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An Interpretive Phenomenological Study on the Influences on Associate Degree Prepared Nurses to Return to School to Earn a Higher Degree in Nursing

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AN INTERPRETIVE PHENOMENOLOGICAL STUDY ON THE INFLUENCES ON ASSOCIATE DEGREE PREPARED NURSES TO RETURN TO SCHOOL TO EARN A HIGHER DEGREE IN NURSING

by

LIANA M. ORSOLINI-HAIN

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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of the

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[redacted]

This work is dedicated to my parents, Sergio and Anna Orsolini;

my sister, Linette Orsolini;

my son, Richard Silveira

and the love of my life, Jack Hain.

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"I have an almost complete disregard of precedent, and a faith in the possibility of something better. I defy the tyranny of precedent. I go for anything new that might improve the past."

~ Clara Barton

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Research Advisor's Statement:

This dissertation is substantially a product of the student's period of graduate study at the University of California, San Francisco and was primarily conducted and written by the student. This published materials dissertation meets the standards of scientific and scholarly rigor and represents philosophical, theoretical, and research investigations comparable in scope and contribution to the standard dissertation it replaces.

Patricia Benner, RN, PhD, FAAN, Dissertation Chair

ABSTRACT OF THE DISSERTATION

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AN INTERPRETIVE PHENOMENOLOGICAL STUDY ON THE INCENTIVES AND DISINCENTIVES TO RETURN TO SCHOOL FOR ASSOCIATE DEGREE-PREPARED NURSES INVOLVED IN DIRECT PATIENT CARE

by

Liana M. Orsolini-Hain

Doctor of Philosophy in Nursing

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The call for a better educated nursing workforce has been growing stronger, coinciding with a concern for patient safety. Currently, about 80% of associate degree (A.D.) prepared nurses do not return to school for a higher degree in nursing. Few have studied this phenomenon. This interpretive phenomenological study sought to determine influences on A.D. nurses who had been in practice at least 10 years to return to school. 22 participants were interviewed over 1-1.5 hours from 3 hospitals in an urban setting in California. High levels of job satisfaction at the bedside received from being able to make a difference in the patient's lives, provisions for life long learning satiety without returning to school, lack of distinctions between nurses with higher degrees at the bedside and lack of perception of how a higher degree will change current nursing practice served as disincentives for nurses to return to school. Implications call for collaboration between service health care organizations and academia to provide more relevant education in the

hospital setting for credit towards a higher academic degree. Collaborative education consortiums need to be formed to capture students completing their A.D. program who can seamlessly continue for a baccalaureate in nursing degree and masters in nursing.

Patricia Benner, RN, PhD, FAAN, Chair

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CHAPTER ONE

Introduction

Significance of the Problem

There is a growing body of evidence that suggests patient care provided by baccalaureate or higher prepared registered nurses results in improved patient outcomes and reduction in health care costs (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Tourangeau, et al., 2006). However, current data on registered nurse educational preparation indicates that about 60% of registered nurses (R.N.s) are currently being prepared at the associate degree (A.D.) level (National League for Nursing [NLN], 2006). Furthermore, as of 2000 only 16% of A.D. prepared R.N.s returned to school to pursue a baccalaureate degree in nursing (B.S.N.) (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000). By 2004, this figure had only increased to 20.7% (U.S. Department of Health and Human Services [USHHS], 2004). The implication of a growing A.D. prepared nursing workforce which mostly does not return to school may be ominous for the future of nursing practice and for patient care.

Few studies explore factors involved

There are relatively few studies examining factors involved in the vast majority of A.D. prepared nurses not returning to school. In a review of the literature this author found 11 quantitative, 5 mixed methods and 9 qualitative studies. Five of these studies were unpublished dissertations (Bryant, 1997; Corbett, 1997; Dean, 1997; Diaconis, 2001; Root, 1991), two were pilots (Diaconis, 2001; Lillibridge & Fox, 2005) and 5 of 9 qualitative studies that were not pilots had less than 20 participants (Dailey, 1994; Dean,

1997; Peters, 2003; Rather, 1992/1994; Thompson, 1992). Of the studies using qualitative methodology, only 4 used interpretive phenomenology. Of the 4 studies using interpretive phenomenology, none studied A.D. prepared nurses who have not returned to school (Dailey, 1994; Dean, 1997; Diaconis, 2001; Rather, 1992/1994). Only 4 studies included A.D. prepared nurses who had not returned to school and utilized mixed method or quantitative methodologies (Delaney & Piscopo, 2004; Graf, 2006; Lange, 1986; Root, 1991).

Statement of the Study Purpose

This interpretive phenomenological study sought to understand the meanings and significance of baccalaureate of science degree in nursing (B.S.N.) or higher education for nurses with A.D. preparation and how this significance influences the possibilities they envisioned for advancing their formal education. This study uncovers meanings of A.D. education for A.D. nurses and explores how A.D. prepared nurses are embedded in their practice. This study illuminates incentives and disincentives for A.D. nurses to return to school and suggests strategies that would be better suited to the A.D. practicing nurse.

Specific aims of this study were to:

1. Understand and interpret what meaning being an A.D. prepared nurse held for participants working in hospitals;
2. Understand and interpret what it would mean to return to school for a B.S.N. or higher degree in nursing;
3. Articulate what prevents participants from returning to school;

4. Understand any cultural influences procured in their under-graduate education or workworld that influences A.D. prepared nurses from returning to school.

Utilizing interpretive phenomenology methodology to interview A.D. prepared nurses who have not yet returned to school, after at least 10 years of practice, may yield new information about why those nurses do not return.

Content of the Dissertation

This dissertation is divided into four parts. The first part (chapter 2) situates the problem of A.D. prepared nurses not returning to school for a higher degree in nursing into the larger phenomenon of an impending gap in clinical nursing expertise. Situating the problem of A.D. prepared nurses not returning to school gives a bigger picture of what is coalescing in nursing clinical practice that may create the "perfect storm," which is defined as a shortage of expert nurses at the bedside. This paper was developed in a policy theory course and many policy theories were examined by the author.

The second part of this dissertation includes a critique of the literature and an exploration of the inception and growth of associate degree in nursing (A.D.N.) programs. The literature review includes a review of literature documenting forces that are directing A.D. prepared nurses to return to school. Because the author found few research studies examining A.D. nurses who had not returned to school, she included studies that included A.D. prepared nurses who had returned and dissertation studies. The historical exploration frames the inception and growth of A.D.N. programs in a new perspective. The formation of A.D.N. programs in community colleges and their subsequent growth was responsible for increasing the overall educational level of the

nursing workforce. This paper explores where evolutionary developments in A.D.N. programs will lead to continue to increase the educational level of nurses in the workforce.

The third part of the dissertation is the methodology section. This section explains how interpretive phenomenology is well suited as a research methodology for studying the phenomenon of A.D. prepared nurses who do not return to school. This sections explains how philosophical and theoretical underpinnings of interpretive phenomenology shaped sample selection, interviewing strategies, and interpretive strategies.

The final section consists of the findings paper from this study. This paper describes the lack of distinction making between A.D. prepared R.N.s and R.N.s with higher degrees in service health care organizations. These A.D. prepared R.N.s felt they were prepared for the practice of nursing, held a strong identity as a nurse, were satisfied with their direct patient care practice, were able to advocate for patients and for themselves, saw that experience in nursing counted heavily with their employers and were able to advance in their careers. They had little or no sense that B.S.N. education would advance or improve their nursing practice.

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CHAPTER TWO

Situating the Problem and Theories:

Examining the Impending Gap in Clinical Nursing Expertise

Abstract

Much has been written about current and future nursing shortages and the numerical gap between nurses available and projected nursing needs. Very little analysis has focused on the implications of the pending *expertise* gap within the nursing workforce. A graying and retiring registered nursing (R.N.) workforce will greatly increase the proportion of novice nurses with minimal experience in bedside practice. The expertise gap will also affect nursing education. This paper explores the implications of these phenomena. Without careful planning, efforts to address the numerical shortage may inadvertently worsen the expertise gap, contributing to unsafe care and affecting nursing retention.

Introduction

While much has been written about the current U.S. nursing shortage (Buerhaus, Staiger, & Auerbach, 2003; 2004; Goodin, 2003; Steinbrook, 2002; United States Department of Health and Human Services [USDHHS], 2002), most analyses have focused on the numerical gap between the projected need for nurses and the nurses estimated to be practicing during the next two decades. However, little attention has been paid to a policy problem that may exacerbate and extend indefinitely the effects of the numerical shortage: an impending critical reduction in overall levels of nursing clinical experience and expertise. This problem will, if not addressed immediately, create a "perfect storm" in which fewer overall numbers of nurses, with less experience and few clinical mentors, will be expected to care for sicker patients with multiple conditions and

higher-level care needs in an atmosphere of greatly increased technological complexity and economic pressures.

The “expertise gap” is due to multiple factors, including: a) increased retirements among experienced nurses, b) an increased ratio of new graduates (in this article we define new graduates as nurses with less than one year of experience) to experienced nurses, c) a shortage of experienced nursing educators, and d) insufficient research to determine best practices in nursing education. We analyze the literature related to the current and projected U. S. nursing shortage and, drawing on Benner’s (1984) work on clinical skill acquisition in nursing, discuss policy initiatives to address the “expertise gap.”

The Nursing Shortage

The U.S. and other countries worldwide currently face a nursing shortage perhaps unprecedented in scale. Unlike previous nursing shortages, the present shortage is not only likely to persist for decades, but shows signs of becoming catastrophic. According to the U.S. Bureau of Labor Statistics (2004), the United States will need more than 1 million new nurses by 2012, which represents almost half of the current FTE nursing workforce. The nursing shortage is projected to grow to 29% by 2020, representing an estimated shortfall of approximately 340,000 - 390,000 full time equivalent (FTE) registered nurses (R.N.s) (American Association of Colleges of Nursing [AACN], 2003; Auerbach, Buerhaus & Staiger, 2007; Unruh & Fottler, 2005; USDHHS, 2002, United States Department of Labor, 2005). This represents a shortage three times the size of the current shortage at its peak in 2001 (Auerbach, Buerhaus & Staiger, 2007).

These demand calculations include consideration that in 25 years, 1 in every 4, instead of 1 in every 6, Americans will be equal or greater than 60 years of age, increasing from 45 million to 89 million (USDHHS, 2000). Hospital discharge data show that older persons utilize significant hospital resources in the U. S. (USDHHS, 2002); this higher utilization of health care resources will greatly tax nursing resources.

Supply of replacement R.N.s will not meet these demands. Although there have been some enrollment increases, U.S. schools of nursing are still turning away thousands of qualified students. Nationally, all levels of nursing programs turned away over 147,000 or 43.7% of all qualified applicants in 2005, due mainly to insufficient faculty (National League for Nursing [NLN], 2005a; NLN, 2006). There has also been a decrease in the percentage of nursing graduates sitting for licensure examinations, despite increases in program enrollments. The National Council of State Boards of Nursing reports a 10% decrease between 1995-2004; 9,353 fewer students took the exam in 2004 as compared to 1995 (AACN, 2005a). Another factor likely involved is the attrition rate of generic nursing students, but few national data are currently available (Wells, 2003). In California, from 2001-2005, undergraduate nursing schools averaged a 17% attrition rate (defined as “leaving the program”), and an average of 14% of students that did not finish on time (Waneka & Spetz, 2006). The phenomenon of overall increasing enrollments with concurrent decreases in graduates sitting for the licensure exam requires further study.

Aging and Retiring Workforce

Although there was a 20.8% increase in enrollments across all types of pre-licensure nursing educational programs from 2003-2004, researchers estimate that a 40%

annual increase is needed to meet the needs of replacing retiring R.N.s alone (Buerhaus, et al., 2003; USDHHS, 2002). The number of practicing nurses under age 30 has decreased by 41% since 1983, leaving about one third of the current R.N. workforce over age 50 (Buerhaus, et al., 2000). The median age of nurses, 46.8 years in 2004, shows a steady upward trend (USDHHS, 2004). A large cohort of these older, more experienced nurses is expected to retire between 2010 and 2020 (Buerhaus, et al., 2003; 2004; Goodin, 2003; Kimball & O'Neil, 2002).

Work redesign in the early 1980s and through the 1990s, which in its many forms often forced nurses to spend increasing amounts of time away from patients, decreased job satisfaction and created for many nurses anxiety about ensuring safe care, increased incentives for older nurses to retire early (Malone, 2003; Weiss, Malone, Merighi, & Benner, 2002). Simultaneously, the shift of services to outpatient settings, cost cutting measures including the replacement of R.N.s with less-educated personnel, and shorter lengths of stay resulted in a more complex, sicker inpatient population (Davidson, Folcarelle, Crawford, Duprat, & Clifford, 1997; Sochalski, Aiken, & Fagin, 1997). As experienced nurses perceived they could no longer deliver high quality care to patients after hospital restructuring resulted in work overload, they reported significantly lower commitment to the job and stronger intentions of leaving for another place of employment (Davidson et al., 1997). Nurses in this study averaged from 7.7 to 13 years of employment at the hospital studied.

In a longitudinal study Burke (2003) found that nurses remaining in hospitals that had undergone restructuring or downsizing experienced significantly less job satisfaction, more emotional exhaustion, more cynicism and less life satisfaction than nurses who left.

Moreover, 68% of nurses who left these hospitals did so to find better jobs or to leave a negative work environment. Over 50% of the 851 nurses surveyed had over 15 years experience (Burke, 2003).

The exodus of a large percentage of older nurses through retirement represents an enormous "brain drain" in experience, judgment, and expertise for the profession. In his book, "Lost Knowledge," DeLong (2004) explicates how losing the knowledge of expert professionals through retirements can be devastating to an organization's performance and productivity. This phenomenon will decrease the ratio of older, experienced nurses to younger, less experienced ones, with implications for the quality and safety of patient care.

Nursing's Desirability as a Profession

One factor contributing to the lack of younger individuals in nursing is the increasing variety of competing professional opportunities for younger women (Buerhaus, et al., 2000; Goodin, 2003; Hinshaw, 2001). The poor image of nursing, often-difficult working conditions, lack of recognition and autonomy, and relatively low pay in many areas, given the complexity and responsibilities involved, have also substantially decreased nursing's attraction for young women (Heller & Nichols, 2001). In a landmark survey of over 43,000 U.S. nurses, one third of those under age 30 who worked in hospitals were planning to leave their positions within a year (Aiken, et al., 2001). Clearly, young women are not replenishing our nursing supply. Only 8% of nurses in 2004 were under the age of 30, compared to 25% in 1980; there was a 4% decrease in nurses under 30 between 2000 and 2004 (USDHHS, 2004).

In 2000, 81,000 nurses working outside of nursing were aged forty-three or younger (Sochalski, 2002). Although there was a 1.4 % decrease in the percentage of nurses who work outside of nursing in the 2004 National Sample Survey compared with 2000, trends from the 1980s show that overall, increasing percentages of nurses leave nursing (Sochalski, 2002; USDHHS, 2004). For example, in the late 1980s only 4.5% of nurses were employed outside of nursing, while 16.8% were employed out of nursing in 2004 (USDHHS, 2004). The increase in nurses employed outside of nursing since the 1980s is cause for concern.

Aging Faculty

Compounding the challenge of increasing nursing program capacities is the aging nursing faculty workforce. According to the National Sample Survey of Registered Nurses, faculty over age 55 constitute 30.1% of all faculty, while the average age of nursing faculty with doctoral degrees in nursing or in related fields is 55.7 years (USDHHS, 2004). Berlin and Sechrist (2002) estimate that between 200 and 300 doctorally prepared nursing faculty will retire each year between 2003-2012, providing they wait until age 62 to retire. Exacerbating this faculty shortage is the declining percentage of younger faculty with doctoral degrees; from 1993-2001 doctorally prepared nursing faculty age 36-45 years declined by over 17%. Moreover, in 1999 almost 50% of nursing doctoral graduates were aged 45-54, suggesting they may have a limited number of years to devote to teaching (Berlin & Sechrist, 2002).

Faculty Shortage

A number of factors, including salary, lure new doctorally prepared nurses toward opportunities other than teaching. Other opportunities may include leadership, clinical

and policy research, and advanced practice (Hinshaw, 2001). For example, nurse practitioners made a national average of $72,480 working full time in 2005 (Tumolo & Rollet, 2006), while an Assistant Professor with a doctorate earned a median of $68,444 (AACN, 2005b). There are no available national statistics that report the average starting salary for an Assistant Professor with a doctorate, which is likely to be lower than the median salary.

Decreasing student enrollment in the 1980s led to a corresponding decrease in nursing faculty positions. In the mid 1990s, responding to increased clinical nursing salaries and expanded employment opportunities, nursing school admissions began to climb again. Nursing programs were unable to find enough full time faculty to meet this new demand and filled this gap by hiring many part time faculty to teach in clinical areas. Since many faculty were no longer teaching both theory and clinical, challenges increased for remaining full-time faculty to sustain a cohesive curriculum between classroom and clinical setting. The gap between demand and actual capacity continues to widen (Brendtro & Hegge, 2000).

Clinical Skill Acquisition in Nursing: Benner's Work

Benner (1984, Benner, Hooper-Kyriakidis & Stannard, 1999; Benner, Tanner & Chesla, 1996) studied skill acquisition in nurses for more than two decades. Her research, drawing on earlier work by Dreyfus and Dreyfus (1980) on skill acquisition in other professions, showed that novice or advanced beginner nurses learn in particular ways, engage in concrete thinking focused on mastering technology, and often have difficulty making distinctions in clinical situations and setting priorities when confronted with multiple demands. Expert nurses, in contrast, grasp clinical situations as wholes, utilize

extensive pattern recognition skills and are able to make fine distinctions and anticipate problems before they occur. Benner identified five stages of skill acquisition in nursing (Table 1).

Benner's concept of clinical forethought is important to considering the expertise gap. Clinical forethought is the ability to foresee, anticipate, and prevent future patient problems. Benner's Expert stage is characterized by a constant vigil of clinical forethought, which leads to early interventions in patient care (Benner, et al., 1999).

Most nurses take at least five years to reach the Expert stage, if it is reached at all (Benner, 1984; Benner, et al., 1996). Benner's work suggests that the Proficient and Expert stages of nursing practice are characterized by the ability to make subtle distinctions based on a deep, individualized knowing of the patient in the particular context of the situation. (Benner, 1984; Benner, et al., 1999; Dreyfus & Dreyfus, 1996; Dreyfus, Dreyfus, & Benner, 1996). Expert nurses who can recognize patient problems early, even before obvious changes in patient symptom presentation occur, intervene earlier to prevent ensuing complications (Ashcraft, 2004; Minick & Harvey, 2003). This skill in the Expert nurse is manifested as an intuitive gestalt that moves the nurse to use proactive measures to prevent likely complications and prepare for the possibility of crisis (Benner, et al., 1999).

Expert-level skills enable clinicians to make keen judgments about when, for example, a patient is responding differently to treatment than most patients do and may require an alternative intervention. This kind of discrimination is particularly important as medical care protocols become increasingly "evidence based." While such protocols are properly based on large studies of what works best for most people with a given

condition, it is particularly important to have informed, vigilant clinicians who can detect signs that a *particular* patient is not like "most people" in some way, and thus may not be helped (or may be harmed) by following standard protocols (DeBourgh, 2001; Dracup, 2006; Kral, et al., 2005; Rogers, 2004).

In contrast, the Advanced Beginner operates using general rules, and needs much clinical support in his/her patient care decision-making (Benner, 1984; Ebright, Urden, Patterson & Chalko, 2004). Ebright and colleagues (2004) documented the phenomenon of new graduate nurses turning to other new graduates for support in clinical decision-making, suggesting that this may happen more frequently in the future due to increasing retirements of experienced nurses. This can create situations where errors in judgment are compounded, reinforced or left uncorrected by colleagues.

There are decreasing numbers of expert or proficient nurse mentors available for less experienced practitioners (Simmons, Lanuza, Fonteyn, Hicks & Holm, 2003). In del Bueno's (2005) study, data were collected from 144 hospitals, 5 ambulatory Care Centers, and 31 health care systems using the Performance Based Development System (P.B.D.S.) to assess competency levels of new graduate nursing employees. P.B.D.S. has been used by more than 350 health care agencies in 46 states. From 1995-2004, researchers found that 65% of new graduate nurses, across all educational preparation levels, did not meet employer expectations for entry-level safe decision making in patient care (del Bueno, 2005).

While most new graduates, immediately upon graduation from nursing school, start at the Advanced Beginner level, many have limited orientation to service areas before having to make high consequence decisions (Ebright, et al., 2004; Simmons, et al., 2003).

Research shows that new graduates need several months to become minimally proficient and feel confident about clinical decision making (del Bueno, 1990; Duchscher, 2003). New graduates verbalize such concepts as clinical judgment, critical thinking, and problem solving as linear processes, showing little awareness of context and salience. Expert nurses, in contrast, seamlessly absorb contextual information, which situates their knowing of the patient; they then intuitively assign different levels of salience to this information, leading to sound clinical action (Benner, 1984).

Early recognition of problems and early intervention to address them can produce positive patient outcomes (Minick & Harvey, 2003; Rivers, McIntyre, Morro, & Rivers, 2005; Smith, et al., 2006). Conversely, late or nonexistent recognition of patient problems leads to negative patient outcomes, significantly increasing morbidity and mortality (Kohn, Corrigan & Donaldson, 1999; Woods & Doan-Johnson, 2002). If a hospitalized patient's condition deteriorates to the point that cardiopulmonary resuscitation is required, the survival rate is only 27% for adults and 18% for children (Nadkarni, et al., 2006). In del Bueno's (2005) study, 50% of "inexperienced RNs" would miss an immediately life- threatening postoperative pulmonary embolus and treat the patient for hyperventilation instead of hypoxia, 25-35% would worsen a patient who has suffered a head injury by utilizing fluid resuscitation, and 33% could not differentiate between dehydration and fluid overload when the patient presented with decreased urine output. Thus, the "expertise gap" among current and future nurses has grave implications for practice.

Education Gap

The number of R.N.s holding solely Associate Degrees is problematic. Several studies have found that an increased proportion of R.N.s with Baccalaureate Degrees in acute care hospitals was associated with significantly decreased mortality of post-operative surgical patients (Aiken, Clarke, Cheung, Sloane & Sliber, 2003; Estabrooks, Midodzi, Cummings, Ricker & Giovanetti, 2005; Tourangeau, et al., 2006) (Table 2). However, 58.9% of R.N.s are currently being prepared at the associate degree level (NLN, 2006). Although as of 2004 only 20.9% of Associate Degree prepared registered nurses returned to school to pursue a Baccalaureate, trends show an increase in the percentage of A.D. prepared nurses returning to school since 1980 (Spratley, Johnson, Sochalski, Fritz & Spencer, 2000; USDHHS, 2004) (Table 3). With the impending gap in nursing expertise, it is imperative that nurses with Associate Degree-level preparation return to school for higher degrees in nursing. Associate Degree-level prepared nurses returning to school for masters and doctoral degrees in nursing will increase the pool of available faculty.

The Expertise Gap: Policy Implications

Health care delivery is becoming increasingly complex. Nurses are caring for sicker, older, more diverse patients with more chronic conditions, who utilize increasingly sophisticated technology at the bedside, and are discharged sooner than ever before (Jennings, 2001; Tanner, 2002). The policy implications of such a less-educated nursing workforce are many. The Baccalaureate of Science in nursing (B.S.N.) degree may become the minimum entry educational level into nursing practice. Many institutions of higher learning are offering clinical nurse leader (C.N.L.) degrees and

doctorates in nursing practice (D.N.P.) to increase the level of education of nurses working at the bedside.

The Expertise Gap May Extend the Nursing Shortage

The expertise gap may actually extend the nursing shortage. While nursing schools increase enrollments, predicted retirements of expert nurses will decrease the number of mentors available for new nurses (Ebright, et al., 2004; Simmons, et al., 2003). This expands the challenges of educating students and mentoring new nurses. Increased demands will be placed on the remaining experienced nurses to orient and mentor new employees and new graduates, leaving students competing with new employees and new graduates for preceptors' time. (Expert nurses also play important roles in teaching new medical residents, a role not addressed here but that would likewise be affected).

Few studies examine senior nurse perceptions about working with undergraduate nursing students or the effects of increased demands on these nurses resulting from increasing enrollment in nursing programs. Factors such as workload demand increases from needing to care for more complex patients, the worsening nursing shortage, and high patient-to-nurse ratios increase the difficulty of finding adequate nursing student clinical placements (Brown, White, & Leibbrandt, 2006; Grindel, Bateman, Patsdaughter, Babington, & Medici, 2001; Matsumara, Callister, Palmer, Cox, & Larsen, 2004). These same factors may strain the relationship between nurses and nursing students. While Grindel et al. (2001) found that staff nurses valued student nurses on their units, another study reported ambivalence (Matsumura, et al., 2004), describing nurses that felt working with students during particularly busy, stressful shifts was a burden.

With the ensuing exodus of retirement-eligible nursing faculty discussed previously, nurse clinicians who may have little to no education or experience in educating undergraduates as well as those seeking graduate degrees (Brendtro & Hegge, 2000) may replace expert nursing educators. The potential ensuing gap in the teaching and learning of clinical expertise at the undergraduate level has important implications for the training and development of novice and advanced beginner nurses, and may affect the trajectory of their development into expert nurses.

Addressing the Nursing Shortage May Extend the Expertise Gap

The nursing shortage has led to much-needed initiatives aimed at improving the image of nursing (Johnson & Johnson, 2002), increasing enrollments in nursing educational programs and increasing enrollments in graduate programs to prepare nursing faculty (Buerhaus, et al., 2004; NLN, 2005a). One approach to the overall nursing shortage has been to increase funding and to accelerate programs to increase the capacity of undergraduate and graduate nursing schools. This approach alone, however, may worsen the expertise problem, since it could result in replacing half of the workforce currently employed in nursing with a majority of new graduates who may have marginal to unsafe clinical judgment. The faculty shortage in nursing education, if accompanied by improved compensation, may drive nurses into seeking educator roles before they have had sufficient nursing experience. According to Benner's research (1984), a minimum of three years experience in practice is needed to reach proficiency and a minimum of five years is needed to develop expertise. Novice nursing instructors who do not yet have clinical expertise will find teaching students more difficult and the quality of education may suffer. Novice nursing instructors, like novice clinical nurses, require

support in their new role through structured mentoring, staff development, and resources to support nursing education conference attendance.

Possible Policy Options

To date, no policy solutions have been proposed for addressing the "expertise gap," but there are some promising programs in nascent stages. The Oregon Consortium of Nursing Education (O.C.N.E.) Model is a statewide coalition delivering a competency-based standardized baccalaureate level curriculum in nursing to four Oregon state universities and eleven community colleges (Gubrud-Howe et al., 2003; Potempa, 2002). This model intends to double nursing school enrollments through increasing clinical placement and clinical delivery efficiencies, such as simulation, sharing of infrastructure and resources between campuses, focusing on competency development. This model will also address the expertise gap by expanding the number of baccalaureate level graduates. Notably, 50%-75% of A.D.N. enrolled students in O.C.N.E intend to complete their B.S.N. degree (Tanner, 2007).

While the O.C.N.E. Model is an attractive solution to addressing the nursing expertise gap, states interested in initiating such a model will have to commit financial and leadership resources to its development. A model such as this requires many stakeholders from universities, community colleges, and the hospital sector to work together. Sustainability must be ensured and program outcomes, such as the percentage of nursing students that complete their B.S.N., student and employer satisfaction, and NCLEX pass rates must be monitored.

In New York (AO2480/ S294) and New Jersey (S2529) state legislatures have introduced bills requiring all licensed R.N.s with associate degrees in nursing to earn a

B.S.N. within ten years for license renewal except for R.N.s already licensed or nursing students in the pipeline at the time of bill enactment. Bills such as these would likely increase incentives for the formation of collaborative education models. Such approaches build on existing resources, since they do not eliminate use of community college nursing programs to assist in easing nursing shortages. Additionally, universities can offer more R.N.-to-M.S.N. programs to increase the overall education level of the workforce beyond the B.S.N. The hospital sector may need to increase scheduling flexibility to allow R.N.s to return to school, since many web-based programs require some face-to-face time. Both state and hospital funded scholarships will decrease barriers for returning R.N.s and may be built around retention plans.

Another comprehensive solution might be state mandated yearlong mentorship or residency programs for new graduate nurses, pairing new graduate nurses with mentors in the Proficient stage of skill development. The Proficient stage is preferred for mentors since Benner's work suggests that Experts sometimes have difficulty articulating explicitly the experiential knowledge informing their judgments-- likely due partly to their now grasping situations as wholes (Benner, et al., 1996). Proficient nurses are able to recognize patient problems in early stages and are typically better able to relate their reasoning to beginners. Proficient and new graduate nurse teams would deliver safer care, since new graduates would be closely supervised and intensively coached. This could decrease the number of failure-to-rescue incidents (Ashcraft, 2004; Minick & Harvey, 2003).

A 2002 report on the nursing shortage published by the Joint Commission on Accreditation of Healthcare Organizations includes a recommendation for development

of nurse residency programs (JCAHO, 2002, pp. 30-31). A residency program model between the American Association of Colleges of Nursing (AACN) and the University Health System Consortium (UHC) is in the implementation phase. As of March, 2007, the UHC/AACN Nurse Residency Program is in 36 sites across 24 states (AACN, 2007). Other residency and internship programs have reported successful outcomes with new nurse recruitment and retention and increased confidence among novices in their ability to recognize changes in patients' conditions (Beauregard, Davis, & Kutash, 2007; Keller, Meekins, & Summers, 2006; Newhouse, Hoffman, & Hairston, 2007). Although this solution could be costly and time consuming to initiate, one 12-month residency program cost only $1000 per nurse resident to implement (Keller, Meekins, & Summers, 2006). This cost estimate includes hiring consultants, speakers, office supplies, journal subscriptions, tuition for classes, assessment instruments and all other costs related to the program that would otherwise not have been incurred. Although models for identifying proficient nurses (who could work with novices) are not well disseminated, some nurse consultants are training health care systems using expertise criteria for nurse staff advancement within clinical ladder systems (Wandel, 2003).

The impending retirements of expert and experienced nurses must be slowed. Financial and ergonomic incentives could encourage senior nurses to stay at the bedside. Examples of ergonomic incentives include providing lift teams and nursing assistants to help with sicker and less mobile patients. In addition to reducing patient mortality, reducing the number of patients nurses care for may prevent burnout and increase job satisfaction, which will help retain experienced nurses (Hatcher, et al., 2006; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

Mandatory nurse-to-patient ratios may reduce the number of patients nurses care for, and thus create more job satisfaction. Critics of mandatory nurse-patient ratios argue (as we have in this paper) that merely increasing the numbers of nurses is not the sole answer. However, preliminary evidence from California shows an increase in the number of licensed registered nurses since the ratios were enacted (Spetz & Dyer, 2005). While other reasons may partly explain this increase, stabilizing nurse-patient ratios may actually help retain experienced nurses by creating a more realistic workload. Pending federal legislation (SB 171) could create mandatory nurse-to-patient ratios like those which have already been enacted in California. The Robert Wood Johnson Foundation commissioned white paper "Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace" recommends a myriad of evidence-based strategies to retain experienced older nurses at the bedside such as increasing work schedule flexibility, creation of new career paths that ensure quality care, and creating retirement programs that provide incentives for working longer (Hatcher, et al., 2006).

The U.S. has traditionally utilized large numbers of internationally educated nurses, mostly from the Philippines, during previous periods of nursing shortages. According to the 2004 National Sample Survey of R.N.s, 59.2% of foreign-educated nurses have their BSN, over 2% were defined as advanced practice nurses with the equivalent of a masters level education in nursing and 2% had doctoral degrees in nursing. Moreover, 90% were employed in nursing. While internationally-educated nurses can be an important part of efforts to help ease the shortage and address the expertise gap, many nursing organizations oppose relying on foreign recruitment as a primary strategy. The American Nurses Association states "…it is inappropriate to look

overseas for temporary workforce relief when the real problem is the fact that the U.S. health care industry has failed to maintain a work environment that retains experienced U.S. nurses in patient care" (ANA, 2005). The International Council of Nurses condemns the migration of internationally-educated nurses to the U.S. from countries where sound human resource planning has not been instituted to protect the quality of care in those nurses' countries of origin. (International Council of Nurses, 2001).

The expertise gap might be addressed by funding nursing education research initiatives. Nursing education research could determine best practices in the teaching and learning of undergraduate nursing students, especially in the areas of clinical reasoning and forethought, how to best accelerate development of clinical expertise in new graduates, and how to assess the effectiveness of increasing nursing program capacity and fast track curricula (Tanner, 2004). There is a paucity of such nursing education research, however, due to lack of federal funding. Yonge and colleagues (2005) determined that between 1991-2000 80% of nursing education research studies had no identified funding source. Only 19% of these studies had 200 or more participants and over half used an investigator-authored questionnaire as the sole method for obtaining data. Less than 70 studies researched clinical teaching and critical thinking.

It seems implausible that the replacement of half of the nursing workforce over the next 10 to 15 years can be effectively addressed without building a stronger research base for clinical nursing education. Ferguson & Day (2005) suggest that due to the lack of current nursing education research, educators rely mostly on tradition, expert opinion and individual practice knowledge gained through trial and error. In addition to researching best nursing education practice, longitudinal studies should be undertaken to

evaluate the effectiveness of innovative pedagogies and methods utilized to increase nursing school enrollments (AACN, 2006; Diekelmann & Ironside, 2002; Ironside, 2001; NLN, 2005b). Recent increases of undergraduate nursing program enrollments also show increasing numbers of underrepresented population, students for whom English is a second language, and older students training for second careers, who have different learning needs than young Caucasian American-born women who in the past made up most of the nursing workforce (Heller & Nichols, 2001; Tanner, 1998). This suggests another reason for studying innovative pedagogies.

There are several efforts to fund research in nursing education, but they are funded at levels inadequate to address the expertise gap. Recent efforts to fund research on technology in nursing education, for example, include Sigma Theta Tau International's (STTI) collaboration with the National League for Nursing (NLN) (Sigma Theta Tau International, 2007). Researchers can apply for up to $5,000 each. While this is enough to evaluate preliminarily a single innovative program at a local school of nursing, it is insufficient for more comprehensive studies. Although the NLN is committed to and has a central mission to advance nursing education research, it must rely on private funding. NLN recently conducted and published a national multi-site, multi-method study on the use of simulation models in nursing education with private funds (Jeffries & Rizzolo, 2006).

In order to significantly increase the comprehensiveness and quality of nursing education research, federal funding may be required. However, there are currently no substantial resources for funding such work available through the National Institute of Nursing Research (NINR), as educational research is not regarded as falling within its

mission of funding clinical and basic nursing research (National Institute of Nursing Research, 2007; Y. Bryan, personal communication, July 21, 2005). The US Department of Education (USDOE) might be considered an alternative federal funding source for nursing education research, but its priorities focus on the "No Child Left Behind" program and preparing students for global competitiveness (USDOE, 2007). Nursing organizations should advocate for NINR, the USDOE, or other federal agencies to develop special funding initiatives for nursing education in order to more efficiently address the nation's nursing workforce and expertise gaps.

Conclusion

The current nursing shortage cannot be addressed effectively by merely increasing the number of registered nurses. In the absence of other measures, doing so will be likely to exacerbate the "expertise gap", in turn creating new pressures on remaining expert nurses and setting the stage for another exodus. The consequences of failure to address the expertise gap are likely to include increased rates of medical error and concomitant negative health outcomes for millions of Americans who need an expert and highly educated nursing workforce to deliver care. A thoughtful, comprehensive approach to the nursing shortage should incorporate Benner's model in considering the clinical expertise of the workforce as well as the numbers of nurses. It should include commitment of new resources to increase clinical placements, simulation and other technology to enhance skill acquisition, internship or mentoring programs in clinical settings, improved incentives (such as ergonomic programs and more flexible schedules) to retain senior nurses, mandatory nurse/patient ratios to ensure more reasonable workloads, and nursing

education research initiatives that are commensurate with the scope and scale of the problems the shortage poses-- for both the public and the profession itself.

Table 1

***Theoretical Framework: Benner Model of Novice to Expert (based on the Dreyfus Model of Skill Acquisition)**

Stage	Name	Years in the Field	Characteristics
1	Novice	Undergraduate nursing school	No or very little experience; experience and context free; Usually rule bound; focus on skill development; task-oriented
2	Advanced Beginner	Beginning of this stage 1-6 months	Starts to intuitively recognize context based on limited experience; much uncertainty in practice; beginning pattern recognition; marginally acceptable performance
3	Competent	2-3 years	Overwhelmed with information due to difficulty in assigning degree of relevance; tries to develop heuristics to deal with information overload; lacks flexibility
4	Proficient	3-4 years	Guided by maxims; plans intuitive care; sees the wholes and the long-term; assesses nuances
5	Expert	5 years or more	Thinking no longer linear; intuitive clinical grasp; deep understanding of the whole picture; early identification and management of a negative trajectory

* Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA; Addison-Wesley.

Table 2

Studies Linking Decreased Mortality Rates With Higher Level of RN Education

Study	n = Hospitals	n = Patients	Outcome
Aiken, et al., 2003	168	232,342	For every 10% increase in the proportion of RNs with BSN or higher degrees, mortality and failure to rescue fell by 5%
Estabrooks, et al. 2005	49	18,142	Higher proportion of RNs with BSN degree associated with lower 30-day patient mortality
Tourangeau, et al., 2006	75	46,993	10% increase in proportion RNs with a BSN associated with 9/1000 fewer patient deaths

Table 3

Trends in Education of the RN workforce

	1980	1996	2000	2004
% of RNs receiving initial degree in Diploma programs	63.2%	36%	30%	25.2%
% of RNs receiving initial degree in ADN programs	18.6%	38%	40%	42.2%
% of RNs receiving initial degree in BSN or higher degree programs	17.4%	26%	29%	31%
% of RNs with an ADN degree who return to school for a higher degree in nursing	8.8%	16.4%	15.5%	20.9%

Data from the Department of Health and Human Services National Sample Survey of Registered Nurses

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CHAPTER THREE

Critique of the Literature and Historical Framework

Incentives and Barriers for Associate Degree Prepared Nurses Returning to School for a Baccalaureate of Science in Nursing

Abstract

Although there has been increasing urgency for nurses to return to school for a higher degree in nursing, most do not. Currently the majority of nurses are being prepared at the associate degree level and about 80% of these nurses never return to school. Surprisingly, few studies have examined this phenomenon. This literature review examines forces that are mitigating the urgency for nurses to return to school, and barriers and incentives listed in 20 studies and 5 doctoral dissertations over the last 30 years for associate degree or diploma prepared nurses for returning to school for a baccalaureate degree in nursing. Implications of this review are to implement evidence based incentives and tear down barriers so that returning to school will become a desirable option for working nurses.

Introduction

There are compelling reasons associate degree (A.D.) prepared nurses should return to school for a higher degree in nursing and it is problematic that the vast majority do not (Orsolini-Hain, Malone, 2007). As of 2004, only 21% of A.D. prepared registered nurses (R.N.s) returned to school to pursue a Baccalaureate degree in nursing (B.S.N.) (United States Department of Health and Human Services [USDHHS], 2004) which is troubling since about 63% of all RNs are currently being prepared at the A.D. level

(NLN, 2006a). In order to keep up with the steadily increasing need for more educational preparation, nearly all A.D. programs are now three years in length. Patient complexity can be expected to increase as technology continues to advance. Nurses will need to learn how to plan systematically in complex adaptive systems and work collaboratively with patients and other disciplines more than ever before (American Organization of Nurse Executives [AONE], 2007). Nurse leaders and service administrators have repeatedly called for nurses with higher level degrees to meet current and future challenges of caring for patients (American Association of Colleges of Nursing [AACN], 2000; Cheung, & Aiken, 2006; Goode, Pinkerton, McCausland, Southard, Graham, & Krsek, 2001). It has been suggested that in order to fulfill nursing's responsibility in current and emerging health care services, a work force is needed within which 70% hold baccalaureate or higher degrees (Goode et al., 2001).

This paper will explore both the incentives and barriers A.D.-prepared registered nurses encounter with respect to returning to a school for a higher degree for nursing.

Background and Significance

It is helpful to situate the phenomenon of A.D.-prepared nurses not returning to school within the context of the inception and growth of Associate Degree in Nursing. Examining past influences that have shaped A.D. education offers insights as to the most effective course of action needed in order to achieve a significantly higher educated nursing workforce than exists today.

The inception and explosive growth of associate degree in nursing (A.D.N.) education was the means for nursing to take control of its own curriculum and shape nursing for more professional practice (Haase, 1990; Orsolini-Hain & Waters, 2008).

Prior to this, student learning experience in diploma programs and the clinical portion of the baccalaureate program was controlled by the hospital. Although the express purpose of the first programs was to prepare a nurse who would work under the direction of a baccalaureate prepared nurse or a physician, employers faced with a nursing shortage placed new A.D.N. graduates in management and other professional roles and reported satisfaction with their performance in those roles (Haase, 1990; Mears, 1978; Montag & Gotkin, 1959; Waters, 1978). This decreased the incentive and the need for A.D. prepared nurses to return to school. Until recently most nurses involved in the day to day practices of patient care were Diploma-prepared nurses; now most of those nurses are A.D. prepared and function successfully in positions which do not require a higher degree in nursing to secure their jobs (Haase, 1990; USDHHS, 1980; USDHHS, 2004).

Characteristics of Nurses Who Return to School

Several studies describe characteristics of returning Registered Nurses (R.R.N.). In most studies of R.R.N.s, the majority were married Caucasian women with at least one dependent child. Unfortunately all study samples lack significant gender and ethnic diversity, making it impossible to draw conclusions about males and non-Caucasian nurses. In studies that identified the educational background of graduates returning to school, all but two of the studies (Bryant, 1997; Martin & Sugarman, 1993) found more diploma grads than A.D.N.s (Baj, 1985; Hillsmith, 1978; Jackson, 1984; Lange, 1986; Lethbridge, 1989). These findings reflect the fact that in 1980, 63.2% of RNs were diploma graduates (USDHHS, 2004).

Studies reporting the age of participants in the 1970s and 1980s found R.R.N.s to be under or near 30 years old (Fotos, 1987; Hillsmith, 1978; Jackson, 1984; Lethbridge,

1989). Studies undertaken in the 1990s and early to mid 2000 showed that school returnees were older, some in their 40s (Bryant, 1997; Delaney & Piscopo, 2004; Leonard, 2003; Lillibridge & Fox, 2005; Root, 1991). This finding is probably related to the older age of students in A.D.N. programs (Orolini-Hain & Waters, 2008; Haase, 1990). Still, three studies (Lange, 1986; Martin & Sugarman, 1993; Root, 1991) showed that R.R.N.s tended to be younger than non-R.R.N.s; Martin's (1992) comparison of mean ages found R.R.N.s to be in their mid 30s rather than mid 40's in a sample size of 132 nurses (61 R.R.N.s, 71 non-R.R.N.s).

While years of experience for R.R.N.s ranged from 0 years to 26 years, most studies reported a mean of experience between 5-12 years; three studies showed fewer years of experience for R.R.N.s than for non-R.R.N.s which implies nurses who return to school do so relatively early into their career (Lange, 1986; Martin & Sugarman, 1993; Root, 1991).

Root (1991) conducted a pilot study comparing R.R.N.s and non-R.R.N.s. She used a modified Education Participation Scale (E.P.S.), modified Reid-Ware Three-Factor Locus-of-Control Instrument, and a modified Barriers to Education Instrument. Correlation coefficients for items on the E.P.S. scale ranged from 0.44 to 1.00 while coefficients for the Locus-of-Control instrument were all above 0.70. She found that R.N.s most likely to return to school were younger and employed for fewer years than R.N.s who did not wish to return. Other characteristics of R.R.N.s were that they were married, employed either above the level of staff nurse or in positions outside of the nursing service hierarchy as utilization review, infection control or staff development. R.R.N.s had higher levels of self-esteem, higher household incomes and higher locus-of-

control than non-R.R.N.s (Root, 1991). Having a higher locus-of-control for R.R.N.s meant that they felt as though they were in control of work and school outcomes which affected whether they succeeded or failed. In contrast R.R.N.s with a lower locus-of-control were fatalistic. Fatalism was defined as the extent of belief a person has in control over luck or fate. Increased fatalism implies a person does not believe they have much control over success or failure. Fatalism may undermine motivating factors for R.N.s returning to school. No other study surveyed level of fatalism in A.D. prepared nurses.

Forces Directing the Return to School

In 1967, only 3% of A.D.N. graduates returned to school although in the same year the American Nurses Association (A.N.A.) encouraged nurses to return to school in "Avenues for Continued Learning" (Haase, 1990). Today, 40 years later, this percentage has only increased to about 21% (USDHHS, 2004). The National Commission on Nursing Education's Lysaught Study (1970)_recommendation that nurses pursue career mobility carved the way for facilitating articulation between A.D.N. and B.S.N. programs (Haase, 1990). Even the National Organization for Associate Degree Nursing, which works towards legitimizing A.D.N. practice, calls for "intensive efforts" to be made for the promotion of national models of increased mobility for A.D.N.s to enter B.S.N. and masters programs in nursing (Mahaffey, 2002). Nonetheless, the number of A.D.N. graduates continues to increase in comparison to B.S.N. graduates. This pattern coupled with the fact that a majority of nurses in practice are A.D.N.s, makes the desired skill mix in the work force of 70% B.S.N. prepared nurses highly unlikely in the near future (Graf, 2006). This phenomenon of increasing A.D.N. graduates is occurring concurrently with a more urgent call for nurses to enter the profession with a minimum of B.S.N. preparation,

due to increased complexity and acuity of patients and the need to operate more sophisticated technological equipment. This also results in the need for nurses to competently deal with resulting more complex ethical issues (AACN, 2000).

Nursing Organizations

Many nursing organizations have called for B.S.N. as minimum entry into nursing practice. The A.N.A. published a position paper in 1965 calling for the B.S.N. as the minimum for entry level into professional nursing practice (Haase, 1990). While at the time, the A.N.A. also believed that there was a place at the bedside for a technical nurse with less than a B.S.N. degree, it has been lobbying for B.S.N. as the minimum entry into practice for all nurses since the 1970s (Cipriano, 1978). For a short time in 1982 the National League of Nursing concurred with the A.N.A. and stated that the B.S.N. should be the entry level for professional nursing practice (Haase, 1990).

The National Advisory Council on Nurse Education and Practice (NACNEP), an advisory board to the Secretary of the U.S. Department of Health and Human Services, has repeatedly recommended increases in the percentages of B.S.N. and higher level educated nurses in practice (NACNEP, 2001; Reams & Stricklin, 2006). The A.A.C.N. has taken the position that B.S.N. level education better prepares practitioners for the expanding role of the nurse, the acceleration of health care delivery changes, and increasing emphasis on community centered care (AACN, 2000). American Association of Nurse Executives (AONE) is calling for B.S.N. minimum educational level for nursing since the nurse of the future must “function as an equal partner, collaborator and manager of the complex patient care journey” (AONE, 2008, p. 1). Additionally, many nurse

leaders and nursing organizations are linking the need to B.S.N. level education for nursing practice to patient safety (Reams & Stricklin, 2006).

Institute of Medicine's *Report*

Although the Institute of Medicine's (I.O.M.) report, "*To err is human: Building a safer health system.*" did not reflect new research, it reported findings that up to 98,000 patients die needlessly in the United States per year due to medical error shocked the healthcare industry out of complacency (Kohn, Corrigan, & Donaldson, 1999). Because this report attributes most of these errors to system and process problems, it would seem that B.S.N. and higher educated nurses are the best to deal with the solutions because baccalaureate and graduate curricula emphasize leadership and management (AACN, 2007). The Joint Commission on Accreditation of Healthcare Organizations (J.C.A.H.O.) developed new National Patient Safety Goals as a result of the I.O.M. report, which are now a major focus for hospital accreditation (Westgard, 2003). Studies were conducted which linked better patient outcomes with increased educational levels of nurses (Aiken, et al., 2003; Estabrooks, et al., 2005; Tourangeau et al., 2006). In the years following the I.O.M. report and these subsequent patient outcome studies, there has been a renewed call for either a higher percentage of B.S.N. prepared nurses or making the B.S.N. entry level into practice (AACN, 2000; NACNEP, 2001; Reams & Stricklin, 2006).

Legislation

New York (AO2480/ S294) and New Jersey (S2529) are currently trying to pass legislation to mandate the B.S.N. as minimum entry into nursing practice. Although New York has been attempting to pass such legislation since 1976 (Haase, 1990), it is conceivable that they are closer to their goal. It is likely that if New York and New Jersey

become successful, more states will allow enact this legislation. North Dakota had the requirement in 2003 but dropped it in 2004 (Huston, 2006).

Magnet Status

The American Nurses Credentialing Center's Magnet Recognition Program was developed to promote quality and excellence in patient care delivery in hospitals by nurses in professional practice (American Nurses Credentialing Center [ANCC], 2008). The A.N.C.C. is the credentialing arm of the American Nurses Association. One of the forces of magnetism, professional development, encourages the formal educational development of nursing staff, which includes higher degree attainment in nursing. Although the magnet process does not explicitly state that nurses must have at least a B.S.N., nurse and patient satisfaction, patient needs and patient care environment outcomes are evaluated against educational level staffing mixes of registered nurses. Magnet hospitals have a significantly greater percentage of B.S.N. prepared nurses than A.D. prepared nurses (Aiken, Havens, & Sloane, 2000).

Employer Incentives

Areas of service, such as hospitals, also have an important role in increasing incentives for A.D. prepared nurses to return to school. There are many innovative ways to accomplish this such as bringing the classroom to the workplace, tuition reimbursement for B.S.N. degree, stipends to attend school, differentiated salaries per level of nursing degree, and promotion of A.D.N. and Diploma prepared nurses who return to school to obtain their B.S.N. (Cheung & Aiken, 2006; Delaney & Piscopo, 2004). Differentiation of salary per degree can be executed through clinical ladder programs. Until the late 1990s, lesser motivating factors included employer and social

expectations or needing a B.S.N. to pursue a graduate degree in nursing (Baj, 1985; Beeman, 1988; Bryant, 1997; Corbett, 1997). However, by the early 2000s, employer expectations for nurses with B.S.N. degrees as employees motivated some nurses to return to school (Diaconis, 2001; Peters, 2003; Zuzelo, 2001).

More recent studies tie salary increases as motivating to pursue B.S.N. education (Delaney & Piscopo, 2004; Graf, 2006). While some employers cite union barriers to providing pay differentials, the Nurse Alliance of Service Employees International Union (SEIU) Healthcare supports programs that would increase the educational advancement of registered nurses (SEIU, 2008).). In one study, A.D.-prepared nurses were four times as likely to pursue a higher degree in nursing if they received an earnings benefit of at least 6.8% (Graf, 2006). These findings certainly hold implications for employers of nurses in that they should seriously consider pay increases based on degree in nursing obtained alone, especially if they want to increase the overall educational level in their nursing workforce.

Experiences of R.N.s Who Returned to School

Several studies report that R.N.s returning to school for their B.S.N. had unexpected transformative experiences. While returning to school was perceived by some as raising potentials (Delaney & Piscopo, 2004), many were amazed at how their perspectives about nursing practice were changed (Lillibridge & Fox, 2005). Others reported that returning registered nurses (R.R.N.) now saw things differently including being able to “see the big picture” (Hillsmith, 1978; Rather, 1992; Rush, Waldrop, Mitchell, & Dyches, 2005; Delaney & Piscopo, 2007). R.R.N.s also noticed subtle changes in areas of thinking, reasoning, and questioning skills (Delaney & Piscopo, 2007;

Leonard, 2003). They reported growing in areas of professionalism and becoming more effective change agents and patient advocates (Delaney & Piscopo, 2007; Leonard, 2003; Lillibridge & Fox, 2005; Rush, Waldrop, Mitchell, & Dyches, 2005; Zuzelo, 2001). Nurses reported recreating their nursing practice because of thinking differently and reported feeling more like a nurse than before starting the program (Delaney & Piscopo, 2007). These nurses felt returning to school for a B.S.N. directly benefited their patients (Delaney & Piscopo, 2007).

An exploratory study of 36 senior students enrolled in a distance education R.N.-to-B.S.N. program discovered the perceptions of professional development of R.N. students in a distance nursing program. These nurses with a mean of about 11 years of experience discovered that the program gave them more than just a ticket to validate or justify their nursing practice to others (Rush, Waldrop, Mitchell, & Dyches, 2005). They reported that their level of professionalism evolved and that they gained knowledge which increased their repertoire of skills. One of the themes that emerged was the discovery that distance R.N.-to-B.S.N. education became a turning point which moved the student out of limbo and into a commitment for pursuing a doable degree (Rush, Waldrop, Mitchell, & Dyches, 2005).

Attraction of Non-Traditional Programs

As early as the late 1970s and 1980s, educators noticed that R.N.s returning to school experienced great frustration (Beeman, 1988; Muzio & Ohashi, 1979; Rather, 1994; Rendon, 1988), hence non-traditional R.N.-to-B.S.N. programs were initiated (Dailey, 1994). Choices of nontraditional programs consisted of articulation between diploma and A.D.N. programs to B.S.N., 2-step programs, and external degree programs

such as Regents College Nursing Program (R.C.N.P.) (Dailey, 1994). The function of R.C.N.P. consisted of evaluation only; the learner was completely responsible for his/her learning (Dailey, 1994). Using a phenomenological approach, 15 R.N.s were studied after completing R.C.N.P. to explore their experiences of being enrolled in this non-traditional program. Daily (1994) discovered that factors involved in R.N.s choosing R.C.N.P. were: (1) held N.L.N. accreditation which would enable nurses to pursue graduate education in nursing after completing their B.S.N.; (2) ability to challenge courses for college credit and not having to experience difficulty with transferring college credits; (3) flexibility with scheduling around the demands of a job, family, and flexibility around being able to move to another geographical location and remain in the program, not having to be physically present for courses or deal with the inflexibility around course times; and (4) lack of redundancy of learning gained from being in R.N. practice before returning to school, acknowledgment of previous nursing experience (Dailey, 1994). Seven of the 15 nurses in this study had ten or more years of experience, moreover, ten had or were completing their master of science in nursing (M.S.N.) degree, while one was completing her doctor of nursing science (D.N.Sc.).

Online Programs

Increasing the possibilities for A.D.N. nurses to pursue further degrees in nursing includes offering more on-line degree programs. When the School of Nursing at Medical College in Georgia discovered that 80% of Georgia's A.D.N. and diploma prepared nurses were employed full time in rural communities with no physical access to a university, they created an on-line R.N.-to-B.S.N. program (Bentley, Cook, Davis, Murphy, & Berding, 2003). Streamlining program admission, transfer of credits, and

increasing flexibility of instruction, graduates of this program surveyed reported 100% satisfaction overall and were in total agreement that this method of delivery was significantly more flexible than on-site classroom meetings. Every year admissions into this program keep increasing by at least 25%, and after three years, enrollment doubled (Bentley, Cook, Davis, Murphy, & Berding, 2003).

Incentives for Returning to School

Many factors influence R.N.s to return to school for their B.S.N. Predominant motivating factors include professional advancement and career mobility, personal satisfaction or growth, and increasing trends towards community oriented healthcare (Baj, 1985; Beeman, 1988; Corbett, 1997; Delaney & Piscopo, 2004; Fotos, 1987; Hillsmith, 1978; Kearney, 1994; Lange, 1986; Martin & Sugarman, 1993; Root, 1991; Thompson, 1992; Zuzelo, 2001).

Lange's (1986) study had a large enough sample size (n=1,268) for group comparisons of "not interested", "very interested", "somewhat interested", and "vaguely interested", which yielded significant values for certain characteristics between these groups. Lange's study (1986) is the only quantitative study to date to describe significant characteristics of a group of "very interested" R.N.s in returning to school versus groups with other varying levels of interest in returning. She found that motivating factors important to this group were opportunities for better job options, personal achievement, increased knowledge and skills, and the pleasure of learning (Lange, 1986).

Delaney and Piscopo's (2004) study (n=101) included both quantitative and qualitative data collection in its analysis of non-R.R.N.s. These researchers devised a demographic tool and statistically compared a group of R.N.s interested in returning to

school with a group not interested in returning for their B.S.N. Although their study found that 28.7% of R.N.s sampled intended to return to school, only 8.9% stated they would return in as early as 2-3 years (Delaney & Piscopo, 2004). Nurses that wished to return but not within a short time frame did not disclose why. Although these R.N.s perceived returning to school raised potentials, they also wanted the effort to be worthwhile (Delaney & Piscopo, 2004). Raising potentials referred to personal and professional growth, which included improved self-image, feelings of achievement, and expanded knowledge base.

Unfortunately, some nurses have seen earning a B.S.N. solely as a way to leave direct patient care nursing (Diaconis, 2001; Jackson, 1984). R.R.N.s were mostly seeking career advancement from the bedside (Root, 1991). An unexpected finding in Root's (1991) study was that R.R.N.s defined professional advancement as becoming a clinical specialist, which would increase more responsibility for patient care, while non-R.R.N.s defined it as taking on administrative positions and leaving patient care.

From the early 1990s to the present, there have been increasing numbers of qualitative studies exploring the phenomena of R.N.s returning to school (Table 1). Nine qualitative studies included in this review interviewed R.R.N.s only. Although most of the studies focused on discovering the experience of R.R.N.s, six uncovered motivating factors for their return to school. Motivating factors included achievement of career goals, the pursuit of graduate education in nursing, flexible convenient program options, personal satisfaction, and feeling the need to have a degree (Dailey, 1994; Diaconis, 2001; Peters, 2003; Rush, Waldrop, Mitchell, & Dyches, 2005; Thompson, 1992; Zuzelo, 2001).

Table 1

Qualitative Methodology Studies that Examine RRNs

Author(s)	**Year**	**Method**	**Sample**
Diaconis, L.	2001	Interpretive Phenomenology	7 (pilot)
Lillibridge, J. Fox, S.	2005	Unspecified: interviews, NVivo used for coding themes	6 (pilot)
Peters, J.	2003	Grounded Theory	15
Rush, K. Waldrop, S. Mitchell, C. Dyches, C.	2005	Grounded Theory	36
Thompson, D.	1992	Grounded Theory	18
Zuzelo, P.	2001	Focus Group	35

Diaconis (2001) conducted a pilot study to explore the lived experiences of seven female R.R.N.s in their first semester of an R.N.-to-B.S.N. program in a small liberal arts college on the East coast. She uncovered 12 reasons these RNs returned to school: (1) career mobility, (2) personal satisfaction and fulfillment, (3) embarrassment over not already having a B.S.N., (4) future orientation, (5) always intended pursuing advanced degree, (6) B.S.N. preferred by institutions employing nurses, (7) increased flexibility of options, (8) commitment to self, (9) perceived lack of authority due to lack of degree, (10) a way to leave the bedside, (11) finding the missing piece, and (12) feelings of distance and isolation due to colleagues with higher degrees.

Lillibridge and Fox (2005) also conducted a pilot study to determine not only how R.R.N.s felt about their R.N.-to-B.S.N. program, but which factors led them to enroll and how their nursing practice had been affected by earning their B.S.N. These R.R.N.s were mostly interested in career advancement, an escape from burn-out, and gaining more knowledge (Lillibridge & Fox, 2005). After B.S.N. completion, they implemented a research based instead of ritual based nursing practice, utilized increased knowledge levels, had a more expanded worldview, were challenged to lead, and applied new thinking skills.

Peters' (2003) grounded theory study of R.R.N.s enrolled in either a B.S.N. or M.S. program found reasons R.N.s returned to school included: (1) increased demands for entry level R.N.s; (2) restrictions on positions due to degree; (3) increased career options such as teaching or working in the community; (4) a broadened scope of many types of nursing; (5) good timing in personal and professional lives; and (6) for the love of learning. Level of coping of the R.R.N.s in this study was modified by resilience, social and spiritual support, which changed thinking and led to perseverance and adaptation for returning to school. Coping was defined as thoughts and actions used to manage tension between demands over resources, which results in decreased stress and strain.

Rush, Waldrop, Mitchell, and Dyches (2005) conducted a grounded theory study to gain an understanding of R.R.N.s with regards to professional development in a distance R.N.-to-B.S.N. program. This was the only study to use data gathered from an online asynchronous discussion board which is a logical way to gather data for respondents in an on-line program. To prevent the problem of "group think," researchers

gave participants the list of interview questions ahead of time to solicit individual reflection on answers. Researchers found that returning to school continued a professional journey for respondents, in which five themes were identified: (1) gaining impetus to return to school from lack of career mobility, uncertain future, or experiencing a professional rut or void; (2) being in educational limbo from many false starts to returning to school caused by changing requirements for program entry, inflexibility of work schedules, and juggling multiple roles; (3) discovery of distance R.N.-to-B.S.N .program made degree attainment seem achievable; (4) the R.N. program became more than just a degree program; it became a means of growing in professionalism, increasing confidence, correction of role misconceptions, and seeing the big picture; and (5) sharing their enthusiasm and experience with on line learning with co-workers, increasing others' interests in pursuing on-line degrees. The researchers' discussion about the years of experience each R.R.N. brought with them in returning to school, in combination with new knowledge learned provided a valuable insight into possibilities for growth in R.R.N.s.

Thompson (1992) used a constant comparative method to gain a greater understanding of R.R.N.s holistic participation in a B.S.N. program. In-depth interviews, code development, field notes, memos and diagramming were used as part of this research methodology. Thompson found the strongest motivators for returning to school included being goal-directed and achievement of career goals. Two main themes identified were (1) finding the right time to return to school, and (2) maintaining a balance. Finding the right time to return included commitment to returning and "reslicing the pie" which represented exhaustible resources. Maintaining a balance referred to the

need to juggle multiple roles and being persistent with educational goals. Thompson developed a Development of Participation Model, which showed the complexity of interactions, including forces of support and forces of non-support that affect committed participation in returning to school.

Zuzelo (2001) used focus group qualitative methodology which led participants through a predetermined query path to obtain data regarding the concerns of R.N.s returning to school for a B.S.N. and to determine the impact of R.N.-to-B.S.N. education on nursing practice. She identified several themes: (1) earning the B.S.N. was seen as a stepping stone to career advancement, (2) fulfilling the personal goal of wanting a college degree, (3) preparing for the work future, (4) being encouraged to seek a degree, (5) feelings of negativity regarding the perceived necessity of getting a B.S.N., (7) recognizing extracurricular benefits of returning to school such as meeting new people and intellectual stimulation, (8) sensing a transformation, (9) recognizing own professional growth, (10) recognizing B.S.N. as an appropriate entry level, (11) identification of helpful program characteristics, (12) preparing for graduate studies, and (13) feeling valued. Zuzelo noted a very interesting contradiction in findings. Although participants identified many ways they felt improved by the process of earning their B.S.N., they denied any changes in their practice. This contradicts other studies' findings that B.S.N. education changed nurses' perceptions of practice (Delaney & Piscopo, 2007; Hillsmith, 1978; Leonard, 2003; Lillibridge & Fox, 2005; Rush, Waldrop, Mitchell, & Dyches, 2005).

Forces Preventing the Return to School

Barriers to Enrollment

Many studies examined barriers to enrollment. Most nurses surveyed worked full-time and cost of the program and other financial concerns were significant barriers in returning to school (Delaney & Piscopo, 2004; Jackson, 1984; Lange, 1986; Leonard, 2003; Martin & Sugarman, 1993; Peters, 2003; Root, 1991; Zuzelo, 2001). Other most cited barriers to enrollment included time, which encompassed concerns about spending it away from family, having to juggle work schedules due to conflicts, and having enough time for multiple roles including the new role of student (Delaney & Piscopo, 2004; Lange, 1986; Leonard, 2003; Martin & Sugarman, 1993; Rush, Waldrop, Mitchell, & Dyches, 2005). Other noteworthy barriers included advancing age (Delaney & Piscopo, 2004; Root, 1991), and decreased confidence in ability to become a student (Jackson, 1984).

Educational institutional practices were inherently difficult for returning students who had multiple role demands (Dean, 1997; Delaney & Piscopo, 2004; Diaconis, 2001). These practices increased time to degree completion which decreased incentives for returning to school (Root, 1991). Lange (1986) reported the barrier of lack of credit for previous learning, which may have been referring to credits not transferring from diploma programs since 68% of her sample of non-R.R.N.s were diploma-prepared nurses. Root (1991) found a barrier to be lack of credit for work experience cited by non-R.R.N.s. Lack of transferable credits for coursework and work experience increases the time it takes to complete a degree. Interestingly, only one study listed a non-R.R.N.'s concern that it took her 6.5 years to earn her Associate of Arts Degree in nursing,

however, she also earned a B.S. in another field during that time (Root, 1991). It was surprising that more R.N.s did not verbalize their concerns that earning an A.D.N. took significantly more than two years to complete, and therefore were less motivated to return to school.

Peters (2003) conducted a grounded theory study of R.R.N.s enrolled in either a B.S.N. or M.S. program at a church sponsored health science university to understand the realities of returning to school. Stressors experienced while returning to school included mostly time, money, and unmet expectations (Peters, 2003). Unmet expectations ranged from not understanding the extent of time involved needed to attend courses and inability of course schedules to fit with work schedules to discovery that much study time was needed to earn good grades. While she does not identify how the curriculum and culture of the learning institution create stressors, she does state that stressors are created by returning to the school which adds complexity to already complex lives of the R.R.N.s.

A significant barrier for R.N.s returning to school is perceived fewer benefits for obtaining a B.S.N. (Leonard, 2003; Martin, 1992; Martin & Sugarman, 1993). Although some R.N.s returned to school because they believed that their employers required a higher degree, most returned for career advancement, which presumably implies that they desired to leave the bedside (Baj, 1985; Beeman, 1988; Bryant, 1997; Corbett, 1997; Delaney & Piscopo, 2004; Diaconis, 2001; Fotos, 1987; Hillsmith, 1978; Jackson, 1984; Kearney, 1994; Lange, 1986; Leonard, 2003; Lethbridge, 1989; Lillibridge & Fox, 2005; Martin, 1992; Peters, 2003; Root, 1991; Rush et al., 2005). None of these studies explained reasons R.N.s wanted to advance their careers and one could surmise some of them were practicing in unhealthy work environments. Clearly, this is an area that

requires further study. Graf (2006) uses human capital theory to analyze benefits versus costs of A.D.N.s returning to school. Cost increases from tuition and books, reduced time at work, and time away from other roles needs to be significantly outweighed by the benefit of increased lifetime earnings of at least 6.8% to increase the chances fourfold of A.D.N.s returning to school (Graf, 2006).

Implications

The question remains: why do so few A.D. prepared nurses return to school to complete a higher degree in nursing? Research has shown that the majority of R.N.s returning to school must balance heavy demands of work, school and family with little incentives from employers or from schools of nursing. With only 21% of R.N.s returning to school, the implication is that barriers clearly outweigh incentives for returning. If this were solely the case though, then removing barriers and increasing incentives would increase the number of A.D. prepared nurses returning to school. With the advent of distance education in nursing and articulation agreements making transfers to state universities less cumbersome, significant barriers have already been removed, yet most nurses do not return to school. This suggests that barriers of time and cost may be insurmountable while incentives to return to school remain too low. There may be other unexplored reasons preventing A.D. prepared R.N.s from returning to school. Perhaps A.D.N.s have a rewarding practice at the bedside and see no need to return to school, especially since many R.N.s do not perceive that a B.S.N. would change the ways they care for patients (Dowell, 2000; Leonard, 2003). Additionally A.D.N.s do not need a higher degree in nursing to secure or keep a job at the bedside that pays a living wage.

There is evidence that some A.D. graduates return to school with the intention of earning a graduate degree (Dailey, 1994; Zuzelo, 2001). These are nurses with a few years of work experience who now wish to qualify for a position such as a teacher or nurse researcher. Others aspire to nurse management positions or roles as a clinical specialist or a nurse practitioner. For these A.D.N. grads, seeking positions requiring a master's or doctoral degrees, the B.S.N. program may seem an unnecessary and time-consuming hurdle. The growing number of R.N.-to-M.S.N. or R.N.-to-Ph.D. programs is more appealing to this group, and are better suited to their career goals.

The reason why an A.D. graduate chooses not to return to school needs further exploration; new research will surely provide a clearer and more detailed picture. Thus far, from an empirical perspective, the population that has been studied is much too small to permit generalization. From the qualitative perspective, there are few studies interviewing non-R.R.N.s and no studies to date wherein A.D. prepared nurses who have not returned to school are interviewed using a qualitative method such as interpretive phenomenology To gain a better understanding of incentives and disincentives for returning to school. Clearly further research is needed to provide a base for enlightened policies and practice.

Educators and nurse leaders also share in the responsibility for increasing incentives and decreasing barriers for A.D.N.s to return to school. Collaborative education models are being launched or considered between community colleges and university schools of nursing, which provide for dual enrollment in the institutions and dual admissions into the schools of nursing (Gubrud-Howe, 2003). The Oregon Consortium for Nursing Education (O.C.N.E.) is producing its' first class of A.D.

prepared nurses in which 60% have placed initial financial deposits for continuing through to Oregon University for their B.S.N. (Tanner, 2007). Competencies and curriculum between the A.D.N. and B.S.N. programs was co-constructed so that transitioning to B.S.N. level education would be seamless for A.D.N.s. This model allows community college infrastructure and resources to be utilized to greatly increase the numbers of nurses educated at the B.S.N. level.

Conclusion

Although the inception and growth of A.D.N. education was instrumental in increasing the numbers of nurses and replacing the flawed diploma systems, it is disappointing to many that the vast majority did not pursue higher degrees in nursing. This is a rather unfortunate unintended consequence of the success of A.D.N. education. A.D.N.s do not have to return to school for a higher degree in nursing to have successful bedside practices. At the same time, we do not make it easy for them to return to school. One participant in 1978 reported, “They impose the B.S.N., but don’t make it desirable, practical or realistic” (Hillsmith, 1978). This statement still rings true today.

The future impetus for increasing the educational levels of the nursing workforce may be in the hands of nursing or may move into the hands of legislators who succeed in making the B.S.N. the entry level for practice. Should one consider the fact that about 80% of A.D.N. prepared nurses do not return to school an ultimate failure in moving the profession of nursing towards a higher educated level? On the other hand, if educators from all levels of nursing education and nursing employers from all sectors of care delivery worked together, couldn’t barriers be torn down and incentives increased for A.D. prepared nurses to return to school in greater numbers? A.D. prepared nurses with

years of experience have much they can offer the nursing profession if they return to school. We must find ways to make it possible.

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Education Evolution: A Historical Perspective of Associate Degree Nursing

Abstract

Exploring the inception and growth of associate degree nursing (A.D.N.) education informs our understanding of what led to such explosive growth so that most of the nursing workforce is currently educated at the associate degree (A.D.) level. The success of A.D.N. programs led to many divisive years in nursing education of differentiation of practice debates that were hardly productive. Work world practices and patient needs are creating pressures on community colleges to join forces with universities to increase the percentage of baccalaureate of science in nursing (B.S.N.) educated nurses. A.D.N. education continues to respond to meet the demands for a better educated nursing workforce.

Introduction

Situating associate degree nursing (A.D.N.) within a historical framework increases our understanding of what forces led to its inception and shaped its growth. The programs have evolved in the 56 years since first established, restructured by influences both within the profession and external to it. An understanding of nursing education's history offers more than an interesting story: In 2008 as in the decade of the 1950s, health care is changing at a dizzying rate, and there is a new call for changes in the structure of nursing education. Nursing's response to the call for change at the midpoint of the last century was effective. Can a review of the past provide a useful way of looking at future possibilities?

Moving Nursing Education to Institutions of Higher Learning

In response to a critical nursing shortage following World War II, a sociologist, Dr. Esther Lucille Brown was commissioned by the Carnegie Foundation to study nursing education. Her report, published in 1948, "Nursing For The Future," recommended that nurses be educated in colleges and universities, and criticized hospital diploma programs in which students were treated as employees (Brown, 1948). A number of nursing leaders and two major nursing leadership organizations, the American Nurses Association (A.N.A.) and the National League for Nursing (N.L.N.) supported moving nursing education to an educational environment (Frederickson, 1978; Haase, 1990). (In baccalaureate programs, the period of clinical study was also typically managed by the hospital.)

Inception of A.D.N. Programs

Several factors drove an increased demand for nurses and the inability of existing programs to meet the demand. Innovations in surgery and the discovery of antibiotics expanded health care services, requiring more care-givers. Congress enacted the Hill-Burton Act (Hill-Burton Act, 1946), funding construction of new hospitals in communities across the country, each needing a nursing staff. In a dramatic change from pre-war patterns, women went to a hospital to give birth. Furthermore, most nurses returning from military service did not re-enter the work force but married and began families (Haase, 1990). The existing schools could not meet the demand. Baccalaureate programs, which had been in existence for 60 years, graduated only 15% of the new nurses each year (Montag and Gotkin, 1959). Hospital diploma programs had been the primary source of new graduates since their founding 100 years earlier, but enrollment in

hospital programs was down; after the war the expectations of young women were changing. They sought college-based education and rejected the on the job training apprentice model of the hospital school. Lastly among important factors, the profession itself had another pressing reason for finding a way of increasing the nurse supply. As early as the 1950s, hospitals, unable to find the registered nurses (R.N.s) they needed, were using auxiliary assistive personnel as nurse-substitutes for non-nursing tasks, a trend that alarmed the profession (Montag and Gotkin, 1959).

These external pressures, coupled with the desire within the profession to take control of its own education and practice, provided a fertile ground for the inception and development of A.D. programs in nursing. At the same time, a national Commission on Higher Education, appointed by President Harry Truman, urged the expansion of community junior colleges, arguing that the nation needed to increase the number of people prepared at the technical or semi-professional level (Russell, 1949). A central mission of the new community college system was to serve the community within which it was situated (Haase, 1990). Searching for a solution to the problems facing nursing, representatives of the National League for Nursing met with the director of the Association of Community Junior Colleges to explore the idea of educating nurses in these 2-year institutions.

The faculty of Teachers College, Columbia University, then the pre-eminent graduate program in nursing, was also exploring new approaches to nursing education under the leadership of Dean Louise McManus. A study group chaired by sociologist Eli Ginzberg (1964) proposed two levels of nurse practitioners—technical and professional--with a different educational path for each. Doctoral student Mildred Montag, who was

influenced by the Ginzberg study, proposed a two-year nursing curriculum to be offered in the community junior college in her dissertation entitled “Education for Nursing Technicians (Montag and Gotkin, 1959).

Dr. Montag received a grant to conduct a research project testing the soundness of her proposal. Would graduates of the 2 year curriculum pass the licensing exam, and would employers judge them to be competent? Six colleges in 6 different states developed experimental programs as part of the 5 year project, with the faculties working together under Montag’s leadership to create a totally new pattern of nursing education.

Less Time, New Strategies

While associate degree programs currently take a minimum of three years to complete, at inception programs required only two years of instruction, including pre and co-requisites. One survey conducted of 16 A.D.N. programs in 1960 showed a range of 39-55 academic units in required nursing courses, and 30 – 39 units in general education (Anderson, 1966). By 1972 the A.D.N. degree was still expected to take only two years to complete (Brown, 1972). In place of a series of courses patterned after the medical specialties, the new curriculum offered what were called “broad fields” courses -- nursing fundamentals, maternal/child care, physical and mental illness, with a primary focus on fundamentals and medical surgical nursing (Zeitz, Howard, Christy, & Tax, 1969). Noting that no nursing program could teach everything a nurse needed to know to begin practice, the faculty focused on skill sets such as observation, thinking, and judging, and organized nursing content in terms of concepts, principles and methods (Crocker, 1972). Clinical experiences in hospitals were deliberately chosen to coordinate with theory and designed as learning opportunities for nursing students rather than repetitive unpaid work

(Haase, 1990; Montag & Gotkin, 1959; Zeitz, Howard, Christy, & Tax, 1969) Knowing that they were part of an effort to change nursing education, faculty in the first programs experimented with teaching strategies that were new at the time (Waters, 2007). Curriculum threads helped make curricula cohesive; clinical pre and post conferences developed from having objective driven learning experiences, and self-paced programmed instruction provided independent study. A number of other innovations were tried, some discarded, some maintained.

A.D.N. Programs Attract Diverse New Learners

The new programs attracted nursing students who were at the time considered non-traditional and typically ineligible for admission to hospital programs. They were older and ethnically diverse, and included men, single mothers, and married women who could not live at the hospital, required by diploma programs at that time (Brown, 1972; Haase, 1990; Montag & Gotkin, 1959). Students who trained in nursing at community colleges came from the local community and remained there to work after graduation (Larowe, 1978). Community junior colleges charged little or no tuition, attracting students with modest financial means (Haase, 1990). They also increased access to education for many because they outnumbered universities and they were geographically accessible, especially in rural areas. The first programs attracted a surge of the new "atypical" students, accounting for a 20% increase in nursing school admissions (Montag & Gotkin, 1959). In Montag's (1972) evaluation of 1,345 A.D.N. graduated in the early 1970s, 28% chose to attend an A.D.N. program because they were attracted to college education and 26% were attracted to the short length of the program.

Success of A.D.N. Education

In 1955, the N.L.N. published four requirements for A.D.N. program success: (1) the nursing program had to be an integral part of the parent educational institution, (2) faculty in nursing had to have the same rights and responsibilities as other faculty, (3) the program must take only two years to complete, including pre-requisites and co-requisites, and (4) students must meet the requirements of the parent institution for admission (DeChow, 1977). All four requirements came to pass relatively quickly.

The A.D.N. experiment was considered a success. Montag's pilot study "The Cooperative Research Project in Junior and Community College Education for Nursing" measured the success of the experimental A.D.N. programs by comparing the graduates' licensing exam scores against those of graduates of diploma programs, levels of satisfaction with A.D.N. graduate performance among nurses in service who held management positions, and levels of satisfaction among the A.D.N. graduates themselves (Montag & Gotkin, 1959). When compared to the performance of graduates of other programs, 77% of A.D.N. graduates were rated the same or better (Montag, 1972). Head nurses who evaluated staff nurse graduates from pilot A.D.N. programs rated 86% of the 85 nurses in the sample as either meeting or exceeding their own standards for staff nursing practice level (Montag & Gotkin, 1959). A.D.N. graduates averaged over a 90% exam passing rate for their first attempt and four fifths of the graduates were employed in nursing, mostly in hospital settings (Montag, 1972; Montag & Gotkin, 1959). Additionally, A.D.N. programs became firmly established within and were fully funded by the college. Growth in the number of programs was accelerated by the Nurse Training Act of 1964, which provided funds for all undergraduate programs in nursing in the

hopes of stemming the shortage (Haase, 1990; United States Department of Health, Education, and Welfare, 1964). By 1980, A.D.N. programs were educating almost 20% of new graduate nurses (U.S. Department of Health and Human Services, 1980). The community college programs grew exponentially while the number of B.S.N. programs grew more slowly (Haase, 1990). Today AD programs account for 58.9% of all undergraduate nursing programs and produce 63% of R.N. graduates (NLN, 2006).

Technical versus Professional

Adopting the proposed restructuring of nursing proposed in the Ginzberg study, and employing a term in use in community college education, Montag described nursing as a two-level profession, with the A.D.N. designated the "technical" or "semi-professional" nurse. The intention was that A.D. prepared nurses would function as members of a team with professional (B.S.N.-prepared) as team leaders. Moreover, Montag believed that because technical and professional nursing were so different, programs should not articulate (Haase, 1990; Montag, 1983). Anderson (1966) supported this belief by proclaiming, "The A.D. program is not intended to duplicate any part of the baccalaureate professional program, nor be the substitute for the first two years of such a program" (p.277). It was introduced as a stand-alone, terminal study program, considered a replacement for the flawed hospital diploma system, and a supplement, not a competitor, to still-emerging professional programs. Montag (1983) further assumed that hospital administrators would have the desire and the personnel resources to ensure that technical nurses would only be allowed to practice technical nursing, and that leadership positions such as charge nurse and management would be the purview of B.S.N. graduates.

In practice, however, citing the nursing shortage and the competent performance of the A.D. graduates, hospitals put these nurses almost immediately in management and leadership positions (Forest, 1972; Hart, 1983), a role for which they had had no preparation in the educational program. Nonetheless, they performed well. Seeing this, A.D. programs began modifying the curriculum to include preparation for management and team leader roles and such training is now included in all programs. Furthermore, the perspective that A.D. graduates need not pursue further education changed by the early 1970s when they were encouraged, even expected to return to school for the Baccalaureate degree, and that the A.D. curriculum should include transfer level courses to facilitate continued study (Moorhead, 1972; Searight, 1976).

Differentiation of Practice

As it became clear that work roles in nursing were rarely based on educational preparation, efforts to change that practice began in earnest. Differentiation of practice debates that have plagued nursing for the last 50 years started in the early 1960s when a preliminary report by the Surgeon General's Consultant Group on Nursing stated that nurses in leadership positions should have a minimum of B.S.N. preparation (Haase, 1990; National Commission for the Study of Nursing and Nursing Education, 1970). Throughout the half-century, numberless local, regional, and national committees, commissions, and study groups have struggled to define, advocate, and legislate differences between graduates of the two programs. Given the fact that graduates of the two programs hold the same license, however, differentiation rarely occurred at the bedside (Frederickson, 1978). Periodic nurse shortages and the shortage of B.S.N. prepared nurses made that expectation unrealistic, and in acute settings nursing service

felt there was no evidence to support differential assignments (Mercadante, 1978). As patient acuity rose in the 1970s and 1980s, patient care increased in complexity which led many A.D.N.s to specialize in a variety of intensive care unit level environments (Haase, 1990). Whether at the bedside or in management, there seemed little or no discernable difference between B.S.N. and A.D.N. graduates in acute care. Even as early as 1978, service directors were declaring that as long as a nurse was competent and caring, then no one working with the nurse really cared what level of education she/he had (England, 1978).

Over the next several years, nursing organizations, educators, and researchers strained to define two levels of nursing practice and to clearly express how technical nursing and professional nursing differed from each other. The pursuit proved elusive (Haase, 1990). By 1980, N.L.N. sponsored papers on curriculum design for A.D.N. programs delineated the A.D. prepared nursing role to include establishing a nursing diagnosis for clients based on their assessed needs; nothing further was mentioned regarding the need for supervision by a professional nurse (DeChow, 1980). One N.L.N.. paper acknowledged that "…the associate degree and baccalaureate degree programs in nursing share a common core of knowledge and skills" (DeChow, 1980, p. 14). When California A.D. and B.S.N. educators, led by Marlene Kramer at the University of California, San Francisco , tried to distinguish curricula based on content, they were unable to do so (Waters, 2007). The NLN sponsored a large number of workshops and published monographs on curriculum design and desired outcomes for A.D. and Baccalaureate programs. In the early years, the search for clarification of differences between the two roles, and thus the curricula, was congenial. A.D. educators did not like

the designation “technical”, however, and it eventually dropped from usage, replaced by “A.D.N.”.

The American Nurses Association (A.N.A.) played an assertive role in trying to legitimize a different practice role for graduates of the two programs. In 1965 it published The Position Paper, invoking the Brown Report of 1948, and asserting that minimum entry for professional nursing practice is the B.S.N. degree, and for technical practice, the Associate degree (American Nurses’ Association, 1965). The focus of the 1978 A.N.A. convention emphasized the urgency of formulating competencies to identify two distinct categories of nurse, and the restriction of the R.N. license to baccalaureate degree holders (Cipriano, 1978).

Despite hard-won sentences etching a difference between nursing taught in and practiced in the two programs, no stable distinctions developed in the workplace. Efforts to change nurse license requirements failed, except in North Dakota, which has since changed back. The A.D. educational experiment was not undertaken with the expectation that the programs would become the dominant source of nurse supply. The performance of graduates in the work place countered efforts to achieve distinctions in licensure or work roles. Waters admits “The [A.D.N.] programs have failed by succeeding. Therein lie the dilemma and the paradox” (1983, p. 43).

The differentiation issue has been seriously divisive and a new approach to the challenges presented by nursing’s multi-tiered system of education is urgently needed. If the evolution of nursing education since the middle of the 20th century can be understood by examining events in the environment coupled with nursing’s responses to such events, a similar examination of the issues facing the profession in this first decade of the 21st

century could suggest constructive professional responses. New strategies are needed, strategies which are unifying, not divisive, and based on a realistic assessment of current educational patterns and work world practices and patient needs.

Emerging Trends

There are periodic anecdotal accounts of role differentiation in acute care settings, suggesting the need for more contemporary research into this trend. In one reported study, Chief Nursing Officers, (C.N.O.s) preferred to employ BSN prepared nurses citing increased patient acuity. In a survey of 44 hospitals conducted in the late 1990s the C.N.O.s reported a staff mix of 51% B.S.N., 28% A.D.N., 12% diploma, 8% masters and 1% doctorate, but said they preferred a 71% skill mix of B.S.N. prepared nurses (Goode et al., 2001). C.N.O.s perceived B.S.N. nurses to be less task-oriented, exhibit stronger leadership and critical thinking skills, and have more professional behaviors than their AD prepared colleagues. In the same study, 43% of hospitals surveyed reported a salary differential for level of education, but differentiation of practice did not occur at the bedside; it occurred in expanded nursing functions, which required a higher level of education than the A.D.N. degree. Another set of recent studies correlate higher nursing degrees with lower patient mortality (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Tourangeau et al., 2006). Many nurse leaders and nursing organizations are linking the need for B.S.N. level education for nursing practice to patient safety due to these studies (Reams & Stricklin, 2006).

Orsolini-Hain and Malone (2007) argue that there in an impending gap in clinical expertise, citing the factors of shortage, aging of the current work force, dominance of

A.D. programs as the source of supply, and the steadily growing need for more expert nurses. If the percentage of A.D. prepared nurses continues to increase, fewer candidates will be available for nursing faculty positions in both B.S.N. and A.D.N. programs. Associate degree programs will continue to be the entry point into nursing for many. A study of trends in the late 1990s indicated that the programs will continue to attract women born between 1950 and the early 1960s. This cohort is more likely to choose nursing in the shorter program when compared with women born after 1965 who are more apt to choose other professions (Auerbach, Buerhaus, & Staiger, 2000).

As in the 1960s when A.D. programs began adding leadership courses in response to work world expectations, contemporary programs have intensified and lengthened nursing courses, pushing more and more of the general education and science components into a pre-requisite category, making most programs at least 3 years in length. Thus, there is no longer a gap of two years between length of ADN programs and B.S.N. programs. Today, earning an A.D.N. degree takes almost as long as earning a B.S.N. This shortened span between A.D.N. and B.S.N. program length may make continuing on to earn a B.S.N. more appealing, especially if the barriers to doing so are few.

A new approach to the licensing issue has also emerged. While the attempt in New York State to legislate the B.S.N. as a requirement for the nursing license failed in 1976 (Haase, 1990), 2007 proposals in that state (AO2480/S294) and the state of New Jersey (S620) would require all licensed R.N. s who hold associate degrees to earn a B.S.N. within ten years for license renewal. An exception is provided for R.N.s already

licensed and students in the pipeline at the time of bill enactment. Currently, both bills remain in committees.

Future Possibilities

Dramatic developments in the system of nursing education itself point to a new direction. Collaborative education models between community colleges and universities, such as in the Oregon Consortium of Nursing Education (O.C.N.E.) are particularly promising. A consortium was formed between community colleges and the state university to co-enroll and co-admit nursing students, with the expectation that about 60% of A.D. students will continue in school to earn a B.S.N., achieving a threefold increase from the national average (Gubrud-Howe, et al., 2003; Tanner, 2007). Other such collaborative models being formed throughout the country have been reported (Sizemore, Robbins, Hoke, & Billings, 2007; Williams, Hall, & Papenhausen, 2005).

The California Institute for Nursing and Health Care's (CINHC) white paper on Nursing Education Redesign for California encourages the formation of Collaborative Education Highways where nursing students can seamlessly progress through to higher level degrees in nursing at both the undergraduate and graduate levels (CINHC, 2008). The overall goal is to have a higher educated nursing workforce across the board so that B.S.N. and masters prepared nurses are encouraged to return to school as well as A.D. prepared nurses.

Currently, Florida, Idaho, Nevada and Utah allow community colleges to confer baccalaureate degrees in nursing (Arizona Nurses Association, 2005). American Nurses Association, California, is lobbying legislators to allow community colleges in California to legalize the offering of B.S.N. degrees independently of a collaborative relationship

with Universities (Moore, Alvy, & Johnson, 2007). In response to a few community colleges offering B.S.N. degrees, the American Association of Colleges of Nursing (A.A.C.N.) developed a position statement for community colleges who wish to offer a B.S.N. program and state that they should meet the same quality standards and accreditation requirements as state university systems (AACN, 2005).

Conclusion

With the inception of A.D.N. education, nursing took control of nursing curriculum and took full responsibility in shaping nurses for a more professional level of practice. Associate degree rather than baccalaureate nursing education was placed in this role because baccalaureate programs in universities were still emerging and had limited growth potential. In contrast, community colleges were expanding exponentially. Prior to the inception and growth of A.D.N. programs, over 85% of graduating nurses' curriculum was controlled by hospitals and physicians. A.D.N. programs were systematically designed and planned so that they had many curricular and pedagogical innovations. This was an advantage that no B.S.N. program shared with other B.S.N. programs. This evolutionary step in nursing education moved students into a purposeful curriculum model designed to help them meet learning objectives efficiently, a model which has continued to change to meet changing needs and work force expectations. Unintended consequences of the creation of the associate degree program also thrust the profession into a half-century of divisive efforts to solve problems inherent in the multi-tiered profession of nursing. With current developments and forces in the health care world propelling nursing education practice towards baccalaureate level education (Orsolini-

Hain & Malone, 2007; Nelson, 2002), new possibilities for developing an educational structure in nursing to meet societies needs are evolving.

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CHAPTER FOUR

Methods:

Interpretive Phenomenology as a Methodology for Studying Associate Degree Prepared Nurses who have not Returned to School

Introduction

Interpretive phenomenology (IP) is an appropriate way to study human behavior and the reasons associate degree (A.D.) prepared nurses do not return to school. IP seeks understanding of how humans are situated in the world and what holds meaning for them (Dreyfus, 1991). Unlike Cartesian based empirical studies, interpretive phenomenology seeks to disclose habits, skills, practices, meanings (both tacit and explicit) and what is of concern to participants engaged in their world (Dreyfus, 1991). Many studies conducted on A.D. prepared nurses were either quantitative, employed mixed methods, or were mostly descriptive in nature. No interpretive phenomenological studies of A.D. prepared nurses who have not returned to school were accessible through a comprehensive search of the literature.

What is held as meaningful in everyday practice for A.D. prepared nurses cannot be exhausted by comprehensively developed questions that solicit opinions, beliefs and interpretations. Narratives, on the other hand, reflect engagement in specific situations and contexts in the person's world. Participants may more easily deliver narratives of what generated concern than accurately produce accurate opinions or explanations in supporting actions or inaction regarding the return to school.

This interpretive phenomenological study sought to understand the meanings and significance of baccalaureate of science degree in nursing (B.S.N.) or higher education

for nurses with A.D. preparation and how meanings and self-understanding influence the possibilities they envisioned for advancing their formal education. Specific aims of this study were to:

1. Understand and interpret what meaning being an A.D. prepared nurse held for participants working in hospitals;
2. Understand and interpret what it would mean to return to school for a B.S.N. or higher degree in nursing;
3. Articulate what prevents participants from returning to school;
4. Understand any cultural influences procured in their under-graduate education or workworld that influences A.D. prepared nurses from returning to school.

World

According to Heidegger (1996/1926) humans are thrown and immersed into their human world and understand it by experiencing what shows up as concernful or mattering to them. World includes everything that is present-at-hand, a milieu of where we live and experience what matters to us, and where we experience the three modes of being (Blatner, 2006). How we are situated in the world depends on how we are thrown into it from our past, and projected in it towards our possible futures, and what possibilities this opens up or shuts down for us. For example, a student nurse attending community college for an A.D.N. may not have considered attending a university as a possibility due to financial and time constraints created by being a single mother with few supports. Later, as a practicing A.D. prepared nurse, the hospital becomes her workworld which may not set up possibilities for her to return to school for a higher degree in

nursing for varying reasons. The nurse may not be able to explicitly state what those reasons are as she works mostly with taken for granted meanings and self-understandings, thus certain work practices or work culture become a part of taken for granted background meanings that are opaque or even invisible to the person. .

Disposedness

The A.D. prepared nurse is disposed of her nursing practice within the same bedside practice clearing as nurses in hospitals who have varying degree levels in nursing. This disposedness, or public mood in hospital-based direct patient care nursing, is one that is steeped in values of caring for patients in a competent manner. Heidegger describes mood as akin to an atmosphere in which we are immersed in and attunes us in a certain way (Blattner, 2006). Thus mood is shared between nurses with A.D.N., B.S.N., and nurses with higher degrees in nursing within same workworlds. According to Heidegger (1996/1926) diposedness cannot be chosen, it just is and reflects the mood of all who share the same clearing. This mood is not explicit and may explain why some nurses cannot easily or even accurately articulate why they have not pursued more formal schooling. This public mood also sets the tone of valuing experience in nursing.

Absorbed Coping

A.D. prepared nurses can be engaged in their workworlds in ready-to-hand, unready-to-hand or present-to-hand modes (Dreyfus, 1991). Ready-to-hand is an engaged, pre or non-reflective type of coping or mode of being which signifies the absence of breakdown in which nursing care runs smoothly. Unready-to-hand mode results from breakdown such as when the patient is not responding to usual treatment, develops an unexpected complication, or when equipment breaks. In this instance, the

nurse becomes reflective and coping becomes more heuristic in nature. Present-at-hand is the most detached theoretical or objective mode that is acontextual and furthest removed from the situation. A.D. prepared nurses in practice often work within the ready-to-hand mode, which makes their ability to verbalize meaning of their practices less available to them. Explicitness comes through reflection, which is borne from break-down or abstract theoretical or scientific theory that is extracted or detached from particular practice situations. The way participants are in the world through absorbed coping justifies using interpretive phenomenology as a research methodology since eliciting narratives bring ready-to-hand situations to the surface for the researcher to interpret. Here, the narrative is a first person, experience-near account (Geertz, 1973) of actual practical situations related to thinking about returning to school, or actual events around returning or not returning to School. In a first person, experience-near account, the teller always reveals more than they explicitly know, or have thought about the story prior to telling it.

The Possibilities in the World

How we are temporally and historically thrown into the world sets up or shuts down possibilities for us (Dreyfus, 1991). What is of concern to a person sets up potential possibilities in actual situations and how participants will act in them (Benner, Tanner, & Chesla, 1996). A.D. prepared nurses who are functioning in hospitals in bedside practice do not usually experience breakdown or unready-to-hand mode because they have solely an A.D.N. Possibilities exist for A.D. prepared nurses to advance their knowledge, skills and possibilities through direct clinical experience, continuing education, on the job training, through clinical promotion and practice development programs, or through national certification as alternative pathways to learning other than higher degree

attainment. While they may desire to have a more advanced degree, it is not a concern for most of them since the workworld public mood does not set a tone that would require one. Aspects about workworld culture, such as inflexibility with scheduling, while aspects about academic culture, such as inaccessibility of courses, decreases easily accessible possibilities for A.D. prepared nurses to return to school.

Embodiment

Embodiment allows us to be present and skillfully involved in the world (Benner & Wrubel, 1989). Without our bodies we would not be Dasein, which allows for absorbed engaged, skillful coping, disposedness that open us up to possibilities for being in the world (Benner & Wrubel, 1989; Dreyfus, 1991). Embodied intelligence is the opposite of Cartesian mind/body dualism, which separates mind from body. While many of us develop embodied intelligence as children growing up in the world, we can develop this in our work practice fields as well. In Novice to Expert, Benner (1984) shows that after many years of practice, many nurses attain the proficient stage of skill acquisition which is characterized by nurses perceiving situations as wholes and pre-reflectively knowing what notions of good nursing care are for a particular patient. Many A.D. prepared nurses reach this stage of skill acquisition and operate proficiently with their embodied intelligence in their practice. Their narratives show immediate grasp of patient situations where breakdown has occurred.

Entering the Hermeneutic Circle

Entering the Hermeneutic Circle occurs at the beginning of and throughout interpretation. The Hermeneutic Circle refers to a way of interpreting data where the researcher brings to the table their own historicity of experiential knowledge and

familiarity with the research topic at hand (Denzin & Lincoln, 2005; Diekelmann, & Ironside, 1998; Van der Zalm, & Bergum, 2000). This pre-understanding is called fore-structure (Dreyfus, 1991). This forestructure enables persons to utilize their own background practices and familiarity with the phenomenon in interpretation of the situation, creating a perspective that begets further interpretations; understanding thus is always circular or hermeneutical, however, not viciously so (Diekelmann & Ironside, 1998). Studying the person's actions, self-understandings and meanings reflected in actual narratives of real events create an open dialogue for understanding the participants' lifeworld.

Researcher's Forestructures

I came to this phenomenon after being an instructor in A.D.N. nursing programs for the last 16 years. Although my first degree in nursing is a B.S.N., I always valued the A.D.N. level as an entry point into nursing, especially if students were immigrants and/or English was their second language. It was very disturbing to me to find out that only 16% (U.S. Department of Health and Human Services, [USDHHS], 2000) of A.D.N.s returned to school; later this number increased to only about 21% (USDHHS, 2004). I always encouraged my A.D.N. students to continue to go to school to earn a B.S.N. or higher degree in nursing, so this statistic perplexed me. Returning to graduate school afforded me the opportunity to research this phenomenon. My pre-understanding of A.D.N. curricula and of bedside hospital nursing practice would be helpful in entering the hermeneutic circle of interpretation if I listened and stayed true to the voices of participants over the voice of my own experiences, or my opinions and prior beliefs.

Interpretive Phenomenology as Research Method

This work was conducted with the spirit of holding a deep curiosity of the phenomenon under study during the interview process. The participant's concerns and meanings were not pre-conceived or assumed by the researcher; the researcher invited assumptions to be deconstructed so that a maximum grasp and understandings of the practical situations as presented by the participant could emerge. Husserl's transcendental phenomenology is descriptive, and assumed to be representational of internal mental content (a cognitivist assumption of the mind and a representational theory of language) (Dreyfus, 1991). Heidegger's interpretive phenomenology in contrast, is situated, descriptive and interpretive, but does not engage in a hermeneutics of suspicion, i.e. looking for theoretical frameworks to explain meanings lying behind the text. The IP maxim "to the things themselves" means that understanding the text as it is situated in practical activity and engagement are the goals of the researcher.

With the aims and strategies of IP in mind, open questioning interview strategy with a semi-structured interview tool was employed to solicit long, uninterrupted, in-depth narratives about how nurses were engaged in and understood themselves in their workworlds.

Data Collection

Institutional Approval

This study was approved by the University of California, San Francisco Committee for Human Research. This committee approved all subsequent modifications to the study protocol which included a modified consent form, demographic tool, and semi-structured interview tool. This committee also renewed the study until data

collection had ended. Since data collection has ended, a study close out form has been submitted to the Committee for Human Research.

Data Sources

Data sources were from the following: (1) demographic tool; (2) digitally recorded and transcribed 1 to 1.5 hour interviews of A.D.N. nurses; and (3) researcher's field notes.

Entré

To gain entré to the research intensive hospital and its affiliate hospital, I first emailed and met with their director of education. The director of education emailed all the nursing managers for all units that employed registered nurses with information regarding the purpose of my study. She told them to anticipate that I would be appearing on their units to hang fliers. I also met with the director of nursing and nursing educators at the private community hospital. The director of nursing arranged for a nursing educator from their nursing education department to escort me to all the units and help me hang research fliers. This nursing educator also helped me recruit participants by inviting staff nurses she knew to have solely A.D.N. degrees to participate in my study. This same nursing educator remained my liaison to this hospital and was my contact person for arranging private interview rooms on site.

Inclusion Criteria and Procedure

Data was collected in a 1 to 1.5 hour long open questioning interview after soliciting nurses with A.D.N. preparation who held no baccalaureate degree in nursing or in another field, who have been in nursing practice for at least 10 years who consented to be participate in this study. This convenience sampling ensured selection of those that

experienced the phenomenon of study. The entire point of interpretive phenomenological methodology is to examine phenomena experienced by those affected, therefore, participant selection must be strategic (Speziale & Carpenter, 2003). After signing a consent form approved by the Committee on Human Research, participants were asked to complete a demographic tool (see Table 1). Semi-structured questions were used as the interview tool (see Table 2) which was designed to illicit narratives about what held meaning for participants in their nursing practice. Each interview was digitally taped and transcribed by a transcriptionist who had signed a confidentiality agreement.

Twenty-two participants agreed to be in this study. All except one had at least 10 years of experience; one participant had 8 years but asked if she could be in the study. Participants worked in one of three hospitals in an urban area in Northern California: (1) a research intensive hospital; (2) an affiliate hospital of the research intensive hospital; and (3) a private community hospital. All participants were staff nurses except for three who were in case management but still experienced significant contact with patients and their families. The first eight participants were in the pilot study. After being in the Hermeneutic circle during the pilot study, the researcher revised the semi-structured interview tool and consented six out of eight participants for second interviews, using the revised tool.

Participant Characteristics

The mean age of participants was 48 years with a range of 36 to 64 years. Mean years of nursing experience for participants was 19.5 with a range between 8 and 36 years. Most participants (n=13) were Caucasian females except for 4 males, 1 African American and 4 Hispanics. Specialty areas participants worked in included medical

surgical, operating room, dialysis, intensive care, emergency room, rehabilitation and subacute care. More than 73% of participants earned over $100,000 per year with one earning over $200,000 but less than $250,000 per year. Half of participants went to A.D.N. programs out of state and mean time from pre-requisites to graduation was 3.7 years. About 60% of the sample was married or with a partner and had an average of 1.5 children.

Data Analysis and Evaluation

A major strategy for data analysis was becoming submerged in the data. Data submersion began by being wholly present during the interviews and writing extensive field notes shortly after each interview was completed. Once interviews were returned transcribed, I listened to the entire interview and compared the digital recording with the transcribed documentation. After making minor corrections and eliminating identifying information such as names of people and places, I inserted comments containing my immediate impressions, reflective thinking based on my own forestructure of understanding, possible emerging themes, questions that came up regarding phenomena, and areas I needed to clarify in subsequent interviews. Entering and being in the hermeneutic circle led to modifications in the semi-structured interview tool during the pilot study.

I continued to write many memos after extensive reflection from exemplars in narratives and then wrote memos regarding themes across narratives. These transcribed interviews, reflective writing, and memos were compared to reflective thinking, writing, and verbal feedback from peers conducting their own interpretive phenomenological research, professors teaching qualitative research methodology, and with my advisor.

Securing multiple perspectives from data interpretation by those with different forestructures helped to crystallize many truths and discourses, resulting in a rich complexity of interpretation of meaning (Richardson & Adams St. Pierre, 2005). Exemplars that supported particular themes were compared across interviews, especially if they were identified from paradigm cases. Paradigm cases are whole interviews that deliver strong examples that give a situated exemplified set of concerns, meanings, self-understandings, habits or practices for participants situated in particular situations relevant to the topics being studied (Benner, 1994; Benner, Tanner & Chesla, 1996). Exemplars are sections of interview narratives that illuminate ways participants are engaged in their world with particular concerns and meanings (Benner, 1994). I then compared all the exemplars that related to each theme and reflected and wrote about any connections or relationships. Themes emerged as reflection and interpretation illuminated qualitative distinctions between exemplars. Thematic patterns emerged from the whole text, from exemplars, and across narrative interviews. My advisor was instrumental in evaluating if the interpretations were a good grasp or understanding of the participants' exemplars.

Unlike the Cartesian model which takes a detached and disembodied view to truth, interpretive phenomenology studies a phenomenon within the everyday context in which it occurs (Dreyfus, 1995). Interpretive phenomenology seeks to disclose the world of participant and the phenomenon at hand (Dreyfus, 1991). In Heideggerian interpretive phenomenology, research and engagement in the world can be uncovered or disclosed from common experiences of the world. Nurses dwell in shared background practices (Dreyfus, 1991); what is disclosed often is agreed upon by those experiencing the same

phenomena. However, understanding of a phenomenon is never complete because it is impossible to make the background meanings in any practical situation completely explicit (Benner, 1994). Ultimately the reader of the research findings judges whether interpretations are compelling and appropriate in relation to exemplars and whether qualitative distinctions between themes are clear.

Conclusion

The phenomenon of A.D. prepared nurses not returning to school for a higher degree in nursing is poorly researched or understood. Interpretive phenomenological research, based on Heidegger's philosophy, is valuable for disclosing what holds meaning for these nurses and what the possibilities may be for them to return to school.

This study is the first instance where interpretive phenomenology methodology was employed to research A.D. prepared nurses who have not returned to school, and thus may uncover nuances not yet disclosed in previous research utilizing other methodologies. These nuances may illuminate incentives and disincentives for A.D. nurses to return to school and may suggest strategies that would be better suited to the A.D. practicing nurse.

Table 1

Demographic Survey

1. What is your sex?
   - Female
   - Male
2. What is your current age?
3. What is your race or ethnic background?
   - African American
   - Caucasian
   - Hispanic
   - Asian, Pacific Islander
   - Other, please specify_____
4. Currently, are you
   - Married
   - Single
   - Living with a partner
   - Divorced
   - Widowed
5. How many children do you have?
6. Are you currently employed?
   - Yes
   - No
7. What is your job title?
8. How long have you been employed with this employer?
9. How long have you been employed as an RN?
10. What is the current annual income of your household?
    - Less than $5, 000
    - $5,000 – 9,999
    - $10,000 – 19,000
    - $20,000 – 39,000
    - $40,000 – 59,000
    - $60,000 – 74, 000
    - $75,000 - $ 99,000

$100,000- $149,000
$150,000 - $200,000
over $200,000

11. Where did you get your Associate Degree in Nursing?

12. What year did you graduate from your Associate Degree in Nursing program?

13. What year did you get licensed as an RN?

14. How many years did it take you to obtain your Associate Degree in Nursing, from the start of your first pre-requisite course to the end of your last course?

15. Have you ever been an LVN?

Table 2

Interview Guide

Questions about being a nurse:

1. As you know I am interested in learning about the experiences of AD nurses that have not yet pursued BSN education. Can you tell me about your nursing career? Please start with your first job, and then briefly describe the positions and settings where you have worked since graduation.
2. Can you give me a particular experience of being an ADN that was particularly gratifying and rewarding? Now how about a particular experience that was challenging or difficult for you being an ADN graduate?
3. As you think back on your experience of being an Associate Degree prepared nurse, what has that meant to you? *Probe: How has being an Associate Degree prepared nurse influenced your nursing career?*
4. When you compare your experience with the experiences of your nurse colleagues, do you think you are more satisfied, less satisfied, or at about the same level of satisfaction with nursing as your nurse colleagues? Please explain.

Questions about distinctions:

1. Tell me about times in your nursing career when you were affected because of your level of education as a nurse. *Probe: Please describe situations where you have felt particularly advantaged or disadvantaged by being as Associate Degree prepared nurse?*

Questions about going back to school:

1. What are your thoughts just now about going back to school to pursue a higher nursing degree (BSN or MS)?

2. Tell me about how you made your decisions about education in your nursing career?

2. What influenced you the most?

3. What helped you or hindered you?

4. Were there any persons who influenced you one way or another? Please describe.

5. Can you tell me about a time you said to yourself, “No, I don’t want to go on or I can’t go on to get a BSN or higher degree?”

6. Can you give me a particular experience where you felt clear about your decision not to pursue a BSN or higher degree?

7. How would you describe “not being ready” to pursue BSN or higher education?

8. What would having your BSN mean to you? What would having your MSN mean to you? Also, what does NOT having a BSN degree mean to you personally and professionally?

9. Can you describe any particular work experience where you felt strongly one way or another about pursuing a BSN or higher degree in nursing?

10. What circumstances or opportunities, if any, might lead you to go back to school to pursue your BSN or higher degree?

    Probe: What do you think are the major barriers for other ADN nurses returning to school to get a BSN? What are the major barriers for you to return? What do you think could be done to make it easier or more desirable to return to school to get a BSN or higher degree in nursing?

11. How would you know if the time was right for you to get a BSN or higher degree in nursing?

12. What would decrease the possibilities for you to pursue your BSN or higher degree in nursing?

Final Questions:

2. Is there anything else you would like me to know?

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CHAPTER FIVE

Findings

The Incentives and Disincentives to Return to School for Associate Degree-Prepared Nurses Involved in Direct Patient Care

Abstract

It is unsettling that 80% of associate degree prepared nurses do not return to school for a higher degree in nursing. This interpretive phenomenological study investigates what influences associate degree-prepared nurses to avoid continuing their professional education and obtain a baccalaureate or higher level degree, the current standard for practicing nurses. Associate degree-prepared nurses did not perceive that their standard of patient care would change with further professional training involved in obtaining a higher educational degree. Although these nurses generally wished they had a higher degree, they did not feel pursuing one was necessary. Furthermore, they did not perceive any distinctions in professional ability between themselves and colleagues with higher nursing degrees. This perceived lack of distinction between themselves and more highly trained nurses added to their belief that a baccalaureate degree was not necessary for success in their profession. The culture of service health care organizations in which associate degree-prepared nurses are employed as well as the attitudes nursing students encountered in their degree programs are likely directly responsible for the practicing nurses' lack of understanding of the relevancy and rewards of returning to school.

Introduction

For the last thirty years nursing leaders have struggled with the paucity of associate degree (A.D.) prepared nurses returning to school for a higher degree in nursing (Searight, 1976; Orsolini-Hain & Malone, 2007; Orsolini-Hain & Waters, 2008). The impetus for this study is the increase in associate degree in nursing (A.D.N.s) graduates being prepared for practice in proportion to nurses graduating with higher degrees in combination with increasing needs of sicker, more complex patients. The current acute shortage of nurse faculty is exacerbated by the problem that the majority of nurses currently being prepared have only an A.D.N. degree and this further decreases the already small pool of registered nurses with advanced degrees that are eligible to become nurse educators (Hinshaw, 2001). Both nursing academic and health care service organization leaders believe that either a better educated nursing workforce is needed, and thus desire a higher proportion of baccalaureate prepared nurses (Donley & Flaherty, 2002; National Advisory Council on Nurse Education and Practice, 2001) or that the baccalaureate degree in nursing should be minimal entry into practice (American Association of Colleges of Nursing, 2000; American Association of Nurse Executives, 2008).

Background and Significance

The call for a better educated nursing workforce has increased in intensity since the Institute of Medicine's (I.O.M.) (Kohn, 1999) groundbreaking report, "To Err is Human," which suggested that up to 98,000 patients die each year due to human error in United States hospitals. While this report does not associate level of nurses' education with these deaths, recent studies suggest a link between the level of education of the

nurse and patient outcomes (Aiken, Clarke, Cheung, Sloane & Sliber, 2003; Estabrooks, Midodzi, Cummings, Ricker & Giovanetti, 2005; Tourangeau, et al., 2006). While Clarke and Connolly (2004) uncovered the shortcomings of Aiken and colleagues' (2003) study, they could not deny the finding that a higher proportion of nurses with baccalaureate and masters degrees was associated with significantly lower mortality rates and failure-to-rescue occurrences. In a meta-analysis of 139 studies, Johnson (1988) found that baccalaureate prepared nurses performed better than AD and diploma-prepared nurses in areas of communication, knowledge, problem-solving, professional role and teaching. Other studies support the conclusion that nurses with baccalaureate degrees out-perform their less educated colleagues in areas of conceptual and theoretical approaches to patient care, leadership proficiency, application of the nursing process, and in the level of professionalism (Giger & Davidhizar, 1990). Examples of professionalism by nurses were interest in research, teaching, and community assessment. The researchers concluded that the approaches of baccalaureate-prepared nurses toward direct patient care were more process-oriented while A.D.-prepared nurses were more content-oriented. Being more process-oriented may better predispose nurses to assessing and changing systems problems regarding delivery of patient care. Since systems problems were cited as a major factor for patient harm in the I.O.M. report (Kohn, 1999) these findings support the need for a better educated nursing workforce.

Chief nursing officers (C.N.O.s) are calling for a greater proportion of nurses with more advanced degrees to be able to safely meet the needs of higher acuity, more complex patients. Goode and colleagues (2001) surveyed C.N.O.s representing 44 hospitals (response rate 55%), who are calling for a 71% proportion of at least

baccalaureate level preparation in nurses they employ. This is in contrast to a study cited in their literature review that American Hospital Executives in 1987 preferred a 55% proportion of baccalaureate in nursing (B.S.N.) prepared nurses. C.N.O.s in Goode and colleagues' (2001) study perceived that B.S.N. prepared nurses demonstrate more advanced critical thinking skills and have more professional behaviors than A.D. prepared nurses. Interestingly, 43% of hospitals who responded to this survey paid salary differentials for degree type and employed an average of 51% B.S.N. level nurses. This is higher than the national average of about 38% B.S.N. level nurses employed in hospitals (United States Department of Health and Human Services [USDHHS], 2004). This higher than national average proportion of B.S.N. level nurses suggests that pay differentials likely lead to an increase in skill mix.

The need for a better educated nursing workforce lags behind current abilities to produce enough of B.S.N. and higher degree graduates in nursing. While over the last 20 years, A.D. programs have increased by over 17% and currently produce 63% of all registered nurses (R.N.s) (NLN, 2006), only about 21% of these graduates returned to school to pursue a baccalaureate or higher degree in nursing (USDHHS, 2004). Since only 37% of pre-licensure programs are B.S.N. level, it is no surprise that they are only able to produce 33% of nursing graduates (NLN, 2006). Additionally, only 20% of these BSN graduates return to school for a higher degree in nursing, a likely explanation for why only 13% of the nursing workforce holds masters or doctoral level degrees (USDHHS, 2004).

The dearth of nurses with baccalaureate and higher degrees is creating a shortage of nursing faculty (American Association of Colleges of Nursing [A.A.C.N.], 2005).

Aging and thus retiring faculty will exacerbate this shortage, and in turn, create a worsening overall nursing shortage. This shortage, in turn, is likely to affect the quality of patient care (AACN, 2005; DeYoung, Bliss, & Tracy, 2002; Hinshaw, 2001; Meyers, 2004). A.A.C.N. determined that a significant factor in schools turning away almost 33,000 applicants in 2004 and 37,500 in 2005 to baccalaureate and higher degree programs in nursing was due to a short supply of nursing faculty (AACN, 2008). Nurses with A.D. preparation who do not return to school decrease the number of potential nursing faculty in the pipeline. This decrease in qualified nursing instructors will likely further contribute to the worsening of the nursing faculty shortage (Orsolini-Hain, & Malone, 2007).

Few studies have investigated reasons A.D. prepared nurses do not return to school. In a review of the literature using Pub-Med, CINAHL, ERIC, digital dissertations, and Google Scholar, this author found 11 quantitative, 9 qualitative, and 5 mixed-methods studies. Five of these studies were unpublished dissertations (Bryant, 1997; Corbett, 1997; Dean, 1997; Diaconis, 2001; Root, 1991) and two were pilot studies (Diaconis, 2001; Lillibridge & Fox, 2005). Of the studies using qualitative methodology, four used interpretive phenomenology, yet none studied A.D. prepared nurses who have not returned to school (Dailey, 1994; Dean, 1997; Diaconis, 2001; Rather, 1992/1994). Of the four studies which included A.D. prepared nurses who had not returned to school, mixed-method or quantitative methodologies were utilized (Delaney & Piscopo, 2004/2007; Graf, 2006; Lange, 1986; Root, 1991).

The four studies of nurses who did not return to school discovered that competing priorities for time, such as work commitment and family obligations, plus institutional

barriers, such as inaccessibility of courses due to large commute distance and lack of credit for previous learning, cost issues, and advancing age were the largest barriers to nurses returning to school (Delaney & Piscopo, 2004/2007, Graf, 2006; Lange, 1986; Martin, 1992; Root, 1991). Of studies that investigated the experience of R.N.s with A.D. or diploma preparation returning to school for a B.S.N. degree, barriers that had to be overcome were almost identical (Beeman, 1988; Dailey, 1994; Dean, 1997; Diaconis, 2001; Dowell, 2000; Jackson, 1984; Leonard, 2003; Peters, 2003; Rush, Waldrop, Mitchell, & Dyches, 2005, Thompson, 1992). Additional barriers identified from these studies included dealing with lack of confidence about returning to school; insensitivity by the educational institutions to adult learning principles as evidenced by mixing experienced R.N.s with generic pre-licensure students; and uncertainty, which resulted in tension, when expert nurses entered the novice role of student (Dailey, 1994; Dean, 1997; Diaconis, 2001; Lillibridge & Fox, 2005; Rather, 1994).

Study Design & Method

An interpretive phenomenological study on the influences of associate degree prepared nurses to return to school to earn a B.S.N. or higher degree in nursing was designed and data were collected in 2006 through 2008. The goal was to create greater understanding of A.D.-prepared nurses' possibilities in their work world context and their perspectives and plans to pursue further education. The increased understanding generated by this study may lead to the formation of attractive R.N.-to-B.S.N. and R.N.-to-Masters in nursing programs that attract A.D. prepared nurses.

Interpretive phenomenology has been used by many nursing researchers to uncover meaning and increase our understanding of lived experiences of participants

(Araujo-Sadala & Rubens, 2001; Benner, 1994; Ironside, 2005). Common themes of the participants were uncovered. By interpreting these meanings and perspectives within and across narratives, the researcher can discover and articulate commonalities and differences in incentives and disincentives to return to school (Christ & Tanner, 2003; DeSantis & Ugarriza, 2000; van Manen, 1997). During the interpretive process, often called, "being in the hermeneutic circle," the researcher brings to the table their own historicity of experiential knowledge, familiarity with the research topic at hand, and knowledge of current relevant literature ((Dreyfus, 1991; Heidegger, 1996/1926). Diekelmann, & Ironside, 1998; Van der Zalm, & Bergum, 2000).

Consent was obtained from a Committee on Human Research for this study. Participants filled out a demographic tool. Semi-structured interviews lasting 1 to 1.5 hours were digitally recorded and transcribed. Field notes were written after each initial interview. Multiple perspectives of narratives from other qualitative researchers who read the interviews and contributed their interpretations allowed for consensual validation of the interpretation of the narratives. Through discussion with other qualitative researchers concerning their interpretation of the interviews, new facets of understanding were uncovered which led to clearer articulation of the A.D.N.s' concerns, meanings and experiences related to returning to school.

Sample

The convenience sample consisted of 22 A.D.-prepared nurses who had not earned a baccalaureate degree in nursing or in another field. All but one nurse had been in practice for at least 10 years. The last nurse had a total of eight years of experience but wished to be included in this study and it was concluded that her work experience was

similar enough to warrant inclusion in the study. The mean years of experience in nursing were 19.5 with the longest being 36. Mean age of participants was 48 years and ranged from 36 to 64. Four nurses were male, four were Hispanic and one was an African American. Fifty-nine percent of the sample were married or with a partner and the mean number of children was 1.5. Participants worked exclusively in direct patient care with the exception of three that were in case management. Seventy–three percent of these nurses made over $100,000 per year and were working in one of three hospitals in an urban area in California. Of the 22 participants, the first 8 were interviewed in a pilot study. The results of the pilot study led to alterations in the piloted semi-structured interview tool. Six out of eight A.D.-prepared nurses in the pilot consented to being interviewed a second time with the revised interview tool.

Overview of Findings

Although about 80% of A.D.-prepared nurses do not return to school for a higher degree in nursing, about 80% of the A.D.N.s in this study wished they had, still desire to, or would strongly consider doing so in order to pursue a new nursing role they were interested in, such as teaching. Nurses considering changing roles from directly caring for patients wished to pursue different nursing roles and/or feared that they would not be able to keep up with the physical demands of direct patient care as they aged. These nurses greatly enjoyed working in direct patient care and were conflicted about the possibility of leaving it for a new role. Most A.D.-prepared nurses also believed that a B.S.N. degree was needed if one wished to pursue management opportunities and thus viewed the B.S.N. as an advanced degree. Not returning to school was related to a variety of cultural practices in health service and academic organizations, as well as perceptions held by

A.D.N.-prepared nurses to be articulated below. These practices and perceptions served as disincentives for these nurses to return to school despite their stated desire to do so.

Findings: Lack of Role, Skill, and Status Distinctions in Direct Patient Care

In many instances A.D.-prepared nurses in this study perceived a lack of distinction in knowledge-skill and roles between themselves and other colleagues with more advanced degrees in nursing. Institutional culture supported a lack of public perception or social distinctions between the functioning and knowledge-skill levels of nurses with different academic degrees.

Feelings of preparedness for the practice

All participants spoke about the varying degrees of struggle they engaged in to complete their undergraduate education in nursing with varying degrees of difficulty. Participants needed almost 4 years (mean = 3.7 years) to complete their A.D.N. programs, almost as long as it takes to earn a B.S.N. Many spoke of their programs having attrition rates higher than 50%, some even as high as 75%. In schools where attrition rates were high, participants felt students that could potentially fail the licensing board exam were being "weeded out." Nurses who survived in programs with high attrition rates felt confident that they would be able to pass the NCLEX-RN exam.

Besides having survived rigorous undergraduate programs, these nurses disclosed many other reasons they felt prepared to practice nursing upon graduation including being immersed in patient care as early as the first week in the curriculum, having a high proportion of clinical hours compared to theory, and needing to study many hours to successfully pass the program. Many spoke of the struggle it took to complete the requirements of their nursing programs, often at the expense of their personal lives and

family obligations. Several perceived they had many more clinical hours than students from B.S.N. programs, which they felt better prepared them for practice than B.S.N. graduates. This perception is at odds with the Board of Registered Nursing requirement of the same number of minimal clinical hours across undergraduate program type. Moreover, since B.S.N. programs have community rotations, they may even require more clinical hours than A.D.N. programs. The following excerpt is from a nurse who was a younger student in her A.D.N. program. She speaks not only about her own struggles, but the struggles of her older peers:

> I was pretty overwhelmed. I don't know – I couldn't understand how anybody could be raising a family or working at the same time they were going through that [school], which a lot of people were. I was so thankful that I only had to work ten hours a week on the weekends. My parents took care of me and I just did my work and went home and slept. So it was a lot of work, it was a lot of studying. Hours a day studying and then we had clinical three or four times a week, five hours a day, plus classroom. It was a lot. They had really high expectations of their students. Only about twenty out of sixty of us graduated.

This narrative reflects the struggle and commitment most participants voiced when describing their experiences in nursing school. The level of difficulty of their programs helped to increase their perception that they were fully prepared to practice nursing for the rest of their careers.

Strong identity as a nurse

Participants were asked the question, “As you think back on your experience of being an associate degree-prepared nurse, what has that meant to you?” Responses varied between passionate declarations of identification as “nurses,” not “associate degree-prepared nurses,” to astonishment regarding the question until it was re-phrased to say

"…experience of being a nurse." Successfully completing a rigorous undergraduate nursing program and passing the NCLEX-RN was a rite of passage for entrants into the nursing profession. Many made proud verbal or physical reference to the letters "R.N." on their name badge. Pride associated with belonging to the profession and being competent in the R.N. role in direct patient care made identifying degree types of other nurses irrelevant to them.

> So to me, being a nurse has just meant being a nurse, it hasn't meant being an associate prepared nurse. That doesn't even cross my mind, the question doesn't come up. I don't look at people and say, "Well, do you have a bachelor's or do you have an associate's?" We don't ask those kind of questions. You're either good at what you do or you're not.

Until recently participants reported that degree types were not allowed on name badges, nor were national certifications such as critical care (C.C.R.N.). Today degree type is as bold and as large as the letters "R.N.," whereas clinical ladder type is much less distinguishable in one institution. This seems contradictory to rewarding movement up the clinical ladder while not rewarding advancing one's educational level. Other nurses commented that job descriptions are changing for direct patient care practice to reflect a preference for higher degrees but that when weighed against years of experience, the type of academic degree didn't really matter:

> There's no job that I ever saw that I wanted that was black-and-white, had to have a bachelor's. I've been here sixteen years. And everything I see that's available, they usually say if you have less than two years' nursing experience you have to have a master's if you have less than five, you have to have a bachelor's. And I've been an R.N. and working for X for so long to the point where even if I wanted that job I'd go in and tell them. You know, it's kind of a grey area; I've been a nurse for so long. So it has not been an issue**.**

Nurses were surprised by hospital nursing position advertisements requiring higher levels of education because they have not seen that these requirements have had any impact on their practice. One nurse spoke of the true attitude of institutional culture towards the A.D. degree as one similar to the military model towards another stigmatized group, “Don't ask, don't tell… nobody ever comes up to me and said, ‘Well, that was a really boneheaded move, are you an associate degree-prepared nurse?’”

Few nurses reported being asked by their peers with higher degrees, where they attended nursing school or what type of undergraduate degree in nursing they held. Participants universally noticed varying levels of competence across degree types, when degree type was known, and echoed their institutional culture that level of competence mattered the most. Some instances of citing incompetence in nurses with higher degrees were linked to new graduate status and lack of experience.

Satisfaction with the practice

All participants verbalized deep levels of satisfaction with their practice stemming from being able to favorably impact patient care in meaningful ways. Nurses gave examples ranging from guiding a ventilator-dependent child with little financial resources to return home, caring for a brain-injured pregnant trauma patient through delivery of a healthy baby and eventual recovery of the mother, and helping dying patients to experience a comfortable death. Even those nurses who described juggling several duties such as taking hourly blood sugars and giving “tons” of antibiotics derived satisfaction from simply, “making it work.” Many spoke about the enjoyment of teaching others with less experience, including nursing students and new graduates who are increasingly found in direct patient care working alongside them.

Those who often found themselves in the charge nurse role spoke about rewards related to helping other nurses advocate for the safe care of their patients and from taking on the challenge of being able to manage a chaotic environment and making the unit function better. One participant spoke passionately about assisting a nurse in the intensive care unit (I.C.U.) with her patient who was in septic shock. The patient was not being managed well by an inexperienced resident who kept leaving the I.C.U. before the patient's blood pressure was stabilized. As she worked with the nurse and the resident she insisted to the resident that he needed to stay in the I.C.U. until the patient was out of danger. She also insisted that, in addition to fluid resuscitation, they needed to switch to a more effective drug to bring up the blood pressure in addition to fluid resuscitation. Although the patient remained very ill, the switch in medication caused his pressure to climb and the nurse was able to keep the patient alive until the attending could come in to evaluate the treatment. She felt that she made a difference.

Nurses who had earned Clinical Staff Nurse III status on the clinical ladder spoke about doing meaningful work with projects that affected patient outcomes. One such nurse noticed that patients receiving apheresis on angiotensin-converting-enzyme-inhibitors (A.C.E.) developed a higher rate of complications such as diarrhea and hypotension. Hypotension with resulting diarrhea can be an indication of shock. After a review of the literature, she learned that patients on A.C.E.-inhibitors, who were receiving apheresis, were more likely to experience anaphylactic or atypical reactions if their medications were not held for at least 24 hours prior to this procedure. She realized that since more patients are being prescribed A.C.E.-inhibitors, the incidence of complications was likely to increase, unless these patients were pre-screened for A.C.E.-

inhibitor use so that their medications could be held at least 24 hours before apheresis. This drove her to apply for a research fellowship at her hospital to investigate this issue further which led to a protocol change:

> As a result I amended the apheresis orders to say that the A.C.E.-inhibitors should be held within 24 or 48 hours before aphaeresis and all patients should be screened for A.C.E.- inhibitors before treatment. Then on the back on the orders I gave a list of A.C.E.-inhibitors and just a warning about the reaction between plasma phoresis and A.C.E.-inhibitors. So that was very satisfying to me.

The above examples and narrative demonstrate perceptions of rewarding nursing practice may serve as a disincentive for these nurses to return to school.

One of the most significant detractors from returning to school for these nurses is their high level of satisfaction with direct patient care in combination with a perceived lack of difference between their practice and the direct patient care practice of nurses with more advanced degrees. All of the participants described satisfying patient care situations. Their deep levels of satisfaction serve as compelling rewards of remaining in direct patient care, while they remain unconvinced that returning to school would significantly alter their current ways of practicing nursing.

Advocacy for patient and for themselves

Participants related many stories of how they were able to successfully advocate for their patients on many different levels because of their perspective that, “It’s always about the patient.” Nurses spoke about making connections with patients and their families so that they would earn trust and, in turn, become more effective in caring for patients. Many nurses empathasized with the fragility of their patient’s lives as they came to the hospital for cancer and other treatments. They felt that listening was one of

the most important interventions they could do in their practice and that listening allowed them to enter their patient's world. The following exemplar was told by an experienced oncology nurse, who learned that although the intensity of engagement with a patient with cancer can take an emotional toll, the satisfaction gained in helping the patient and their family fight to live and then perhaps later, to facilitate having a good death was well worth the involvement:

> So she had multiple myeloma, not a good prognosis. She was about early fifties, very stunning, captivating woman. You could tell she took good care of herself and she was just a force to contend with. And over the few weeks of treatment I got to know her, talk to her, got her story. A phenomenal woman, single mom, put herself through school, became an RN. She did so many things. She was raising two kids, going back to school, getting her nursing degrees, getting her bachelor's – I think she had her master's and worked for insurance companies. Every time she would come in for a transfusion, she'd need platelets, she'd need her blood, we would go out of our way to block that whole room for just her because she was there just for a few hours. We'd order out food, she hated the hospital food.

The nurse was emphasizing the personalized connected care that she and her colleagues gave to this patient. Other examples of nurses successfully advocating for patients included an operating room (O.R.) nurse who orchestrated a special recovery for an immunosuppressed infant receiving a bone marrow transplant since he could not be recovered with other patients; a pediatric nurse who successfully transferred an human immunodeficiency virus (H.I.V.) positive teen with unstable blood pressure from the pediatric floor to I.C.U. after initially meeting resistance from the patient; and an I.C.U. nurse who enforced policy among her peers for the appropriate rate of infusion for intravenous potassium replacement. All participants related some instance of their abilities to be effective in their practices by advocating for patients.

Nurses were also effective in advocating for themselves to work in their preferred areas of direct patient care areas and for their financial benefits. All felt they were making a living wage. Their financial stability, in combination with the level of satisfaction they had in their practice, significantly increased the quality of lives. Nurses experienced agency within hospitals in making lateral transitions to different specialty areas or between hospitals and often across state lines. As long as they wished to remain in direct patient care, having an A.D.N. degree was not a barrier. Fifty percent of participants are practicing in a different state than where they attended nursing school and obtained their first nursing jobs.

Participants stated that their ability to advocate effectively for their patients and for themselves gave them a great deal of satisfaction with their work. However, nurses reported advocating for patients on an individual level, not on a system-wide level. While a few nurses spoke about systems problems in their unit, they could not conceptualize that returning to school might impart tools to change systems for the good of several patients. They cannot know about what might be missing in their practice or what they do not know.

One O.R. nurse spoke about how difficult it was to cater to the simultaneous demands of an O.R. team when in the role of circulating nurse, and did not understand the possible ineffectiveness of triaging these demands. She cleverly resorted to putting the onus of triaging on the team, creating more demands on them by asking them to decide what order she should perform requested tasks. While this may have worked in the short term, depending on the dynamics of the team and the circulating nurse, it does not seem to be a judicious or plausible long term solution. Such an evasion of use of

judgment on the part of the circulating nurse abdicates the needs and responsibilities of this role. There is little evidence that A.D.-prepared nurses in this study felt the need for the more advanced skills to impact their worklife organization and work demands. It was clear from the interviews that most of these participants had not developed strong leadership or change agent skills. The following is an example of not having the effective leadership, research and organizational skills to take a common issue to a system level of problem solving:

> It's really frightening even in an I.C.U. how many times you find things that are not compatible, that are run together where the… silly things like: They maintain that propofol needs to be run alone. Well, propofol should be alone, but it doesn't have to be. There are things that are compatible with it and when you don't have enough lines to push something that's questionably compatible – questionable compatibility with something else versus like the fentanyl with the propofol, which is compatible, fine, then I think you're making a mistake. I consider it inappropriate. Other people don't necessarily. And I've even had things like "Oh, it'll be fine. It's been running like that for two days." Probably so. [sigh] Nothing's happened, the line hasn't clotted off, okay. I kind of go with that but, still, if I can rearrange it, I will rearrange it and then let the next nurse come on and go, "Oh, propofol needs to be run alone. That's what we say." Okay, switch it back over, go ahead, [chuckle] but I'm not going to do it on my shift."

This nurse does not imagine that this is a system and procedural issue that needs to be solved on the unit and hospital-wide level. While her method was effective for her, it does not change or promote the change of practices between interdisciplinary team members for the good of all patients. The nurses in this study understood that their advanced level of experience allowed them to take initiative to improve individual patient care situations, but they did not have the skills, training, or professional standing to create

or collaborate to effect system-wide changes that would address more than the individual case.

Worker bees

Many nurses felt their own role was in direct patient care and this entailed "getting dirty," which was defined as performing the day to day hands-on care of patients. Some used metaphors such as "worker bees," "grunt," or "in the trenches" to describe their position. Nurses did not make reference to their status in a derogatory way, but as a realistic assessment of their practice. They enjoyed doing this type of work and felt it was how they could make the most difference. Additionally, most participants spoke vehemently about not wanting to be in management or in a job where they had to "push paper" and be removed from direct patient care. While three participants were case managers, they still had significant patient contact.

A few of the nurses avoided promotion up the clinical ladder because they would have to be in charge more often or work on policies. They perceived these activities as less than desirable than direct patient care. These nurses did not view their roles in caring for patients as ones that could or should tackle system-wide issues that ultimately could affect the quality of care they deliver. The path of least resistance was instead to find immediate work-arounds for these problems.

> I'm fine with – not being the person making the policies and writing the papers and managing – looking at statistics and stuff. I'll be much happier out there doing the hands-on care. Because somebody has to do it and if you enjoy it you should be that somebody and I'm okay with that. I see a lot of people kind of moving straight from one or two years of clinical experience, kind of away from that because I don't think they want to be that person running around. I kind of have a high energy at work anyway so I

> don't mind – so the E.R. was great for me. It was perfect because I could just run all over the place. Five different patients in five different rooms– doing five different things and that is fine with me. But I don't want to do the other stuff. I don't care about policies; I don't care about any of that stuff. I find that stuff all more annoying than not but I know it's important and it has to exist. But I'm okay just knowing what to do and doing the hands-on.

An almost universal exception to wanting to remain in patient care was when participants spoke about aging and the possibility of not being able to keep up with the laborious demands of a job in direct patient care. When envisioning this possibility, nurses speculated about returning to school in order to qualify to teach undergraduate level nursing. Several felt they already had the skills required to teach nursing. This feeling might have resulted from their experience teaching student nurses and new graduates on their shifts. They believed returning to school for a more advanced degree in order to teach was only necessary because of degree requirements for a different job rather than to attain a different level of skill and knowledge. Nurses were less likely to desire to return to school if they perceived returning to school was merely a mechanism for cross training into some sort of advanced practice that would remove them from direct patient care.

Experience counts **"**You've got to do the practice"

Health care service institutional support for experience and on the job training of the staff nurse trumps support for returning for further academic education. Although at times some participants worried about their marketability having only an A.D.N., this never became an issue for any of those A.D.N.s in securing jobs. Nurses recalling recent job descriptions that stated "B.S.N. preferred" found employers making exceptions for years of experience. If they were currently employed within the institution in which they

wanted a transfer, they were confident that their level of competence would supersede any preference for an advanced degree. One nurse recalled that hospital management tried to influence her A.D. prepared friend, who was already at the highest rung of the clinical ladder, to return to school for a more advanced degree in nursing. She spoke with incredulity that her friend was not approached much earlier in her assent up the ladder, after all what incentive does she have to return to school when she is already at the highest salary level? Another nurse reported that only after an A.D. prepared friend was hired to manage a unit did she receive pressure to return to school. These mixed messages are quickly deciphered by nurses since having only an A.D.N. had never interfered with their careers in nursing. The following testimony is from a nurse who was worried about securing a job in California but quickly realized having solely an A.D.N. was not a problem:

> I applied at all the local E.R.s and got great reception. I got offered jobs everywhere I went. One of my main concerns was since I only had an associate degree and I feel like I'm in a world of higher advanced degrees. And it was a concern that it would impinge on getting a job and it didn't at all. They just looked at me as somebody that had ten, eleven years of E.R. experience and they were fine with that.

The nurses themselves valued experience over a higher academic degree. Many believed their “real” education did not begin until after they graduated from nursing school. All but a couple of participants could not see the possibilities of how a more advanced degree could improve their direct patient care practice. In addition to experientially learning from their practice these nurses took specialized training courses related to their clinical work. One participant made a distinction between “degree type” and “what you know” inferring that degree type did not necessarily impart different

knowledge than that gained by experience. Perhaps because nursing work requires experience based know-how these A.D.N.s could not imagine academic coursework, other than specialized clinical courses in their own field, would add to their practical experienced-based learning.

Just-in-time learning practices: "On-the-job learn and go"

Typically nurses receive "just-in-time education" which is highly specialized for their clinical practice. In-service education classes are geared to new practice patterns already emerging in their practice. There is little lag time from knowledge acquisition to knowledge use. These training programs are tailor-made for particular patient populations that the hospital serves. A nurse working in the operating room attended courses taught by physicians about surgical instrumentation so she could better assist him/her during surgery. She also learned more about specific pathologies that create the need for surgery. A nurse who recently transferred from rehabilitation nursing to a hospital-based skilled nursing unit is prioritizing her learning experiences to gain more knowledge about gerontology since her experience has been mostly with younger trauma victims. A dialysis nurse attends his professional organization's conference yearly to learn about any changes in dialysis delivery equipment. Even after 30 years of practice, participants reported that they were still learning pertinent facts or new ways of caring for their patients on an almost daily basis. The following nurse frames this as a continuing process:

> By studying the things that I need to learn at work, if I have a diagnosis, I search for it so I can understand it better. I take classes. We do in-services. – and I think that's why I like to work in I.C.U. because we do heart and lung transplant and it's like I can – always learning, always learning…We have different machines and we have so much responsibilities –we get in-service but we don't get

> to use them all the time. So you always have to be reviewing if you get the patient because you don't remember. So that's always a challenge. And not just the machines, it's also physiologically what happens to the patient. So it's like you always have to – like you have to study, you have to learn it. So I have a big backpack full of books

Certainly A.D.-prepared nurses are not the only nurses which engage in the continual pursuit of learning in a practice-based profession. However, A.D.-prepared nurses who are diligent about learning may feel their ongoing study results in a level playing field with colleagues with higher degrees who also practice in direct patient care. The resulting knowledge and skills learned past the point of graduation may contribute to A.D. nurses' perception that there is a lack of distinction between degrees of nurses in direct patient care practice. This perception may decrease A.D. nurses' incentive to return to school for a more advanced degree. The high level of relevance of hospital based classes and continuing education specialty programs and nurse certification programs, coupled with the perception of the low relevance of advanced degree content, may also act as a deterrent for A.D.-prepared nurses to return to school.

Possibilities for Advancement

Clinical Ladder

Participants spoke about the clinical ladder as being solely project and clinical practice-based so that earning an advanced degree in nursing did not confer movement up the ladder. One nurse reported that her pay increased 8% after earning her Clinical Nurse III, which added almost $1000 more per month to her salary. This served as an adequate incentive for her to initiate and maintain a pain-reporting tool and chart-audit system on her oncology unit, whereas, no pay differential was offered to her for returning to school.

Research Fellowships

Hospitals desiring Magnet Status, a national quality appraisal program for hospitals (Aiken, Havens, & Sloane, 2000; American Nurses Credentialing Center [ANCC], 2008), in addition to encouraging clinical promotion programs provide incentives for nurses across all levels of preparation to apply for in-house research fellowships. These fellowships pair the nurse with an advanced-practice nurse who mentors them in forming a research question, conducting a literature review and launching a unit-based research study. Two participants in the present study spoke about such experiences that culminated in changing policy and procedures for the good of the patients on their units. As noted earlier, a nurse changed screening protocols in her dialysis unit for apheresis patients on A.C.E.-inhibitors to decrease complication rates (see section "S*atisfaction with the practice"*) while another nurse changed sedation wake-up protocols for ventilated patients, which decreased I.C.U. lengths of stay.

> Through the Nursing Education Department each year they have evidence-based fellowship programs for whoever wants to join. What you do is you fill out an application, and you send it to the coordinators to say, "This is a problem or something you want to actually change practice there on your unit and what the problem is and what you want to see happen." If they say it's okay then you have to find a mentor which has to be a C.N.S. or an N.P. and mine was my clinical nurse specialist on my unit, and then you have to work out your program. So you develop your resource people – they take you through everything. They take you through your people question, through how to research the literature, how to come up with the evidence that reflects your program, just everything. There was a protocol that none of the nurses were doing that had been out a year and nobody was doing it. I actually did it once and it worked and I saved a patient from being trached. So I said, "Oh, everybody should be doing this, this is a wonderful thing." So my research question was for a mechanically ventilated patient in the I.C.U. on continuous infusion, by re-implementing a sedation wake-up protocol does it decrease I.C.U. length of stay

> and associated complications? So I re-implemented it and now it's time for me to re-collect the data and see if it's made any difference, which I'm supposed to be doing this month. I was really excited about it. You know those things grow tentacles, which I'm sure you're finding out. You start off with one thing and then all this other stuff pops up.

While these research apprenticeships empowered A.D.-prepared nurses to learn the process of research and ultimately led to significant increases in the quality of care delivered on their units, the idea was further reinforced that they can develop and learn without returning to school. Although it has historically been the purview of academia to teach research; the phenomenon of being apprenticed to accomplish highly relevant research and equivalent learning at their work site gives A.D.-prepared nurses in research fellowships one less reason to return to school.

This data suggests that nurses who engage in projects or research fellowships that increase their status on the clinical ladder feel able to make a larger contribution to patients' lives through these activities than they would by pursuing a higher academic degree. These participants were proud of their action research project. In developing a standardized care plan for bariatric patients, one nurse can potentially affect the care of all bariatric patients, not solely the ones she is assigned to care for. The draw of being able to make a direct contribution to patient care is a powerful one and certainly serves as strong reinforcement to working within the hospital system in order to advance learning. To facilitate more in-process improvements, hospitals have hired Advanced Practice Nurses to encourage action-oriented research projects, and projects designed to collect the best evidence for particular standards of practice. As preceptors to undergraduate nursing students, nurses are given the opportunity to impart their hard won experiential

and specialty-gained knowledge to others, no matter what their degree and therefore make a contribution to the nursing profession.

Lack of Meaningful Distinctions

All participants in this study felt that earning a more advanced degree in nursing was either simply a mechanism to validate their current practice to the outside world or open opportunities in nursing away from direct patient care. Attending school was thought to be "empty academicism" with no real advance in knowledge and skill by most of the A.D.N.s who had not returned to school. Most nurses spoke of the possibilities of returning to school if they wished to become school nurses, public health nurses, nurse practitioners or to teach in undergraduate nursing programs. Most did not believe they had to return to school to become a researcher or to perform better direct patient care. For example, a nurse who had extensive experience as a research assistant at a major medical center and had enrolled patients with chest pain in the emergency room into a clinical trial did not imagine she needed more academic preparation to further her research skills and knowledge. Nurses in research fellowships pointed out that they were already conducting unit-based research. Many believed the need for a more advanced degree set up an artificial barrier to advanced practice positions that they already felt qualified to perform, such as teaching undergraduate nursing.

Surprising was the notion in this study that even to return to school to simply obtain a B.S.N. was mostly advantageous if one wanted to pursue management:

> I think people immediately said things too like, well, they were going to be able to go into management positions and things like that because of their degrees where associate nurses were probably never going to. So I think there was also a feeling that these

> people had higher aspirations that they thought their degree would take them to.

This belief may be a hold over from the early days of A.D.N. programs when diploma and A.D. prepared nurses cared exclusively for patients in hospitals, while B.S.N. prepared nurses were rarely found in hospitals, or were in upper management positions (Haase, 1990). Although the number of B.S.N. prepared nurses working as staff nurses in hospitals has risen to about 38% (USDHHS, 2004), almost all participants in this study believed that returning to school was necessary only if one were to pursue a management position and all felt that becoming a manager was undesirable for them.

An Appraisal that Advanced Degree Does Not Improve Direct Patient Care Practice

With few exceptions A.D.-prepared nurses did not perceive their practice to be different from those of R.N.s with more advanced degrees who also practiced in direct patient care. Moreover, a few had great difficulty speculating how their practice could change after earning a more advanced degree, and most felt their practice would not change at all. Many felt they would continue to act upon core values imparted to them in their undergraduate programs or from their personal philosophies about life and believed education could not improve upon this. Examples of core values which embodied many of their practices were giving holistic or competent care.

Perhaps A.D. prepared nurses do not see differences in direct patient care practices between themselves and nurses with higher degrees because such differences become invisible when level of competence for basic care delivery becomes the primary defining benchmark of care. The following excerpt illustrates how the practice of nurses with higher degrees in direct patient care becomes invisible in an environment which values experiential knowledge above all else:

> Again, you're given credit for your years of experience; it doesn't have anything to do with how much education you've had. I really don't believe in my heart that I would be any better or any worse in my practice whether I went to school for two years or whether I went for four years. I don't think it makes any difference. I think that it's been – and I don't know this for a fact but in my head I look at a B.S.N. program more of a theory kind of thing and I'm way more hands-on and I think I got everything I needed out of the program that I was in. So I've had thirteen, fourteen years in the O.R. I know a lot of stuff that I don't care if you're master's prepared, if you come into the O.R. and you've never been there before you're going to need me and it doesn't matter how long I went to school because I know what goes on and you don't, so let me help you, let me teach you. And, again, maybe that's why I don't ever feel like my level of education is an issue because nobody – again, don't ask, don't tell, nobody knows. I don't know who has B.S.N.s and who has diplomas and who has associates and I don't care because if they're competent and they do what they're – they work within their practice and they're good at what they do it doesn't matter.

Nurses with advanced degrees who were the most visible to participants were clinical nurse specialists (C.N.S.). Differences noticed were an increased depth and breadth of pathophysiology and general theoretical nursing knowledge, an increased ability to mentor and teach research and evidence-based practice, and the ability to accomplish projects at the hospital level. The C.N.S. role was not perceived by these nurses to be one of a direct patient care nurse. However, the two nurses engaging in research fellowships saw that certain functions of the C.N.S. could become integrated into direct patient care practice. Aside from the C.N.S. role, one nurse was surprised when asked about masters prepared nurses in direct patient care because she had only seen them in management positions.

While many participants spoke about system-wide issues affecting their nursing practice, none perceived that returning to school could impart tools on how to change the system. Perhaps this is because they felt it was up to management to do so, yet they also

perceived that these systems issues never seem to go away. One nurse used the term "jaded" as coming to terms with systems problems that seem to be perpetual. She surrenders to the fact that she won't or can't change them:

> You get to that point where you just kind of throw your hands in the air and you go "This is what it is." And instead of seeing the good, maybe, you just see what's normal. The tantrums, the things – the problems with the system, all of those things. You become jaded in that you've – When you're first in practice and you're young and you're bright-eyed and you're full of enthusiasm and hope, I think it's a wearing down process. That you've spent so many years in so many institutions and everything's always the same. It's the same problems, the same – too many managers, not enough workers, all of those things. And finally you just give up trying to fix them and I think that's what I mean by "jaded." Instead of maybe seeing something positive about the situation, you just go "Well, it's been like this forever, it's never going to change.

Perhaps if she believed systems could be changed and that it could be her role to change them, she might see returning to school as a possibility, but only if she could imagine learning how to change hierarchical bureaucratic systems in school. In sum, most of these nurses did not have a vision of what would be learned in baccalaureate nursing programs.

Implications

Many of the participants were confident in their level of competence often valuing their associate degree education over their baccalaureate prepared colleagues. This defense could, in itself, become a psychological barrier to returning to school for a baccalaureate degree, since returning to school conflicts with nurses' long-held position about their level of competence to practice nursing. There may be some cognitive dissonance in returning to school after having asserted and proved to themselves their capability of providing good direct patient care. Cognitive dissonance occurs when two opposing view points cannot be reconciled (Festinger, 1957). Those who experience dissonance find ways to reduce it by avoiding behaviors that would increase this

dissonance or by changing belief systems (Aronson, 1997; Festinger, 1957). Thus, even if the nursing student originally believed that a higher degree would impart a higher level of skill, after practicing for a number of years she or he might change to the opinion that doing so would not alter her or his already competent nursing practice. Affirming their current nursing practice while avoiding returning to school and aligning their belief system to rationalize that returning to school is unnecessary reduces an internal struggle that could challenge participants' current way of thinking about their practice. Such a stance of affirmation of skill is evident in the following participant's statement:

> Looking back on my experiences, I don't look at it as being any different than if I'd had a higher degree because I've never been interested in the administrative side of nursing, it's just not me. I'm not cut out to be an administrator at all. I don't have that in me. So, I don't know if it's any different than what – if I had gone and gotten my bachelor's degree, either way. Because ever since I started nursing it was all about experience and you never got paid differently so there wasn't – it's like I never even think about it that I'm different than somebody else who has a different degree. It's just you're an R.N., you're an R.N. It's all about experience and what you've done and what you know, not so much about the degree... I was neither turned down for a job nor did they say, "You're not qualified for because of your degree." Never. None that I can think of. I've never been discriminated that way.

Clearly, A.D.-prepared nurses do not feel compelled to return to school for a higher degree in nursing when they feel satisfied with their practice and do not perceive any differences between themselves and their peers with higher degrees who are also in direct patient care. There is no doubt that the nurses value delivering high quality patient care and believe they are doing so on an individual and sometimes, a unit-wide basis. Institutional practices, such as non-differentiation in pay or clinical ladder level, inadvertently reinforce nurses' perceptions that they do not need to return to school and have taken the place of academia in creating spaces, resources, and incentives for nurses

to learn and advance in their jobs. Unfortunately, there is a vast disconnect between this enriched on-the-job training and academic learning. Academic institutions have difficulty keeping up with the rich learning environments of hospitals and the intense focus on clinical learning and training in these settings. The National Carnegie Study of Nursing Education found a real practice -education gap between nursing education institutions and the needs of service health care organizations (Benner, Sutphen, Leonard, & Day In Press; Rodriquez, 2008). An exception is long-term and gerontological care settings that have not focused so much on clinical teaching and learning (Benner, et al., 2008).

If A.D.N. prepared nurses perceive that returning to school for a higher degree in nursing can be as relevant for their practice as current methods employed in developing their practice knowledge and skills, then they may enroll in R.N.-to-B.S.N. or R.N.-to-M.S.N. programs. Ways to increase the relevance of these degree programs may include collaborations between health care service organizations, professional nursing organizations, and academic institutions to tailor curriculum to the needs of specific patient populations. Most nurses in this study felt they were competent generalists and able to adequately prepare for specialty practices without returning to formal schooling. They saw few possibilities for improving their practice or changing their current roles through returning to school. One has to ask whether this perception of the value of more schooling is accurate since none of these nurses have ever been enrolled in an academic program. Schools of nursing have not yet made the case for their relevance for these practicing A.D. nurses.

Service health care organizations need to change institutional practices in order to value and encourage a better educated nursing workforce. Nurses need to see tangible

rewards for returning to school. Rewards for earning a higher degree in nursing must be competitive with rewards given for climbing the clinical ladder. If nurses can foresee that earning a more advanced degree can increase their salaries, they may become more motivated to temporarily sacrifice their own quality of life and commit long hours to formal schooling. Some hospitals may believe unions discourage rewarding nurses for higher degree attainment because they represent nurses with a myriad of degree levels. However, many unions are likely to support any program or incentive that develops their members. A model such as the single salary scale for teachers which gives pay raises not only for years of experience in teaching but also for advanced degrees may serve to provide incentives for the vast majority of nurses in the workforce to return to school (Consortium for Policy Research in Education, 2007; Hanushek, 2006). Graf (2006) found that A.D.N.s were four times as likely to pursue a higher degree in nursing if they received a 6.8% pay differential. Other incentives include: providing full tuition up-front; stipends to support time off while in school; allowing greater flexibility with scheduling; and seeking magnet status to promote evidence based nursing.

Formal schooling may become more appealing to A.D. prepared nurses if it is offered in the learning environment they are already familiar and comfortable with, their work place. Cohorts of nurses can enter a degree program co-sponsored by health care service organizations on-site, which may entail not only face-to-face professor time, but tele-conferencing and on-line offerings as well. Hospitals and other institutions pooling their resources with a university can offer courses simultaneously to several cohorts using educational technology. Forming cohorts of nurses in practice does not devalue their experience as mixing them with undergraduate generic B.S.N. students might (Lillibridge

& Fox, 2005; Rather, 1992/1994). Several examples of partnerships between educational institutions and service health care organizations that includes on-site courses, up-front tuition scholarships, pay increases for higher degree level and schedule flexibility demonstrate that a culture for learning and for advancing educational levels in nursing can be accomplished through making learning more accessible to working nurses (Cheung & Aiken, 2006). Such partnerships can use the talents of service health care organizations to act as consultants of curricula for patient-specific content and to help prepare the professional nurse needed to provide care in the 21rst century. Academia can provide experts in teaching and learning, provide pedagogical resources and deliver not only content, but new skill sets to nurses returning to school.

Various states such as Arizona participated in the Robert Wood Johnson's "Colleagues in Caring" project which led to the formation of regional and state forums between nursing education and service health care organizations that examined ways to collaborate to decrease the education/practice gap (McNamara, 2000). Arizona's project eventually led to the formation of seamless statewide articulation agreements between community colleges and state universities to reduce barriers for A.D.N. students who wished to continue schooling for a B.S.N. degree. The Oregon Consortium of Nursing Education (O.C.N.E.) was formed between Oregon community colleges and their state university to co-enroll and co-admit nursing students with the expectation that about three times the national average of A.D.N.s would continue in school for a higher degree in nursing in their system (Gubrud-Howe, et al., 2003; Tanner, 2007).

Such collaborative models should be designed to simultaneously enroll the A.D. and diploma student in a pre-licensure program, and a state university school of nursing.

They would minimize curriculum redundancy so that after completing an A.D. degree students can continue in school for 12 more months to complete a B.S.N. Nursing educators need to address the system unfairness in designing A.D.N. programs that last 3.7 years but do not provide four years worth of academic credit, nor a baccalaureate degree. Streamlining should also occur in A.D. programs which currently require over 70 semester units including prerequisites and almost four years to complete. Benner and colleagues (2008) found that although the length of time it takes to complete an A.D. program is a minimum of three years, many programs took significantly longer due to oversubscription in pre-requisite courses and wait time for oversubscribed nursing programs. Therefore, it is not uncommon for A.D. nursing students to spend four to five years completing their associate degree.

At this time of acute shortage of nurses and nurse educators increasing the collaboration between degree-granting institutions and creating partnerships in education between degree-granting institutions and health care institutions is urgently needed. Other similar collaborative models being formed throughout the country have been reported (Sizemore, Robbins, Hoke, & Billings, 2007; Williams, Hall, & Papenhausen, 2005). California Institute for Nursing and Health Care (2008) in their white paper with strategic action plan recommendations “Nursing Education Redesign for California,” is calling for the formation of “Education Highways,” which decrease barriers for nurses with baccalaureate and masters degrees to return to school as well.

Streamlining curriculum in these programs should not only reduce subject redundancy, but should improve access to course materials by increasing web-enhanced courses, require fewer days per week of face-to-face time, allow transfer of previous

courses taken and sanction credit-for-work experience. State universities must reduce barriers, such as heavy on-site unit loads required for conferring a B.S.N. degree, heavy general education requirements and differing prerequisites between same-state programs.

Conclusion

This study lays bare practices, beliefs and attitudes that A.D. prepared nurses report to have influenced their decision not to return to school for a higher degree in nursing. There are many strategies that can be employed to not only make returning to school easier for working nurses but to make it desirable as well. Academia and health care service organizations need to join forces to find successful ways to promote a better educated nursing workforce in order to provide better patient outcomes. Both need to change practices to encourage nurses to return to school. Also the difficult problems of cognitive dissonance that occurs when A.D. nurses defend themselves against status inequities or the need to return to school need to be addressed. A.D. graduates have a built-in secondary ignorance about what they do not yet know in relation to their work. For example, few have any sense of agency and knowledge related to changing ineffectiveness in the hospital system. Of course, the possibility must be entertained that the B.S.N. does not sufficiently give additional knowledge, especially to the effective continuing clinical learners. But the research demonstrating improved patient outcomes with greater percentages of B.S.N. graduate nurses points to added value for additional education of nurses. The lack of distinctions, incentives and actual practical advantages to nurses in direct patient care practice for completing their B.S.N. degree may be overcome by providing more A.D.-to-M.S.N. programs that take advantage of the prior clinical learning of the A.D.N.

The potential benefits of improved patient care should be motivation enough to increase efforts to change policies and patterns so that more than 20% of nurses in the workforce return to school for a higher degree in nursing. But, for these non-returning A.D.N.'s, the message of the advantages to improving direct patient care with a B.S.N. has not convincingly reached them. How to provide this message without eroding their self-confidence or bolstering their defenses about their sense of competency is a challenging problem that needs to be explored.

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CHAPTER SIX

Dissertation Summary:

Conclusions and Implications for Policy and Future Research

This study illuminates the phenomenon of A.D. prepared nurses in practice who have not returned to school for a higher degree in nursing. Many cultural institutional health service practices and values influence these nurses to not to return to school. Academic institutions still present formidable barriers that serve as deterrents for nurses in practice to return to school. While nursing leaders, nursing organizations, service health care organizations and academic institutions are all calling for a better educated nursing workforce their actions deliver a mixed message to nurses in practice. These nurses learn quickly that their positions at the bedside are secure and thus quickly and easily rationalize that they do not need a higher degree. Service health care organizations positively reinforce this position in multiple ways. Moreover, they provide ways for nurses to expand their learning and make unit wide changes based on evidence but are unable to confer any academic credit for this growth.

It is time for service health care organizations and academia to come together in new ways. Consortiums which include all levels of undergraduate and graduate nursing programs, and service health care organizations can facilitate seamlessness in continuing education towards a higher degree level for A.D.N. students as well as break down barriers for nurses in practice who wish to return for a higher degree. Academia can increase access to coursework by utilizing more alternative forms of course delivery and by bringing courses to the workplace. Cheung and Aiken (2006) document many possibilities for service health care organizations and academia have come together to

create a culture of learning, which included bring courses on site and aligning them with work schedules. Tuition costs paid up front or yearly stipends that covered more than simply tuition were awarded by many service health care organizations to decrease financial burdens of nurses who returned to school. Other health care service organizations increased incentives for their nurses to return to school such as salary differentials for advanced degrees. While these practices significantly increased the number of nurses returning to school in the service health care organizations featured by Cheung and Aiken (2006), many nurses in this dissertation study considered it a burden to continue working their current commitments while returning to school. They admitted that if stipends covered their tuition, books and other fees in addition to the equivalent of one workday per week (so they could afford to cut back work hours for study) they would find returning to school a more realistic possibility.

Nursing students in A.D.N. programs that were part of a consortium with universities could be co-enrolled in each institution and nursing program so that continuing their education in pursuit of a B.S.N. degree could be seamless. They would not have to re-apply to the university or school of nursing and their financial aid would follow them regardless of nursing program type. Curriculum could be streamlined by minimizing redundancy so that continuing for a B.S.N. degree would only require three more semesters. A.D.N. students continuing with their education can work part time as registered nurses to relieve financial pressures of being in school for many years. A.D.N. programs need to be completed in three years (including prerequisites) so that earning an A.D.N. degree does not take as long as earning a B.S.N. or almost as many units. This can be a challenge when impacted prerequisite courses prevent students from taking and

completing them in a timely manner. Service health care organizations need to alter their cultures so that A.D.N. students here the message loud and clear that they need to continue schooling for a B.S.N. or higher degree. This can be facilitated if service health care organizations become consortium partners.

There are few studies of the experiences of A.D. and diploma-prepared nurses who returned to school for a higher degree in nursing and a paucity of information about how doing so changed their nursing practice. Extensive searches of various databases yielded no studies of B.S.N. or masters-prepared nurses who have returned or not returned to school for a more advanced degree. If we wish to heed to call for a better educated nursing workforce, we will need to conduct further study into the phenomenon of nurses not returning to school for a higher degree in nursing.

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