They had no energy left for learning, and thinking only served to distract them from their objective; they simply wanted to get the work done on time "without killing anyone."

## Theme 2: The Meaning of Nursing

At approximately 2 months to 3 months into their practice, participants began to experience a formal separation from themselves as students. This decided readiness to let go of the role of the student and grab hold of the professional role of the nurse was precipitated by several factors. The participants were:

1. Emotionally, spiritually, and physically exhausted;

2. Growing weary of the dichotomies between what they had learned and what they were now experiencing in practice;
3. Searching for more stability in their professional role expectations;
4. Coming to terms with the realities of their working environment;
5. Accepting their inadequacies and imperfections; and
6. Gaining a sense of mutuality with their professional peers.

It was by virtue of this process of letting go that the nurses came to understand what nursing meant to them. They spent time reflecting on the significance of the profession in their lives, explored how they "measured up" to their nursing colleagues, and contemplated whether nursing was something to which they could commit themselves.

We were discussing how we felt about being inadequate, inexperienced, and almost constantly struggling through functioning in the wards. She said, "I have a real love-hate relationship with nursing." That's exactly how I feel; when I've done something well, or I'm at the end of a tough shift, I *love* the job. When I don't know what I'm doing, or if I'm struggling with a situation, or anticipating a situation where I'm unsure of myself, I *bate* it! . . . At the beginning I felt almost like I wasn't even part of the big picture. I felt so low on the totem pole, I felt so incompetent because of all the questions I had to ask. I didn't feel like I was really doing anything to make them better. I just felt like I was going along, just keeping the status quo, so it was really hard to see any meaning in what I was doing.

All participants made the decision to carry on in the nursing profession; this was a pivotal point in their evolving professionalization.

## *Comfort With Fallibility*

Participants resigned themselves to their own fallibility, recognizing that they needed to learn to understand that some degree of uncertainty is always in the job. Several participants spoke of how letting go of some of the idealism they had carried with them from their nursing education afforded them a sense of freedom to discover who they were as practicing nurses in their new world. Stepping back from the student role, they reflected about their position

on the healthcare team and gained a sense of mutuality with nursing and medical colleagues.

I do not feel like so much of a burden anymore. I believe this is due to two things: 1) I have more experience and therefore am more independent in my practice; and 2) I have established relationships with my coworkers. I don't feel so awful when they help me out, or when I need to ask them to do things for me. I realize that this is part of the working relationship.

Concurrently, they could now shift the focus from themselves to their patients, and their nursing care became grounded in patient advocacy.

### *Self-awareness and Trust*

As their trust in themselves increased, and their need to establish themselves as independent practitioners also advanced, the nurses grew dissatisfied with the unidirectional discourse between themselves and senior staff. They sought a more in-depth understanding of their practice routines, and began to draw relationships between their previously acontextual knowledge and the practice experience they were rapidly attaining. Relevancy, logic, and reasoning took hold in their thinking and participants began to see how prospective analysis provided a means to understanding and improving clinical outcomes. Reflection assumed an element of critique and the participants were back in the learning mode once again.

I do a lot of reflection. For me, reflection is going over and thinking about what I've done [during] the course of a day, a week, or [during] a specific situation and thinking about what I did, about if that's what I should have done, if there was something else I could have done. I also do a lot of thinking about feelings, a lot of self reflection about how I am progressing and how I am different now than I was 2 months ago.

### *Patient-centered Caring*

Participants perceived their patients more holistically, and caring became connected with knowing. They saw nursing from a broader perspective and with that, the performance of tasks and the subsistence of ward routines became a smaller part of their vision for nursing care. Comfortable with their tasks, the participants ventured into more central issues of "being a nurse." They offered their patients an

understanding of how the pieces of their puzzle produced some portrait of their health. Advocating on behalf of the patient took precedent for the participants, and individuating nursing care to meet the varying needs of their patients became paramount.

She was showing signs of chest pain so I gave her a nitro, however her emotional self told me that she was anxious. She did not say this, I just knew. So I sat with her and held her hand. I helped her slow her breathing down. I noticed her anxiety subsided when I sat with her and I knew this was important, [because] less anxiety equals less oxygen demands on the heart. That time I did not worry about time restrictions or all the other work I had to do. I knew that my focus and priority was this one patient in particular who needed me.

### **Theme 3: Being a Nurse**

At approximately 5 months into their practice as registered nurses, these participants gained a sense of self-determination through discrimination in both their nursing practice and interactions with others.

I really [think] this is a turning point for me, or at the least a time where I will learn a lot about myself: what I want, what I am capable of, and what I can accomplish. I just know that life is too short not to be happy. I'm planning on staying where I am for a while, because if I were to give up now, I would always regret not giving it my best shot. . . . I seem to be enjoying this stage in my career much more than the first stage of starting out. There is a lot that I don't know, but to counteract that, there is now a lot that I do know.

### *Puppet off a String*

At this stage of the research period, participants began to formulate opinions based on experience with clinical nursing issues and evolving collegial relationships: "I was no longer a puppet on a string." They were far less likely to compromise their care standards to maintain the status quo, and understanding the rationality of expected tasks, protocols, and standards of practice was an essential part of their practice.

Questioning, which had taken a temporary back seat to prescriptive ways of being, came front and center; it was their perceived right to question and they would do so if they deemed it necessary. A bold-

ness was evident in their interactions with senior nursing and medical staff as they advocated for their patient's needs. They began to believe in themselves as beginning nurses, and they were determined to grow into their professional roles; they understood this would occur only through questioning and establishing the meaning behind their nursing actions.

I feel a lot more confident dealing with the other staff and I'm still much the rookie there, but I don't feel so bad about it anymore. I feel like I have a right to ask questions and to question others as well. . . . I'm also not afraid of looking stupid if I need to ask a question. It's also a lot easier for me to ask the questions now because I know a lot of small things so usually the questions I'm asking are higher level and they don't sound so dumb.

Critical assessment of information, the importance of clinical context, and the relevancy and priority of nursing acts became important to the participants. Discriminating truth from fallacy encouraged them to challenge prescribed ways of being and the idea of referent power. The participants took this opportunity to reframe their positions within the hierarchy of their nursing units, marking their spot as contributing members of the nursing team.

### **Critical Thinking**

Accordingly, the new nurses adopted what they believed to be a critical way of thinking about their nursing. To these participants, critical thinking was a distinctly nonassumptive process, not unlike the nursing process, in which the participants were responsible to assess, diagnose, plan, intervene, and evaluate within the scope of their nursing responsibilities. Critical thinking was distinguished from problem solving by virtue of its exploratory intent: "for critical thinking you don't have to have a problem."

Problem solving is something that I would say is concrete. With problem solving, you do always have to come to some decision if you want to solve your problem. I would say critical thinking is the biggest sphere, problem solving is inside that and decision making is even inside problem solving. Decision making involves making the best choice from a set of options. Decision making doesn't necessarily mean that you're generating those options either. In my mind, decision

making is more looking at a list or looking at a set of stuff that's already there for you and deciding. Critical thinking involves appraising the situation and I don't think problem solving does that. In problem solving, you know what the problem is, whereas with critical thinking you go into a situation and you don't necessarily know what you're dealing with yet.

Clinical judgment was seen as the outcome of critical thinking within the context of nursing. Decision making did not presume the application of a critical thinking process and was, therefore, more directly related to the problem solving process.

The participants admitted that critical thinking was often triggered by a problem, a clinical aberrancy outside the scope of the new nurse's experience portfolio, or an intuitive feeling of discomfort. Having identified the issue of concern, critical thinking provided a contextual framework by which one could generate potential alternative approaches to its resolution. Choosing to act on these possibilities was not a certain outcome. This process of generating options was superimposed on an already devised system of information organization; participants called these "systems maps," "roadways," or "clinical pictures." These organizational frameworks afforded the participants a systematized way to sift through data and make decisions on their relevancy and accuracy for the clinical situation at hand.

### **Professional Maturation**

There was a distinct sense of building during this stage of the participants' evolution. They had gained experience, and were now expanding that knowledge base and augmenting their understanding of significant clinical events. They saw knowledge and experience as synergistic, with meaning attached to knowing and understanding rather than just doing. Having mastered the unit routines, practice standards, and performance tasks, the participants started to focus on the quality and effectiveness of their nursing care. Though tasks remained central to their roles as professional nurses, those tasks were broader in scope and implication.

If I look back to nursing school, it was learning how to make a bed and you just went in and made a bed and left. Now, while I'm making a person's bed I can notice how much they ate on their breakfast tray. Thinking about the procedure has grown into thinking about the patient and about why and what the results mean.

## Professional Relativity

By this point, the participants had acquired a sense of professional relativity; they saw themselves as nurses now and this altered their interactions with those around them. They were inclined toward interdependent relationships with senior nursing and medical staff and could consult with their colleagues when making clinical decisions. By “becoming a little more adventurous” in their interactions with others, the participants had started to gain the independence they sought, while retaining the quality care standards of their nursing education.

Finally, the participants evolved into full practice. They reminisced about their student days, and reflected on the behaviors of incoming students as separate from their own history.

I was actually pretty surprised at myself because even though at the time I felt really lost, when I looked back at my charting, I knew exactly what was going on even though at the time I really did feel swamped and “whoa, what’s happening.” Ironically it was a student’s patient that actually went downhill and the poor student was standing there and it kind of hit me like a ton of bricks what it felt like to be a student. I remembered exactly what it was like, she was really lost. . . . and it hit me that wow, I’m not like that anymore.

Coming to terms with their responsibility, and experiencing relative success in dealing with multiple clinical issues combined to mature the participants’ trust in themselves. They had pride in their accomplishments and saw these successes in perspective when measured against that which they had yet to achieve. They felt like valued and worthy members of the healthcare team, and this acceptance of themselves reawakened their desire to learn and grow.

## The Transition

An overriding theme of this study deserves particular emphasis in this article. During the course of the 6 months during which the participants engaged in dialogue with the researcher, they evolved in their ways of being as nurses and learned different ways of knowing about, and expressing that knowledge within their new nursing roles. This transition from being *students* to being *nurses* was traumatic for these participants.

## Change as a Constant

The concept of change was perpetual for participants in this study. Though change was not explicitly

addressed in literature about the graduate nurses’ experience, the term *adjustment* was used commonly, though the exact nature of this concept was poorly defined.<sup>9-16</sup> Participants of this study could be said to have experienced a typical change reaction when entering the practice world, and while adjusting to those elements of practice which were different from what they had become accustomed to as students.<sup>17</sup> Both developmental and planned, the changes experienced by the graduates closely paralleled Lewin’s<sup>17</sup> force field analysis of change.

Upon introduction to their clinical practice, the participants experienced relatively equal driving and restraining forces in their movement from student to nurse; if anything, the participants’ shared experiences suggested less support for making the change to the role expectations of the professional nurse as they supported remaining in the student role. The familiarity of the role of student, and the unknowns involved in entering fully into professional practice were strong restraining forces. Gradually, the participants began to explore meaning in the tasks they were performing, desired acceptance as professionals in their own right, and grew tired of the dichotomies which predominated this middle ground. These factors shifted the restraining forces, increasing the force behind the elements driving their transformation from student to professional nursing practitioner.

At approximately 2 months, the participants could be seen moving into the *unfreezing* phase of Lewin’s model;<sup>17</sup> uncomfortable with maintaining the dysfunction of the student role in their now professional nursing practice, the participants recognized the need to give up certain elements that afforded them comfort, in order to engage in professional nursing. Ultimately, at 6 months, participants would *refreeze* at another level of functioning; interdependent and confident, while understanding and accepting their inadequacies and recognizing their limitations as opportunities for learning and growth.

## Stress

The stress experienced in the beginning of professional nursing practice is well documented in the literature.<sup>9,14,18-20</sup> In their recent study of 35 graduate nurses from 3 acute-care hospitals in the American Midwest, Oermann and Moffitt-Wolf found the predominant stresses to be a lack of experience as a nurse, a lack of organizational skills, and the newness of clinical situations and nursing procedures. Also

found, but not emphasized in their study, were the stresses of frequent interruptions, having to rely on others, and a lack of support from other RNs on the unit. The findings of my study validated those factors as significantly stressful. Several participants described working with families and dealing with their questioning as distracting and disturbing; dealing with families intruded into the nurses' overall goal of completing tasks and performing daily routines. This factor was not isolated in the literature as stress inducing.

Oermann and Moffitt-Wolf<sup>14</sup> identified adapting to the graduate nurse role from one of student and interacting effectively with physicians as ranking low on the stress scale. This was not the experience of this study, in which all participants spoke extensively of the transition from student to nurse and, most remarkably, of their interactions with physicians as contributing greatly to their level of anxiety during the initial stages of their practice.

There was one particularly nerve-racking part of the day. Since mine was the only patient, rounds [took him a long time]. The doctor is intimidating; he grills the residents, and often screams at them. The doctor said that shame is a good motivator for learning.

Also, all participants affirmed an overwhelming sense of responsibility upon entry into professional nursing practice; this sense of being held accountable for decisions and clinical outcomes was staggering to them.

### ***Lack of Self-confidence***

Haffer and Raingruber's<sup>21</sup> recent interpretive phenomenological study of 15 nursing students at varying stages of a BSN (Bachelor of Science in Nursing Degree) concluded that reasoning was significantly and negatively influenced by self doubt and diminished self-confidence. This finding was also supported by Scott<sup>22</sup> who suggested that critical thinking or general reasoning ability was substantially reduced because of high levels of anxiety. Critical reasoning in the clinical practice environment was limited for all participants of the study. Also, participants subjectively and qualitatively expressed high levels of anxiety during the initial 5 months of their nursing practice. The suggested relationship between these variables in the literature could have accounted for the limited clinical reasoning ability of the participants evidenced in this study.

### ***Emotions***

Oermann and Moffitt-Wolf<sup>14</sup> described potential threats to optimal clinical practice as: the difficulty in maintaining a patient's right to know the diagnosis and plan of care, experiencing fear of rejection by others, inability to complete assignments and responsibilities on time, harming a patient due to lack of knowledge and experience, and working with intimidating staff. These are congruent findings with the participants of this study, although emotions which tended to be negative (fear, anxiety, apprehension, and intimidation) were spoken about more frequently by participants of this study than was reported by Oermann and Moffitt-Wolf. This discrepancy can be accounted for by Oermann and Moffitt-Wolf's single-point-in-time study approach, and by the polar representations of *fear* and *stimulation* in their Likert-scale options.

Graduates of Oermann and Moffitt-Wolf's study reported predominantly positive emotions in their initial introduction to clinical practice, as did the participants of this study. Had their study been extended over time, it may have shown that the exhilaration and eagerness with which the participants approached their initial introduction to practice was replaced by fear, apprehension, intimidation, and overwhelming emotions as the reality of professional practice set in, as was shown by this author's research. Also, based on the previous teacher-learner relationship between the researcher and two of the participants in this current study, there could have existed a comfort and familiarity that contributed to the degree of disclosure around more negative feelings. Finally, the extreme changes experienced by the nurses in this study during the span of 6 months would call into question the validity of studying the impact of graduate nursing experiences at isolated points in time.

### ***No Preceptor Support***

Participants described themselves as easily distracted, short on time to complete projects, and lacking in needed guidance from their new nursing peers; this was supported by Oermann and Moffitt-Wolf's<sup>14</sup> findings. A remarkable finding of this study, which was not supported in the literature on graduate nursing experiences, was the virtual lack of preceptorial presence during the introduction to clinical nursing practice. This participant described feeling "trapped" by the overwhelming responsibility and no access to assistance from senior staff:

I guess the trapped feeling is being alone; it's not having that person there vocalize what you're feeling. The trapped feeling is being totally and utterly alone and in charge of these people that you know you can't handle and that's the trapped feeling; no matter who you ask to get help you're not going to get it.

Only *one* participant in this study referred to the significance of a preceptorial relationship in the first 6 months of practice.

The need for acceptance by senior nursing staff was a finding that was variably supported in the literature. Oermann and Moffitt-Wolf<sup>14</sup> revealed no significant relationship between social support and stress, but established positive correlations between social support and practice stimulation, and the development of confidence in clinical practice. This would support the finding of this study that graduate nurses are inclined to feel validated or invalidated by the responses of senior nurses to their decisions and clinical judgments. Oermann and Moffitt-Wolf identified that "consistent preceptors who provided positive reinforcement and guided [the participants] learning"<sup>14(p23)</sup> was a factor that facilitated the new nurses' learning.<sup>23</sup>

An important theme in Oermann and Moffitt-Wolf's 1997 study was "the need for support from preceptors for graduates to develop their clinical competencies. . . . Similarly, a lack of support and guidance from preceptors inhibited their learning."<sup>14(p230)</sup> Further, this author's current research suggests that senior nursing practice, practice decisions, and problem-solving approaches profoundly influence the practice base development of the newly graduated nurse.

There were boundaries [in school] and now I'm swimming in an ocean and I can't find my boundaries. I just don't know where they are and that affects my judgment and my thinking `How am I going to make a judgment when I can't figure out what my borders are? I'm still fashioning [my practice] by the senior nurses. I mean I see senior nurses doing things and I take and use that knowledge because I have no boundaries. It's frustrating too for me because I see other nurses and they do that and they just know and I'm just wondering how they know because I don't. I'm starting to put those borders in place just from what I've seen. Every nurse is different but I'm trying to make myself borders from what their borders are like and what they are doing.

The lack of evidence to support the existence of nurturing and guiding relationships between the participants of this study and their senior nursing preceptors is disappointing and concerning. Based on the information provided here, the importance of and the need for strong, supportive mentoring relationships between new nurses and senior staff cannot be overemphasized.

### *The Experience of Loss*

The experience of loss by the participants in this study was significant. Though not identified as such in the literature, the feelings of aloneness and vulnerability expressed by the participants seemed reasonable considering their perceptions of the many losses they had incurred. At various points throughout the research journey, all participants described losing several or all of the following:

1. The ideal world of caring and curing they had come to know through their education;
2. Their innocence;
3. The familiarity of academia;
4. The protection of clinical supervision by nursing instructors;
5. Externally set boundaries of care and safety;
6. A sense of collegiality and trusted relationships with peers;
7. Grounding feedback.

The participants went on to describe feelings of being disillusioned by what they thought would be a warm, nurturing, and welcoming collegial environment, disappointed in themselves for not performing as expertly as they had come to expect from themselves as students, and abandoned by what they had learned in their sheltered nursing education in the realities of their new professional practice context. These losses were never acknowledged as such by the participants or by their new colleagues, nor was there support to guide them through this process of adjusting to their sense of loss.

### *Disillusionment, Disappointment, and Detachment*

Participants expressed disillusionment with what they perceived to be inconsistencies between what they had been taught to expect from a nurse's role, and what they observed in practice.

It was just that hard on me emotionally and mentally that I just felt that I couldn't do it. I

thought I don't want to be here . . . I should go back to school and do something else that I'm not going to hurt anybody, like Commerce or something. I've been trying to decide what else I could do with my life that wouldn't be nearly so stressful. A job where I could still be around people, but not have to work 12-hour shifts, get up at 6:00 AM, or deal with excrement every hour of the day.

Participants generally felt disappointed in the practice they observed; it did not meet the standards they had come to know. Jasper touched on this in her study of 65 graduate nurses during the first year after their convocation. She claimed that the experience of practicing nursing as a graduate "contrasted markedly with what they experienced as students."

I really am getting a reality check [about] what nurses do. There is an idealistic view of the nurse as Florence Nightingale, and then there's what I do. There's endless paperwork! There is the waitress aspect (I actually had someone ask for their roast beef "au jus"), and then there is the "servant to the doctor" crap to deal with.

Congruent with participants in this study, Jasper claimed that her participants felt inadequately prepared for their new role. This is identified as a persistent problem throughout the literature.<sup>29-32</sup> In addition, participants in the current study claimed that their education had been detached and fragmented, disallowing full engagement in the realistic role expectations of the practicing nurse. Feeling that they had been excused because they were students motivated a sense of betrayal in the participants; they believed that by sheltering them from the responsibility for decisions and clinical judgments, their educators had clearly disadvantaged them.

### **Dichotomies**

A significant finding in this study was that of the polarities that existed in the newly graduated nurses' practice. Not explicitly supported in any of the existing literature, the participants of this study claimed to be caught in the middle of seemingly polar perspectives on many issues:

1. The *caring dichotomy* in which they practiced efficiency rather than what they had been educated to believe was effective care;
2. The *quality dichotomy* in which they had come to expect that their nursing care would consist of quality entities, such as providing

comfort measures, attending to the needs of family, and advocating for patients self-determination, when instead they found themselves maintaining a powerful structure and an ordered routine, which facilitated fixed functioning of the nursing unit;

3. The *dependency dichotomy* where the nurses wanted to be perceived as independent, capable practitioners by their colleagues, yet frequently were required to reach out for assistance, exposing their naivete and ignorance;
4. The *practice dichotomy*, which accentuated the differences between what they had been taught in school as the ideal, and what was truly practiced in the clinical setting;
5. The *focus dichotomy*, in which the new nurses found themselves affected by the impact of any given situation equally on self, as on their patient; and
6. The *experiential dichotomy* where they understood experience to be the key to their professionalization, yet they had little control over how they gained this desired experience; the nursing expertise which would afford them respect, mutuality, and independence in their practice seemed elusive.

These polar issues served to confer an enormous frustration on the participants.

### **Study Reflections**

The experience of initiating practice in the world of professional nursing as described by these five newly graduated nurses was disturbing. The author frequently wondered what might have been done to ease this transition, or at the least, what might have been done to support these struggling nurses through this experience. Nursing administrators and continuing nursing educators are strongly encouraged to acknowledge the intensity of this experience for the newly graduated nurse and to share these research findings with their front-line nursing, medical and support staff (Figure 2).

### **Clinical Placement**

Participants clearly demonstrated low self-confidence and a striking need for acceptance by their peers, factors which influenced their decision making and clinical judgement. Attention *must* be given to adequate lengths of orientation as determined by ongoing assessment and communication of needs

between orientees, senior nursing staff, and nursing management. Whenever possible, newly graduated nurses should not be floated to other wards until they have had a minimum of 1 year of nursing practice experience in a consistent practice environment. The findings of this study could also be thought to suggest the potential for clinical safety issues when combining the new graduate level of confidence, skill, intellectual and emotional development with the highly acute, fast-paced clinical areas of emergency and critical care nursing that require unusually high levels of problem-solving, critical thinking, and clinical judgment. Although the current study was not performed in either of these contexts, this issue demands more extensive study.

Consideration should be given to developing creative ways to introduce senior nursing students to the professional nursing practice environment. Consideration might be given to a senior assistant role for third-year (assuming a four-year baccalaureate nursing program) completion students to work as nursing assistants under the direction and support of registered nurses. This could be an opportunity for hospitals, and particularly understaffed nursing units, to provide both an initial work environment and a nursing routine orientation and ultimate employment enticement to prospective graduate nurses interested in working within those clinical areas.

Finally, initiatives which could reduce the stress experienced by the graduate nurse upon introduction to professional nursing practice are strongly encouraged. Programs which provide for supernumerary employment of graduate nurses allow for integration into the role of professional nurse while at once acknowledging the anxieties that exist with the acute increase in workload and responsibility from that of a student. As well, employment of graduate nurses “outside” of the normal staffing ratios and quotas allows the new nurse to feel a part of the work environment without adding to the workload of the seasoned ward nurses with whom the new nurse is seeking acceptance.

### **Supportive Partnerships**

Participants indicated a desire for functional and emotionally supportive mentors in the clinical areas to which they were assigned. Implementation of formal and informal preceptorship and mentoring programs could serve both to provide support for the new nurse, and to affirm and validate the value of senior nursing staff members’ knowledge and exper-

<p><b>At 1–3 months</b>  Dependency on senior nursing staff for optimal nursing care modeling  Prescriptive adherence to practice “rules”  Blinding fear of physicians  Focusing on the impact of decisions on self (selfimage interests)  Overwhelming sense of loss and disappointment  Fear of error due to clinical boundary obscurity  Unquestioned acceptance of perceived authority perspective  High sensitivity to criticism—detachment  Focus on “doing” rather than “knowing”  Disillusioned with realities of nursing practice</p> <p><b>At 3-5 months</b>  Exhaustion (emotional, spiritual, physical, intellectual)  Dichotomous experience of practice (many nursing practice factors exist alongside directly opposed factors)  Greater comfort with own fallibility  Seeking stability and acceptance  Critically analyzing nursing peers’ practice  Gaining sense of mutuality in relationships</p> <p><b>At 5-6 months</b>  Self-determination evolving  Discriminating optimal from sub-optimal practice in self and others  Questioning process and content of nursing care  Professional maturation evolving  Seeing self relative to others  Overwhelming sense of responsibility for nursing outcomes</p>
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Figure 1. Issues in graduate nursing practice.

tise.<sup>5</sup> Nursing units should consider offering incentives to these senior nursing staff in the form of time-in-lieu, financial honorariums, or credit toward continuing academic advancement to acknowledge and provide some initiative for the expanded efforts entailed by such a commitment.

### **Nursing Practice Environments**

The issue of the work life and practice environment of direct-care nurses demands ardent consideration. The data presented in this study suggests a prescriptive, intellectually oppressive, or at the least cognitively restrictive, working environment for the nurses in these acute care centers. All participants of this study reported significantly disturbing views of the relationships between physicians and nurses, medical students, and multidisciplinary health team members. Although all participants adamantly claimed “we should not be treated that way by our

Recognize the intensity of the new nurse's practice experience  
 Encourage a balanced life in the new graduate  
 Limit overtime expectations of the new graduate  
 Spend time "checking in" with the new graduate's progress  
 Formally connect the new graduate with a 6-month mentor  
 Maintain a no-floating policy for new graduates up to 1 year  
 Consider graduate nurse transition initiatives for 6 months to 1 year after employment  
 Orient/precept new graduate nurses a minimum of 2 weeks full-time with a 0.5 workload and access to direction and practice assistance  
 Consider senior assistant positions for completed third-year BSN students  
 Explore incentive programs for senior nursing staff to foster preceptor/mentor interest  
 Engage in frequent qualitative analysis of nursing unit work-life quality  
 Create work relationship models that foster interdependency of physicians and nursing staff  
 Model zero-tolerance for disrespect in the workplace

Figure 2. Suggestions for nurse managers

colleagues," they did not actively engage in addressing abusive behavior that was directed at them, nor did they see other more seasoned nurses or managers taking steps to challenge this unacceptable behavior. Healthcare managers and administrators should be alarmed by these findings and committed to exploring the origins of these disempowering interactions between physicians and nurses, the reasons why this behavior continues to occur unchecked, and the impact of such an oppressive environment on the health and well-being of employees and patients alike. Perhaps it is time for some fundamental changes in the relationships between medicine and nursing, administration, and healthcare providers as a whole.<sup>1,33</sup>

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