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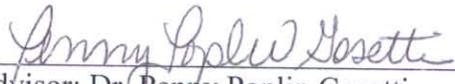
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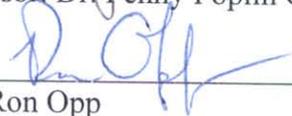
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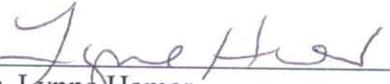
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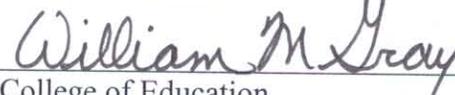
The Doctor of Philosophy Degree in

Higher Education

  
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December 2004

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An Abstract of  
Clinical Nurses Transitioning Into a Faculty Role: A Cultural Analysis of the  
Nursing Profession, the Academic Discipline of Nursing, and the Academic Professorate

Cheryl L. Schriener

Submitted as partial fulfillment of the requirements for  
Doctor of Philosophy Degree in Higher Education

The University of Toledo

December 2004

Nursing faculty are initially socialized into the culture of the nursing profession and then must transition into the culture of the academic discipline of nursing as they assume their new professorial role. This study explored how cultural similarities and differences influenced the transition of clinical nurses into a faculty role. The study was guided by Peterson and Spencer's (1990) model of organizational culture and Schlossberg's (1995) adult transition theory.

A qualitative design focused on a phenomenological method of ethnographic inquiry was utilized. Multiple methods of data collection, including document review, interviews, and participant observation, were used to examine elements of culture. Six themes emerged from the cross-case comparative data analysis including: (a) stressors and facilitators of transition, (b) deficient role preparation, (c) changing student culture, (d) realities of clinical teaching and practice, (e) hierarchy and reward, and (f) cultural expectation versus cultural reality.

Study results led to the following conclusions. First, cultural dissonance exists in new nursing faculty as nurses adjust to a faculty role based on the values they bring from clinical practice. Second, cultural dissonance creates conflict in nursing faculty that influences the transition of nurses into academe. Third, access to faculty mentors who understand the issue of cultural dissonance will facilitate nurses' transition into faculty roles. Fourth, cultural dissonance can be improved through formal education and socialization to the faculty role. Finally, colleges of nursing must adapt to the values inherent in the nursing profession.

Implications for policy and practice include providing clear expectations for the faculty role, increasing the availability of programs in nursing education, increasing access to faculty role models, improving resources and support for clinical faculty, and creating a reward structure based on values inherent in the nursing profession.

The nursing profession is experiencing a shortage of new faculty at the same time current faculty are building the level of doctoral preparation expected to fulfill the norms of other academic programs. An understanding of how cultural dissonance affects the transition of nurses into faculty roles is of special importance to higher education administrators due to the escalating shortage of nursing faculty throughout the country.

## Dedication

This dissertation is dedicated to a truly inspirational nurse educator,

Mary Beth Hayward

Mary Beth, you lived your life embedded in the values of nursing.

As my teacher, mentor, colleague, role model, and friend

you inspired me to reach my dreams;

even though I did not always realize what they were.

In honor of your lifelong devotion to nursing education,

I dedicate this work.

## Acknowledgements

I would sincerely like to thank the members of my committee for their time and expertise given to this project. I would especially like to thank my committee Chair, Dr. Penny Poplin Gosetti for the continued guidance and support she has provided throughout this process. It was because of her influence as an educator that the original idea for this dissertation became a reality. I would also like to thank Dr. Lynne Hamer for her contributions particularly to the qualitative research focus of this project. I truly admire her dedication and commitment to teaching and to students. I also want to thank Dr. Ron Opp for his valuable suggestions and support in the completion of this dissertation.

This research would not have been possible without the participants of this study who willingly gave up their time to share the stories of their own transitioning experiences. I am truly amazed at the level of trust and sincerity these nurses extended as I pursued my research goals. I would also like to acknowledge the financial support of the National League for Nursing through the Nursing Education Research Grant that supported this study.

I will never be able to thank my family enough for their continued support and understanding throughout my entire doctoral program. I'm not sure any of us really realizes how important the people in our lives are to us until we are enmeshed in any one of life's more difficult journeys. My husband, Joe, and my children, Cindy, Michelle, and Mike have been extremely understanding and supportive of all the times I had to put my role as a student before my role as a wife and mother, and I truly appreciate their willingness to help me achieve my educational and professional goals.

Lastly, I would never have completed this process without the continued support and encouragement from my fellow classmates and friends, Sue Idczak, Kelly Phillips, Pat Bower, Sandy Calvert, Joan Rocks and Mary Anne Kubat. We all started this journey at different points in time, but we have been brought together as friends for *all* time. I cannot express how important your friendship has become and how much you have helped me throughout this process, because I always knew there was someone who understood the tremendous task we were all undertaking.

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## Chapter One

### Introduction

Culture is defined by Kuh & Whitt (1998) as the “collective, mutually shaping patterns of norms, values, practices, beliefs, and assumptions that guide the behavior of individuals and groups” (p. 13). Through an examination of culture, the behavior and actions of various groups can be interpreted and understood. Faculty, students, and administration comprise subgroups of culture that are present in higher education institutions.

The assessment of faculty culture is a multifaceted process and encompasses many elements as an individual’s culture comes together with the institution’s culture during the process of faculty socialization. Tierney and Rhoades (1994) described faculty life as a “distinct professional sphere governed by the norms of professional collegiality” (p. 11) with the separate disciplines that faculty embody having a profound influence on their behavior within the institution. Individuals “carry culture with them” (p. 217); hence, a person’s adjustment to a new environment is reflected by the unique culture the person has developed during prior personal and professional experiences (Van Mannen & Barley, 1984).

The majority of faculty teaching in schools of nursing have risen from the ranks of professional nursing, which has its own distinct culture. Nursing faculty are initially

socialized into the culture of the nursing profession and then must transition into the culture of the academic discipline of nursing and the culture of the academy as they assume their new professorial role.

This study presents a description and analysis of the perceived similarities and differences of three distinct cultures, the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate as described by nurses who are transitioning from a clinical practice role into a faculty role within a College of Nursing (CON). An examination of the culture of the nursing profession, the culture of the academic discipline of nursing, and professorial culture, can provide a framework for understanding patterns of behavior among nursing faculty within institutions of higher education. An enhanced awareness of the influence of culture reported by individual nursing faculty as they transition from a clinical role into a faculty role within a CON can assist college and university administrators in the development of strategies that will contribute to improved faculty retention in schools of nursing.

#### *Background of the Problem*

Tierney and Rhoades (1994) described the culture of faculty life as a “complex interplay of symbolic meanings” (p. 9) based on five independent cultures including the nation, the profession, the discipline, the individual, and the institution. The culture of the nation, the academic profession, the academic discipline, and the individual are all enacted within the culture of the institution, and both academic discipline and institution link the individual to the academic profession (Ruscio, 1987). Although all of these cultural affiliations are important to the understanding of culture in higher education, this study focused on the influence of the culture of the nursing profession, the culture of the

academic discipline, and the culture of the academic profession on individual nursing faculty as they transition from clinical practice into an academic role. To aid in the understanding of this issue, a brief background of the historical perspectives of nursing education, nursing faculty preparation, and culture as related to the nursing profession, the academic discipline of nursing, and the professorate are presented.

### *Historical Perspectives of Nursing Faculty Education*

Nursing as an academic discipline is a relative newcomer to the academy, having crossed the threshold into higher education institutions a little more than 100 years ago. As a result of this expansion of nursing education into colleges and universities, the nurse as faculty member has evolved from a clinical practice position to an academic role (Ruby, 1998).

Nursing education arose from informal, institutional-based programs, primarily focused on the apprenticeship training of nurses. The first organized training school for nurses, the Deaconess School of Nursing, originated in Kaiserwerth, Germany in 1836. The curriculum at the Deaconess School included lectures in theory as well as bedside instruction, which were all provided by physicians (Anderson, 1981).

The need for trained nurses in the US was fueled by casualties experienced during the Civil War, leading to the development of the first American schools of nursing in 1873. In the ensuing 20 years, 35 nursing schools were initiated, most of which were affiliated with hospitals whose primary mission was the provision of care for patients (Anderson, 1981). With this rapid expansion of hospital-based training of nurses by physicians, the fundamental focus of nursing education was clinically based rather than academic.

By the late 1890s, physician lecturers were gradually being replaced by graduate nurses, although formal training for nurse educators was non-existent in the US. Issues related to nursing education, including lack of standardization of nursing programs and limited preparation of nursing faculty were being identified on a national level. It became clear that hospital-based programs were not adequately preparing nursing faculty to assume positions in higher education. As a result of the need for improved academic preparation of nursing faculty, the first masters degree program for nurses interested in teaching was initiated at Teachers College, Columbia University in 1899 (Anderson, 1981). The university soon became the recognized institution that would provide the education required to prepare future nursing faculty.

#### *Preparedness of Professional Nurses for Faculty Roles*

In contrast to other academic disciplines, schools of nursing have never been fully staffed with educationally well-prepared faculty; specifically those with terminal degrees (Hinshaw, 2001). Requiring a terminal degree for teaching has been the customary practice in most established scientific disciplines but has been impossible to enforce in nursing because of the limited number of nurses with doctoral degrees. In 1978, only 15% of faculty teaching in baccalaureate and masters degree nursing programs held earned doctorates (Hinshaw, 2001).

Although the situation has improved over the last 25 years, only 50% of nursing faculty currently hold doctoral degrees, a figure that remains below that of other academic disciplines that require doctoral preparation to enter the professorate (AACN, 2000). Of the 284,000 full-time instructional faculty in degree-granting institutions in the US at the start of the 1998 academic year, 58% of faculty across all disciplines were

doctorally-prepared. For faculty in the fields of education and engineering, 70% and 76% respectively, held doctoral degrees, while health science fields, including nursing, reported only 29% of full-time faculty being doctorally-prepared (NCES, 2002).

Consequently, while professional nurses bring a strong clinical background to their new faculty role, their professional education is not always relevant to the skills necessary for assuming a faculty position. As a result, most novice nursing faculty are under-educated in the level of preparation necessary to meet the educational norm expected in other academic disciplines.

The median time from entry in a masters program to completion of a nursing doctorate is almost 16 years, nearly twice as long as the 8.5 years found in other fields (AACN, 2003). According to a 1999 survey of earned doctorates in the US, the median time from baccalaureate degree to doctoral degree was 10.4 years with the least years found in the physical sciences and mathematics area (8.0 years) and the longest span occurring in the disciplines of education and the professional fields (14.0 years). The survey data revealed that in the professional disciplines, which include nursing, a large proportion of doctoral recipients worked full-time in their field before beginning any doctoral education and many continued to work full-time while enrolled in doctoral studies (National Opinion Research Center, 2000).

In comparison to graduates of other doctoral programs, nursing doctorates are significantly older at the time of degree completion. Of the 365 nursing doctoral degrees awarded in the US in 1999, the median age of graduates was 46.2 years compared to the median age of 33.7 of all doctoral awardees, a difference of almost 13 years (AACN, 2003). Also in 1999, engineering and science degree holders completed their doctorates

in their early 30s compared to the average age of 37.5 years for professional degree recipients (National Opinion Research Center, 2000).

The norm for entry into a nursing faculty role traditionally occurs after years of clinical practice, following the completion of a masters program in nursing. Additionally, most nursing masters degree programs have recently eliminated their education tracks to promote an increased emphasis on preparation for clinical roles in nursing, which include clinical nurse specialists and nurse practitioners. The result of this increased masters degree focus toward clinical preparation, versus one of preparation for a teaching position, has been the hiring of many masters-prepared clinicians for faculty positions in schools of nursing (Kelly, 2002; Krisman-Scott & Thompson, 1998).

Since the current pattern for nurses pursuing a teaching career is to enter doctoral study after many years of clinical experience following completion of both the baccalaureate and masters degrees, the professional norm supports clinical nurses who adopt a later career path in the academy (Hinshaw, 2001). Furthermore, the majority of nursing faculty pursue their doctoral degree on a part-time basis while maintaining full-time employment in nursing, which is not the typical approach found in other academic disciplines (AACN, 2003).

#### *Culture as Related to the Nursing Profession*

The concept of culture as related to the profession of nursing can be traced back to the original writings of Florence Nightingale (1859), which reflected the values of character, obedience, and a spiritual calling from within as being essential to nurses. Madeline Leininger, a nurse anthropologist, first identified nursing as a unique culture with identifiable norms, values, and beliefs, forming the basis of the study of the culture of

nursing in the 1960s (Leininger, 1967, 1968, 1970). Most significant to Leininger's description of the culture of nursing is the concept of caring as a value that belongs at the heart of nursing and has been used to guide the development of nursing knowledge.

Leininger (1995) defined the culture of nursing as "the learned and transmitted lifeways, values, symbols, patterns, and normative practices of members of the nursing profession" (p. 208). She also defined a subculture of nursing as "a subgroup of nurses who show distinctive values and lifeways that differ from the dominant or mainstream culture of nursing" (p. 208). Of further significance in Leininger's (1986) description of the culture of nursing is the concept of "caring" as a value that belongs at the heart of nursing. Leininger proposed that the humanistic value of caring has shifted in importance during the most recent era of nursing. She developed the cultural care diversity and universality theory of nursing, which has been used to guide the development of nursing knowledge through the concepts of both "culture" and "care" (Leininger, 1988, p. 152).

According to Kuh and Whitt (1988), culture is based on the shared values and beliefs of its members. Expert values are standards for action that are adopted by the profession and provide the framework for evaluating the beliefs and attitudes that influence behavior (Eddy, Elfrink, Weis, & Schank, 1994). The development of specialized values is an important part of professional socialization (Weis & Schank, 2000). The professional organization for nurses, the American Nurses Association (ANA), has identified a set of values that has been used to form the basis for the standards by which the professional nurse practices. The Code of Ethics for Nurses describes the primary goals, values, and obligations of the nursing profession. The fundamental values and commitments of all professional nurses is portrayed in the first three provisions of the Code, which includes

nurses' respect for human dignity, nurses' primary commitment to the patient, and nurses' protection of human privacy (ANA, 2001).

*Culture as Related to the Academic Discipline of Nursing*

Disciplinary culture reflects the norms and assumptions of the profession for which the school provides preparation, with differences in the culture affecting the socialization, tasks, and behaviors of faculty members (Becher, 1981). The way in which individuals understand the unique culture they have developed while working in prior organizations will affect that person's adjustment to a new environment. Continuous interaction between various cultures can lead to acculturation, the adoption of the values, norms, and behaviors of another culture (Austin, Ahearn, & English, 1997).

Disciplinary differences are evident at the very beginning of an academic career. Faculty from different disciplines exhibit a variety of attitudes, values, and personal characteristics, which influence a person's cultural identification (Kuh & Whitt, 1988). Belonging to a "disciplinary community" (p. 24) creates a sense of identity, personal commitment, and in many ways defines a person's life (Becher, 1989). According to Bergquist (1992), faculty often identify with their discipline rather than with the role of teacher. The strength of a person's socialization into the discipline may affect whether the individual identifies predominantly with professorial culture or the culture of the academic discipline.

The American Association of Colleges of Nursing (AACN) is the national organization and lead accreditation body for baccalaureate nursing programs. As an accrediting organization, AACN emphasizes the importance of values education and presents a vision for nurse educators to integrate values into the philosophical base of

nursing. The seven essential values of the academic discipline of nursing faculty, which have been identified and are thought to be reflective of the behavior of professional nurses include altruism, equality, esthetics, freedom, human dignity, justice, and truth (AACN, 1986).

#### *Culture as Related to the Academic Professorate*

According to Tierney and Rhoades (1994), the academic professorate consists of faculty who share common values and beliefs, perform comparable work, and share a collegial identity with each other. Although faculty may represent very diverse disciplines, they generally identify with each other as colleagues belonging to the culture of the academic profession, sharing similar interests, values, and assumptions (Tierney & Rhoades). Therefore, professorial culture provides an overall general identity for all faculty, regardless of disciplinary association (Kuh & Whitt, 1988).

The American Association of University Professors (AAUP) is the professional organization most often identified with by the academic professorate. The mission of AAUP includes defining the values and standards for higher education in order to maintain quality education in America's colleges and universities. AAUP supports the "Statement on Professional Ethics," originally adopted in 1966 and revised in 1987, as a reflection of the values and standards expected of the academic professorate. The Statement on Professional Ethics includes responsibilities to students, colleagues, the institution, and the community. The standards focus on respect, honesty, confidentiality, objectivity, academic freedom, and self-discipline in the transmission of knowledge and the free pursuit of learning (AAUP, 2004).

#### *Transition from Clinical Practice to Academe*

Faculty in professional schools, such as nursing, hold a dominant presence in American institutions of higher education. Professional school faculty are in a unique and often conflicting position as they have a commitment to ensure academic standards, to create new knowledge, and to deliver client-oriented services, which include the transmission of vocational skills (Halpern, 1987). Additionally, individuals entering the academic community in applied professional fields, such as nursing, tend to do so later in their professional careers than faculty in other disciplines (Becher, 1989). Preference in recruitment to faculty positions in schools of nursing is commonly given to candidates who have had professional work experience, with recruitment almost entirely confined to practicing nurses, most whom have had no prior teaching experience (Becher, 1987).

The transition from clinical practitioner to faculty role requires experiences beyond the clinical setting and the academic education of nursing. According to Infante (1986), “becoming a nurse educator requires a change in knowledge, skills, behaviors, and values to prepare for the new assimilated roles, settings, and goals shared by new reference groups” (p. 94). This shift in behaviors, values, and goals can be viewed from a cultural perspective related to the perceived similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate.

#### *Statement of the Problem*

Based solely on the professional statements related to all three cultures, the basic values of justice, respect, confidentiality, and human dignity seem to be shared among the cultures of the nursing profession, the academic discipline of nursing, and the academic profession, even though a potential for conflict in roles has been reported in the literature

when nurses transition between professional positions. This potential for role conflict may be related to the perceptions and experiences of clinical nurses working in the profession of nursing compared to the perceptions and experiences faced by nurses as they transition into faculty positions. While justice, respect, confidentiality, and human dignity appear to be valued in the professional organizations of all three cultures, the way these values are manifest and played out and the norms that are based on those values, may vary between cultures.

According to Kuh & Whitt (1988), the underlying assumptions and beliefs that are shared by the members of a culture comprise the core component of that culture. Espoused values and beliefs are those that form an individual's identity within the culture (Peterson & Spencer, 1990). In nurses who transition from clinical practice to academe, differences may exist in how espoused and embedded values related to the socialization and cultural perspectives of the nursing profession, the academic discipline of nursing, and the professorate are enacted.

The perceptions and experiences of the professional culture from which a person comes into faculty life have not been well integrated into previous studies on academic culture, creating a theoretical hole in this area. Bledstein (1976) chronicled the historical aspects of the development of professional culture in America, but the more recent and well-cited works of Kuh & Whitt (1988) and Tierney & Rhoads (1994), which describe the culture present in American colleges and universities, do not focus on the individual faculty's "culture of origin" or the culture of the profession. Additionally, most nursing faculty come directly from a practice setting and have not been formally socialized into the academic discipline of nursing, much less the culture of the larger professorate,

evidenced by the lower percentage of nursing faculty with doctoral degrees compared to other academic disciplines (NCES, 2002).

While this issue of under-preparedness of nursing faculty as related to terminal degree attainment has been well substantiated in the literature (AACN, 2000, 2003; Hinshaw, 2001; NCES, 2002), the cultural variations between the nursing profession, the academic discipline of nursing, and the professorate have not been previously studied as related to transition to the faculty role. The experiences of nurses who transition between these varying cultures and the perception of what each role's cultural values represent and how the values are enacted may be quite different.

The perception of role conflict during transition between clinical nursing and the faculty role also has been reported in the literature but has not been empirically linked to the cultural perspectives of the differing roles of nurses. Previous studies have validated perceived role conflict in nursing faculty primarily related to workload (Crane-Roberts, 1998; Locasto & Kochanek, 1989; Sienty, 1988; Williams, 2000), job satisfaction (Cavenar, 1987; Esper, 1995; Fain, 1985; Johnston, 1988), and balancing the traditional faculty components of scholarship, teaching, service, and practice (Charron, 1985; Lambert & Lambert, 1993; Pappas, 1988; Rapson, 1980; Steele, 1988; Tolve, 1997; Wold, 1994) with little reference to the cultural aspects of the differing roles, including the effect of socialization experiences.

Studies on academic culture (Bess, 1978; Clark, 1984; Rusio, 1987) support the belief that faculty develop an identification with a specific academic discipline through the socialization process that occurs during graduate school. According to Ruscio (1987), socialization into the professorate comes after an "intense introduction into the world of

scholarship” (p. 359). Although faculty socialization as a cultural process has been well documented in the academic literature (Kuh & Whitt, 1988; Ruscio, 1987; Tierney & Rhodes, 1994), the role that socialization has on professional nurses as they transition into faculty positions in schools of nursing has not been studied.

The limited literature that specifically explores nurses’ socialization focuses primarily on the transition of nursing students into the nursing profession (Benner, 1984; Holland, 1993; Kramer, 1974; Perry, 1987; Shank & Weis, 1989). Research describing the concept of socialization during the continued growth of clinical nurses into academic roles, the path taken by most nursing faculty, is sparsely represented in the literature and tends to focus on role conflict issues related to workload (Forsbrey, 1995; Locasto & Kochanek, 1989; Mobily, 1991) and job satisfaction (Cavenar, 1987; Demarest, 1988; Fain, 1985; Johnston, 1988). It seems logical that the concept of professional socialization would influence nurses as they transition into a faculty role from a clinical nursing position; however a review of the literature shows that this issue has not been studied from a cultural framework. Consequently, prior socialization research has addressed role conflict issues in nurses and nursing faculty, without the exploration of the culture from which they came and whether cultural variations affect the transition of nurses into a faculty role.

Through the recent evolution of nursing education from apprenticeship training into institutions of higher education, the process of academic socialization of nurses to the faculty role of scholarship, teaching, and service has not kept pace with other academic disciplines that require a doctoral degree for beginning faculty positions (AACN, 2003; Berlin & Sechrist, 2002; Hinshaw, 2001). This lack of early socialization to the

academic discipline of nursing may be a factor in the potential for role conflict in novice nursing faculty who have been acculturated into the profession of nursing, rather than the academic discipline of nursing or the more general culture of the professorate.

The academic discipline of nursing is a subgroup of the overall academic professorate. Nurses who transition from clinical practice into faculty positions have been influenced by the experiences and values of the profession of nursing as they enter into the world of academe. Anecdotally, cultural differences between nurses in various roles have been recognized in the profession as a concern, however issues related to the culture of nurses who transition from clinical nursing into the academy have not been studied and presented in the literature. No prior research can be found that specifically explores the cultural variations within the nursing profession, the academic discipline of nursing, and the academic professorate that may influence the transition from clinical practice to academe.

#### *Purpose of the Study*

The purpose of this study was to identify and describe the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate as described by nurses who were transitioning from a clinical nursing role into a faculty role within a CON. Additionally, this study examined how cultural differences and similarities affected the transition of individual nurses into a faculty role from professional clinical practice. The focus of this study was not limited to an individual faculty member's current culture, but also explored the culture from which the nurse came.

#### *Research Questions*

The following research questions were examined in this study:

1. What are the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate as reported by individual nursing faculty?
2. How do cultural similarities and differences affect the transition of individual nurses from a clinical nursing role into a faculty role?

### *Significance of the Study*

The shortage of educationally-prepared nursing faculty is a growing and pressing issue across the nation that is interwoven with the current deficit of registered nurses (Hinshaw, 2001). Faculty shortages at nursing schools are contributing to the overall decline in new enrollments in nursing programs at a time when the need for nurses continues to grow (AACN, 2004; Anderson, 2002; Berlin & Sechrist, 2002; Hinshaw, 2001). According to a recent AACN report, nursing schools across the country cited faculty shortages as a key reason for refusing admission to over 5,000 qualified applicants in 2002 (AACN, 2003). Of the schools responding to the AACN survey, 62% reported an insufficient number of faculty as the reason for not accepting all qualified applicants into entry-level nursing programs.

Factors cited as contributing to the nursing faculty shortage include an aging faculty workforce with shortened retirement timelines and the departure from academia of younger nursing faculty. According to Berlin & Sechrist (2002), egression from academic life is the major reason for the loss of younger faculty members, resulting in an 18% decline of nursing faculty less than 45 years old between 1993 and 2002. The

current deficit of qualified nursing faculty has resulted in the inability of educational programs in nursing to meet the national demand for nurses, currently and in the future.

In examining nursing's past and the recent evolution of nursing education from the clinical arena into the academic setting (Anderson, 1981; Ruby, 1998), today's nursing education occurs within a formal academic structure. Unlike other health disciplines such as physical therapy, medicine, and pharmacy, which require a terminal degree for faculty positions, only half of all nursing faculty hold doctoral degrees (Anderson, 1994). Consequently, the nursing profession is experiencing a shortage of new faculty at the same time current faculty are building the level of doctoral preparation expected to fulfill the norms of other academic programs. An understanding of how cultural variations affect the transition of nurses into faculty roles is of special importance to higher education administrators due to the escalating shortage of nursing faculty throughout the country.

Culture has been identified as a key factor contributing to the effectiveness of institutions of higher education (Peterson & Spencer, 1990). An assessment of the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate among nurses who move into academe from the role of clinical nursing can assist higher education administrators in their support of new faculty during their transition from clinical practice into the faculty role. Additionally, an examination of the cultural influences of individual nurse's experiences during faculty role transition will lead to administrative strategies that will contribute to improving faculty recruitment and retention in colleges of nursing to potentially reduce the national shortage of nursing faculty.

### *Definition of Terms*

For the purposes of this study, the following definitions will be utilized:

#### *Academic Discipline*

“The unit of association in which faculty members spend large portions of their professional lives” (Ladd & Lipset, 1975, p. 56). Disciplinary associations are tied to the ideas, interests, norms, values, and professional styles of the group (Tierney & Rhodes, 1994).

#### *Beliefs*

Assumptions that influence the way a group of people think and behave. Beliefs guide a person’s behavior and determine the way reality is perceived (Kuh & Whitt, 1988).

#### *Culture*

“The collective, mutually shaping patterns of norms, values, practices, beliefs, and assumptions that guide the behavior of individuals and groups” (Kuh & Whitt, 1988, p. 13).

#### *Culture of the Academic Discipline*

“A reflection of the norms and assumptions of the profession for which the school provides preparation, with differences in the culture affecting the socialization, tasks, and behaviors of faculty members” (Becher, 1981, p. 24).

#### *Culture of Nursing*

“The learned and transmitted lifeways, values, symbols, patterns, and normative practices of members of the nursing profession” (Leininger, 1995, p. 208).

### *Culture of the Professorate*

A general identity shared by faculty that includes the basic values of dissemination of knowledge, autonomy, and collegiality (Kuh & Whitt, 1988).

### *Embedded Values*

Values held by members that often are unspoken and serve to guide the actions of members (Peterson & Spencer, 1990, p. 11).

### *Espoused Values*

Values that are openly communicated by members. Espoused values often present the organization in its “ideal, rather than actual, form” (Peterson & Spencer, 1990, p. 11).

### *Norms*

Unwritten rules reflecting the values of the group, which guide the behavior of group members (Kuh & Whitt, 1988).

### *Profession*

“A group of people who engage in similar types of work, share common values and beliefs, and derive a similar sense of identity from their work” (Tierney & Rhodes, 1994, p. 11).

### *Role Conflict*

“The result of two roles which occur simultaneously; in that compliance with one role makes compliance with the other role difficult.” “Role conflict is a consequence of the interaction between the characteristics of the person and the objective conditions of the role that person assumes” (Lambert & Lambert, 1993, p. 172).

### *Socialization*

The process through which individuals acquire, through implicit and explicit actions, the values, attitudes, norms, knowledge, and skills needed to exist in a given culture (Tierney & Rhoades, 1994).

### *Transition*

“The process during which novice faculty move from the role of initiate to full member of the academy” (Tierney & Rhodes, 1994, p. 40).

### *Values*

Widely held beliefs that serve to guide members’ responses to situations, provide meaning to social actions, and establish standards for social behavior (Kuh & Whitt, 1988).

### *Limitations and Delimitations*

Due to the qualitative nature of this study, the results presented by this research are not intended to be generalizable to all populations of nursing faculty. Therefore, the results of this study are not generalizable to nursing faculty at other colleges of nursing, nor are the results generalizable to other nursing faculty at the college where the research was conducted due to the specific criteria requirements for study participants. Additionally, the results of this study are limited because during qualitative interviewing, the potential exists for study participants not to answer all questions honestly.

Qualitative researchers select sites from which they can learn the most about the issues of importance to the purpose of the research (Glesne, 1999). The greatest potential for uncovering cultural variations exist in a baccalaureate setting due to the combined focus on scholarship, service, teaching, and practice in four-year universities compared to the

focus on teaching at two-year colleges. Therefore, this study was delimited to faculty who teach in a baccalaureate nursing program. Additionally, this study was delimited to nursing faculty, employed in a CON in a Midwestern university, who recently transitioned from clinical practice to a full-time faculty role.

### *Assumptions*

The data from this study were intended to provide a rich description of the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate as reported by individual nursing faculty. More specifically, this study provides insight into the effect of culture on individual nurses who transition from professional clinical practice into a faculty role.

Along with the already identified limitations and delimitations, the following assumptions guided this study. It was assumed that faculty participants would be truthful in their responses throughout the data collection process. Another assumption made in this study was that issues of role conflict existed in this population of nursing faculty and these issues warranted study from a cultural perspective. An additional assumption was that the role demands of the faculty chosen for this study were representative of the roles experienced by nursing faculty in other baccalaureate colleges of nursing.

### *Summary*

This chapter provided an introduction to the influence of culture on nurses who transition from a clinical nursing role into a faculty role. A background of the historical perspectives of nursing education, nursing faculty preparation, and culture as related to the nursing profession, the academic discipline of nursing, and the professorate was presented. The statement of the problem included a discussion of potential similarities

and differences that may exist between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate and how cultural variations may influence nursing faculty during their transition process. The purpose of the study and the research questions were presented along with a discussion of the study's significance in assisting with faculty recruitment and retention strategies for colleges of nursing. Finally, the limitations and assumptions of the study were discussed.

The remaining chapters provide a complete description of the study and a thorough report of the study's findings. Chapter two includes a review of the theoretical and empirical literature in the areas of professional culture, faculty culture, professorial culture, organizational culture, and socialization with an emphasis on the cultures of the nursing profession, the academic discipline of nursing, and the academic professorate.

Included in Chapter three is a description of the research design and rationale for the study, the data collection methods and study procedures, the research setting and participant selection, and the method used for data analysis. Also described are issues related to the role of the researcher, including ethics, rapport building, the researcher's biases, subjectivity, and experiences that prompted this research. Chapter three concludes with a discussion of how trustworthiness and validity were assured.

Chapter four provides a description and analysis of the qualitative data revealed in the study, through a focus on the research questions, which included: the similarities and differences between the cultures of the nursing profession, the academic discipline, and the academic professorate and the effect of culture on the transition of clinical nurses into a faculty role. Six overarching themes that emerged from the data are described within the context of the findings of the study.

The final chapter provides an overall summary of the study with a discussion of the major findings. Additionally, chapter five includes recommendations for policy and practice, suggestions for future research projects, and a discussion of the conclusions of the study.

## Chapter Two

### Review of the Literature

A review of the literature was conducted to uncover relevant research in the following areas: (a) professional culture, specifically the culture of the nursing profession, (b) faculty culture, including the subculture of the academic discipline of nursing and the overall culture of the academic professorate, (c) socialization, (d) organizational culture in higher education, and (e) adult transition theory. A selection of relevant empirical literature and theoretical concepts lending support to the proposed research questions and research design are presented.

The literature review includes emphasis in two primary areas, empirical studies and theoretical perspectives. Empirical studies reviewed in Chapter 2 focus on the culture of the nursing profession, the culture of the academic discipline of nursing, the culture of the academic professorate, and nursing socialization. The overall conceptual framework of each of these four areas is presented in the introductory section of each discussion.

Following the review of the conceptual framework and presentation of the empirical research related to this study, a review of organizational culture in higher education and the theoretical perspectives of the transitioning process are discussed. This review of the related empirical and theoretical research provided a framework for the investigation of the influence of culture on transitioning nursing faculty.

### *Culture of the Nursing Profession*

A review of the literature was conducted to uncover the shared values, beliefs, practices, and assumptions of the nursing profession. Discovering the values, beliefs, and assumptions of the nursing profession led to a better understanding of what comprised the culture of nursing. According to Kuh and Whitt (1988), culture is based on the shared values and beliefs of its members. Values are standards for action that are adopted by the profession and provide the framework for evaluating the beliefs and attitudes that influence behavior. The development of professional nursing values is an important part of the socialization of nurses (Weis, Schank, Eddy, & Elfrink 1993).

Conceptually, culture in relation to nursing values can be traced back to the original writings of Florence Nightingale. Nightingale (1859) wrote about what she believed should be central to all nurses; that nurses should be of good character, that nurses should be obedient beyond question, and that nursing should be a spiritual calling from within. The standards of goodness described by Nightingale represent the moral aspect of nursing's culture, which can be viewed as initial core values in the nursing profession. Although Nightingale did not use the term culture in these very early works, her principles formed the basic foundation for nursing practice and are reflected as the beginning of the culture of nursing.

Reference to nursing as a specific culture first occurred during the late 1960s, through the works of Madeline Leininger. Leininger (1967, 1968), a nurse anthropologist, was the first to describe nursing as a unique culture with identifiable norms, values, and beliefs. Prior to Leininger's first article published in 1967, there had been no depiction of nursing as a culture with her early work forming the basis for the study of the culture of

nursing. Additional research specifically related to the culture of nursing in the years following Leininger's preliminary writings is markedly limited in the literature.

Leininger described caring as the "heart of nursing," and that caring can be a "powerful means for healing and promoting healthy life ways" (Leininger, 1986, p. 3). Additionally, Leininger defined common values present in nursing culture including, valuing independence, autonomy, self-reliance, dependence upon high technology, and the empowerment of women (Leininger, 1995). Leininger stressed the fact that nursing as a culture is not a static notion and that culture changes over time. One of the primary changes noted in the values of nursing from the early era of the 1940s to recent years, is the value of caring for patients through interpersonal skills and commitment has shifted to reliance on high technological skills and efficiency (Leininger, 1995).

Leininger's background in anthropology and qualitative research is strongly reflected in her writings. She defined the culture of nursing as "the learned and transmitted lifeways, values, symbols, patterns, and normative practices of members of the nursing profession" (Leininger, 1995, p. 208). In her theory of nursing culture, Leininger described nursing as having two types of features, ideal and manifest, that are transmitted to others. Leininger defined ideal cultural features as "attributes that are most desired, preferred, or the wished for values and norms of a group" (p. 209). She defined manifest culture as "what actually exists and is identifiable in the day-to-day world as patterns, values, lifestyle, and expressions" (p. 209). Similar to classic anthropological and sociological descriptions of culture (Herskovits, 1955; Mead, 1955), Leininger described how differences existed between the ideal and manifest culture of nursing. Additionally, Leininger discussed differences in the emic patterns (i.e., inside expressions of culture

known by members) and etic patterns (i.e., outsiders understanding) specific to the culture of nursing.

Leininger's (1970) original intent in describing a culture specific to nursing was to help nurses discover and understand the primary norms, values, and beliefs of professional nursing. Leininger hoped that an understanding of nursing culture would advance the knowledge and practice of nursing and help nurses achieve a personal sense of identity as a professional discipline. Throughout the 1970s and 1980s, Leininger continued her exploration of nursing culture with the development of the Cultural Care Diversity and Universality Theory of Nursing. This theory has been used to guide the development of nursing knowledge through the idea that nursing has a unique culture with the concept of caring being the primary value of nursing. Leininger described caring as being the most important value in nursing that reflects the "essence of nursing" (Leininger, 1986, p. 2). The consistent theme in Leininger's work was caring as the central, dominant, and unifying value of professional nursing practice.

In addition to Leininger's Cultural Care Diversity and Universality Theory of Nursing, values identified to be specific to nursing practice have been formally identified by the ANA (1985, 2001), the professional organization for nurses. ANA's Code of Ethics for Nurses has been used to form the basis for the standards by which professional nurses practice. The Code of Ethics for Nurses serves as the public document of the official organization for nursing that declares how nurses view the nursing profession, both individually and collectively as profession.

The fundamental values of nurses are found in the first three provisions of the code. These values include nurses' respect for human dignity, nurses' primary commitment to

the patient, and nurses' protection of patient privacy. Of particular interest is that the concept of caring is not specifically outlined in ANA's Code of Ethics for Nurses, although it could be assumed to be reflected in the value of respect for human dignity.

Leininger addressed the apparent resistance of the nursing profession to regard caring as a key value in a 1985 article; *Care Facilitation and Resistance Factors in the Culture of Nursing*. In the article, Leininger stated that many nurses do not embrace caring as a professional value because the notion of caring often invokes a feminine, negative, and powerless image. An additional factor related to caring resistance as a professional nursing value involved the increasing need for technological competency among nurses. Also Leininger proposed that providing services to patients focused on caring did not increase cost efficiency or cost containment, which is a necessity in a competitive health care environment. These basic themes continue to be reflected in the current nursing literature, although the focus on caring as a nursing value has received increased attention in professional nursing since these early writings of Leininger.

Another conceptual issue related to the culture of nursing includes the comparison of values, beliefs, and assumptions of nurses who identify with differing subcultures of nursing. In a classic article published in 1970, Leininger proposed that cultural variations exist among nursing subgroups within the overall culture of nursing. Leininger identified a subculture of nursing as "nurses who show distinctive values and lifeways that differ from the dominant or mainstream culture of nursing" (p. 208). She referred to these nursing subcultures as the "tribes of nursing" and identified four major tribes that appear in four different geographical regions of the United States. Consistent with the anthropological perspective on culture, Leininger (1994) defined a nursing "tribe" as a

large number of nurses who “claim common group identify, are generally loosely organized, but remain as an identifiable large group with shared values and beliefs” (Leininger, 1994, p. 20). According to Leininger (1995), all of these subcultures share some common values and practices of the overall American nursing culture, particularly with respect to autonomy, professionalism, self-reliance, empowerment, and a desire for power.

The final conceptual issue that is important to consider when discussing the culture of nursing is how cultural norms are transmitted to group members. According to Kuh and Whitt (1988), the existence of a cultural group is dependent on ensuring that the knowledge gained by its members is transferred to new members. Transformed culture is creative, not stagnant. While aspects of culture persist across generations, culture is continually changing as members bring their own understanding and interpretation of the cultural norms and expectations over time (Trice & Beyer, 1993).

The process in which the culture of nursing is transmitted to new nurses is primarily accomplished during nursing student’s experiences in schools of nursing and during clinical experiences obtained in institutional settings. Benner (1984), in her seminal book *From Novice to Expert*, described the process of how the professional knowledge and culture of nursing is learned during the socialization process of nurses, first in schools of nursing and later through stages of learning as a nurse’s expertise evolves during his or her professional practice.

#### *Empirical Studies Related to the Culture of Nursing*

Several empirical studies were found that supported Leininger’s theory of nursing culture as well as lending additional support to the value of caring in nursing. Most of

the nursing research discovered during an extensive review of the literature focused on the following: (a) professional nursing values, specifically the value of caring, (b) the transmission of professional values to students and graduate nurses through rituals and traditions, and (c) the existence of subcultures in nursing. Although these individual studies examined aspects of nursing culture, which led to a better understanding of nursing culture (i.e., values, beliefs, and rituals associated with nursing), none of the empirical studies were conducted within a cultural framework.

*Culture and caring.* In a study of caring behaviors in nurses, Condon (1987) presented a phenomenological analysis of the experience of caring in nurse-client interactions. Condon identified four themes that described the meaning of the experience of caring in a nurse-client interaction from the perspective of the nurse, including: (a) the client's existential presence, (b) the nurse-client encounter, (c) the nurse's availability, and (d) consequences for the nurse and client.

Although Condon's original research did not focus specifically on nursing culture, additional work by Condon (1987) explored the evolution of the culture of nursing as related to the values described by nurses in her phenomenological study. Condon described the culture of nursing as having two distinct aspects, moral and scientific. The moral aspect of nursing culture represents the values, beliefs, and assumptions inherent in the profession of nursing, while the scientific aspect of nursing culture is the knowledge and skills that define nursing.

Condon (1987) also proposed that the continuing evolution of the culture of nursing is influenced by the larger societal culture, which was also described by Leininger. Condon stated that the concept of caring has had significant impact on the development of

nursing's culture and is a fundamental, but frequently "unacknowledged moral foundation of nursing" (p. 27). Additional studies by Cooper (1988) and Noddings (1984) described caring as a value fundamental to nursing, although only Condon focuses on the connection of caring to the foundational culture of nursing. These studies provided additional support to the concept of caring as being an important value in the culture of professional nursing even though caring is not listed as a standard for nursing practice in ANA's Code for Nurses.

*Rituals.* Rituals can be defined as patterned symbolic actions that reflect the values and beliefs of a group (Wolf, 1988). Rituals help transmit important values to the culture's members and describe and shape cultural patterns (Kuh & Whitt, 1988). Several studies were found that focused on rituals unique to nurses from a cultural perspective.

In a 1996 ethnographic study of rituals in nursing, Strange described nurses as a cultural group that is defined by unique rituals and behaviors, with the process of ritualization occurring through interactions with colleagues, educators, and mentors. Strange also identified language as part of nursing's culture and concluded that language unique to nurses is used to strengthen transference of nursing knowledge among members.

Silberger (1998) provided a historical review of the development of rituals within the culture of nursing. Silberger traced the development of rituals in nursing back to the 19<sup>th</sup> century with the wearing of a uniform as the first ritual identifying a person as a nurse. The ritual of wearing a uniform became a symbol of the profession associated with sincerity and caring. Silberger described how the transformation of nursing's culture

over time has moved from a weak, and subordinate behavior pattern, to a stronger, autonomous, educated discipline. She concluded that rituals define part of the culture of nursing, which strengthens the profession.

An ethnographic study of nursing culture and rituals by Holland (1993) also clearly identified nursing as a cultural group with a distinct pattern of behaviors and socialization of new members. The central focus of the culture of nursing, described by Holland, was the provision of care to the sick, which was carried out through rituals specific to nursing, including (a) asking about patient's well-being, (b) participating in end of shift report, and (c) putting on the uniform. Holland described nursing rituals as being embedded within the hierarchy of the hospital system.

According to Holland, nursing and its cultural system developed alongside that of medicine, and both medicine and hospital culture greatly influenced nursing's values, beliefs, and practices. Leininger (1995) and Silberger (1998) also discussed the interrelatedness of medicine, nursing, and hospital culture, particularly related to the affect of hospital organizational culture (i.e., institutional policies) on nursing practice.

*Professional values and beliefs.* Several studies were found that identified common values in nursing and the process of socialization of nurses new to the profession. In a study of senior undergraduate nursing students, Heiderken (1970) compared the values of students who wanted to pursue a teaching career in nursing with those who intended to pursue a career in clinical nursing practice. In the study, two instruments were used to assess the work motivation of the students and to measure work values specific to teaching and clinical practice. Data were collected from both undergraduate and graduate students in nursing to determine if the general work values of students preferring a

teaching career differed from the work values of students preferring advanced clinical practice.

An interesting conclusion of Heiderken's (1970) study was that student nurses who preferred a future teaching career had different values than those who preferred a future career in clinical practice. Of particular note was that students who preferred clinical practice as a career valued altruism significantly higher than students preferring a teaching career in nursing. Although this study was one of the first to look at differences in values between potential nursing faculty and potential clinical nurses, a major limitation of this study was that these were students who had not yet assumed the role of either faculty or clinical practice. Heiderken's study provided foundational support for later research by Perry (1987), Schank and Weis (1989), Elfrink and Lutz (1991), and Weis, Schank, Eddy, and Elfrink (1993) that focused on how students learn the values of the profession through their nursing school experiences.

A historical review by Partridge (1978) examined the evolution of nursing's values within society. She echoed the thoughts of Leininger (1978), Holland (1993), and Silberger (1998) of the strong influence that medicine and hospital cultures have had on nursing values. Of particular interest, Partridge stated that the values nurses convey through their behavior are often not aligned with values believed to be important by others, including those of student nurses, employers, and patients. She made a particularly poignant reference to the fact that the value of human kindness, which many believe should be inherent to nursing's culture, is absent in nurses' relationships with each other and in their professional activities.

In a qualitative study of graduate nurses, Perry (1987) described nursing culture as being formed from elements of the personal and professional attributes of the individual nurses. Perry also discussed how the values, beliefs, and practices of nursing are passed on to nursing students during their classroom and clinical experiences. Perry pointed out the existence of conflicting values between what students learn from the academic setting and what they gain from the practice arena. This finding may lay the foundation for differences in the way nursing values are espoused and enacted in clinical settings versus academic settings. Of particular interest in Perry's study was the discrepancy between the formal overt messages and the informal covert messages that new graduate nurses received, which she concluded might be dominant throughout a nurse's education and clinical experiences.

Several studies focused on the professional values of nursing as outlined in ANA's Code of Ethics for Nurses. In an interesting quantitative study of 117 practicing clinical nurses, Shank and Weis (1990) discovered that only 50% of the respondents were familiar with the ANA Code of Ethics for Nurses as the professional values statement. This lended support to the idea that professional statements may have little relationship as a reflection of values or as a direction of values shared by nurses.

In another quantitative study by Schank and Weis (1989), values inherent in the ANA Code of Ethics for Nurses was compared to the actual values held by graduate nurses. The study revealed that values dealing with professional issues (e.g., respect for individuals and accountability) were more frequently identified as being important to nurses than values focusing on social issues (e.g., maintaining the health needs of the public). The findings of this study indicated that values identified most frequently by

clinical nurses related to patient care issues rather than social issues of the profession, although many practicing nurses were unfamiliar with the professional code of ethics for nursing. This finding also supported that the perception of an overall consensus of values among nurses may not exist.

A qualitative study by Schank, Weis, and Ancona (1996), examined how the values articulated in the ANA Code for Nurses were reflected in the institutional philosophy of nursing, as described during interviews with nursing administrators in 10 healthcare institutions. An interesting finding of this study was that a major influence on the personal nursing values held by the administrators related to the nursing experiences administrators had during their professional career. This finding lends support to the notion that prior professional experiences may affect the values and beliefs of individual nurses, which related to this study of the influence of nursing culture on transitioning nurses.

*Subcultures of nursing.* Several studies were uncovered that explored differences in values between various subcultures of nursing, which were first identified by Leininger in 1970. A quantitative study by Ulrich (1987) examined differences in work values of practicing nurse administrators and graduate educators in nursing administration programs. Ulrich's premise was that different groups adopt symbols, meanings, and values as their own and then transmit these symbols, meanings, and values to individuals aspiring to join the culture of that group. Ulrich's study used an inventory to measure the value intensity that participants placed on 11 work value constructs, including altruism, object orientation, security, control, self-realization, independence, money, task satisfaction, solitude, data orientation, and prestige.

Ulrich's (1987) findings demonstrated that significant differences existed in the values of practicing nurse executives and those of nursing educators in nursing administration programs. The study reported that nurse executives valued the control construct more than nurse educators. The control construct described the value nurses place on having an opportunity to take a leadership role and to be responsible for the work performance of others. In contrast, nurse educators valued solitude (i.e., the value nurses placed on the absence of close relationships) more than the nurse executives. Ulrich concluded that conflicts arise in nurses who are socialized by a subculture whose values are different from the subculture they wish to join. Ulrich's study clearly supported the research question for this study examining the influence of culture on nurses who transition into different roles. While Ulrich's study did not specifically look at nursing faculty transition, it did explore issues related to transition with an examination of the difference in values between nurses in differing roles.

Two additional studies reflect differences in various nursing subcultures. In a doctoral dissertation by Horton (1998), nurse anesthetists were examined as a subculture of nursing and tensions between nurse anesthetists and anesthesiologists were identified as having a major influence on the cultural development of nurse anesthetists. Additionally, an ethnographic study by Owensby (1997) described the subculture of nurses working in long-term care facilities and the effect of institutional culture on staff turnover and interpersonal relationships between nursing staff.

In conclusion, all the empirical nursing studies presented were supportive of the existence of a culture of nursing even though research specific to the culture of nursing beyond Leininger's work remains limited. The review of the nursing literature related to

the culture of nursing indicated that although there is a unique and shared overall culture of nursing, differences exist between nursing subcultures that may reflect different values and beliefs from the dominant nursing culture. According to Leininger (1995), nurses may experience cultural shock when they realize that their own norms and values differ from other nurses who belong to a different subculture of nursing. Nurses also may face culturally related conflicts in their role as they assume employment in the various subcultures of nursing. Leininger stated that nurses who understand that differences in norms, values, and beliefs exist within the nursing profession may be able to experience a significant increase in their job satisfaction and professional goals and achievements, which added further support for the need for this study.

#### *Faculty Culture*

According to Kuh and Whitt (1988), faculty comprise a subculture within the overall organizational culture of higher education institutions. The culture of the academic professorate can be envisioned as the umbrella under which the culture of the academic discipline resides. Therefore, the academic discipline can be seen as a subculture of the overall professorial culture, each having distinct values, norms, and beliefs.

Snow (1959) originally presented the idea of a discipline as a cultural entity in higher education in his book, *The Two Cultures and the Scientific Revolution*. Snow's book was a breakthrough in the development of cultural understanding in higher education because it encouraged further discovery into the idea of cultural entities or subcultures in higher education research. Theoretical perspectives and empirical studies pertaining to both the academic discipline of nursing and the overall academic professorate are reviewed in the following section.

*Culture of the Academic Discipline of Nursing*

A review of the academic literature revealed extensive theoretical research related to academic disciplines in general. The literature supported the concept of disciplinary subcultures with faculty in various disciplines exhibiting diverse values, beliefs, and attitudes that are related to the subculture of the discipline (Becher, 1981, 1987, 1989; Bowen & Schuster, 1986; Ruscio, 1987).

In several frequently cited articles, Becher (1981, 1987, 1989) described academic disciplines through a structural framework, classifying higher education disciplines based on the characteristics of their unifying features, cultural correlates, and process of socialization into the culture of the discipline. Becher reported that variations in disciplinary culture reflected differences in the nature of knowledge within the disciplines. Additionally, Becher asserted that the overall academic profession is characterized more by similarities than by differences, although he stated that differences within the profession have a greater influence on academic life than similarities among faculty. Even though Becher's studies are not specific to the academic discipline of nursing, his work suggested that cultural similarities and differences among nurses would influence the socialization and transition of nurses into the faculty role.

Ruscio (1987) described the role taken on by individuals in the academy as a function of the overall institution and of the discipline as well. According to Ruscio, both the institution and the discipline link the faculty to the academic profession. In accord with Becher, Ruscio described disciplinary culture as an individual component of the academic profession.

Ruscio (1987) reported that disciplinary cultures are affected by the differences in the missions of varying types of institutions. For example, disciplinary culture in a community college will be different from the disciplinary culture found in a research university because the overall missions of the schools differ significantly. Consequently, differing missions between institutions affect the socialization and transition process of faculty members.

In contrast to the abundance of academic literature related to disciplinary culture, limited research was found that focused on the specific academic discipline of nursing from a cultural perspective, with nearly all of the research uncovered focusing primarily on the integration of professional nursing values into nursing program curriculum. AACN, the national organization overseeing the accreditation of most baccalaureate and graduate nursing programs in the country, demonstrated the importance of values and values education in baccalaureate nursing programs with the publication of the Essentials of College and University Education for Professional Nursing document (AACN, 1986). In this publication, AACN identified the primary values that the organization believes should be integrated in baccalaureate nursing programs.

The seven essential values for nursing education identified by AACN are altruism, equality, esthetics, freedom, human dignity, justice, and truth. Empirical studies related to the AACN values in baccalaureate nursing programs are reviewed in the ensuing section as well as research related to overall values identified by nursing students and nursing faculty.

AACN is credited with being the first national organization to define competencies of baccalaureate nursing graduates in relationship to values and recommended that programs

preparing nurses include learning opportunities related to seven values. As was noted in the previous literature related to professional values for the nursing profession, an organization's professional statements may have little relationship to the actual values inherent in programs of nursing and an overall consensus of values among nursing faculty may not exist.

*Empirical Studies Related to the Culture of the Academic Discipline of Nursing*

In the single study found that related specifically to the academic discipline of nursing, Donaldson and Crowley (1978) examined the distinction between academic disciplines and professional disciplines and described the similarities and differences related to research and theory in each. Academic disciplines included the sciences (e.g., physics, physiology, sociology) and liberal arts (e.g., math, history, philosophy) with theories that are descriptive in nature. In contrast, professional disciplines (e.g., law, medicine, nursing) were defined as being practice oriented, generating both prescriptive and descriptive theories.

An interesting conclusion presented by Donaldson and Crowley's (1978) research was that professional disciplines should be viewed as "emerging along with, rather than from academic disciplines" (p. 116). In this study, Donaldson and Crowley described values that were intrinsic to professional nursing as having shaped the value orientation of the academic discipline of nursing. These values of professional nursing included: (a) humanitarian service, (b) preserving the self-respect and self-determination of clients, and (c) fostering self-care behavior leading to individual health and well-being. Inherent in Donaldson and Crowley's work is the distinction made between the theories and research characteristics of academic disciplines and professional disciplines. Donaldson and

Crowley's work established an initial inquiry into the possibility that differences exist between professional nursing values and the values of the academic discipline of nursing, although this can only be inferred from their writings.

In contrast to the limited research pertaining to the academic discipline of nursing, empirical studies related to overall values held by nursing students at various points throughout the educational process and shortly after graduation are well represented in the nursing literature. Early studies conducted by Blair (1972), Kramer (1974), and Williams, Bloch, and Blair (1978) examined values of nursing students and found that values held by students from time of entry into a nursing program often change by the time of program completion.

In a study of undergraduate nursing students in three nursing programs, Blair (1972) found significant increases in the valuing of support, independence, and achievement in students from the time of program admission to graduation. Additionally, Blair reported a decrease in graduate nurse's values of conformity, benevolence, and orderliness as compared to the same student's values at the time of entry into the nursing program.

A study by Williams et al. (1978) demonstrated results similar to those reported in Blair's study (1972). In the Williams et al. study, values of students entering a nursing program were compared to values revealed as the same students completed the first year of academic study. Williams et al. revealed that nursing students demonstrated significant increases in the values of support, recognition, and independence and significant decreases in the values of benevolence, conformity, and practical mindedness at the completion of the first year of being in the nursing program. This study not only supports the conclusions offered by Blair, it also suggests that student's values change

early in their nursing education. Of additional interest is that these initial studies of nursing student values presented a potential relationship between student nurse's values and the processes of socialization during transition to both a nursing student role as well as a professional nursing role, even though this relationship was not demonstrated empirically in any of these early studies on student culture (Blair, 1972; Kramer, 1974; Williams et al., 1978).

These initial studies of nursing students lay the foundation for the existence of explicit and often changing values as students progress through programs of nursing. Subsequent research on values in nursing focused primarily on the comparison of values identified as critical to nursing education by AACN, to values identified by faculty and students in baccalaureate nursing programs.

A study by Thurston, Flood, Shupe, and Gerald (1989) was one of the first to look at nursing student and faculty values compared to the baccalaureate nursing values identified by AACN. In a descriptive study of students and faculty, Thurston et al. examined both professional and personal values of 54 faculty and personal values of 351 students at a large Midwestern School of Nursing. The dual purpose of Thurston et al.'s study was (a) to determine evidence of faculty commitment to the seven professional values described by AACN, and (b) to compare the personal values held by nursing faculty and nursing students within the School of Nursing. Study results demonstrated that of the seven AACN professional values, faculty showed greatest commitment to the value of human dignity. This suggested that the value of human dignity is of primary importance to nursing faculty. In relation to personal values held by nursing faculty and students, results revealed that nursing students were more like the faculty who teach them

in terms of personal values held, with the values of being responsible, honest, and loving, the most frequently held values cited by both faculty and students.

In comparison to the findings of Thurstan et al. (1989), a 1994 study of the values of 656 nursing students and 350 nursing faculty in 26 baccalaureate nursing programs revealed that professional values of students and faculty differ significantly (Eddy, Elfrink, Weis, & Schank, 1994). Nursing faculty, particularly those faculty with more years of teaching experience, rated the values of equality, dignity, and freedom higher than students, while students rated the value of esthetics higher than faculty. Differences noted in the results of these two studies may be related to the significantly larger sample of Eddy et al. Additionally, Thurstan et al.'s study examined the personal values of nursing students and faculty, while Eddy et al.'s research focused on professional values of nursing students and faculty. The findings presented by Thurstan et al. and Eddy et al. suggest that personal and professional values of nursing students and nursing faculty are more different than similar, although this was not empirically presented in the literature.

In a related study, Elfrink and Lutz (1991) surveyed 697 nursing faculty in baccalaureate schools of nursing across the country about their perceptions of educational practices related to the seven AACN values. The result of Elfrink and Lutz's study indicated that the majority of nursing faculty were in agreement that the AACN values were representative of values needed by nurses in clinical practice. The faculty respondents also supported the need for integration of AACN's values into baccalaureate nursing curriculum.

A subsequent study by Weis, Schank, Eddy, and Elfrink (1993) compared program objectives in 26 baccalaureate nursing programs with professional nursing behaviors that

were reflective of the seven AACN values. Findings of Weis et al.'s research indicated that most of the professional values of AACN were found in the program objectives of the majority of the nursing programs surveyed. However, two AACN values, truth and esthetics, were identified in only a small number of the nursing programs surveyed. Interestingly, faculty respondents in Thurston et al. (1989) also ranked commitment to esthetics as being less important than other AACN values, in contrast with student nurses in Eddy et al.'s (1994) study who valued esthetics higher than faculty did at the time of the research.

The results of studies by Thurstan et al (1989), Eddy et al. (1994), Elfrink and Lutz (1991), and Weis et al. (1993) demonstrated that through self-report, nursing faculty appear to be in agreement that the key values identified by AACN should be included as essential components of baccalaureate nursing curricula, although many of the baccalaureate nursing programs surveyed reported minimal evidence that the values of truth and esthetics are actually included in current program objectives. The findings are consistent with previous studies in which esthetics was the most frequently omitted value in nursing education programs with many nursing faculty rating the value of esthetics as less important than the other AACN values, even though research has shown that student nurses tend to value esthetics higher than faculty. Additionally, the findings of these studies indicated that differences existed between values that nursing faculty espoused to be important and values nursing faculty actually included in the design of their courses, which is important to the focus of this study on espoused and embedded values in newly transitioning nursing faculty.

Of interest related to the design of this study, is that the studies cited above (Eddy et al., 1994; Elfrink & Lutz, 1991; Thurstan et al., 1989; Weis et al., 1993) were all conducted within a quantitative methodology (e.g., self-reported survey research). The qualitative research methods used in this research study revealed not only espoused values, but this study also reported embedded values present in each of the three cultures. While espoused values would be identified through self-reported survey research, the embedded values revealed in this study would not be discovered through quantitative methodology alone.

The information uncovered in these empirical studies of nursing values provided the foundation for the exploration of values between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate. Differences in personal and professional values between students during their educational experience and nursing faculty may influence nurses as they transition from clinical practice into faculty roles.

#### *Culture of the Academic Professorate*

A review of the academic culture literature revealed much discussion surrounding the existence of an overall academic culture among the professorate across disciplines and institutions. From the review of the literature, substantial agreement was found to support the existence of several values held by most faculty (Bowen & Schuster, 1986; Clark, 1987; Kuh & Whitt, 1988; Morrill & Spees, 1982; Ruscio, 1987). These key values were interpreted as foundational to those shared by the members of the professorate, which would in turn reflect the culture of the professorate.

Frequently cited in the academic literature on professorial culture are the works of Clark (1984, 1987, 2001) which described the key ideologies of the professorate as being three broad values embraced by most academics. Clark's results were based on a qualitative research design that focused primarily on interviews with 170 faculty members from 6 fields of study in 6 institutional types. Disciplines represented by Clark's participants included, physics, biology, political science, English, business, and medicine. The institutions in which faculty worked ranged from public and private research universities to community colleges. Interview questions focused on the nature of faculty work, faculty involvement in the disciplines and institutions, beliefs faculty held about their profession, faculty forms of authority and sense of power, faculty career patterns and opportunities, and faculty participation in organizations outside their schools. In addition to the interviews, participant observations and document analysis were also conducted.

The results of Clark's (1987) study revealed three prevailing ideologies identified throughout the professorate. The first ideology of the professorate related to "the service of knowledge" (p. 130). Creating knowledge and transmitting it to students was the most common ideological theme expressed among academic professors. Clark ascertained that knowledge loses its value when handled dishonestly; therefore academic honesty was identified as an additional key ideology of the professorate. The third ideology shared by professors is professional autonomy, which included the notion of academic freedom. Organized structures in the academy, including the process of tenure and peer review, were developed by the professorate to assure that autonomy and academic freedom were protected.

Along with Clark's views of shared values and beliefs among faculty, the idea of a faculty culture existing across disciplines and institutional types was further supported by Bowen and Schuster (1986) and Austin and Gamson (1983). Bowen and Schuster interviewed 532 faculty members and administrators at 38 campuses and noted similar shared faculty values to those reported by Clark (1987) including, dissemination of knowledge, autonomy, and collegiality. Austin and Gamson (1983) also revealed that the values of dissemination of knowledge, autonomy, and collegiality were a part of professorial identity. Furthermore, Austin and Gamson's research demonstrated that intrinsic factors of autonomy and academic freedom were more important to faculty than extrinsic factors related to workload or promotion and tenure structures.

As was cited in the literature surrounding the culture of the nursing profession and the culture of the academic discipline, professorial culture is not stagnant; it changes over time as the attitudes, values, and behaviors of people moving in and out of the institution reflect the values, assumptions, and beliefs inherent in the professorate (Kuh & Whitt, 1988; Manning, 1993).

Similar to the professional statements issued by ANA and AACN, AAUP, the primary professional organization for the professorate, defined the fundamental values for higher education in a Statement on Professional Ethics originally adopted in 1966 as Association policy, and revised in 1987 (AAUP, 2004). The Statement was approved by the Association's Committee on Professional Ethics and adopted by the Association's Council in 1987. AAUP is the professional organization most often identified by members of the academic professorate in higher education institutions across the country.

AAUP described the Statement on Professional Ethics as providing guidance to professors in their responsibilities to students, colleagues, the institution, and the overall community. The Statement on Professional Ethics included values of respect, honesty, confidentiality, objectivity, academic freedom, and self-discipline in the transmission of knowledge and the free pursuit of learning. These values were consistent with the values identified by Clark (1987), Bowen and Schuster (1986), Austin and Gamson (1983), and Kuh & Whitt (1988) as being commonly held by faculty within the overall professorate, regardless of academic discipline.

Another element of overall professorial culture related to the type of institution at which faculty are employed. Boyer (1997) reported that scholarship in the form of research, publications, and grant writing is emphasized more than teaching as the key method for knowledge dissemination at research institutions, whereby community colleges focus on teaching effectiveness as the primary consideration in promotion and tenure issues. Therefore, faculty will often seek employment at institutions with cultures that match his or her own professional values and beliefs (Boyer; Kuh, 1993; Kuh & Whitt, 1988).

Tierny (1999) also discussed how institutional culture impacted faculty expectations and resultant productivity. Tierny and Rhodes (1994), examined the relationship between faculty productivity and overall academic culture and stated that although faculty are associated with varying institutional types and varying disciplines, they share common values and beliefs and have an overall professional identity as colleagues in the academic professorate.

In summation, two perspectives on faculty culture have been identified in this section of the literature review: (a) the existence of an overall professorial culture having shared values, which include knowledge dissemination, academic honesty, and professional autonomy among members, and (b) the existence of a subculture made up of academic disciplines, whose members exhibit shared values and beliefs unique to the discipline. Although a consensus of values among the entire professorate may not necessarily exist, the literature supported the presence of commonalities in values among faculty in institutions of higher education. Because of the lack of literature specifically focused on the academic discipline of nursing framed from a cultural perspective, an examination of the similarities and differences in the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate and an exploration into the influence of culture on nurses who are transitioning from clinical practice into a faculty role was warranted.

### *Socialization*

#### *Socialization in Institutions of Higher Education*

A preponderance of literature exists on socialization within institutions of higher education, including the frequently cited works of Tierney (1993), Tierney and Rhodes (1994), and Tierney and Bensimon (1996). According to Tierney and Rhoades (1994), socialization is a “ritualized process that involves the transmission of culture” (pg. 21). During the process of socialization, individuals come together, defining the beliefs and values common to the group and are then enmeshed within the culture of the institution (Tierney & Bensimon, 1996).

Kuh and Whitt (1988) define socialization as “the acquisition of values, knowledge, attitudes, skills, and expectations appropriate to a particular culture” (pg. 37). A common theme noted throughout the academic literature is the close relationship between culture and the socialization process of faculty (Van Maanen, 1984; Van Maanen & Schein, 1979) although the importance of an individual’s prior professional culture on the socialization experience has been less represented in the existing academic research. The primary focus on the socialization process in academe appears related to socialization that occurs during graduate school (Bess, 1978; Corcoran & Clark, 1984; Freedman, 1979; Tierney & Rhodes, 1994) and the process of faculty socialization during the promotion and tenure years (Tierney & Bensimon, 1996).

Tierney and Rhodes (1994) depicted faculty socialization as a process consisting of two unique stages, anticipatory and organizational. Anticipatory socialization occurs before an individual assumes a faculty role. According to Tierney and Rhodes, much of the anticipatory socialization of future faculty occurs during a person’s graduate school experience. The stage of anticipatory socialization is the time when students begin to adopt the values, beliefs, and norms of both their individual discipline and the overall professorate. This is of particular importance to note because the majority of nursing faculty pursue their doctoral degree on a part-time basis while maintaining full-time employment in nursing (AACN, 2003). This part-time graduate school experience does not promote the same degree of socialization that occurs during full-time graduate studies undertaken by individuals in many other academic disciplines. As a result, this limited anticipatory socialization stage experienced by nurses pursuing graduate study may

influence the overall socialization process of clinical nurses during transition into a faculty role.

The second stage of faculty socialization portrayed by Tierney and Rhoades (1994), organizational socialization, involves the phase of initial entry into the institution followed by a second phase of role continuance. The initial entry phase includes all interactions occurring with potential faculty before assuming the faculty role and immediately after beginning employment at the institution. The role continuance phase begins after an individual assumes a faculty position and includes the process of both formal and informal socialization occurring throughout the faculty's promotion and tenure years.

Although socialization primarily occurs when new members enter the faculty ranks, it is frequently described as an ongoing event that takes place during the entire faculty experience, including the promotion and tenure years (Tierney and Bensimon, 1996; Van Maanen, 1984). Tierney and Bensimon described the process of obtaining tenure as the key socialization method for new faculty, with tenure being the cultural process used to familiarize new faculty to the institution's values and beliefs. Van Maanen described the "chains of socialization" as shaping an individual's expectations and assumptions about higher education and portrays graduate school experiences and transitioning to a faculty role as "links" in the chain (p. 213). According to Van Maanen, previous cultural experiences influence an individual's socialization and transition into a new role.

An aspect important to the discussion of faculty socialization is the notion of academic socialization as a "bidirectional process" instead of a unidirectional one (Tierney & Bensimon, 1996, pg. 37). A bidirectional process of faculty socialization is defined as

being one in which both the individual and the organization experience change. This is in contrast to viewing faculty socialization as unidirectional in which only individuals change in the adoption of organizational norms. The important point suggested by Tierney and Bensimon is that the potential should exist for individual faculty to influence and possibly even change the inherent culture of the institution, just as the cultural norms of the institution may change the beliefs and values of individual faculty.

One predominant theme that emerged in the academic socialization literature was that the discipline, rather than the institution was the key factor in faculty socialization (Kuh & Whitt, 1988; Ruscio, 1987; Tierney & Bensimon, 1996). Ruscio (1987) examined the role of socialization and the importance of socialization in faculty who identified with a specific discipline. Participants in Ruscio's study stated that the discipline was the motivation to teach; they were inspired by a teacher after already having identified an interest in the subject. Once in graduate school, the academic profession was the way participants could continue studying the subject. Ruscio's study identified the process of socialization as being important for the future aspirations and continued productivity of the new scholar. Furthermore, Ruscio stated that differences in the mission of individual disciplines affected faculty member's socialization and transitioning process.

Ruscio's study demonstrated that socialization into academics is important to new faculty and should not be minimized. Ultimately, identification with an academic discipline generally occurs during graduate school and in an individual's initial faculty experience (Kuh & Whitt, 1988). Therefore, the academic discipline "is the first mark of identity a professor receives," with differences in institutional mission affecting the recruitment and socialization of faculty (Ruscio, 1987, p. 332). This was of importance

to this study of the influence of culture on transitioning nursing faculty because of the interrelatedness between disciplinary missions and cultural values.

In relating overall academic socialization to the specific socialization experiences of nurses, AACN (1986) included socialization as a critical element of nursing education. The importance of socialization in nursing schools is demonstrated in the following statement from AACN's *The Essentials of College and University Education for Professional Nursing*: "through the socialization process, the student develops a sense of identity and commitment to the profession by internalizing the norms, values, knowledge, skills, and behaviors shared by members of that profession" (p. 3). Empirical studies related to the socialization of nurses to the profession and the socialization of nurses to a faculty role are presented in the following section.

#### *Socialization of Nurses to the Profession*

Much of the literature on nursing socialization focuses on the transition of nursing students into the nursing profession, (Holland, 1993; Perry, 1987; Shank & Weis, 1989) and has been presented in a previous section of this literature review. One study that was not reviewed previously is Kramer's (1974) seminal study of nursing socialization. In her research, Kramer explored the process of anticipatory socialization in graduate nurses. Kramer demonstrated that graduate nurses most often identified former faculty as role models, although she pointed out that nursing faculty did not possess the same values as nurses in the clinical practice setting. Therefore, Kramer concluded that graduate nurses had limited opportunity for anticipatory socialization into a clinical nursing role because of the differing values between nursing faculty and clinical nurses. Her results also indicated that a lack of adequate anticipatory socialization in preparing

undergraduate nursing students to move into the professional work force resulted in reality shock for many new graduate nurses.

Looking back on this early work in nursing socialization, Kramer's (1974) research provided a framework for the examination of the socialization of nurses in a professional role. Interestingly, Kramer's discussion of nursing socialization reflects the historical trends of American nursing education. According to Kramer, when nurses were trained in apprenticeship programs located in hospitals there was little disparity between the values of the educational program and the values found in the clinical setting. When most students graduated from hospital-based nursing programs, minimal role transition was necessary, as most graduate nurses accepted clinical positions within a hospital setting. As nursing programs began to move from the hospital setting into institutions of higher education, nursing education became more academically focused. Nursing programs based in higher education institutions adopted the norms and behaviors inherent in educationally-based institutions, which differed from the norms and behaviors found in hospital-based organizations.

Kramer's (1974) work provides a foundation for the exploration of cultural similarities and differences in nurses with varying roles, particularly as related to socialization. This study of the influence of culture on nurses who are transitioning from clinical practice to a faculty role builds on Kramer's original research and lends further support to her foundational socialization work from a culture perspective.

#### *Socialization of Nursing Faculty*

Research specifically describing the concept of socialization during the transition of clinical nurses into faculty roles is sparsely represented in the literature. Most research

that exists flows from primary research questions related to role conflict in nurses who have assumed new faculty positions. Hence, much of the literature related to nursing faculty socialization focused primarily on issues of role conflict related to workload (Forsbrey, 1995; Mobily, 1991; Sienty, 1988), job satisfaction (Fain, 1985; Johnston, 1988), and balancing the traditional faculty components of scholarship, teaching, service, and practice (Charron, 1985; Lambert & Lambert, 1993; Pappas, 1988; Rapson, 1980; Steele, 1988; Tolve, 1997; Wold, 1994). In the preceding studies, faculty socialization was not the primary research question, although many of these studies included aspects of faculty socialization related to the study's findings. A review of studies that included related discussions of nursing faculty socialization are presented in the following section.

In a study of nurse educators' first faculty positions, Sienty (1988) assessed the role strain experienced by 31 novice nurse educators in their first year of teaching. Results of Sienty's study indicated that high demands related to the faculty role induced role strain in novice nursing faculty and those faculty with high levels of role strain reported being less likely to stay in academe. Of particular interest was the finding that new faculty having formal teacher preparation exhibited less role strain than novice faculty without formal preparation in an educator role. Although this study does not specifically discuss the issue of socialization, this finding suggests that socialization experiences occurring during graduate school affect the level of role strain occurring during transitioning of new faculty.

In a related study of role strain in nurse faculty, Mobily (1991) examined the relationship between selected faculty experiences and the degree of role strain experienced in full-time tenure track nurse faculty. Findings of Mobily's study indicated

that the majority of faculty experienced role strain primarily due to work demands. Additionally, six statistically significant relationships between role strain and faculty socialization experiences were revealed. Significantly higher degrees of role strain were reported by faculty who: (a) held a masters as his or her highest earned degree, (b) taught in the undergraduate program, (c) had clinical teaching responsibilities, (d) spent ten or more hours per week in the clinical facility, (e) did not have opportunity to attend faculty development offerings in scholarship, and (f) had a lack of fit between his or her academic role orientation (i.e. the selective emphasis or lack of emphasis in the roles of teaching, research, and service).

Adding support to Sienty's (1988) study, Mobily's findings suggested that limited anticipatory and organizational socialization experiences contributed to increased role strain in nurse faculty, particularly in faculty without doctoral preparation. This is an important finding given that 50 percent of nursing faculty do not have a terminal degree (AACN, 2000, 2003; NCES, 2002).

A study by Forsbrey (1995), examined how moving from a faculty position in an associate degree nursing program to a faculty position in a baccalaureate degree nursing program affected role conflict and role ambiguity in nurse educators. Forsbrey looked at faculty socialization as a method to reduce role conflict and role ambiguity in transitioning nurse faculty. Forsbrey's study expanded the knowledge presented by Mobily (1991) by specifically examining the process of faculty orientation in nurse faculty who were transitioning between associate degree and baccalaureate degree nursing programs. In her research, Forsbrey recommended the implementation of orientation programs for nursing faculty new to a baccalaureate program in order to

facilitate the process of socialization and role transition for former associate degree nurse faculty.

Several studies in the nursing literature looked at role conflict issues in nurse faculty as related to job satisfaction. Although none of these studies specifically focused on socialization of nurse faculty, several common themes related to socialization were identified. Fain (1985) examined the relationship between perceived levels of role conflict and role ambiguity to job satisfaction of nursing faculty. Results indicated that perceived role conflict and role ambiguity were associated with low levels of job satisfaction among full-time nurse educators in a baccalaureate nursing program. Additionally, Fain's results indicated that faculty teaching from one to five years had a higher role of role ambiguity and role conflict than faculty teaching 16 years or more. Of further interest is that faculty with a masters degree exhibited a higher role ambiguity and role conflict than faculty holding a doctoral degree.

Although Fain (1985) did not specifically examine faculty socialization, her findings suggested that the process of organizational socialization, (i.e., socialization occurring as a result of being in a faculty role), decreased the level of role ambiguity and role conflict found in nurse faculty with varying years in faculty positions. Furthermore, Fain's research supported the academic socialization research, which stated that anticipatory socialization of future nursing faculty primarily occurred during an individual's doctoral school experience. As stated previously, since only half of all nurse educators possess terminal degrees, Fain's research provided additional support to the lack of anticipatory socialization experiences in many nurse faculty. Additionally Fain's research provided a

framework for connecting issues of role conflict, job satisfaction, and socialization experiences in nurse faculty.

From a different, but interesting perspective in the continued investigation of role conflict and socialization in nursing faculty, Johnston (1988) examined the relationship between faculty nativity and role conflict, role ambiguity, and job satisfaction among nursing faculty at 21 accredited schools of nursing in eight states in the southern United States. One issue uncovered in Johnston's research focused on whether the socialization experiences of inbred faculty (i.e., those holding a degree from the employing institution) affected role perceptions and job satisfaction in nursing faculty. According to Johnston, the practice of faculty inbreeding is linked to outcomes of faculty socialization, specifically that inbred faculty should experience an easier socialization process than non-inbred faculty.

Contrary to what was anticipated from prior inbreeding research, Johnston (1988) concluded that no significant relationship existed between faculty nativity and role conflict and role ambiguity. Since anticipatory socialization occurs during an individual's graduate school experience, the results of this study suggested that anticipatory socialization events did not influence the presence of role conflict in nursing faculty. Although this study presented conflicting results to previously described socialization research, intervening variables, such as age of the faculty and number of years in a faculty position, were not controlled for in this study. Additionally, Johnston's research did not delineate between inbred faculty who have held positions at other universities and then returned to their graduate institutions to join the faculty ranks. These are significant variables that potentially affected the study's outcomes.

Additional research was found that explored role conflict in nursing faculty as related to balancing the traditional faculty components of scholarship, teaching, service, and practice (Charron, 1985; Lambert, 1991; Pappas, 1988; Rapson, 1980; Wold, 1994; Tolve, 1997), but since none of these studies addressed faculty socialization as a factor in role conflict in nursing educators, they will not be discussed in this literature review.

This extensive review of the nursing literature revealed only three studies (Clark, 1988; Davis et al., 1992; Morris, 1993) that presented primary research questions focused on the socialization experiences of new nursing faculty. Clark examined the formal and informal methods of socialization used during nursing faculty orientation in schools of nursing. In Clark's study a survey was used to determine faculty orientation practices of 121 nursing faculty in nursing programs throughout the country. Clark's findings indicated that conversation with other nursing faculty was identified as the most effective type of informal faculty socialization.

Clark's (1988) research was further supported by a study by Davis et al. (1992), which used a nurse faculty competency questionnaire to determine the mechanisms through which new nursing faculty obtained competencies needed for teaching. Davis et al. revealed that novice nurse faculty ranked informal socialization experiences as the most important method of learning the faculty role. Both Clark's and Davis et al.'s research sustained the fact that new nursing faculty constructed their faculty role identity through relationships with other nursing faculty, which was an informal aspect of organizational socialization (Tierney & Rhoades, 1994).

In contrast to the quantitative methods used to study the socialization experiences of new nursing faculty, a qualitative study by Morris (1993), examined the lived experience

of 11 female nursing faculty who were identified by their peers as being effective in the faculty role. The results obtained from Morris's study differed from the quantitative work of Clark (1988) and Davis et al. (1992), in the fact that Morris identified themes related to values and effective teaching behaviors of nursing faculty. Effective female faculty, the focus of Morris's study, were found to value hard work, caring, interaction, a sense of humor, and the worth of others.

Morris (1993) concluded that a successful transition into a professional nursing role cannot be assumed to be sufficient preparation for a nursing faculty position. She further stated that the socialization experiences of nurses new to a faculty role and the ability of new faculty to develop a sense of connectedness with the faculty role was important to developing effectiveness as faculty. Of importance to note in Morris's study, was that faculty participants developed into effective female nurse faculty despite a lack of a formal orientation and socialization into the faculty role.

Infante (1986) reported a conflict in roles between clinical nursing and nursing faculty. Although not a research study, Infante wrote about the influence of a nurse's prior socialization experiences when transitioning from a professional nursing role into an academic position. She stated that the role of a clinical nurse and the role of a nurse educator often conflicted in the values and beliefs held by the individual nurse.

According to Infante, "becoming a nurse educator is not an additive process; that is, it is not a matter of adding the role of educator to that of the nurse. It requires a change in knowledge, skills, behaviors, and values to prepare for the new assimilated roles" (pg. 94).

In summary, the research presented in the preceding section explored the process of socialization from three perspectives: (a) socialization in higher education institutions, (b) socialization of professional nurses, and (c) socialization of nursing faculty as an academic discipline. One of the prevailing themes emerging from the academic socialization literature was the depiction of faculty socialization as a process consisting of two unique stages, anticipatory and organizational (Tierney & Rhodes, 1994). Additionally, the academic discipline, rather than the institution, surfaced in the literature review as being the key factor in faculty socialization (Kuh & Whitt, 1988; Ruscio, 1987; Tierney & Bensimon, 1996).

Previous research on the socialization of nurses primarily addressed the transition of nursing students into the nursing profession (Holland, 1993, Perry, 1987; Shank & Weis, 1989). Furthermore, most of the literature related to nursing faculty socialization focused on issues of role conflict related to workload (Forsbrey, 1995; Mobily, 1991; Sienty, 1988), job satisfaction (Fain, 1985; Johnston, 1988), and balancing the traditional faculty components of scholarship, teaching, service, and practice (Charron, 1985; Lambert & Lambert, 1993; Pappas, 1988; Rapson, 1980; Steele, 1988; Tolve, 1997; Wold, 1994). Only three studies were found that primarily focused on the socialization experiences of new nursing faculty (Clark, 1988; Davis et al., 1992; Morris, 1993). Although each of these studies provided information regarding nursing faculty socialization and Morris's study revealed values inherent in effective nurse educators, none of the research presented by Clark, Davis et al., and Morris, was framed from a cultural perspective.

While Infante (1986) supported the existence of conflicting roles between clinical nurses and nursing faculty, no prior research was found that specifically examined the

culture from which professional nurses come and the influence of that culture on the transition of clinical nurses into a faculty role. As demonstrated in the preceding review of the nursing socialization literature, empirical studies examining the cultural perspectives of nursing faculty socialization and the socialization experiences of nurses in differing roles using a cultural framework had not been conducted prior to this study.

### *Theoretical Framework*

A theoretical framework is used in qualitative research to help in the development of research questions and design for the initial stage of data collection and analysis (Glesne, 1998). According to Glesne, as data analysis proceeds, the researcher may use additional theoretical frameworks to examine data from another point of view. Theoretical perspectives related to organizational culture in higher education, and adult transition theory shaped the research questions and design of this study. The final theoretical framework focused primarily on Peterson and Spencer's (1990) model of organizational culture and Schlossberg's (1995) adult transition theory.

### *Organizational Culture in Higher Education*

Much of the scholarly research related to culture in higher education has been informed by the works of Kuh and Whitt (1988), Tierney and Rhoades (1994), Manning (1993), and Peterson and Spencer (1990). Studies of organizational culture provide a conceptual framework for understanding the values, beliefs, norms, and assumptions that influence the actions and behavior of individuals and groups (Cameron & Ettington, 1988; Kuh & Whitt, 1988). A key component in the study of organizational culture is that culture is not static and the cultural components of an organization may change over time (Peterson & Spencer, 1990).

Most of the existing theory for studying the components of college and university culture have been presented along institutional and organizational lines, with faculty culture being viewed as a subculture of the overall institution. Therefore, a model of organizational culture was used in this study to examine the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate.

Peterson and Spencer's (1990) conceptual model of organizational culture was the primary theoretical framework used in this study to examine elements of the three cultures. Peterson and Spencer's model includes typologies that were grouped under five categories ranging from approaches that are explicit to approaches that are implicit. The model included the following approaches to the examination of culture: (a) geospatial, (b) traditions, myths, artifacts, and symbolism, (c) behavioral patterns and processes, (d) espoused values and beliefs, and (e) embedded values and beliefs. A discussion of these five approaches and the way findings related to each approach surfaced in this study is presented in the following section of the literature review.

The geospatial approach included findings related to the most explicit aspects of the three cultures being studied. Geospatial findings were noted especially during the participant observations (e.g., the CON facilities, campus maintenance, classrooms and faculty offices). The second approach, traditions, myths, artifacts, and symbolism provided additional information about the shared assumptions, values, and beliefs held by faculty members. Theoretically, this approach often elicits values that are idealized rather than carried out. As the study progressed, it became apparent that findings related

to this approach into the examination of the three cultures appeared much less frequently than findings related to the other approaches.

In contrast, findings related to the behavioral patterns and processes approach frequently surfaced throughout all stages of data collection. The behavioral patterns and processes approach included the identification of patterns of behavior that were present in the CONs operations, including those that were sustained over time and those that were both formally defined and informally developed within the college. These aspects of culture were noted during the participant observations, document review, and interviews.

Elements related to the espoused values and beliefs approach also appeared frequently throughout all phases of data collection. Findings related to the espoused values and beliefs approach focused on the values and beliefs that faculty members stated about the nursing profession, the academic discipline of nursing, and the academic profession. Most of the findings related to espoused values and beliefs appeared throughout the participant interviews.

The final approach identified in Peterson and Spencer's model of organizational culture, embedded values and beliefs were the most implicit concepts to surface from the study. Embedded values and beliefs related to the culture of nursing, the culture of the academic profession, and the culture of the professorate emerged as themes that were identified through interpretation of the data obtained during the study.

As data collection and analysis proceeded throughout this study, it became apparent that the primary findings of the study appeared as the more implicit components of culture, which included findings related to behavioral patterns and processes, espoused values and beliefs, and embedded values and beliefs.

### *Adult Transition Theory*

Many theoretical perspectives on adult transition were found in the literature including, Van Gennep (1960), Turner (1969), Fiske and Chiriboga (1990), Lazarus and Folkman (1984), and Schlossberg (1981, 1995). Much of the transition literature focused on the longitudinal approach of life events entailing change (Fiske & Chiriboga; Lazarus & Folkman), while other transition perspectives (Turner; Van Gennep) centered on symbolic behavior where individuals pass through stages (i.e., rites of passage).

While any of these approaches could be used in describing adults in transition, Schlossberg's (1995) model was chosen as the primary transition framework for this study because of the model's focus on transition as a unique and individual experience. According to Schlossberg, each person's transition differs and each individual is unique. Because this study focused on individual nurse's perceptions of the similarities and differences between cultures, the model's focus on individuals made it well suited as the conceptual transition framework for this study. Additionally, Schlossberg's model has been cited as a conceptual framework in both the nursing literature and in research related to higher education.

Schlossberg (1995) defined transition as "any event, or non-event that results in changed relationships, routines, assumptions, and roles" (p. 27). Schlossberg's adult transition model is comprised of three major concepts: (a) approaching transition, including transition identification and the transition process; (b) coping resources, including situation, self, social support, and strategies; and (c) strengthening resources. The individual aspects of the model are described in the following section.

*Approaching transitions: Type, context, impact.* Approaching transitions describes the nature of the transition, including the type, context, and impact of the transition. The model describes three types of transition: (a) those that are anticipated, (b) those that are unanticipated, and (c) those that are expected but do not occur (i.e., non-events). Context, refers to the relationship of the person to the transition and the setting in which the transition occurs. The third nature of transitions, impact, is determined by the degree to which a transition alters an individual's daily life. According to Schlossberg (1995), an examination of the "degree of difference between the pre-transition and the post-transition environments" (p. 33) is one method of determining the impact of the transition. Schlossberg's model stressed the importance of looking at each individual's transition process as unique and being aware that people experiencing one transition might also be in the midst of other transitions in their lives, which makes coping with the transition more difficult.

*The transition process: Changing reactions over time.* A key concept in Schlossberg's (1995) model is that although a transition may be linked to one event or non-event, transitions are actually processes that occur over time. In the model, the authors merged the work of other researchers, including Lenz & Myerhoff (1985), Van Genep (1960), and Turner (1969), to describe an integrative model of the transition process as a series of phases, identified as "moving in," "moving through," and "moving out" (pg. 44).

The moving in stage occurs when individuals in transition become familiar with learning the rules, assumptions, and expectations of the new role. The moving in stage is associated with the early socialization process that occurs during transition to a new role.

The moving through period is defined as the time when individuals in transition have “learned the ropes” of the new role, but are now confronting additional issues such as how to balance other relationships and responsibilities. The moving through period equates to the “period of liminality” described by Turner (1969) and Linz and Meyerhoff (1985). The last period in the transition process, moving out, occurs when individuals leave the role or disengage from the relationships, routines, and assumptions associated with the role.

*Coping with transition: The four S's.* The last concept of Schlossberg's (1995) model focuses on the factors that influence an individual's ability to cope with transition including: (a) situation, (b) self, (c) support, and (d) strategies. According to Schlossberg, a person's ability to cope with transition is effected by his or her resources (i.e., assets and liabilities) in each of these four areas. This ratio of assets versus liabilities explains why some people react differently to similar situations, and why the same individual may react differently at different times.

The first *S*, situation, refers to factors unique to the individual's transition process including the timing of the transition, what aspects can or can not be controlled, the degree of role change resulting from the transition, and whether the person has had previous experience with similar situations. The second *S*, self, includes the assets and liabilities that each individual brings to the transition, including personal characteristics and psychological resources unique to each person. The third *S*, support, refers to the type of social support each individual brings to the transition process. The last *S*, strategies, refers to the methods and modes of coping that each individual uses during the transition process.

Schlossberg's, (1995) model of adult transition was well suited as a theoretical framework for the examination of the cultural components of the nursing profession, the academic discipline of nursing, and the academic professorate, primarily due to the model's focus on transition as a unique and individual experience. The concepts presented in Schlossberg's model aided in the description of the similarities and differences between the three cultures examined in this study and were particularly useful in explaining how cultural similarities and differences affected the transition of individual nurses from a clinical role into a faculty role in a CON.

#### *Summary*

This chapter presented an overview of the literature related to research in the areas of professional culture, faculty culture, and professorial culture; with a particular emphasis on the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate. Additionally, empirical studies related to socialization and theoretical perspectives of organizational culture in higher education and adult transition were provided.

A dominant concept revealed in the literature was that the nursing profession, the academic discipline of nursing, and the academic professorate possess values and beliefs consistent with having a culture unique to each entity. This was supported by the determination of shared values, beliefs, and assumptions that existed within each of the three cultures presented. The preceding review of the literature has shown the existence of values present in all three cultural areas despite the fact that there was an overall lack of research specifically focused on the academic discipline of nursing framed from a cultural perspective.

Based on the information discovered through the preceding review of the literature, a study to examine the similarities and differences in the cultures of the nursing profession, the academic discipline of nursing, and the academic professorate, and an exploration into the influence of culture on nurses who are transitioning from clinical practice into a faculty role was indeed warranted.

## Chapter Three

### Methodology

This chapter provides an overview of the research design and methods utilized in this study. The methods and procedures used for this investigation are organized in the following sections: (a) research design and rationale, (b) research setting, (c) participant selection; (d) data collection methods, (e) pilot study, (f) study procedures, (g) role of the researcher, (h) data analysis, and (i) trustworthiness and validity issues.

#### *Research Design and Rationale*

The study design was based on a qualitative research approach using the process of naturalistic inquiry. Qualitative methods provide a holistic description of the complex phenomena of culture and are useful in identifying and understanding the nature of cultural processes (Eisner, 1991; Lincoln & Guba, 1985; Whitt, 1993). The use of a qualitative design in this study facilitated identification of the unique aspects of the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate and aided in the understanding of the influence of culture on nurses as they transitioned into a faculty role.

According to Lincoln & Guba (1985), naturalistic inquiry is disciplined inquiry conducted in natural settings using methods of observation, interviewing, and document review. Several prominent characteristics of naturalistic inquiry have been identified in the literature with the following key characteristics incorporated into the design of this study (Eisner, 1991; Frankel & Wallen, 2000; Lincoln & Guba, 1985; Patton, 1990):

1. The natural setting was used for the collection of data.
2. The researcher acted as the primary instrument of data collection through observation, interviewing, and document analysis.
3. Data were analyzed inductively to define working hypotheses, which emerged from the data as the study progressed.
4. The research report is descriptive and incorporated expressive language and the “presence of voice” in the text (Eisner, 1991, p. 36).
5. The research was interpretive in nature, aimed at the discovery of the meaning events have for the individuals who experienced them and the interpretations of those meanings by the researcher.
6. The research design was emergent (as opposed to pre-determined) and involved repeated cycles of data collection and analysis.
7. The results of the study were judged using special criteria for trustworthiness rather than the researcher making judgments about the usefulness and credibility of the study’s results.

This study described the influence of cultural elements on nurses who were transitioning into a faculty position. According to Marshall & Rossman (1995), the strength of using a qualitative design for research that is exploratory or descriptive in nature is in the “unique value of the context and setting” (p. 39) and the fact that qualitative methods facilitate a “deeper understanding of the participant’s lived experiences of the phenomenon” (p. 39). The use of a qualitative methodology was necessary to fully investigate the influence of culture and the interplay of various cultures as reported by individual nurses who were transitioning into a faculty role.

Many different traditions of qualitative inquiry exist. Creswell (1998) identified five primary methods of inquiry in qualitative studies including (a) biography, (b) phenomenology, (c) grounded theory, (d) ethnography, and (e) case study. The research questions of this study could have been explored using several of Creswell's traditions, but phenomenology and ethnography were the most fitting approaches to consider.

According to Creswell, the main focus of a phenomenological study is on "understanding a concept or phenomenon" (p. 37). Accordingly, Creswell defined the primary focus of ethnography as the study of behaviors shared by group members. The research questions of this study were closely related to both traditions of phenomenology and ethnography. Since the primary focus of this study was to examine elements of culture (e.g., values, beliefs, assumptions, norms) through the experiences of individual nurses who were transitioning to a faculty role, the emphasis of this study design was a phenomenological approach with some aspects of ethnography included. The use of these two traditions aided in the understanding of concepts related to the culture of the nursing profession, the academic discipline of nursing, and the academic professorate, as described by individual nurses.

### *Research Setting*

According to Marshall & Rossman (1995), the ideal setting in which to conduct qualitative research is where the following criteria can be met: (a) access can be achieved, (b) a mix of the phenomena of interest exists, (c) the researcher is able to establish trust and rapport with the participants, and (d) the quality of the data and credibility of the study is assured.

This study was conducted at a CON located within a large Midwestern metropolitan university. The CON selected offers programs at both the undergraduate and graduate level leading to bachelors, masters, and doctoral degrees in nursing. This setting was chosen because it was believed that the greatest potential to discover variations in the cultures being examined in this study existed in an institution offering baccalaureate and graduate degrees as compared to colleges offering only associate degrees. The rationale to support this criterion is related to the following assumptions: (a) a greater chance existed that the educational preparation of nursing faculty would vary in a baccalaureate/graduate degree program where the Ph.D. is the preferred degree for faculty members, (b) more full-time faculty are employed in a baccalaureate/graduate degree nursing program as compared to more adjunct and part-time faculty in associate degree nursing programs, and (c) the nursing faculty in a baccalaureate/graduate degree program were more likely to carry out the interrelated mission of teaching, research, and service versus the more singular mission of teaching found at associate degree colleges.

The use of this setting maximized the opportunity to find participants who could inform me about the unique aspects of the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate to expand the understanding of how culture influenced nurses as they transitioned into a faculty role. Additionally, this setting led to a richer quality of data related to the phenomena of interest, which led to credible results.

#### *Participant Selection*

The study participants were chosen using a purposive sampling technique. The goal of this study was to obtain differing views and interpretations that revealed the cultural

perspectives of nursing faculty who were transitioning from clinical practice into academe. Purposive sampling was selected as the primary sampling method for this study because participants were chosen who possessed the necessary information needed by the researcher. Purposive sampling provides richer data than either a convenience or random sample and is frequently the method of choice in qualitative research (Frankel & Wallen, 2000; Lincoln & Guba, 1985).

The specific criteria I looked for in the participants chosen for this study included the following: (a) nurses who had a full-time faculty appointment in the CON, (b) a mix of nurses who had received their Ph.D. and those without a Ph.D., and (c) nurses who had recently transitioned from clinical practice into a faculty role, defined as three years or less in the position.

In order to maximize the opportunity to obtain data that addressed my research questions, I selected faculty with full-time appointments in the CON. I based this criterion on the assumption that full-time faculty would be better able to relate the values, beliefs, and norms inherent in the culture of the academic discipline of nursing and the culture of the academic professorate than faculty without full-time appointments. Additionally, I included faculty who had terminal degrees and those who did not. As indicated in the literature concerning the under-preparedness of nursing faculty as related to terminal degree attainment, nursing faculty have not achieved the educational norm of other academic disciplines. I assumed that the experiences of nurses with varied educational preparation may differ during transition to a faculty role.

Additional criteria for the selection of participants included nursing faculty who had recently taken on a faculty position in the CON. Recent transition for this study was

defined as a nurse who was coming from a clinical practice position and who had assumed a full-time faculty appointment within the last three years at the time of the study. This addressed the main focus of the research question as to how cultural variations affected the transition of nurses into a faculty role. The perception of role conflict during transition between clinical nursing and the faculty role has been reported in the literature, therefore this study focused on cultural aspects related to role transition to provide a better understanding of the similarities and differences between the three cultures.

The CON selected for this study had approximately 70 nursing faculty members with about one third holding Ph.D.s and the remaining faculty holding no terminal degree. In this particular CON, only faculty with doctoral degrees are considered to be on the tenure track. The remaining full-time faculty without terminal degrees had similar job duties of those on the tenure track, including classroom and clinical instruction, serving on and chairing committees, and attending college and university level meetings. Additionally, many non-tenure track full-time faculty at the CON conducted active research, actively participated in grant writing, and published in scholarly journals.

The Associate Dean for Research in the CON was the primary contact person during the data collection process of the study. During the initial stage of the study design, the Associate Dean of Research provided the names of 10 faculty members whom she believed met the stated criteria for the study and whom she believed could help me understand and answer my research questions. Of the 10 faculty identified as meeting the criteria of the study, four had Ph.D.s and six did not. Two of the potential participants were pursuing doctoral study, one was a man, and all had assumed full-time faculty

appointments within the last three years. All potential participants came to the CON from a clinical practice position.

After receiving approval from the University of Toledo Human Subjects Review Board, I attempted to contact each potential faculty participant at his or her college office by telephone. I found that many of the potential participants were not in their CON offices at the times I was attempting to contact them, therefore I proceeded to send each potential participant an individual email at his or her college email address. This CON contact information was listed in the college online directory and was public information.

The purpose of this initial email contact was to introduce myself, explain the intent of the proposed research, determine his or her interest in participating in the study, and confirm that each potential participant met the stated criteria. If the faculty member indicated that he or she wished to participate in the study during this initial email contact I scheduled a time to talk to each participant individually for a brief telephone screening. Following the telephone screening with each potential participant, I scheduled an appointment for the initial formal interview. I obtained written consent for his or her participation in the study at the beginning of the initial interview.

#### *Data Collection Methods*

Multiple methods of data collection including interviews, participant observation, and document review are the main activities used in qualitative research (Glesne, 1999; Lincoln & Guba, 1985) and were the primary methods used in this study. The use of multiple methods during data collection is one form of triangulation, which enhances the trustworthiness of the study by attempting to counteract any threats to the validity of each individual method (Marshall & Rossman, 1995). According to Whitt (1993), the

constructs of culture-values, beliefs, and assumptions-are best examined using interviews, observations, and document analysis. Data were collected at the selected CON during spring of 2004. The following is a description of each of the data collection methods used in the study.

### *Interviewing*

Qualitative interviewing utilizes open-ended questions to uncover different perspectives about the phenomena being studied (Marshall & Rossman, 1995). During this study, I conducted standardized, open-ended interviews to elicit information from nurses who were transitioning from a clinical nursing role into a faculty role in order to examine the values, beliefs, and assumptions they had about the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate.

Interviewing, combined with the observation of events within an institution, contributes to the understanding of the meanings held by people in their daily lives (Marshall & Rossman, 1995; Spradley, 1979). The specific purpose of conducting interviews with faculty participants was to better understand how cultural similarities and differences have affected each participant's transition into his or her faculty role. Data obtained during the interview (e.g., values, beliefs, norms) helped explain the culture from which each participant was working during his or her faculty role transition. Furthermore, an exploration of each participant's experience in a clinical role led to a more complete understanding of similarities and differences that existed between the three cultures and provided insight into the elements of the culture from which the faculty participant came that influenced his or her transition into academe.

The research design included three interviews with each participant. The first was a brief telephone screening to present general information about the study and to ensure that potential participants met the study criteria. This telephone screening was followed by an initial formal interview with each participant. I continued the formal interview process with a second interview with each participant. The goals and procedures used in conducting each interview are outlined in the following sections.

*Telephone screening.* After receiving email responses from 7 of the 10 potential participants, I conducted a brief telephone screening with the 7 faculty members who expressed an interest in participating in this study (see Appendix A). The purpose of this telephone screening was to establish a personal contact with each participant and to assure that he or she met the criteria established for the study. During the telephone screening, I also began the process of establishing rapport with each individual, as I tried to assist him or her in being comfortable in participating in future interview sessions with me.

At the telephone screening, I introduced myself, explained the purpose of the study, and discussed the procedures for data collection. I also obtained general information regarding the faculty member's availability for participation during spring, 2004 as well as verified that each participant met the criteria for the study. A date, time, and place to conduct the initial formal interview were determined at the conclusion of the telephone screening.

*Formal interviews (initial and second).* Two formal interviews (one initial interview and a second follow-up interview) were conducted with faculty participants. Conducting multiple interviews with multiple respondents improves the trustworthiness of a study

and assists in the development of trust and rapport with the participants, thereby increasing the validity of the interviews (Glesne, 1999). Additionally, multiple interviews with each faculty member allowed time between the interview sessions for participants to reflect upon the prior interview. This allowed for a deeper exploration of the values, beliefs, and assumptions that were being revealed.

The two formal interviews were scheduled at a convenient time and place for each participant with 60 minutes set aside as the time frame for each interview. An interview guide was used for both interviews, although supplementary questions were asked during the interviews based on the participant's responses, which allowed for further reflection on the responses.

The goal of the first interview was to begin to uncover the values, beliefs, and assumptions participants had about the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate as well as to begin exploring each participant's transition from clinical practice to his or her current faculty position. The initial interview guide (see Appendix B) was designed to solicit information about the values, beliefs, and assumptions related to the profession of nursing, the academic discipline of nursing, and the academic professorate, and to begin to understand each participant's faculty role transition. At the start of the first interview, each participant completed a written consent form including permission to audiotape the interview (see Appendix C). Although every participant agreed to audio taping of the interviews, faculty members were offered the option of refusing audio taping while still being invited to participate in the study.

A second interview with each participant was designed with the dual goal of member checking and gaining further insight into elements of culture identified during the initial interview. At the beginning of the second interview, I shared my interpretations from the first interview with that participant and asked if my understanding of what he or she revealed was correct to gain assurance that I was accurately representing the participant's ideas. As part of the emergent design of this study, depending upon the participant's response to my shared interpretations from the first interview, I asked additional questions. Furthermore, each interview led me to ask subsequent interviewees different questions based upon the data that were gathered. Although a second interview guide was developed and followed (see Appendix D), additional questions for each participant were generated based on the ongoing analysis of data obtained from the document review, the initial interviews, and the participant observations.

Written analytic and personal notes were kept following each interview, which assisted in data analysis as well as in highlighting the key issues that were discussed during the interview. The personal field notes also provided the opportunity to record potential questions that I wanted to ask during the second interview. Examples of notes that were kept included my thoughts and feelings during each interview session, body language demonstrated by each participant, and any ideas and impressions I had during the interview related to the research questions. Interviews were transcribed verbatim within one week following each interview.

### *Participant Observation*

The classic form of data collection in naturalistic research and an essential element of qualitative research is observation of participants in the context of a natural scene

(Lincoln & Guba, 1985; Marshall & Rossman, 1995). Observation of activities within the organization is a useful source of information about the culture, the history, and the values of the institution and assists in understanding the setting, the participants, and their behavior (Glesne, 1999; Whitt, 1993). I focused my observations on events attended by the individual faculty participants of this study because observational activities, by providing a knowledge of the context in which events occur, led to a deeper understanding of the concept in question (i.e., culture) than interviews alone (Whitt).

Participant observation was used as an additional method of data collection in order to gain a more complete understanding of how cultural variations affected the transition of individual nurses from professional clinical practice into a faculty role. During the observations, I focused on the individual participant as the unit of analysis of my study. I observed each participant during two separate activities in which he or she was involved within the context of the CON. I specifically looked to see if the information I obtained during the initial interview with each participant and the document analysis matched the values, beliefs, and norms that I observed during the observations. Using interview data, document analysis, and participant observation data as a triangulation method improved the trustworthiness of the study.

In conducting this research, two categories of participant observation were utilized. First, general observations of events during which the faculty participants interacted with other faculty were conducted. The purpose for these faculty-to-faculty participant observations was to observe the role of the individual participants within the context of the CON and to explore how the values, beliefs, and assumptions of each participant were enacted. For the faculty-to-faculty observations, I attended CON committee meetings

that individual participants attended during the data collection period. In addition, I observed one general nursing faculty meeting that was attended by several faculty participants.

The second category of participant observation utilized in this study focused on events during which the individual faculty participants interacted with students. The goal of conducting these faculty-to-student participant observations was to observe how the values, beliefs, and assumptions that were presented during the interviews matched the values, beliefs, and assumptions that were enacted during the observations. For the faculty-to-student observations, I attended a nursing class, lab, or clinical experience taught by each faculty participant.

Each participant chose the individual events that he or she wanted me to observe. With the exception of one participant, I conducted the participant observations following each participant's initial interview and prior to the second interview. Because of this sequencing of interviews and observations, information obtained from the initial interview transcripts, the document review, and the participant observations were used to generate additional questions for the second interview. This order of data collection also provided the opportunity to check my observations and document analysis with each participant during the second interview, which led to my obtaining enriched information during the interview.

My role during the observations was primarily that of observer as participant. As described by Glesne (1999), this approach occurs when the researcher has limited interaction with the participants of the study, but her primary role is more observer than participant. I organized the data generated from these observations in the form of field

notes, which are the primary method of recording qualitative research data (Glesne). In order to provide a rich account of the observations, I included descriptive, analytic, and personal field notes as additional data for the study.

Data generated during the participant observations were initially recorded through the use of jotted notes that were taken during each event. Following each observation, I expanded the jotted field notes into full field notes that provided a complete description of the event that occurred. I also wrote personal and analytic notes to supplement the descriptive notes, which included my thoughts and feelings about each experience and also included an initial attempt of data interpretation. The written field notes provided additional data about the faculty participants, beyond what was obtained during the interviews, that assisted in my understanding of how cultural similarities and differences between the nursing profession, the academic discipline of nursing, and the academic professorate influenced nurses as they transitioned into a faculty role. Full field notes were completed within two days of each observation.

#### *Document Review*

Document review is another important form of data collection used in qualitative research. Qualitative researchers analyze documents that are produced at the setting and are used during events taking place everyday (Marshall & Rossman, 1995). Document analysis can be used in conjunction with observations and interviews to help understand the values and beliefs of study participants. This study incorporated an analysis of documents from the CON, including the student handbook; the faculty manual; the CON philosophy, mission, and values statements; a standard letter of appointment for full-time faculty; faculty meeting minutes (past 2 years); renewal, promotion, and tenure

guidelines for the CON; CON policy manuals; the CON strategic plan; and the CONs most recent accreditation study from AACN, which was generated in 2002. At the time of the initial interview, I asked each faculty participant for any additional documents that he or she believed would assist in answering the research questions of this study. I also asked each participant for a copy of his or her vitae at the time of the initial interview. Faculty participants were given the right to decline permission to review these individual documents, although no one did.

The purpose of conducting this document review was to obtain a better understanding of each participant's transition into his or her faculty role by relating information that was uncovered in the documents to the context of each participant's behavior and actions as a faculty member at the CON. It was assumed that the expectations of faculty in the CON would be projected in the documents chosen for review, which led to a more thorough understanding of the values, beliefs, and norms uncovered during the interviews and participant observations.

The inclusion of a document review in this study provided additional information that was not attainable through interviews and observations alone. Primarily, the interview and observation data were corroborated with information obtained from the review of documents, which increased the likelihood that the study findings were trustworthy. Questions that were used in the analysis of documents are outlined in Appendix E. The documents were reviewed as the preliminary method of data collection, prior to conducting any interviews or observations. I also reviewed additional documents provided by the participants during the interview process. I primarily used information obtained during the review of documents to generate additional questions asked during

the interviews. Conducting a review of key CON documents early in the data collection phase of this study enabled me to ask questions during the interviews that focused specifically on the espoused and embedded values of the three cultures being examined. Additionally, I reexamined several documents (i.e., the CON philosophy, mission, and values statements) after the interviews had concluded, as participants' espoused and embedded values began to emerge within the framework of the CON and the overall institution.

### *Pilot Study*

Prior to this study, a pilot study was conducted as a preliminary investigation of the influence of culture on transitioning nursing faculty. The pilot study was conducted using the same data collection methods (e.g., document review, interviewing, participant observation) and data collection procedures as were used in the subsequent research study.

As part of this pilot study I interviewed two nurses who were faculty members in a different School of Nursing than the final research setting. The names for the two pilot study participants were obtained from a senior faculty member in the School of Nursing who served as the contact person for the pilot study. Both participants of the pilot study held full-time faculty appointments in the baccalaureate undergraduate nursing program. Additionally, both participants were nurses who had transitioned into a faculty role within the last three years and both had M.S.N. degrees. Similar to what was found in the literature regarding the limited number of doctorally-prepared nursing faculty, the School of Nursing in which the pilot study was conducted had a small number of Ph.D. faculty, none of whom had transitioned into a faculty role within the last 3 years.

A review of documents was performed prior to the initial participant interviews and included many of those described in the document review section of the subsequent study. Additionally, I attended one class, one clinical conference, and one committee meeting in which the participants were involved. The informed consent, telephone screening guide, and both formal interview guides included in the final study were also used during the pilot study.

One outcome of conducting this pilot study was the determination that the interview questions were successful in soliciting responses about the varying elements of culture to be uncovered in the subsequent research study. Additionally, I was able to obtain information about the influences of culture on transitioning nurse faculty as well as check the content of the questions and the length of the planned interviews.

#### *Data Collection Procedures*

The following steps provided the framework for the study of the similarities and differences of the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate as described by nurses who were transitioning from a clinical nursing role into a faculty role within a CON. Data collection with each participant proceeded in the following sequencing: initial email contact, telephone screening, initial document review, first formal interview, review of additional documents specific to the individual participant, two participant observations, and a second formal interview. The entire process of data collection was conducted individually, with two faculty participants scheduled within several consecutive 2-3 week periods of data collection. I continued to proceed through the entire process of data collection with two more faculty participants during the next 2-3 week timeframe. I

continued this sequencing of data collection until saturation of data was complete and no new information was gathered.

*Advance Preparation*

1. Permission to conduct the investigation was requested from the Dean of the CON. I initially contacted the Dean by email and then by telephone and received both email and verbal permission to conduct this research with full-time faculty in the CON, provided they voluntarily agreed to participate in the study. The Office of the Dean provided the name of the Associate Dean of Research for the CON as the college's contact person during the study. This contact person was maintained throughout the course of the study.
2. In December 2003, a site visit was made to the CON during which I met with the Associate Dean of Research for the CON. At this meeting, I was informed that human subjects approval would not be necessary from the University where the research occurred, although the CON did require a copy of approval from the University of Toledo Human Subjects Review Board, before data collection began.
3. During this initial site visit, I provided the Associate Dean of Research with the criteria for selection of participants, a copy of the most recent draft of the study proposal, and a list of documents that were to be reviewed during the study. Examples of documents reviewed have been previously described. The initial documents for review were obtained prior to the formal interviews or participant observations. The document review was the initial form of data collection for this study and analysis of these initial documents was completed

prior to conducting the first formal interview. Additional documents for review (e.g., faculty participant's vitae) were obtained from individual participants at the time of each initial interview.

4. At the time of the initial site visit, the Associate Dean of Research provided a list of 10 potential study participants whom she believed met the criteria for this study. Additionally, a letter of support for the study was obtained from the Associate Dean of Research.
5. Following successful proposal defense, I contacted two faculty members from a different School of Nursing who agreed to participate in a pilot study. I completed the entire process of data collection for the pilot study before beginning the proposed research study. At the same time I requested approval from the University of Toledo Human Subjects Review Board by completing all necessary paperwork.
6. Following approval from the University of Toledo Human Subjects Review Board and after completing the pilot study, I contacted the potential faculty participants individually by email to invite their involvement in the study, followed by an initial telephone screening of the 7 faculty members who agreed to participate (see Appendix A). A thorough explanation of the purpose of the study, the type of data to be collected, and the expectations of being a study participant were provided to all potential participants at the time of this initial screening. After each faculty member agreed to participate in the study, a date, time, and place to conduct the initial interview was arranged at the conclusion of the telephone screening. I began the data collection

procedure with two faculty participants at a time, proceeding through the entire data collection process, meeting individually with two more faculty participants at a time until saturation of data was complete.

7. The initial telephone screening, informed consent form, initial interview guide, second interview guide, and document analysis guide are included in the following appendices (see Appendices A, B, C, D, and E).

#### *Entry*

1. Written permission to conduct the participant observations and the interviews were obtained through a signed consent form from all faculty members who participated in the study (see Appendix B). At the time of each initial interview, the consent form was reviewed with each participant and the participant's questions about the study were addressed prior to the start of the interview.
2. Two open-ended, formal interviews (approximately 60 minutes per interview) were conducted with study participants after obtaining his or her written consent. The specific focus of the first and second interview has been described in the previous data collection methods section.
3. Observations were conducted during the data collection period of the study after obtaining the written consent of participants and following the first interview. The specific faculty-to-faculty and faculty-to-student interactions that were observed have been described in the data collection methods section.

4. The entire process of data collection (document review, interviews, and participant observations) was conducted with two faculty participants at a time until saturation of data was obtained and regularities emerged.

#### *Tentative Constructions*

1. Field notes of all observations and audiotapes of all interviews were kept to record information obtained during data collection. I described what was seen and heard as well as what I was thinking, feeling, and reflecting during the experience through descriptive, analytic, and personal field notes kept throughout the entire data collection experience.
2. Participants were asked to provide feedback at the beginning of the second interview regarding my interpretations of the initial interview, document analysis, and observations with each individual participant and the accuracy of the information collected.

#### *Exit*

1. Participants were thanked for their time and effort to participate in this study and were informed that a final summary report of the conclusions of the study would be provided if requested.

#### *Role of the Researcher*

Concerns related to all qualitative research studies include ethical issues, the establishment and maintenance of rapport with the participants, and an awareness and control of the researcher's subjectivity related to the study questions, which are addressed in the following section.

*Ethics*

Ethical considerations are an important concept in all research studies, but are acutely significant in qualitative studies because of the intimate nature of the researcher-participant relationship. Qualitative researchers need to assure that the participant's privacy was maintained, that no methods of deception were used throughout the study, and that issues of reciprocity were considered as primary ethical considerations of the research study (Glesne, 1999).

The qualitative data collection methods of this study (e.g., individual interviews, document review, participant observation) prevented the assurance of each participant's anonymity. In an effort to protect each participant's confidentiality and right to privacy, identifying information was not used during the final write up of the study and specific information obtained during the interviews and observations was not shared with anyone not involved in the research or dissertation committee. Additionally, pseudonyms were used during all phases of the research process. Assuring the confidentiality of study participants was further improved by the fact that the research setting was located in a different part of the state from the researcher's doctoral university and the researcher had no professional or personal connection with anyone at the research setting at the time of data collection.

Before agreeing to participate in the study, each potential participant was informed of the data collection procedures used in the study, that his or her participation was entirely voluntary, and that he or she could withdraw consent and terminate his or her participation at any time during the study. Additionally, each participant signed an informed consent letter before any interviews or observations were conducted.

No deception or covert observations were used during any aspects of the study. Additionally, no study participant received any direct compensation for his or her participation in the research, although the process of interviewing provided individual participants with the opportunity to understand how cultural issues may have influenced his or her transition to a faculty role.

### *Rapport*

Building and maintaining rapport with study participants is crucial to obtaining rich data in a qualitative study. According to Glesne (1999), rapport is marked by “confidence, trust, and acceptance” between the researcher and the study participant (p. 96). For this particular study, it was important that each participant feel comfortable with me as a researcher in order to reveal information regarding his or her professional life and experiences related to transition to his or her current faculty role.

One method of developing rapport with study participants is through the use of multiple interviews with participants and multiple observations within the research setting (Glesne, 1999). I conducted two interviews with 6 of the 7 participants during the course of one 10-week academic term. My consistent presence in the research setting (weekly visits) demonstrated to each participant that I valued their involvement in the study and I was committed to learning from the information they shared with me. This continual presence throughout the entire academic term aided in the establishment and maintenance of rapport with each participant throughout the study.

Additionally, I informed each participant of my professional interest in the influence of culture on clinical nurses who transition to a faculty role through my past experience as a faculty member in a baccalaureate CON. My past and current positions in a CON

helped establish my own professional credibility, which led to rapport building with each participant.

### *Researcher's Subjectivity*

Maintaining objectivity while conducting and analyzing qualitative research is crucial to enable the researcher to interpret the data in an impartial and accurate way. In qualitative research, objectivity and controlling researcher biases during data collection and analysis is described as “being willing to listen to and observe participants and then be able to describe and interpret the data accurately” (Strauss & Corbin, 1998, p. 43). Part of the maintenance of objectivity during a qualitative study involves the acceptance and accountability of the researcher’s own subjective lenses prior to the study investigation.

My personal interest in the influence of culture on nurses as they transition from clinical practice to a faculty role is an outcome of my own experiences during the transition process. I view my inquiry into this topic from three different lenses, including (a) a personal lens, (b) a professional lens, and (c) a caring lens.

First, I was able to explore this research topic from a personal lens, having been a new nursing faculty member transitioning into a faculty position in a CON coming directly from years of clinical practice. My interest in this research primarily stems from my own experience during this transition to a faculty role, which did not proceed as smoothly as I anticipated it should. As a result of this experience, I temporarily stopped out of my faculty position and it was this decision that further fueled my interest in exploring the influence of culture on transitioning nursing faculty.

Additionally, I see my personal lens closely tied to my professional lens, which is reflected through several of my colleagues' transitioning experiences and my current experience in an administrative position in a nursing program. As a former faculty member in a CON, I became acutely aware that some nurses seemed to transition into the academic role more easily than other nurses did. I wondered what phenomenon influenced how easy or how hard this transition was accomplished. I also began to raise questions about whether cultural variations existed between clinical nurses and nurses in academe and was there some connection between cultural variations and ease of transition? Was the issue one of similar people choosing similar disciplines, or was it the fact that the specific discipline shapes an individual's values, beliefs, and behavior? Through this professional lens, my concern about this research extended beyond my personal experiences to the experiences of my colleagues in nursing faculty positions.

Finally, I view my interest in this subject through my caring lens. I wanted to understand and improve the process of transition for faculty colleagues as well as to improve the learning environment of students who are very much affected by faculty issues surrounding transition.

As a nurse who has maintained a variety of professional roles for 30 years, first as a clinical nurse, then as a nursing faculty member, and most recently in an administrative position in a CON, I have a broad understanding of both the nursing profession and the academic discipline, and a more limited understanding of the academic professorate. My past experiences enabled me to develop interview questions that got at the heart of my research questions and aided in my interpretation of the data that were collected.

It was important that I recognized the personal bias and assumptions that I had going into this study. First, I assumed that cultural influences were a primary component of how individuals viewed and made sense of their world and that culture was learned and transmitted among members of a given group. Second, I assumed that the values, beliefs, and norms reflected in the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate may be enacted differently in individuals who are transitioning into faculty positions in a CON. Finally, I assumed that cultural differences had an effect on the transition of nurses from a clinical nursing role into a faculty role.

#### *Data Analysis*

Data analysis can be defined as an “ongoing process of bringing order, structure, and meaning” to the data collected with reduction and interpretation of the data occurring continuously throughout the study (Marshall & Rossman, 1995, p. 111). Analyzing data in a qualitative study involves synthesizing the information obtained through observations, interviews, and document analysis into a rich description of events.

According to Glesne (1999), coding is a “progressive process of sorting and defining” (p. 135) the data collected throughout the entire study. Coding of the data obtained during this study was based on both a priori and emergent code lists. The a priori codes that were established prior to data collection were based on a combination of the key components of Schlossberg’s Transition Theory and Peterson and Spencer’s conceptual model of organizational culture as discussed in Chapter 2. These components were used in the initial categorization of data and contained factors related to adults in transition, including aspects concerning the individual and the environment, as well as factors

related to professional culture, disciplinary culture, professorial culture, and socialization (see Table 1).

Each of the initial codes in Table 1 identify the a priori concepts that were expected to emerge in the data collected during the study. A codebook was used throughout the data collection process to assist in the organization and interpretation of data. According to Glesne (1999), the use of a codebook aids in the organization of data as evolving themes begin to emerge throughout the study. Each verbatim transcript was read with emerging themes highlighted manually and corresponding codes were assigned to each section of the transcript.

This same procedure was followed with the information collected during each participant observation and each document analysis. All of this information was manually transcribed into the codebook. Additional themes emerged from the data that required revision of the initial code list as new categories were identified. These additional categories reflected findings that were also coded, which enabled me to build the analysis and interpretation of the data beyond description.

Analysis of data in a qualitative study is an ongoing process; therefore this analysis began with the document review during the initial data collection phase of the study. Information obtained during the document analysis, initial telephone screening, and initial interview with each participant was organized and coded. This early interpretation of data allowed for the identification of key categories and themes that emerged from the data. The coding process was continued throughout the observations and the second set of interviews with each participant.

Table 1

*Initial List of Codes*

Category	Label	Code
Individual Role Transition	IRT	1
Type: anticipated, unanticipated, nonevents	Irtty	1.1
Context: relationship to transition and the setting	Irtco	1.2
Impact: alterations in daily life	Irtimp	1.3
Transition Process	TP	2
Reactions over time	Tprot	2.1
Moving in	Tpmi	2.2
Moving through	Tpmt	2.3
Moving out	Tpmo	2.4
Coping with Transition	CT	3
Situation: timing, control, role change, prior experience	Ctsit	3.1
Self: personal characteristics, psychological resources	Ctself	3.2
Social Support: types, functions, measurement	Ctsupp	3.3
Strategies: categories, coping modes	Ctstra	3.4
Nursing Culture	NC	4
Geospatial	Ncgeo	4.1
Traditions & myths	Nctm	4.2
Behavioral patterns & processes	Ncbpp	4.3
Espoused values & beliefs	Ncesvb	4.4
Embedded values & beliefs	Ncemvb	4.5
Academic Disciplinary Culture	ADC	5
Geospatial	Adcgeo	5.1
Traditions & myths	Adctm	5.2
Behavioral patterns & processes	Adcbpp	5.3
Espoused values & beliefs	Adcesvb	5.4
Embedded values & beliefs	Adcemvb	5.5
Professorial Culture	PC	6
Geospatial	Pcgeo	6.1
Traditions & myths	Pctm	6.2
Behavioral patterns & processes	Pcbpp	6.3
Espoused values & beliefs	Pcesvb	6.4
Embedded values & beliefs	Pcemvb	6.5
Socialization	S	7
Anticipatory	Sant	7.1
Organizational	Sorg	7.2
Other	O	8

Coded data were used to identify the values and beliefs of individual nurses related to the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate. Additionally, data were obtained that described how individual nurses transitioned from a clinical practice into a faculty position in a CON, which aided in the understanding of the influence of culture on nursing faculty transition. The data analysis required continued examination and reexamination of each interview transcript, which enabled me to identify the categories and themes that were significant to cultural influences of nurses transitioning into faculty roles.

#### *Trustworthiness and Validity*

Lincoln and Guba (1985) identified credibility, transferability, dependability, and confirmability as four key constructs for assuring trustworthiness in qualitative research. Comparing Lincoln and Guba's constructs to measures of reliability and validity in quantitative studies, credibility relates to internal validity, transferability relates to external validity, dependability relates to reliability, and confirmability relates to objectivity. In this study, the construct of credibility (i.e., internal validity) was demonstrated through the use of multiple data collection methods (e.g., interview, participant observation, document review) and by conducting multiple interviews with each participant over the course of an entire academic term. Interviewing each faculty participant two times over several months assisted in the development of rapport with each participant and also allowed each participant time to reflect upon what was shared during the first interview. This enhanced the richness and depth of information that was obtained during the second interview.

Transferability (i.e., external validity) refers to the applicability of findings in the research setting to other settings (Lincoln & Guba, 1985). The construct of transferability is problematic in most qualitative research studies and was difficult to assure in this study since data were collected in only one setting with only 7 participants. This reduced the generalizability of the findings to other populations and settings. Although the researcher cannot guarantee transferability of this study, the data presented in this study can be used by the reader to determine whether the findings are applicable to other settings.

The final two constructs identified by Lincoln and Guba (1985), dependability (i.e., reliability) and confirmability (i.e., objectivity), were addressed in this study through the use of member checking and an awareness of my own subjective biases that affected the results of this study. Dependability refers to the consistency of the inquiry processes used over time, while confirmability refers to the quality of the results in terms of how well the results are supported by the participants and by events that are independent of the researcher (Marshall & Rossman, 1995).

I shared my interpretations from each interview and asked each participant if my understanding of what he or she revealed was correct to gain assurance that I was accurately representing the participant's ideas, which increased the dependability and confirmability of the study. Furthermore, assuring that the researcher has expertise in the topic being studied as well as ensuring the researcher has presented her biases toward the topic also improves the overall trustworthiness of the study (Glesne, 1999). My personal interest in this research topic and a reflection of my own subjective lenses have been addressed and I continued to reflect upon my own biases throughout the data collection

period and during analysis of the data, so as not to enter preconceived notions into the conclusions of the study.

According to Maxwell (1992), the five types of validity that can be assessed in the context of qualitative research include descriptive, interpretive, theoretical, generalizability, and evaluative validity. Descriptive validity, or the factual accuracy of the data, was assured initially through the use of jotted field notes during which I recorded the data generated during each participant observation. Following each observation, I expanded the jotted field notes into descriptive field notes that provided a complete description of the event that occurred. Through my field notes I ensured that I provided a rich description of the experiences observed, which added to the data obtained during the participant interviews. This descriptive data contributed to my understanding of the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic profession as nurses transition to a faculty role.

Interpretive validity is an understanding of the phenomena under study from the “emic” perspective of the participants (Maxwell, 1992, p. 289). The process of member checking, conducted at the start of the second interview, of both the initial interview data and participant observation data, improved the interpretive validity of this study. The interviews provided information from nurses who were transitioning into a faculty role in order to understand the values, beliefs, and assumptions they had about the various cultures being studied.

Theoretical validity, according to Maxwell (1992), refers to whether the research conducted explains the concepts being studied beyond a description and interpretation of

the phenomena. The theoretical framework for this study included a model of organizational culture and adult transition theory. I improved the theoretical validity of this study by obtaining continued feedback from the faculty participants concerning whether I accurately represented the values, beliefs, and norms uncovered during this research as concepts related to the topics being studied; specifically cultural influences on faculty transition. Additionally, the use of a model of organizational culture and adult transition theory during interpretation of the data led to theoretical validity beyond a mere description of the concepts being examined.

#### *Summary*

This chapter provided an overview of the research design and rationale for the study, data collection methods and study procedures, and the method used for analysis of the data collected during the study. A description of the research setting and the method for participant selection was presented. Issues related to the role of the researcher, including ethics of the study design and methods of building rapport with the participants were discussed. Additionally, the researcher's biases, subjectivity, and experiences that prompted this research were presented. The method of how trustworthiness and descriptive, interpretive, and theoretical validity were assured during this study was also discussed in this chapter.

## Chapter Four

### Results

This chapter presents the findings obtained from the review of CON documents, observations, and interviews with recently transitioning nursing faculty. The results section begins with a description of the context of the setting in which the study was undertaken and a summary of the characteristics of the participants. The steps of the analysis process are chronicled along with a description of the a priori categories and a discussion of how the emergent categories surfaced from the data. Subsequent themes that emerged from the data are presented and supported with participant quotes. Analysis of the qualitative data was guided by the following research foci of the study: (a) what are the similarities and differences found between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate, and (b) what is the effect of culture on the transition of clinical nurses into a faculty role?

#### *Institutional Characteristics and Context of the Setting*

The study was conducted at a CON located within a large Midwestern metropolitan university. The university is Carnegie classified as an extensive doctoral/research university (Carnegie Foundation, 2004). The CON has programs at the undergraduate and graduate levels and awards bachelors, masters, and doctoral degrees in nursing.

Data collection was ongoing throughout a four-month period in the spring of 2004. Weekly visits to the campus were made during the entire data collection period. During

each weekly visit to the campus, I performed a combination of observations and formal interviews.

I completed 13 formal interviews during the data collection period. My initial goal was to perform two formal interviews with each of seven participants and I was able to meet this objective with six participants. I completed only one formal interview with one participant due to her having to cancel an interview because of family illness. I was not able to reschedule her final interview before the end of the academic year.

In keeping with the terms of consent, the interviews ranged from 45 to 75 minutes in length, with the average time of most interviews being approximately one hour. All participants chose the place that their interviews occurred, with the majority of interviews taking place in the participants' offices in the CON. Only one participant chose to use a conference room for both interviews, primarily because the office space was shared with another faculty member.

On-campus observations took place in a wide variety of settings including four theory classes, one lab class, one general nursing faculty meeting, two CON committee meetings, and two conferences between a student and a faculty member participant. A total of 11 formal observations were conducted, which ranged from a one-hour meeting to observations of theory classes lasting over four hours each. One four-hour off campus clinical observation was conducted during the evening shift at a local hospital. The participant involved in this off campus observation had specifically requested that I do the observation in the clinical setting.

Four of the study participants were not involved in any CON committees that met during the data collection period of the study; therefore, I was unable to observe a

committee meeting with each participant as originally planned in the design of the study. For these four participants I observed a theory, lab, or clinical class that they taught. Additionally, because the study was limited to one academic term, I was unable to observe one participant in any setting beyond the two formal interviews.

On each of my weekly campus visits, the staff, faculty, administration, and students in the CON were very welcoming and willing to assist me in any way they could to make the data collection process run smoothly. Throughout the course of the four months I visited the campus, I came to know most of the full-time faculty, several staff members, and quite a few students by name. I was given open access to documents that I had requested to review as well as received open invitations to committee and faculty meetings. Only on one occasion was I asked to leave a meeting before it ended due to confidential student information that was being presented during the second half of the meeting.

#### *Characteristics of the Participants*

The names of 10 potential participants who were thought to meet the criteria of the study were provided to me prior to the start of the study by the Associate Dean for Research in the CON. One potential participant was not currently in a full-time faculty position at the time of the study; therefore, of the 10 potential faculty members, 9 were invited to participate in the study. Two invited faculty members declined to participate, each citing the reason of being too busy to devote the time necessary for the interview component of the study. The following is a description of the overall characteristics of the seven CON faculty participants.

All participants met the original study criteria of holding full-time faculty appointments in the CON, having been in their current faculty position for one, two, or three academic years, and coming from a clinical practice role. All participants were White and six of the seven were women. The years of each participant's prior clinical nursing experience ranged from 5 to 38. The average number of years of clinical practice prior to assuming his or her current faculty role was 18 years.

Two of the seven participants were doctorally-prepared with the remaining participants holding a masters degree in nursing as their highest degree. Two of the five masters prepared participants were currently pursuing doctoral education. It is interesting to note that the two potential faculty members who declined to participate in the study were both doctorally-prepared, tenure-track assistant professors. In addition, all participants were certified in a specialty area of nursing practice with six of the seven faculty members holding nurse practitioner certification and one being certified as a clinical nurse specialist.

Five participants were at the clinical instructor rank, one was an assistant professor, and one was an associate professor. Three of the participants at the clinical instructor rank were responsible for leading a major undergraduate or graduate level nursing course in the CON. The majority of the participants taught some or all lecture classes in their assigned course and had at least one clinical or lab group per term. Additionally, many of the participants maintained a separate clinical practice in addition to their teaching responsibilities.

The participants were equally divided in relation to the number of years in their current faculty position at the CON. Two were completing their first year of teaching,

three were in their second year, and the remaining two participants were completing their third year at the CON. Only one participant had significant previous teaching experience 15 years prior to her current faculty appointment.

All seven participants were very willing to share their stories about their individual transition from a clinical practice role to their current faculty role. All participants responded quickly to my initial invitation to be included in the study, freely giving their time for the interviews and providing me with observational opportunities. Participants were very excited about the research topic and very passionate and forthcoming with their stories.

For the most part, participants were not concerned about being identified within the CON as being a part of this study. In fact, six of the seven participants were very open to their colleagues about their inclusion in this research project, even to the point of leaving their office doors open during the interviews and introducing me and my purpose on campus to other faculty members and students in their classes. Only one participant expressed concerns about being identified as a part of this study. Because of these concerns, I was careful to limit my interactions with her to the interviews and observations only. I never addressed her in other situations when I was on campus and I did not identify myself during the observation I had of her class and of two meetings that we both attended

#### *Participant's Transitions in Schlossberg's Adult Transitions Theory*

Schlossberg's adult transition theory was used as a guiding framework in the initial stages of data analysis for this study. As presented in Chapter 2, Schlossberg's model is comprised of three major concepts: (a) approaching transition, including transition

identification and the transition process; (b) coping resources, including situation, self, social support, and strategies; and (c) strengthening resources. During data analysis, it became apparent that the elements making up the first concept, approaching transition, were similar for all participants, compared to the factors related to coping and strengthening resources, which differed among participants. Since the elements of transition identification-including the type, context, and impact of the transition-and the transition process were similar for all participants, these factors were presented as an overall summary in the following section.

*Transition identification.* The process of transition identification involves the nature of the transition; including the type, context, and impact of the transition. Schlossberg's model describes three types of transition: (a) those that are anticipated, (b) those that are unanticipated, and (c) those that are expected but do not occur. Context refers to the relationship of the person to the transition and the setting in which the transition occurs. The third nature of transitions, impact, is determined by the degree to which a transition alters an individual's daily life.

All of the participants in this study identified the type and context of their transition from a clinical practice role to a faculty role as being very similar. The type of transition was described as one that was planned for and anticipated by all participants. Although each participant had varying reasons for making the move to a faculty role, all described the event as one that was expected and sought out. Additionally, the context of the transition was the same for each participant. All were full-time faculty members in the CON, who had transitioned into their current role within the last three years.

The third aspect of transition identification, the impact of the transition, varied among participants. As each participant described the effort of his or her transition into a faculty role it became clear that some participants transitioned more easily than other participants. Three participants described the impact of their transition as being minimal and felt they were coping well through this process. In contrast, two participants related that the transition was much harder than they had anticipated and they were having a very difficult time coping with the entire process of transition. The remaining two participants reported having some difficulties with transition but stated they were coping.

*The transition process.* A key concept in Schlossberg's model is that a transition is a process that occurs over time. In the model, the transition process is described as a series of phases, identified as moving in, moving through, and moving out. The moving in stage occurs when individuals in transition become familiar with learning the rules, assumptions, and expectations of the new role. The moving in stage is associated with the early socialization process that occurs during transition to a new role.

The moving through period is defined as the time when individuals in transition have learned the ropes of the new role, but are confronting additional issues such as how to balance other relationships and responsibilities. The last period in the transition process, moving out, occurs when individuals leave the role or disengage from the relationships, routines, and assumptions associated with the role.

Even though all participants in this study had recently transitioned into a faculty role in the CON, they differed in where they fell in the transition process. Only one participant described her experience as being in the moving in stage as this was her first year in a faculty position at the CON. Four participants were in the moving through

stage. They seemed to have learned most of what they needed to survive in their faculty role although most indicated that they still had much to learn about education in general. Two of the participants were actually in the moving out stage as both were not returning to their faculty positions in the following academic year.

#### *Data Analysis Process*

A thematic analysis of all data obtained, including documents, observations, field notes, and interviews, was conducted. The analysis process began with a review of documents and continued with each interview and observation that was conducted. Analysis of the data obtained from the interviews and observations was accomplished through the process of coding, which allowed data to surface from the a priori categories into emergent categories and finally, into emergent themes.

#### *Coding*

All interview transcripts and field notes were hand coded in the following manner. A list of a priori codes was used in the first reading of each transcript. Open coding occurred as each transcript was read and re-read while searching for categories of meaning. Readings of each transcript resulted in hand-written coding using the a priori categories as well as emergent categories that surfaced during the readings.

#### *a priori and Emergent Categories*

A description of the process that was used to move from the a priori categories to the emergent categories and finally, to emergent themes will chronicle the steps used in the analysis of this data. During the analysis process I moved out of the a priori categories that were originally presented in Chapter 3 to a revised list of emergent categories. With each reading and re-reading of the data, categories emerged in a different configuration

from the a priori list. This was especially noted as I arranged the data from each participant together with data from all participants using cross case comparative data analysis. With each level of rearranging the data I was able to see new patterns develop among the categories. I found that the a priori categories were not incorrect, but rearranging them into a different order led to the development of the emerging themes. A summary of the initial a priori categories and the resultant emergent categories are presented in Table 2.

The a priori categories of individual role transition, transition process, and coping with transition did not separate out as categories in the data. The data presented themselves more clearly as separate transition factors, which were originally included in the a priori category of *coping with transition*. The final category that emerged: *transition factors*, included the subcategories of (a) *situational transition*, (b) *self in transition*, (c) *strategies for transition*, and (d) *support in transition*.

*Transition factors*. Data related to participants' transition comprised the subcategory of *situational transition*, which included the participant's expertise as a clinician and his or her prior experience as a preceptor. Participants' personal and family values and having had role models in nursing were factors that made up the *self in transition* subcategory. Factors that comprised the subcategory of *strategies for transition* included participants' participation in formal faculty development within the university and participants' informally seeking advice from colleagues in the CON.

After a first reading of the transcripts, I recognized that when participants talked about socialization it was the same thing as social support structures; therefore I eliminated the a priori category of socialization during my initial coding of the data.

Table 2

*Summary of a Priori and Emergent Categories*

a priori categories	Emergent categories
	Transition factors
Individual role transition Type, context, impact	Situational transition Expertise as a clinician Experience as a preceptor
Transition process Reactions over time Moving in, through, and out	Self in transition Personal values Prior role models
Coping with transition Situation, self, support, strategies	Strategies for transition Formal faculty development Informal advice seeking
Socialization Anticipatory Organizational	Support in transition Formal orientation Informal mentoring
	Behavioral patterns and processes in:
Nursing culture Geospatial, traditions & myths Behavioral patterns & processes Espoused and embedded values & beliefs	Nursing Success as a clinician Institutional structure
Academic disciplinary culture Geospatial, traditions & myths Behavioral patterns & processes Espoused and embedded values & beliefs	Academic discipline Role preparation Effectiveness as an educator Clinical competency and practice Changing student values
Professorial culture Geospatial, traditions & myths Behavioral patterns & processes Espoused and embedded values & beliefs	Professorate Hierarchical structure Stress of obtaining tenure

Table 2 (continued)

*Summary of a Priori and Emergent Categories*

a priori categories	Emergent categories
	Espoused values in:
	Nursing
	Value clinical competency
	Value commitment to nursing practice
	Value autonomy
	Academic discipline
	Value love of teaching
	Value autonomy
	Value integrated scholarship
	Professorate
	Value research and scholarship
	Value service to the college
	Embedded values in:
	Nursing
	Valuing the “art” over the “science of nursing
	Academic discipline
	Valuing the “science” over the “art” of teaching
	Professorate
	Valuing funded research over the “art” of nursing and the “science” of teaching

Socialization factors appeared to fit more closely into the *support in transition* subcategory; therefore I merged socialization into *support in transition*. All participants essentially had the same formal organizational socialization, but what emerged as different was the informal socialization process in terms of faculty support. Participants

talked about the formal orientation process at the CON and informal mentoring among faculty as types of support they received during their transition from a clinical practice role to a faculty role.

The final reorganization of the a priori categories included a more specialized focus on *behavioral patterns and processes, espoused values, and embedded values*. The original a priori categories included (a) geospatial, (b) traditions and myths, (c) behavioral patterns and processes, (d) espoused values and beliefs, and (e) embedded values and beliefs of nursing culture, academic disciplinary culture, and professorial culture. During analysis, factors related to geospatial, traditions, and myths did not surface in the data. The factors that strongly appeared were related to *behavioral patterns and process, espoused values, and embedded values*. Therefore, instead of discussing the three cultures separately as I had originally proposed, data were presented as *behavioral patterns and processes, espoused values, and embedded values* in each of the three cultures, *nursing, the academic discipline, and the professorate*.

*Behavioral patterns and processes*. Factors related to behavioral patterns and processes in nursing included participants' success in a clinical role and issues related to the organizational structure of hospital-based institutions. In the academic discipline area, data emerged related to participant's lack of preparation for a teaching role, feelings of inadequacy as an educator, difficulty in maintaining clinical competency, and the issues of changing student values. Finally, data that emerged related to the behavioral patterns and processes in the professorate category were the hierarchical structure of an academic environment and the stresses related to obtaining tenure.

Of particular interest were data related to student culture. Student culture was not one of the a priori categories, but data encompassing student culture appeared early and frequently during the coding process. This led to the inclusion of changing student culture as an emergent category. As I continued to code the data and as I examined the a priori and emergent categories, it became clear that changes in student culture was more than a category; it became an emerging theme.

*Espoused values.* In response to specific questions about values, participants identified important values in nursing as being clinically competent, having professional autonomy, and being accountable for patient outcomes. When asked about important values for the academic discipline of nursing, participants identified their love of teaching, being autonomous, and participating in integrated scholarship. Participants identified research and scholarship and service to the college as the values important to the professorate.

*Embedded values.* Embedded values of the nursing profession, the academic discipline of nursing, and the professorate also came forward in the data. The embedded values of the three cultures differed from the espoused values. Embedded values in nursing were identified as valuing the “art” over the “science” of nursing. In contrast, embedded values in the academic discipline were detected as valuing the “science” over the “art” of teaching. Professorial embedded values were identified as the value of funded research over the value of the “art” of nursing and the value of the “science” of teaching.

Data from the emergent categories were then analyzed for common themes and patterns. This final examination resulted in the emergence of six overarching themes: (a)

stressors and facilitators of transition, (b) deficient role preparation, (c) changing student culture, (d) realities of clinical teaching and practice, (e) hierarchy of reward, and (f) cultural expectation versus cultural reality. A summary of the emergent categories leading to the emergent themes is presented in Tables 3, 4, 5, and 6.

### *Emerging Themes*

#### *Stressors and Facilitators of Transition*

A prevalent theme among participants focused on factors related to the transition of nurses from a clinical practice role to a nursing faculty role. This theme cut across several categories, and emerged from data particularly arising from the *transition factors* and *behavioral patterns and processes* categories. This theme is presented as two separate headings, stress in transition and facilitators of transition. A discussion of the stresses related to faculty members' transition from a clinical practice role into a faculty role is presented first, followed by a description of factors that facilitated faculty members' transition. To assist the reader in keeping track of quotes attributed to each participant, each quote has been labeled with a participant number.

*Stress in transition.* Much of the stress in transition was related to the labor intensiveness of a faculty appointment in a CON, especially the heavy teaching loads given to junior faculty. Participants clearly indicated that the transition from a clinical practice role to a faculty role took a great deal of energy and was more work than they had originally anticipated.

While many faculty members spoke specifically about situations of their transition and their strategies for coping with transition, one participant's comment denotes the power of this theme overall. The high level of energy needed in a faculty role was particularly

Table 3

*Transition Factors Leading to Emergent Themes*

Emergent categories	Emergent themes*
Situational transition	FT, DRP
Expertise as a clinician Experience as a preceptor	
Self in transition	ST, FT, DRP
Personal values Prior role models	
Strategies for transition	FT, DRP, RCT, CSC
Formal faculty development Informal advice seeking	
Support in transition	FT, DRP, RCT, CSC
Formal orientation Informal mentoring	

\*Emergent themes:

ST – Stress in transition  
 FT – Facilitators of transition  
 DRP – Deficient role preparation  
 CSC – Changing student culture  
 RCT – Realities of clinical teaching  
 RCP – Realities of clinical practice  
 HR – Hierarchy of reward  
 CECR – Cultural expectation versus cultural reality

Table 4

*Behavioral Patterns and Processes Leading to Emergent Themes*

Emergent categories	Emergent themes*
Nursing	ST, FT, DRP, RCP, CECR
Success as a clinician Institutional structure	
Academic Discipline	ST, DRP, CSC, RCT, CECR
Role preparation Effectiveness as an educator Clinical competency and practice Changing student values	
Professorate	ST, CSC, HR, CECR
Hierarchical structure Stress of obtaining tenure	

\*Emergent themes:

ST – Stress in transition  
 FT – Facilitators of transition  
 DRP – Deficient role preparation  
 CSC – Changing student culture  
 RCT – Realities of clinical teaching  
 RCP – Realities of clinical practice  
 HR – Hierarchy of reward  
 CECR – Cultural expectation versus cultural reality

Table 5

*Espoused Values Leading to Emergent Themes*

Emergent categories	Emergent themes*
Nursing	RCT, RCP, CECR
Value clinical competency	
Value commitment to nursing practice	
Value autonomy	
Academic Discipline	CSC, RCT, CECR
Value love teaching	
Value autonomy	
Value integrated scholarship	
Professorate	HR, CECR
Value research and scholarship	
Value service to the college	

\*Emergent themes:

ST – Stress in transition

FT – Facilitators of transition

DRP – Deficient role preparation

CSC – Changing student culture

RCT – Realities of clinical teaching

RCP – Realities of clinical practice

HR – Hierarchy of reward

CECR – Cultural expectation versus cultural reality

Table 6

*Embedded Values Leading to Emergent Themes*

Emergent categories	Emergent themes*
Nursing	DRP, CSC, RCT, RCP, CECR
Valuing the “art” over the “science” of nursing	
Academic Discipline	RCT, RCP, HR, CECR
Valuing the “science” over the “art” of teaching	
Professorate	HR, CECR
Valuing funded research over the “art” of nursing and the “science” of teaching	

\*Emergent themes:

ST – Stress in transition

FT – Facilitators of transition

DRP – Deficient role preparation

CSC – Changing student culture

RCT – Realities of clinical teaching

RCP – Realities of clinical practice

HR – Hierarchy of reward

CECR – Cultural expectation versus cultural reality

noted by participant #4 who stated, “It’s a lot more work than I thought it would be. It takes me 10 hours to prepare a two-hour lecture; that’s minimum.” In addition to the amount of time needed for lecture preparation, this faculty member related that always having something that needed to be completed was an additional stress in his faculty role

when he stated, “It doesn’t actually go away—there’s not the end of a clinic day. There are always papers to grade or things to be planning for.”

Participant #2 also talked about the tremendous amount of energy needed in her faculty role.

I guess I would say that this role adjustment is more tiring than I thought it would be, and I don’t know whether or not that’s because I’m that many years older or what—it takes a lot of energy.

In addition to the level of energy needed to teach, participants also talked about the amount of time and effort it took to do the job well. Participant #4 stated, “I think that you could do this job easily—like just show up and be kind of sloppy, but to do it well, it takes a lot more energy than I thought.” This same faculty member illustrated the amount of effort needed to be an effective educator.

The difference is between downloading PowerPoint slides and just talking for the two hour lecture, [compared to] actually planning a lecture and writing a lecture that makes some sense in terms of the course. I don’t think there’s maybe like a 20% difference in improvement; but the amount of work it takes to do it very well is exponential.

Another faculty member expressed frustration that people outside academe do not understand the tremendous amount of work it takes to be a good teacher.

I think there are many people who don’t understand how much energy it takes to be a *good* faculty person. It takes a tremendous amount of energy and I still bristle at the—“them that can, do; and those that can’t, teach; and those that don’t, teach teachers to teach”—I think that that’s really unfair. (Participant #2)

Although all participants at every level of teaching, including clinical, lab, and lecture, revealed the stresses of transitioning to a faculty role from a clinical practice role, many participants stated that junior faculty, with clinical assignments only, often face the greatest struggle to survive in their new position in the CON. Participant #3, who works closely with several clinical faculty members commented, “New clinical faculty are on

the front line with the day to day interactions with students, which is very stressful.” A clinical instructor echoed a similar thought when she stated, “New clinical faculty come in and they don’t know what they’re doing. There’s nobody to tell them this is what you need to get done” (Participant #5). This clinical instructor talked about how her past experience as a hospital nurse in her clinical setting helped her transition into her faculty role, an experience most new clinical faculty do not have.

I’m a staff nurse [at the hospital], so I knew when I started teaching that I need to get my I.D. so I can get into the supply room and I need to have it coded so I can get into the med station and get the meds out—little tiny things that nobody tells you.

Another stress related to transition from clinical practice into a faculty role emerged as participants expressed feelings of ambivalence and self-doubt associated with their current faculty role. This role ambivalence was noted as faculty members frequently talked about having had a high level of expertise and self-confidence as a nurse clinician, but having less confidence in their abilities as an educator. Several faculty members expressed their lack of self confidence as an educator consistently throughout the interviews and observations. This ambivalence between expertise as a clinician and effectiveness as an educator cut across many categories, but primarily surfaced as participants described their past clinical experiences, which appeared throughout the *situational transition* category. This theme also surfaced as participants talked about their limited teaching abilities, which emerged throughout the *behavioral patterns and processes in nursing* category.

Feelings of self-doubt were particularly illustrated by participant #4 when he talked about his continued struggle with role ambivalence at the end of his second year in a faculty role. He stated, “I’m very comfortable as a nurse practitioner—I have other NP’s

call me. I can mentor nurses. I really feel like I've been doing it a while, so I can address most patient concerns." His lack of experience as a teacher surfaced in poor evaluations from students in a previous class, which created much doubt in his mind about his own effectiveness as an educator. He stated, "I was crushed when I got those evaluations, because—I didn't know where to start. I thought I was a miserable failure."

This ambivalence between the roles of clinician and faculty continued to surface as participant #4 described feelings of self-doubt over his ability to teach, compared to his self-confidence as a nurse practitioner.

I didn't even want to call myself an educator, really—give me the toughest patient—those are the ones that I want. I know I can win them over. If [other nurses] had a problem with a clinic patient, they'd call me because I had been doing it a while. Then with the students, it's like I almost don't know where to start—it just kind of gets to me, still.

Feelings of conflict and self-doubt in the educator role that were expressed by participant #4 were also noted by other participants. One faculty member believed that her ineffectiveness as an educator was also reflected in poor student evaluations. She viewed herself as an expert clinician; however being viewed as a less than expert educator caused her to question her decision to continue to teach.

I'll be honest; when I saw my [evaluations] it was like someone had cut my heart out. It was very devastating and I really spent last summer and this fall—really questioning if this was the right place for me. My mantra through all of that has been, you know what, I was such a good [clinician] and maybe I'm just not a good teacher. (Participant #3)

Several participants indicated they identified more with being a nurse in clinical practice than with being a faculty member. Participants' uncertainty of role identification added to the stress of transition from a clinical practice role to a faculty role. This discovery emerged from several categories including *situational transition* and the

*behavioral patterns and processes in nursing* as participants discussed their past expertise in a clinical practice role. When outsiders asked about his current position, participant #4 would reply, “I’m a nurse practitioner,” instead of saying, “I’m a clinical instructor.” This conflict of role identification was especially noted several times throughout the initial interview when he stated, “I really don’t know anything about teaching, so I always say I’m a nurse and a nurse practitioner.”

This same faculty member described his perception of role conflict as the “impostor syndrome.” He indicated that being a clinical instructor was not the same as being a “real” faculty member, even though he acknowledged that he held a faculty appointment in the CON.

I always introduce myself as a nurse practitioner and a nurse, not as a clinical instructor, like the impostor syndrome. To say that I’m on faculty here—I mean I know that I am, but I’m not an associate professor. (Participant #4)

Another participant spoke of having dealt with the impostor syndrome throughout her professional nursing career.

I went through my super-serious phase and I really began to realize that super-seriousness was more a façade of discomfort because I wasn’t sure [of what I was doing]—it was like the impostor syndrome. (Participant #2)

Although she did not specifically focus on her current faculty role, her comment lent support to the finding that ambivalent feelings and self-doubt may occur in nurses in a variety of roles, including both clinical practice and educational positions. She continued to talk about the impostor syndrome and how she was not always who she appeared to be in her professional career.

I have had to struggle with the impostor syndrome—but I laugh about it now, because it’s taken me, I guess, until I’m kind of senior to realize that the impostor syndrome is an impostor—it makes you do things that are stupid. (Participant #2)

Another stress related to the transition of nurses from clinical practice to a faculty role centered on the fact that there was no clear indication of what was expected of a person new to the faculty role. One clinical instructor stated, “You don’t get a job expectation.” She stated there was no explanation for new faculty of “what you have to do as a clinical instructor, besides showing up in clinical” (Participant #5).

Participant #5 expressed frustration not only about the lack of direction from senior faculty members about her faculty role, but also with the fact that other clinical instructors do not understand the faculty role expectations either. She was concerned that new faculty are not told what the job expectation is, and even after being in the role for some time, no one shared with new faculty what the faculty role expectations are. She illustrated a situation where clinical instructors are unaware of what is expected practice for a faculty role as she talked about how she valued being available to students on a regular basis.

If my door [is open] and my light is on, I’m here. That’s one thing that I think should be expected of all the clinical instructors. I don’t think you have to be here for six hours, but if you’re here for a couple hours, then [students] know they can come see you if they need to. I can probably count on one hand the number of [faculty] that you see regularly that are here.

Additionally, the lack of feedback from colleagues regarding job performance was reported as a factor that contributed to the stress of transition for several participants. Although all participants received regular feedback from students in the form of course and clinical evaluations, several participants expressed they had no clear sense of how colleagues believed they were performing in the faculty role. Participant #4 talked about the importance of knowing that colleagues viewed him as being a good educator, which surfaced as data in the *support in transition* category.

I don't think I'm insecure, but I honestly didn't know how [a senior faculty member] thought I was doing. I know I like what I'm doing. I know I try really hard, but I don't know if she saw me as an effective teacher or not.

Another faculty member related the lack of colleague feedback to an overall sense of isolation within the CON. She stated, "We're all trying to get into the survival mode, and we don't have a strong support network or really a support network at all" (Participant #7). She expressed her belief that there is a need for mentoring in the CON to support faculty members who have limited experienced.

*Facilitators of transition.* Faculty members' prior nursing experiences emerged as factors that helped participants transition into their current faculty role. Data revealed that a part of faculty members' ability to successfully transition into their faculty role was related to experiences they previously had in their clinical practice role. One of these experiences that emerged throughout the *situational transition* category was having been a preceptor to students while in clinical practice. All seven participants related that they had precepted students in the clinical setting at some time during their nursing career. One participant noted, "I've always enjoyed teaching. Back even in my hospital days I was always the preceptor" (Participant #7).

Participants indicated that the experience of working with students in the clinical setting was what led them to consider teaching as their present career choice. One clinical instructor related her experience as a preceptor as being a key factor in obtaining her current faculty position.

A friend of mine who had graduated with me had just accepted a position as a clinical instructor here and I talked to her about it and I thought, I've always enjoyed being a preceptor, I think I would like to do that. So, that's how I ended up at the college. (Participant #6)

Even though participant #6 had not actively sought out her current faculty position, she described her recent transition from a clinical practice role into a teaching role as something she has enjoyed and as a role that she was familiar with because of her prior preceptor experience.

It wasn't something I was actually seeking, but I had an inkling that I would enjoy it, and I certainly have. And I was always a preceptor when I was in the unit for both students and new staff, so teaching really was not new to me.

Another participant made the decision to assume a faculty role in order to balance both her love of teaching and clinical practice. She stated, "It's a great complement. It's a great mix—schizophrenic at times, but I feel like I've kind of really found my niche" (Participant #7).

For many participants, prior experience as a staff nurse at the same facility where they now have students was helpful in their transition to a faculty role. One clinical instructor stated, "It helped that I was a staff nurse and I do clinicals in the [hospital] where I was working. I knew the patients and I knew how things ran." (Participant #5)

In addition to the experience of precepting students, having had administrative experience was another facilitator in the transition process. Three participants reported having had experience as an administrator in their former clinical positions. These faculty members stated that having experience as a nursing manager reduced some of the stress related to transition to their current faculty role. These data emerged throughout the *situational transition* category.

Of particular interest was that only participants with former clinical management positions indicated that the transition to a faculty role had been easier for them than for

other participants. One faculty member described how previous management experience helped her work with unsuccessful students.

I think having been in a manager role has really helped me with dealing with some of the students—just in terms of trying to be consistent and very clear about my direction; particularly in situations where I had students that weren't cutting it. (Participant #1)

She related one particular incident with a student who was unsuccessful in the clinical setting and how her past experience in hospital management helped her deal with this issue in the college setting.

I had this student and she just wasn't going to make it in clinical—I remember going in to [my mentor] and she said, “Oh, my gosh—you have all this documentation,” and I said, “Well, don't I have to have that?” That's the paper trail I had to do in my [management role]—so I was just kind of following my hospital mode. (Participant #1)

Reliance on prior administrative experience as a positive factor in working with students was echoed by another faculty member who stated, “From my management background, I feel like I can deal with the students” (Participant #7). Another faculty member cited not only her administrative experience as a benefit in her faculty role, but also her past successes in nursing.

Since this is towards the end of my—active career in nursing—I don't have a lot to prove to anybody—or myself. I also think that I've established enough of a reputation that I don't have to spend a tremendous amount time worrying about how I'm going to build this at work. (Participant #2)

Related to the facilitators of transition theme was whether or not participants held a terminal degree. Interestingly, both participants who held a Ph.D. indicated that while the doctoral degree did not help prepare them for a career in teaching, their terminal degree was an advantage during their transition to a faculty role.

I think the transition is fairly comfortable. I also think the fact that I have the doctoral degree has been helpful, because I don't have the pressure of people

telling me that I need to be more educated. I can say, “Read my wall.” (Participant #2)

Having obtained a high level of achievement and self-accomplishment was also expressed by the two doctorally-prepared participants. One faculty member described her high level of self-confidence when she stated, “The fact that I have a lot of experience and fair degree of role confidence and competence is very helpful. I believe that if you were not really feeling very comfortable, that your transition would be difficult” (Participant #2). She also described how past successes in her nursing career may have helped her transition to a faculty role. She stated, “The fact that I have been demonstratively successful in my career—I had the yardsticks of success for the career, and I realized that, man, you know this was a little kid from [nowhere]-who’d a thought?”

Even though several faculty members described their transition as being less stressful than some of their colleagues, transition to a faculty role from a clinical practice role was described by some participants as an overall “struggle to survive.” All participants conveyed that it took a tremendous amount of time and effort to learn how to survive and thrive in academia and many admitted having feelings of ambivalence about their ability to perform well as an educator, especially having come into academe from very successful clinical practice roles. One faculty member conveyed feelings of struggle, ambivalence, and self-doubt about her new role in academe. She described her difficulties as a course head, having responsibility for large amounts of lecture every week, as a kind of “learn by doing” experience. She stated that she viewed her faculty role “from a survival standpoint.” She reported her frustration with being responsible for four hours of class time each week as “trying to think about how I can endure it as well as

the students and make it meaningful. Within my limited scope, I try different strategies but I know I'm just really out there sometimes" (Participant #7). She described the difficulties she faced in her faculty role as a continual struggle, one that she sometimes questioned why she continued to endure.

When I was hired as a course head for this course, my clinical assignment was not in the course so I couldn't even follow along. I didn't know where the bathroom was or how to sign into the computer system, let alone—here's the clinical group and this is what they're doing, and here's what you should be teaching. When I think about that, I must have some kind of a deranged disease to even put myself in this position. (Participant #7)

### *Deficient Role Preparation*

Another key theme to emerge from the data was the acute awareness by participants that none had received any formal training on how to be a teacher. While all the participants received formal education in the art and science of the nursing profession, none of the participants had been prepared for a career as an educator. As one participant asked during the interview, "How do you go from expert clinician to expert teacher with no formal teacher education?" (Participant #4). This lack of instruction in pedagogy emerged as a theme that was noted by all seven participants and surfaced as data from interviews and observations related to several categories, including *situational transition*, *strategies for transition*, *support in transition*, and *behavioral patterns and processes in the academic discipline*.

Most faculty members indicated that learning how to teach was self-taught and essentially something they had to acquire on their own. Although many participants discussed various strategies they learned and support they received during their transition to a faculty role, which included formal faculty development, informal advice seeking, formal orientation, and informal mentoring, most relied primarily on the "learn as you

go” method of education. While discussing the lack of preparation for her current faculty role, participant #5 stated, “Nobody really taught me how to teach. I just kind of went in and did it. This is my third year teaching this course, so just through the years, I learned what works and what doesn’t work so well.” Another faculty member expressed similar thoughts about not being formally prepared for the clinical instructor role. She stated, “It’s a self-taught position. I just did what I felt came naturally to me, and looking back, thank God it worked” (Participant #6).

One faculty member blamed her lack of knowledge of basic teaching methods as being partly responsible for her feeling that she was not “good enough” in her teaching role. She stated, “With the students, I feel some inadequacies—some personal weaknesses when it comes to methodologies and teaching techniques” (Participant #7). Although she stated that her lack of teaching skills was a difficult experience, she put the responsibility of needing to improve her competence in pedagogy on herself. She stated, “Being aware of my [lack of knowledge] is a frustration, but something I’m willing to take on as my own self-learning here in this environment.”

Although participants frequently reported an overall lack of knowledge of teaching methodology as an issue in their transition into their faculty role, one clinical instructor described her struggle with teaching as being more related to evaluation and organization. She stated, “I guess the big thing for me was the teaching part wasn’t so bad, but it was evaluating the students and learning how to organize myself” (Participant #5). This faculty member’s need for assistance in evaluation techniques and organizational skills revealed that lack of preparation for a teaching role encompassed different aspects of teaching, not just methodology.

Every participant at some point during the interview process stated, “I was a very good clinician,” but not once did any participant ever state, “I am a very good teacher.” Participants talked frequently about their strong clinical skills, while repeatedly questioning their ability to be an effective teacher, much less an expert educator. This notion of strength in clinical competency compared to weakness in teaching ability was expressed by all faculty members at both the masters and doctoral level.

Participants stated that graduate education in nursing, while it prepared them well for a clinical practice role, did not prepare them for a career in nursing education. Faculty members reported having strong clinical expertise, but they were searching for answers as to how they could develop proficient skills in teaching. As one faculty member stated, “All of a sudden there’s this role change and I want to be an expert instructor, but where do you learn how to do that?” (Participant #4).

Additionally, the elimination of graduate nursing programs that focused on education was mentioned by participants as having decreased the opportunity for nurses to advance their careers in nursing education. One faculty member was visibly angry as she talked about the “terrible job” she felt nursing education was doing to prepare nurses how to teach. She stated, “The fact that we have gotten rid of nursing education as a masters level specialty is awful. You have to be an NP or an CNS to teach, is crap—let’s just put it right on the line” (Participant #3).

Participants indicated that the lack of good role models in nursing education made transitioning into a faculty role more difficult. The need for exemplary role models in nursing education was clearly an area of concern for many participants. One faculty member stated, “You need an excellent expert” (Participant #4). He described the

dilemma for new nursing faculty as not only the lack of excellent role models in teaching, but also not knowing how to find nursing faculty members who are superior educators.

I could ask other [faculty], but I don't know who the really good educators are and I know there are some teachers that students like better [than others]. Who really helps us develop as professionals?

A related issue expressed by several faculty members was the limited opportunity available for them to observe good role models in education. These data emerged primarily throughout the *self in transition* category as participants related the need for role models in clinical practice as well as in the CON. Much of the problem with access to role models stemmed from the fact that most participants seldom had the opportunity to participate in observations of colleagues who taught classes or clinical. The opportunity to interact with peers was reported to be much greater in the hospital setting than in the CON. One faculty member stated, “As a clinical instructor, you're in your own little world. There's not a lot of crossover, or seeing other instructors in that role” (Participant #6).

To compensate for the limited access to role models in education, many participants stated they modeled former teachers and trained students the way they were taught in their own nursing education programs. When asked how he learned to teach, participant #4 stated, “I do what my instructors did for me.” Another faculty member, when asked the same question, reported that she also “modeled former teachers” (Participant #3). But she admitted that the method she used might not be the best way to learn the role of faculty.

When I first came I thought it was going to be really easy to teach. I thought, I've had bad teachers. I've had good teachers. I'll just model my good teachers; but that doesn't necessarily work.

Several participants commented that limited knowledge in pedagogy led to decreased satisfaction for both faculty and students. One faculty member stated, “You’ve got a lot of us in teaching who’ve never been taught how to teach, and that’s a problem. I think that it increases our turnover” (Participant #3). Participants additionally reported that good teaching led to increased satisfaction and happiness in both faculty and students. One participant explained how teaching ability affected student and faculty satisfaction and the overall status of the school.

I think people come in and think it’s going to be something different than what it is. I think it decreases satisfaction not just in the clinical instructor and any other faculty level position. It decreases student satisfaction and then the reputation of the school hurts. (Participant #3)

Another faculty member described a situation that illustrated the effect of good teaching on student satisfaction. She described a comment made to her at the beginning of the term by a student who stated, “I just haven’t felt like the clinical instructors want to teach or are encouraging about us.” In response to this student’s comment, participant #6 thought to herself, “I bet she feels completely different at the end of this [term] because she hasn’t had me yet.” She then described a conversation that occurred between herself and the same student on the final day of clinical in which the student’s attitude about her nursing education had completely changed.

So today I asked her, “How do you feel now?” And the student said, “My husband’s remarked about it and my family has remarked about it. I’m in a good mood now and I love school.”

### *Changing Student Culture*

An emerging theme that surfaced during classroom observations and interviews with many of the participants was that the values, beliefs, and behaviors of students have changed. This emerging theme of changing student culture cut across several categories; including *strategies for transition*, *support in transition*, and *behavioral patterns and processes in the academic discipline* and the *professorate*. The noted changes in student

culture were closely related with how clinical nurses transitioned into their faculty role because student behavior affected the way faculty taught and how faculty felt about their new role, which affected faculty members' transition.

Several participants discussed their observation that today's nursing students are angry and mistrustful of the educational process and of nursing faculty overall. This was particularly noted throughout the *behavioral patterns and processes* category as faculty members revealed how students in the CON acted during class and clinical. Participants indicated that the anger and mistrust noted in students was different from past generations of students and especially from participants' experiences as student nurses.

The issue of angry students was raised by one faculty member when she was asked to describe something she disliked about her current faculty role. She responded, "I think the major thing that has surprised me is the student group. At the risk of sounding like I have Alzheimer's, I don't remember students being as angry as they are" (Participant #2). Another faculty member talked about the draining effect student anger had on faculty.

It's a generational thing. The [students] don't work as hard. They're angry if you push them; and maybe it's only 5 or 10% of the class, but that 5 or 10% just wrings you dry. (Participant #3)

Faculty members expressed frustration with students' apparent lack of trust of faculty. Participant #2 appeared to be very disturbed with students' continual challenging of faculty. She stated, "Students whom we have don't trust us and I've been trying to figure out what's underneath that." She was particularly concerned with student accusations that faculty are not providing the knowledge students need to be successful graduate nurses.

The challenging is not the challenging that I would expect— it's, where do you get off thinking that you know what you're really doing because there must

something that [faculty] are holding back. I have the feeling that a lot of the students think we're withholding information that they need to pass [boards] and I can't quite figure that out.

Another faculty member described students' dependence on faculty for their own learning as a reflection of changing student values. Participant #3 reported this value change in students was the biggest disappointment in her faculty role.

I can't help wonder what's the value system that this generation has, and how do they think they're ever going to learn it, and why do they think that there's such minute pieces of knowledge that they need to know.

This faculty member related her perception of anger in students as a reflection of students' lack of accountability for their own learning. She stated, "My students are angry because my book is big and I demand they read full chapters." In response to students wanting to be told from exactly what pages quiz questions will be written, she stated, "I'm sorry but all bets are off. I can't give you that" (Participant #3).

As this theme of changing student culture emerged throughout the initial interviews, I asked participant #1, during her second interview, to talk about the current class of students and whether she had noticed any changes from prior groups. She stated, "This particular class—they don't seem that vested in each other, where a lot of past classes got a lot of support from their peers. These guys don't seem to do that." She shared her thoughts that the current student culture was different from her own educational experiences in nursing school.

It seemed like when I was in graduate school, we were always doing things with the people in our class, and I knew lots of their husbands and their families. I knew a lot about the other students, and it doesn't seem with this particular class, that they've been that cohesive.

She described how this changing student behavior has affected her method of teaching. She stated, "The students are not very conversational. That's why I ended up

doing the name picking thing [in class] to force them to participate—It's difficult to get them to interact" (Participant #1).

The highly competitive nature of the nursing program was something often mentioned by participants when discussing the change in student culture. Faculty members stated that because of the competitive admission process into the nursing major, nursing students tended to be high achievers and were used to being at the top of their previous undergraduate classes. This was noted throughout several categories, but surfaced most often when participants talked about student behavior and its effect on faculty, which emerged throughout the *behavioral patterns and process in the academic discipline* and the *professorate* categories.

One faculty member described the competitive admission process and how this competition affected students. "We have 600 applicants for the undergrad program here—we admit 150. Our average GPA at the freshman level is 3.5, and they're still acting like numb nuts" (Participant #3).

Faculty members stated that students accustomed to receiving As in their first two years of undergraduate study, often receive Bs and Cs when they enter the nursing major. Several participants indicated that students reflected their disappointment about receiving lower grades through anger and distrust of the nursing faculty and the educational system overall. Participant #2 described this dynamic, which is reflected in students' wanting to blame the faculty member for their grades.

When you take this group of students, all of whom score over 1200 on their SAT's; they all have GPAs of 3.6 or higher; they all are accustomed to getting A's. Then they get into a group where they're the norm. I think there is a lot of hostility about the fact that they're not top dog anymore and it's obviously the professor's fault—and so to get a B on a paper is a very, very difficult situation.

This faculty member discussed her frustration with the aggressive nature of student behavior and how this had affected her interaction with students. She stated after a class during which students had been particularly hostile she said, “You know, we’re not the enemy. I really am dedicated to making things work for you, and I’m not sure why you perceive that they’re not working” (Participant #2).

Emerging throughout the theme of changing student culture was that students’ overall expectation of what they believed nursing education should be did not match the realities of their educational experience. This surfaced in the *espoused and embedded values in the academic discipline* subcategory and was expressed by participant #3 when she stated, “There’s this terrible gap between expectations and reality” in students. She described her experience of students reacting with anger when she presented her perception of this conflict between expectation and reality in nursing school. She told the students, “You may have gotten As in high school. You may not have had to work hard, but [nursing school] is an entirely different ballpark.” In her attempt to ground students in the reality of nursing education she told students, “You need to be aware that your undergraduate nursing program is the hardest thing you will ever do. That doesn’t mean we sit here and try to make it harder, it’s just inherently tough.” Students responded to her frank discussion of the difficulties encountered during nursing education with even more anger. Participant #3 expressed disappointment as she attempted to deal with students’ continued hostility.

The reality of changing student culture is that student behavior has a strong effect on faculty and how they respond to students in the classroom and clinical setting. The changes noted in student culture were closely related to the difficulty experienced during

faculty role transition as negative student behavior affected not only how faculty responded to students, but also the way faculty responded to their new role. Participant #2 reported that she has become defensive with students as she discussed how student behavior had affected her teaching. She stated, “I feel more defensive than I want. I find with some of the students now—it’s a challenge for them to point out why you don’t know what you’re doing, and I find that very uncomfortable.”

### *Realities of Clinical*

All participants, even those who did not teach clinical courses, talked about issues related to clinical nursing throughout the interviews. Clinical concerns focused on two specific areas; those related to clinical instruction and those related to clinical practice. Therefore, the overall theme of the realities of clinical is presented as two separate headings, teaching and practice.

*Teaching.* An overarching theme that emerged during the interviews was that the clinical teaching role was very unique. Essentially, participants revealed that nursing faculty who teach in the clinical setting are in a “world of their own,” which is a very different world than that experienced in a clinical practice role or a non-clinical faculty role.

One participant, a clinical instructor, revealed the differences between being a clinical instructor and being in a clinical practice role when she stated, “I feel like in the clinical instructor role, you’re kind of caught between worlds. I’m not hospital staff, but I probably feel more a part of that than as a CON faculty” (Participant #6). She described a recent situation that emphasized her struggle with how she was seen by others, as a clinical nurse or a clinical faculty member.

Nurses week was a few weeks ago and the [hospital nurses] were getting gifts. I didn't get anything nurses week because—I'm not a staff nurse. And I couldn't participate in things that were going on in the college because I was at the hospital teaching clinical. So it's like I float between worlds.

Another clinical instructor described the isolation she felt in her faculty role. When asked about some of the difficulties in transitioning from clinical practice to a faculty role, participant #1 stated, "It's more isolated than working at the hospital—that was probably the hardest thing for me to get used to last year." She related that the isolation she experienced in her faculty role was the result of faculty "always doing their own thing." She stated, "Some are busy doing their research and others are busy teaching and when they're not teaching, they're putting together their lectures." In comparison, she reported having much greater contact with colleagues in her previous clinical practice position.

There's not as much interaction between the faculty, as there is at the hospital where you're working and there's someone to have lunch with everyday. You're interacting with a great deal more people. A lot of times I'm not even [at the college]—you know—physically in my office—so that I think contributes to the isolation also.

Many participants indicated that working in a clinical faculty role was more stressful than working in a traditional clinical practice role. These data emerged throughout the *behavioral patterns and processes in the academic discipline* category, as faculty members talked about their experiences as clinical instructors. Even participants who did not teach in the clinical setting described this situation as a stress faced by clinical faculty based on their observations and interactions with clinical instructors in the CON.

While faculty members admitted that the potential existed for serious consequences if mistakes are made in any clinical situation, the responsibility of overseeing students who are providing patient care greatly increased the stress felt by clinical faculty. One clinical

instructor described the difficulty of being responsible for multiple students in the clinical setting. She stated, “Working with the students is hard because you’ve got 8 to 10 students with you on the floor and it’s not like you’re just worrying about yourself” (Participant #5). She described the difference in stress she experienced as a clinical instructor compared to the stress in a clinical practice role. “You certainly have stressful days when you’re practicing, but it’s not like you’re following after anybody else. The mistakes you make are yours, rather than [the students] and you’re always trying to clean up after them.”

Participants also expressed concern that senior faculty who do not practice in a clinical setting were less clinically focused overall and had a minimal understanding of the clinical issues faced by faculty teaching in a clinical setting. These data emerged primarily throughout the *embedded values in the academic discipline* category, as participants talked about their current academic role.

One faculty member noted that the senior faculty member to whom she reported was doctorally-prepared and had limited clinical experience. Participant #7 stated that when she asked for advice related to clinical issues, the senior faculty member suggested, “that she look elsewhere for guidance.” Another faculty member revealed her frustration with senior faculty who do not understand how stressful it is for faculty who teach clinical courses in a particularly passionate way.

I get real frustrated with faculty that seem to have lost touch. They need to go over to the clinical setting and see how bad it is. They need to understand what our clinical faculty are facing every day. They need to see [clinical faculty] having to put up with students talking back to them on the unit and then turning around and doing something that could actually be deadly to a patient; and see how [the clinical instructor] is supposed to handle it when they’ve never been given one iota of orientation, let alone being taught how to teach. (Participant #3)

Participants reported that not only do senior faculty members lack an understanding of clinical problems; they also do not support clinical instructors. One participant reported that clinical faculty look for support from other clinical instructors because “they don’t get support from the senior faculty” (Participant #1). She described a situation in which a senior faculty member told a clinical instructor that “she didn’t need to worry” about not getting a basic orientation to the clinical setting. She related how important it was to students for clinical faculty to get the information and support that they needed in the clinical setting.

It’s a big deal to the clinical instructor and it’s an even bigger deal to the students if [the clinical instructors] don’t know what they’re doing. Students already feel like they don’t know what they’re doing clinically, but they need to know where the bathroom is, who do I call if I’m going to be sick, what’s the name of the nurse that I’m going to be working with, and how do I get up the floor? If you can erase that bottom hierarchy of needs, then [students] can really learn.

Participants frequently talked about their perception that senior faculty do not value the role of clinical faculty. Participant #3 stated, “I feel we have a gestalt here of a lack of respect for our masters prepared faculty.” Even though she did not teach in the clinical setting, this faculty member had a good understanding of issues faced by clinical instructors. She stated that clinical faculty feel that, “they’re the infantry.” “Clinical instructors are the ones that have the day-to-day interaction with the students and “they’re the ones where the rubber really hits the road.”

This faculty member described her frustration with senior faculty who don’t understand what clinical instructors face daily in the clinical setting. She stated, “They are the instructor on the unit when the student does some really dork, boned-head thing on the unit. They’re the main face to our public, and I get real frustrated [with senior faculty] who don’t get it” (Participant #3).

Another faculty member described a division that existed among junior and senior faculty in the CON. She stated, “I think there’s a general consensus within us as clinical faculty that there is a great divide [here]” (Participant #7). She described this division among faculty as a “reason that other clinical instructors have chosen to leave.”

In contrast, working with a senior faculty member who had recent clinical experience and who demonstrated an understanding of clinical issues was a plus for one participant.

She was my clinical instructor when I was an undergrad, before she got her Ph.D. She’s more clinically focused, which is nice, because when you talk to her about a clinical issue she understands what you’re talking about because she’s been there. (Participant #5)

A reality of clinical teaching that emerged throughout many of the interviews was that clinical faculty had less access to resources and support systems than faculty teaching theory courses had. As mentioned previously, clinical faculty often described a lack of support from senior faculty members, particularly as problems in the clinical setting arose. Several participants reported that this lack of support for dealing with clinical issues resulted in a “revolving door” syndrome where clinical faculty are less satisfied in their faculty role, therefore returning to clinical practice. In reference to several clinical instructors who left after their first year in the CON, one faculty member stated, “They didn’t really know what they were doing or what resources were available to them, so they got frustrated and they just left” (Participant #1).

One clinical instructor, who had been in her faculty role for three years, described a recent medication error made by a student in the clinical setting, which caused her to reevaluate whether she wanted to remain in teaching. The situation described by participant #5 demonstrated how the stress of clinical teaching can be a factor in the

decision to leave a faculty role as well as the fact that clinical instructors have great responsibility for things over which they have little control (i.e., student actions).

I had a bad week—a student had a med error on Tuesday. It was just one of those things that could have really happened to anybody but this is my third year and this is the first med error I've had. If I could have quit [that day] I would have. (Participant #5)

Also related to the realities of clinical teaching were faculty members' concerns about the large number of students in clinical groups. In response to an administrator's suggestion to increase the size of a clinical group to eight or more students, participant #3 responded, "We are at points where the clinical instructors, at the end of a year could say, 'This is not worth it. If I would have had one student less every [term] it would be tolerable'." She described the effect of large clinical groups on faculty as being similar to the weight of steel. "Clinical faculty fail with the more we load on them."

Several participants stated there needed to be more support for clinical faculty in the CON. After hearing in a faculty meeting that the average new graduate nurse's salary matched the salary of junior faculty in the CON, participant #3 responded, "How dare we not get down and kiss their feet? How dare we not try to improve their numbers in clinical?"

Faculty members reported that assigning clinical faculty to different courses every term also increased the stress on clinical faculty. This emerged during the interviews and observations primarily throughout the *behavioral patterns and processes of the academic discipline* category. Participants stated that lack of consistency in course assignments increased the level of stress on clinical faculty, which contributed to turnover of faculty in clinical positions. One faculty member stated that she asked for more regular assignments, "for my own personal sanity, as well as for growth and understanding of

what I'm doing" (Participant #7). She described how the lack of continuity in course assignments has affected her ability to perform well in the classroom as well as the resultant effect on student learning.

I've been a clinical instructor for three different classes each [term]. As the academic year progresses, I haven't been able to feel like I can have continuity. I know what I would do different if I would teach this course again in the fall, but I won't be. I just know that I'm not giving the students the best that I could if I had some more continuity.

This faculty member expressed extreme frustration with having new course assignments every term. She reported that she walks away from every course feeling, "I don't ever want to do this again." She stated that if the department chair was doing assignments for next year at that point in time, she would say, "Don't do this to me again. Don't do this to the students again. It's not fair."

Another faculty member, who does not teach clinical courses but who works closely with several clinical instructors, was very passionate about the issue of course continuity for clinical faculty. She stated, "They can't just be shifted from course to course. They're not widgets we can shift into slots" (Participant #3). She described her sense of frustration with the overall treatment of clinical faculty in the CON.

We expect [clinical faculty] to have such high levels of expertise in specialty areas, and yet we're going to turn around and shove them in any old peg hole that we need them to stem the blood flow. I get real frustrated with that. Why is it I feel like I'm one of few people that respects what [clinical faculty] bring to the table and more senior people here don't?

*Practice.* In addition to the many issues that participants' shared about the realities of clinical teaching, data emerged that were related specifically to maintaining a clinical practice role in nursing. Although the issues related to clinical practice were mentioned

less frequently than the overall issues related to clinical teaching, they did emerge as a factor in participants' transition into a faculty role.

Similar to the thoughts shared by participants about feeling ambivalent about their faculty role, several clinical faculty members also expressed feelings of ambivalence related to their clinical practice role. One participant described her feelings about clinical practice as “bittersweet, because sometimes I love clinical practice and sometimes I hate it” (Participant #7). She reported conflicting feelings about clinical practice related to situations that were beyond her control in the clinical setting. She stated, “I love my clinical role because I can see progress and see growth in patients and I enjoy being part of that. I hate it because of the inadequacies of a clinical setting.”

Participants reported a great deal of difficulty maintaining their own clinical competency while in a full-time faculty role. A comment heard frequently was the need to remain in a clinical practice role in addition to the teaching role, in order to stay competent in clinical skills. This need to keep up their clinical competency skills was expressed by participants across all levels of faculty, regardless of whether or not they currently taught or practiced in the clinical setting. These data emerged primarily from the interviews throughout the *espoused and embedded values in nursing* categories as faculty members talked about valuing clinical competency and clinical success.

Although many participants stated that clinical competency was an important value for professional nurses, they also reported that it was a struggle for them to retain their clinical skills in a faculty role. One faculty member stated, “Much of the clinical work has to be done over and above what you're doing” (Participant #1).

Both participants who were leaving their current faculty positions to return to clinical practice at the end of the academic year stated the primary reason for their decision to leave teaching was due to a compelling desire to practice clinical nursing. This need to return to clinical practice was described by participant #6 as, “what I went to school for and struggled through those [NP] boards. I felt like I needed to practice nursing.”

The other faculty member who was not returning to a faculty position stated that she was leaving teaching because she did not believe she was developing as a practitioner in her current faculty role, despite the fact that she has enjoyed teaching. She stated, “I like to practice and I like to take care of patients, so that was the biggest factor in my leaving” (Participant #5). She described the challenge of staying clinically competent while working in a full-time faculty position as being an additional factor in deciding to leave her teaching role. “I had thought about teaching part-time and practicing part-time, but then having two part-time jobs is too difficult.” Embedded in the statements made by this faculty member was the value of growth and learning that she felt she could not reach in her current faculty role but she could obtain in a clinical position.

One faculty member summed up the realities of clinical practice in her response to a question I asked about her long-term plans as a faculty member. She described in detail the ambivalence she felt in her faculty role while feeling compelled to maintain her clinical practice. When asked if she would be staying in a faculty role for the remainder of her professional career, she stated, “I don’t know. It’s hard to know, what I want to be when I grow up” (Participant #7). She described clinical practice as being the key focus in her professional career.

I can’t really see myself leaving clinical practice because all through the years the thing that has grounded me—my rudder—is direct patient care. I know it’s what I

do best, and I don't think I hold onto to it because of security as much that I just feel that's what I'm supposed to do.

The importance of staying clinically-focused as a faculty member was noted by many participants. One faculty member discussed the need for faculty to stay clinically grounded. "I think that for our student's sake, we have an obligation to be clinically real. I would never want to become so academically-minded that I would lose touch with my clinical side." (Participant #7)

### *Hierarchy of Reward*

A theme that consistently emerged throughout the data was related to the structure of the reward system that existed in the CON and university setting. Participants stated that the primary emphasis at the CON was for all faculty, even those at the clinical instructor level, to be involved in research and scholarship. Faculty participation in research and scholarship emerged as a key factor for advancement within the university. Participants stated they perceived research and scholarship to be the primary value inherent in the academic discipline of nursing and the professorate, although most faculty members did not mention research and scholarly activity as a value they strongly held.

When asked about the research and scholarship expectations at the CON, participant #7 stated, "That's definitely a professed value and goal that we are strongly encouraged to take on." Another faculty member discussed how she limited committee involvement to be able to focus more on research. She stated, "I serve on several committees. I've done other stuff at the university level, which I try to keep in check, because you don't want to do too much—the college doesn't want to see your research suffer" (Participant #3).

One participant related that because she is a clinical faculty member, the pressure to do research is less than if she were in a tenure-track position, but participation in funded research would be something important to work toward. She stated, “This is a research-intensive university and my ace in the hole is that I’m clinical faculty, but if I could get enough research dollars to be able to justify some of my salary, that would be really good” (Participant #2). Although she did not have to establish a research focus to stay in her position, she made it clear that funded research was highly valued in the CON.

Additionally, faculty members reported there were limited rewards in the CON for good teaching, even though being a good teacher was a value that emerged throughout the *embedded values in the academic discipline* category. Of particular interest was the concept that “teaching can only hurt you” (Participant #1). She stated that poor student evaluations decreased faculty members’ chances for promotion and tenure. Furthermore, she reported there was not much reward for good teaching and that receiving good student evaluations did not improve a faculty member’s likelihood for promotion and tenure.

There’s a great amount of praise if you’re getting grants and you’re bringing money in, but there just doesn’t seem to be a lot of positive reinforcement for what you’re doing for the students, even though that could take an enormous amount of time particularly if you’re a course head for a big course. (Participant #1)

She described faculty participation in funded research as the activity that was rewarded the most in the CON. “If the students love you and your teaching evaluations are wonderful—that’s great. But do you have an RO1 [grant], or do you have an RO3 [grant], or are you NIH funded?” (Participant #1).

Other participants described situations in which faculty members who had poor student evaluations were rewarded with decreased workloads. In contrast, faculty members who were regarded as good teachers were actually given more classes to teach, resulting in increased workloads. One faculty member stated, “If you can’t teach, you get rewarded with more time off because they’ve pulled you out of the courses; but that means [the better teachers] actually get super-loaded” (Participant #3).

A powerful comment from participant #3 related to concerns she had that faculty who are the least effective teachers are often rewarded for poor teaching by being moved out of the classroom and into administrative roles. This, in turn, gives the least effective teachers more power within the structure of the CON and the overall institution.

The problem is that the [faculty] they will ride hardest about low board scores are the ones that are going to change whatever they have to, because it’s those of us with no power. When you look at who’s teaching our courses, it’s mostly junior associate professors and our assistant professors and then our masters prepared faculty. (Participant #3)

Participation in a funded research project was reported by most participants as being imperative for them to remain in their faculty role. Participant #1 stated, “There’s a definitive focus on research and not just small grants.” This focus on funded research was directly related to the promotion and tenure process in the CON.

The college wants national funding and you get the distinct impression from some of the junior faculty that they truly feel if they don’t get the big grants—whether they’ll get tenure or not, is in jeopardy. Faculty need those big dollar grants—between \$500,000 and a million dollars and [achieving] tenure rests on that. (Participant #1)

Along with the pressure to obtain funded research, faculty members also reported high levels of stress related to the overall promotion and tenure process within the CON. Even

though clinical faculty are not part of the tenure process at the CON, they also reported that the tenure process was very stressful for faculty who were on the tenure track.

One faculty member stated, “I think tenure streaming is very stressful.” She described the stress related to the tenure process as being difficult because the faculty member has little control over much of what is needed for obtaining tenure.

You don’t really know where you’re standing and there are so many things that are external to what you have control over—For all the grants I’ve written—to have so many that weren’t funded. The reality is, I have to pull in a huge grant before they’ll consider me for tenure. (Participant #3)

She related how important it was for her to receive tenure in her faculty role when she stated, “You know what, I’m going to stick out through tenure; and if I’m not granted tenure, then I’m getting a message from somebody that I need to make a course correction in my life, and that’s ok, but I’m going to stick this out” (Participant #3).

When asked about her perception of the pressure on tenure track faculty to obtain funded research to achieve tenure, another faculty member stated, “It affects everything they do. It’s just an enormous amount of pressure for anyone. They have different ways of dealing with [the pressure]. It’s more pressure on them to really perform—so that piece of it is difficult” (Participant #1).

Additional data related to the hierarchy of reward in the university setting were that most participants reported that faculty were expected to have completed a terminal degree in order to be promoted within the CON. One faculty member who was pursuing a Ph.D. stated, “The dean’s emphasis now is becoming more and more research [oriented] and that’s the direction the College is taking” (Participant #4). He indicated that in order to keep his job, he needed to help the CON reach that goal, so he decided to pursue a Ph.D.

One of the key findings to emerge in the hierarchy of reward theme is that doctorally-prepared faculty are “rewarded” in the sense that they are the only faculty members in the CON who are allowed to pursue tenure, which is considered the highest achievement in a university setting. One faculty member revealed the strong thrust to obtain a doctoral degree began while she was teaching clinicals as a graduate student.

Well, they always push to get your Ph.D.—they started encouraging me for that when I first came back for my masters degree. Even as a clinical instructor, you were sort of geared toward—you should publish. (Participant #5)

Participant #4 believed that a Ph.D. should be the minimal educational qualification for someone in a faculty position in a CON. Even though he did not have a doctoral degree, he believed that a faculty member in his position should have one. He stated, “The way I look at it, the appropriate person to have my job would have a Ph.D. and be an experienced nurse practitioner.” He described a conversation he had with a senior faculty member who felt there should be more Ph.D. tenure track faculty and fewer clinical instructors in the CON, despite the fact that the current number of non-tenure track faculty with MSNs was greater than those on the tenure track who hold Ph.D.s.

In contrast to the perception that the CON should have more doctorally-prepared faculty members than those with only masters degrees, participant #3 commented that she did not obtain a Ph.D. to be teaching in the clinical setting. She presented a markedly different thought about Ph.D. faculty teaching clinical courses.

I know there are schools around the country that want to have all Ph.D. prepared faculty teaching clinical. Well, that’s a joke. If you think I’m going to go teach clinical four days a week; that’s not what I got this [Ph.D.] for, or I would’ve done that 10 years ago.

*Cultural Expectation Versus Cultural Reality*

The final theme to be presented, cultural expectation versus cultural reality, emerged throughout many of the interviews and observations. This theme represented an overall disparity of what participants expected from a faculty role compared to the realities participants faced in academe. Data related to the cultural expectations versus cultural realities theme were so strong that they surfaced in 9 of the 13 total categories including, *behavioral patterns and processes, espoused, and embedded values* in all three cultures, *nursing, the academic discipline, and the professorate.*

Data related to espoused and embedded values of faculty members surfaced frequently throughout the cultural expectation versus reality theme. The identification of espoused and embedded values in nursing, the academic discipline, and the professorate are presented under separate headings, followed by an overall discussion of the data related to disparities in cultural expectation versus cultural reality.

*Espoused values.* Espoused values are values that are openly communicated by members of a culture (Peterson & Spencer, 1990). According to Peterson and Spencer, espoused values may be expressed by members in terms of what is expected rather than what actually occurs within an institution. In this study, espoused values emerged from participants' verbatim interviews and were professed in their statements.

When asked about values, participants described what they believed to be the primary values inherent in each culture: the nursing profession, the academic discipline of nursing, and the academic professorate. Overall, faculty members identified competency in nursing practice as the primary value held by nurses in a clinical role. When asked what she felt was most valued to her as a nurse, participant #1 replied, "Clinical competency is very important."

In addition to valuing clinical competence, faculty members also reported they valued having a commitment to nursing practice in their clinical role. This espoused value was expressed by participants in a variety of statements, including “making a difference to patients,” “helping patients and families,” “being a caregiver,” and “being an expert nurse practitioner.” One faculty member reported this commitment to practice as a need “to share my expertise and to leave the profession with more practitioners who have better skills than I did when I got out” (Participant #2).

Another faculty member described her commitment to nursing practice as being able to “make a difference” in both her clinical practice and faculty roles. Interestingly, she related feeling confident that she had a positive impact in the clinical setting, but she stated she was unsure whether she could also make a difference in her faculty role. She stated, “I haven’t [figured out] what opportunity is at the college for me to make a difference” (Participant #7).

Autonomy was an additional espoused value that was reported by participants as being important to nurses in a clinical role. One faculty member described how autonomy was important in his past clinical practice position. He stated that as a nurse practitioner, he sought out “autonomous roles.” “I really like being given a project and then doing it my way. I like the independence of being accountable for the outcomes” (Participant #4).

When asked what they valued in their current faculty roles (i.e., the academic discipline), participants most frequently stated they valued their “love of teaching.”

A small part of it is the attraction to summers off and the two weeks at Christmas; but the reality is, you could be a traveling nurse, or work for an agency and get two weeks off for Christmas and take the summer off, and make a whole lot more per hour than what they do here; so I really think their love of teaching keeps them here. (Participant #3)

Participants spoke about being able to “train the next generation of nurses” as being related to the primary value of love of teaching that was important in their faculty role. One faculty member described this value as “having a moral obligation to educate the next generation of nurses” (Participant #2). Another faculty member described this value as a “personal calling” to share her “love for nursing, to inspire young nurses and just make that difference” (Participant #7).

A comment by one faculty member revealed her belief that the education of students should be the most important value of a CON, one that is valued above research and scholarship. She stated, “While research is important to move up the academic ladder, I’ve always argued that a nursing school that doesn’t focus on teaching is kind of like a hospital that doesn’t focus on patient care” (Participant #3). She described her strong belief in the value of teaching when she stated, “It’s really what [a CON] is there for. This building doesn’t exist for a few of us to do research. This building exists to train the next generation of nurses.”

Participants revealed that the value of autonomy was important not only in their clinical practice; it was also highly valued in their faculty role. One faculty member described how autonomy in her faculty role was greater than the autonomy she had as a nurse practitioner. She stated, “I really feel like I’m shaping these courses. There were certainly decisions within the practitioner role that you could make, but they were more limited” (Participant # 1).

Another espoused value stated by participants as being important in their faculty role was the integration of teaching, research, and practice. When asked to describe an important value to faculty, one participant stated, “I like the idea of the integrated scholar

very much, with the teaching, research, and practice—I like being able to combine all three” (Participant #4).

Even though this faculty member stated he valued working in the teaching, research, and practice environments of the university, he also related the difficulty he had feeling competent in all three areas.

I could do practice with my eyes closed, but the teaching and the research I can't do as well. I like talking to the faculty who have a subject area of expertise, so I want to be able to bring that here too. (Participant #4)

When asked what was valued in the professorate, faculty members stated that research and scholarship were the most important espoused values of faculty working in the university. Participant #7 stated, “I see and value research as a need, especially in my specialty area. I always had a sense that I *probably* would want to do research.” Faculty members consistently stated that the value of obtaining funded research was the most important value to the professorate, although none of the participants named research as the primary espoused value important in their own faculty role. Several faculty members additionally stated that service to the college was an important espoused value in the university setting.

*Embedded values.* In contrast to explicit espoused values, embedded values are the implicit values that are held by faculty members at a deeper, often unacknowledged level (Peterson & Spencer, 1990). Embedded values are the values that are often not overtly stated, but can be understood in what is expressed through participants' actions and words. These values are seldom acknowledged openly by members of a culture and they may conflict with the more visible espoused values. According to Peterson and Spencer, embedded values, more than espoused values, guide the actions of group members.

In contrast to the espoused values that were presented as verbatim quotations in the preceding section, the embedded values were not always concretely expressed through exemplars from the verbatim interviews of faculty participants. The embedded values discovered in this study emerged throughout the interviews and observations and were implied by participants rather than stated during the interviews.

Valuing the “art of nursing” over the “science of nursing” emerged as the primary embedded value of faculty members related to the nursing profession. Although participants specifically identified principles related to the science of nursing (e.g., technology, clinical competency) as the espoused values they held in their nursing career, they frequently talked about experiences and interactions with patients and families as guiding their actions in their professional career. Participants often spoke passionately about past experiences that focused on the caring aspects of nursing (e.g., patient advocacy, patient interactions), which are more closely related to the art of nursing than the science of nursing.

A conflict that emerged from the cultural expectations versus cultural reality theme was that while values related to the art of being a nurse were most important to nurses in professional practice, values related to the science of nursing were most rewarded in the nursing profession. One participant who had been a nurse for over 30 years stated that while she tried to focus on the caring aspects of nursing, the health care system “punishes nurses for connecting with people because it takes time and screws up your productivity” (Participant #2).

In contrast to valuing the “art” over the “science” of nursing, the primary embedded value to emerge related to the academic discipline was that participants’ valued the

“science of teaching” over the “art of teaching.” When asked what they valued most in a faculty role, participants consistently stated they valued “interactions with students,” “a love of teaching,” and “making a difference in students.” These espoused values focused on the “art” of teaching rather than the “science” of teaching, which centered more on values related to teaching skills and methods.

While participants’ stated that values related to the art of teaching were most important to them in their faculty role, the majority of participants reported they did not possess the necessary teaching skills to flourish in an academic position. Faculty members frequently talked about “not knowing how to teach” and the “lack of teaching ability” as the key issue that guided their behavior in a faculty role; instead of the espoused values related to the art of teaching. During the interviews, faculty members expressed more concern with learning how to teach, over anything related to the espoused value of their “love of teaching.” Consequently, faculty members judged success in their current faculty role primarily on the value of competency in teaching skills, instead of what they stated as their espoused value of interacting with students. Therefore, values related to the science of teaching (e.g., competency, skills) emerged as the guiding values in the CON.

One disparity emerged that overlapped both the *embedded values of nursing* and the *embedded values of the academic discipline* categories. Faculty members talked about the importance of nurses remaining clinically competent in their professional practice, although they reported that it was very difficult for them to remain clinically competent while in a faculty role. Participants professed the importance of maintaining their own

clinical competence but often related fear of losing their clinical skills because their immediate focus was learning the technical skills of teaching.

The final embedded value to emerge from the data, related to the professorate, was valuing funded research over both the art and science of nursing and the art and science of teaching. Even though faculty members consistently espoused that research and scholarship were the key professorial values of the university, their actions and comments revealed a mismatch between what they truly valued as faculty members in a university setting, compared to what they professed was valued in the university setting, obtaining funded research.

While faculty members admitted to supporting the espoused university value of research and scholarship in their verbatim comments, in reality, the actions of these participants were guided by differing values. Although participants were continually striving to achieve the espoused value of funded research in their professorial role, none had been successful at achieving it at this point in their transition. The actions of the faculty members who participated in this study were primarily guided by the embedded values identified in both the culture of nursing (e.g., valuing the art over the science of nursing) and the culture of the academic discipline (e.g., valuing the science over the art of teaching), although almost every participant reported repeated efforts towards research and scholarship that had been unsuccessful. This disparity between faculty members' espoused and embedded values surfaced as a key finding in this study.

*Disparities in cultural expectations and cultural realities.* One of the disparities in cultural expectations versus cultural realities to emerge from the data related to differences between the espoused and embedded values in nursing and the espoused and

embedded values in the academic discipline. When asked to describe a value that was important in clinical practice, participants frequently talked about valuing clinical competency and success as a clinician. The disparity emerged as participants revealed that not only were they not able to maintain their own clinical competency in a faculty role, clinical competency was not perceived as being a key value held in the academic discipline or the professorate. This theme surfaced as participants talked about their espoused values and the embedded values that emerged from the data throughout the *espoused and embedded values in nursing and the academic discipline* categories.

In addition, while faculty members consistently stated that clinical competency was not highly valued at the CON, they firmly believed the reason they were hired into a faculty role was because of their expertise in clinical practice, not their ability as a teacher or a researcher. One faculty member stated, “I was hired because I was a nurse practitioner and because I was familiar with the clinical [specialty]. But my competency in teaching really never entered into the picture. I was told, ‘You just do the course’” (Participant #7).

An additional disparity in cultural expectations versus cultural realities was the hierarchical structure of the clinical setting was quite different from the institutional structure found in an academic setting. Participants expected a structure similar to their past experience in a hospital setting. This discrepancy in institutional structure was described by participant #1 as being in a new setting where “the rules have all changed.” She described the structure of the CON as being much different from what she was used to in her prior clinical role.

I worked at [a hospital] for 14 years before I came here, so I knew all the players, and what I should say and, what I shouldn't say, and what was appropriate. And

then I come here and the rules have all changed. There's a definite difference between those who are senior faculty, those who are junior faculty, and those of us who are clinical instructors.

In explaining this difference in hierarchical structure, faculty members described the clinical institution (i.e., hospital) as an organization where having a masters degree identified them as a specialist; someone who was looked up to in terms of experience and expertise. In contrast, in the CON within the university setting, a masters degree was perceived as the minimal level of education for a faculty position. Instead of being respected, admired, and looked up to, faculty members reported that the only way they could achieve stature in the CON was to have a Ph.D. and participate in a funded research project. This difference in hierarchy and reward surfaced as participants talked about their past clinical experiences and their educational preparation which emerged throughout the *behavioral patterns and process in nursing* and the *academic discipline* categories.

Not only were faculty members not respected as having expertise in their current faculty position, several participants also noted that they were accustomed to being the person in charge in other settings, which was quite different from their current faculty role. One faculty member reported that not being in charge in her current role has been a frustration she has had to deal with during her transition from clinical practice to academe.

I think a frustration is that I am used to being in charge, and I am not in charge of a lot here, and so I have to be very careful that I don't get to be a bull in the china shop and say, "Well, this is the way we did it [where I came from] and if you just do it this way it will be fine." (Participant #2)

Another participant described her role in previous clinical nursing positions as being "one of the go to people." She stated, "Any position I've ever had, I've always worked

myself up to being one of the go to people, you know, where everyone asked me [how to do things]" (Participant #6). She related that she did not see herself as someone who was looked up to in her current faculty role.

Of particular interest was the fact that several faculty members explained their perception of the differences that existed in the institutional culture of hospitals and colleges using the metaphor of having been seen as the "top dog" in the hospital setting (Participant #4). This faculty member described himself as being seen as a *beginner* in his new faculty role, rather than being seen as an *expert* in his previous clinical role as he discussed this disparity in the hierarchy of each institution.

In the [hospital] I have nurses, medical assistants, and receptionists who ask me questions a lot, and I have to decide what to do and what they're going to do. I've been very comfortable in that role and I feel like I do a pretty good job. But then to come here and to be a beginner again—people aren't going to ask me questions about the curriculum or about applying for a research grant here.

Another faculty member described how she perceived the difference in institutional structure between the hospital and the CON, using the same "top dog" metaphor. She stated, "When you're at the hospital with a masters degree, you are either seen as a clinical expert or you're in a more leadership kind of position; you're seen as a top dog." She related that when a masters prepared nurse enters a faculty position from a clinical practice role, "You get into the system where you're really not anything until you have your Ph.D." (Participant #1).

This faculty member described a situation in which she requested to move into an empty office to be closer to other faculty members in her specialty area. When she made this request to one of the senior faculty members, participant #1 was told, "You can't move into the office across the hall. You don't have a Ph.D. You can't have an office

with a window if you don't have a Ph.D." She stated, "Even though all these offices were empty, I was told, 'You cannot have a window, unless you have your Ph.D.', and I thought that was very, very interesting." She talked about a colleague who had refused to move into an office with a window after receiving her doctoral degree.

One of the other clinical instructors had just finished her dissertation and administration told her, "Well, you can move across the hall because you have your Ph.D." In response, she said, 'No, I like the office I have; it's just fine.' (Participant #1)

Additionally, the two participants who were pursuing Ph.D.s while maintaining their full-time faculty role, reported difficulty in doing both concurrently. Participants stated the CON valued getting a terminal degree more importantly than maintaining a clinical practice. Describing the difficulty in maintaining a clinical practice while in a faculty role, participant #4 discussed how he would be forced to give up his practice if it interfered with his teaching. This was in sharp contrast to his statements during the interviews that he highly valued his role as a clinical practitioner.

If [my department chair] had been a little more critical [of my performance here], I think I would have dropped practice and focused on my teaching—because I want to be good at teaching. I think the practice, honestly, will be the first thing to go. I don't want to give that up, but it would have to be.

The final disparity between cultural expectations versus cultural reality focused on the espoused value on research and scholarship that emerged from the professorate, in comparison to the espoused value on clinical competency that emerged in nursing. This disparity additionally touched upon the espoused value in the academic discipline related to faculty members' love of teaching.

This difference in espoused values in the three cultures was expressed by one faculty member in an especially poignant way. During her interview, participant #7 related the

reason she had not pursued a terminal degree with more vigor while in her current faculty role, as she revealed her personal ambivalence about doctoral education in nursing. She stated she envisioned having an advanced degree as an “advanced mentality of a distance where we’re not real anymore, because we can talk it but we just can’t do it.” She emphatically stated, “I don’t ever want to be one of those.” This same faculty member described her thoughts about obtaining a doctoral degree as being a “trade off” to clinical practice. She questioned whether having an advanced degree moved a nurse further away from the actual practice of nursing. This was noted in a very emotional statement that is filled with serious doubt and questions about advanced nursing education.

If there was anything that’s held me back from making advances in [pursuing my doctorate] more seriously, it’s been because I like what I do and I like where I’m at clinically. You know, I don’t want to leave my [clinical perspective] and I hope it’s not a trade-off in a major way. I’m hopeful that there is a blend somewhere that I can find. I don’t know. Is it there? Can you tell me?  
(Participant #7)

### *Summary*

This chapter provided a description and analysis of the qualitative data revealed in this study, which focused on (a) the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate, and (b) the effect of culture on the transition of clinical nurses into a faculty role.

Six overarching themes emerged from the analysis of the data including: (a) stressors and facilitators of transition, (b) deficient role preparation, (c) changing student culture, (d) realities of clinical teaching and practice, (e) hierarchy of reward, and (f) cultural expectation versus cultural reality.

Stressors related to the transition of clinical nurses into a faculty role included the extreme amount of work involved in a faculty position, the amount of time to do the job well, an overall struggle to survive, participants' feelings of ambivalence and self-doubt about their teaching ability compared to their expertise as a clinician, and receiving little feedback from colleagues regarding job performance. Things that facilitated clinical nurses' transition into a faculty role focused primarily on participants having prior experience as a preceptor and having previously worked in a clinical management position. Although having a Ph.D. did not help prepare participants for a faculty role, faculty members who held a terminal degree believed it made their transition easier than faculty who did not have a Ph.D.

Deficient role preparation for a faculty position emerged as a factor in nurses' transition from clinical practice to a faculty role. While every participant stated they were expert clinicians, no faculty members expressed that same competency in teaching. Additional findings that emerged within this theme related to the lack of opportunity for nursing faculty to role model good educators and the lack of advanced educational programs for nurses wanting to pursue teaching careers.

Changes in student culture focused on students who were angry and mistrustful of nursing education and nursing faculty, students' dependence on faculty for their own learning, and students' expectation of nursing education not matching the reality of nursing education. The reality of changes in student culture is the resultant effect on the way faculty teach and how faculty members responded to their new role.

Realities of clinical teaching focused on the unique role of being a clinical instructor, including the difference between clinical practice and clinical teaching, the isolation

connected with clinical teaching, the multitude of stressors associated with being a clinical instructor, and the lack of support from senior faculty. Clinical practice issues also affected faculty members' transition into their current role and included feelings of ambivalence related to a clinical practice role, difficulty in maintaining clinical competency as a faculty member, and the importance of staying clinically-focused.

Findings related to the differing structure in clinical institutions compared to university settings emerged in the hierarchy in reward theme. Faculty participation in funded research and having a terminal degree was most rewarded in the CON and the university, in contrast to the minimal rewards given out for good teaching. Additionally, the opportunity to pursue promotion and tenure, the highest reward in academe, was granted only to faculty with doctoral degrees.

The final theme, cultural expectation versus cultural reality, presented overall disparities of what were expected from a faculty role compared to the realities that were found to exist. Espoused and embedded values in the nursing profession, the academic discipline of nursing, and the professorate were identified and described. As compared to the espoused values stated by faculty members, it was the embedded values that were discovered, which ultimately guided participants' actions within their current faculty role.

## Chapter Five

### Discussion and Findings

This concluding chapter presents a summary of the study and a discussion of the major findings of the study. Additionally, this chapter offers recommendations for policy and practice related to the transitioning process of clinical nurses into faculty roles as well as providing suggestions for future research projects related to the findings of this study. The chapter is organized into the following sections: (a) summary of the study, (b) discussion of the findings and study limitations, (c) implications for policy and practice, (d) conclusions, and (e) recommendations for future research.

#### *Summary of the Study*

The purpose of this study was to identify and describe the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate as described by nurses who were transitioning from a clinical nursing role into a faculty role within a college of nursing. Additionally, this study sought to understand how cultural differences and similarities affected the transition of nurses into a faculty role from professional clinical practice. Differences between nurses in various roles have been recognized in the profession as an issue, however this concern has not been previously studied from a cultural perspective.

A review of the theoretical and empirical literature revealed that the nursing profession, the academic discipline of nursing, and the academic professorate all possess values and beliefs consistent with having a culture unique to each entity. The literature

review revealed an overall lack of research focused on the academic discipline of nursing framed from a cultural perspective, therefore an examination of the similarities and differences in the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate and an exploration into the influence of culture on nurses who transitioned from clinical practice into a faculty role was warranted.

The study's research questions were closely related to traditions of both phenomenology and ethnography. Since the primary focus of this study was to examine elements of culture (e.g., values, beliefs, assumptions, norms) through the experiences of individual nurses who were transitioning to a faculty role, the emphasis of this study design was a phenomenological approach that included elements of ethnography. This use of these two traditions aided in the understanding of concepts related to the culture of the nursing profession, the academic discipline of nursing, and the academic professorate, as described by individual nurses.

This study utilized both a conceptual model of organizational culture and a theoretical framework of adult transition. Peterson and Spencer's (1990) conceptual model of organizational culture served as the organizing framework used to study the elements of the culture of the nursing profession, the academic discipline of nursing, and the academic professorate. The study was guided by three typologies from Peterson and Spencer's model, which included an examination of the behavioral patterns and processes, espoused values, and embedded values of each of the three cultures. Additionally, the aspects of the study related to the transition factors of nursing faculty

(e.g., situation, self, strategies, and support) were guided by tenets adapted from Schlossberg's adult transition theory.

Potential participants who met the criteria for the study were identified by the Associate Dean for Research in the CON. Following an initial telephone screening to assure that participants met the criteria for the study, 13 formal interviews were conducted with seven participants during a four-month timeframe. Additionally, I conducted 10 on-campus observations and one off-campus observation during my weekly visits to the CON. A review of documents, including the student handbook; the faculty manual; the CON philosophy, mission, and values statements; a standard letter of appointment for full-time faculty; faculty meeting minutes from the past 2 years; renewal, promotion, and tenure guidelines for the CON; CON policy manuals; CON strategic plan; participant's vitae, and the CONs most recent accreditation study was also conducted.

Analysis of the data, through the process of coding, allowed data to surface from a priori categories into emergent categories, which led to the discovery of six emerging themes including: (a) stressors and facilitators of transition, (b) deficient role preparation, (c) changing student culture, (d) realities of clinical teaching and practice, (e) hierarchy and reward, and (f) cultural expectation versus cultural reality. First, transitioning from a clinical practice role to a faculty role surfaced as a stressful situation for all participants although the amount of stress related to transition varied among faculty members, primarily based on participants' past experiences that facilitated the process of transition. Second, not having been educationally prepared for a faculty role was a key issue that affected the transition of all participants. Third, the values, beliefs, and behavior of students differed greatly from what faculty members expected. This

change in student culture affected the way faculty taught students and the way they transitioned into their faculty role. Fourth, issues related to both clinical teaching and clinical practice entered into the transition of all participants, regardless of whether they taught clinical courses or not. Fifth, the hierarchy of reward differed greatly in clinical institutions compared to the reward system found in university settings. Clinical competency and expertise were most rewarded in the hospital setting, which was quite different from the lack of recognition for clinical competency in the CON, where the highest reward (e.g., promotion and tenure) was dependent on obtaining funded research. Finally, disparities were found to exist between what faculty members expected from a faculty role compared to the realities that existed. A level of dissonance was identified between the espoused values stated by faculty members and the embedded values that guided the actions of faculty members in their current role.

### *Discussion*

The discussion of the findings identified during this study is presented around the two research questions examined. Findings related to similarities and differences between the three cultures, the nursing profession, the academic discipline of nursing, and the academic professorate are discussed first, followed by a discussion of how cultural differences affected the transition of nurses from a clinical practice role into a nursing role.

#### *Similarities and Differences between the Three Cultures*

The first research question examined in this study was: What are the similarities and differences between the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate? The study explored aspects

(e.g., values, beliefs, assumptions) of each of the three cultures. Some of the espoused values in the three cultures were consistent with the espoused values noted in the literature review. Additionally, while several of the espoused values between cultures were similar, the embedded values were found to be quite different from the espoused values in two of the three cultures and between the three cultures. Therefore, the following discussion focuses on both the similarities and the differences in the espoused and embedded values found in each culture.

*Values in the culture of the nursing profession.* One espoused value of nurses in a clinical role was a commitment to nursing practice. This commitment to nursing practice was described by participants in a variety of ways, including a focus on “caregiving,” “making a difference,” and “helping patients.” This finding concurs with studies by Leininger (1986), Condon (1987), Cooper (1988), and Noddings (1984), which all described the concept of caring as an important value in the culture of professional nursing.

Additionally, autonomy and clinical competency were reported by participants as espoused values of the nursing profession, which were similar to values identified by ANA, the professional organization for nurses that sets the standards by which nurses practice (ANA, 1985). Additional studies by Schank and Weis (1989), Weis and Schank (2000), and Matheny (1989) supported the values of autonomy and clinical competency as being important to nursing practice.

Although participants of this study did not specifically describe how they formed the values that were important to them in the nursing profession, the literature reported that values related to the nursing profession are formed during students’ educational

experiences (Elfrink & Lutz, 1991; Heiderken, 1970; Perry, 1987; Schank & Weis, 1989; Weis et al., 1993).

Valuing the “art of nursing” over the “science of nursing” was identified through this study as the primary embedded value related to the nursing profession. A difference in espoused and embedded values in nursing was particularly noted as participants spoke about wanting to maintain a caring focus toward patients, while feeling the pressure to focus more on the technology of clinical skill competency. One participant even reported her perception that the health care system punished nurses for contributing to the caring aspects of nursing compared to rewarding competency in the technological aspects of nursing.

Leininger (1985) noted a similar discord between valuing caring, and valuing technology, when she reported that the health care system discouraged nurses from embracing the value of caring because of the necessity for increased efficiency in a competitive health care environment. Even though Leininger reported her findings almost 20 years ago, this same issue exists today. A study by Perry (1987) also reported a discrepancy between what nurses are taught to value (i.e., caring), and the technological skills highly valued in their professional practice. Both Leininger’s and Perry’s studies add support to the findings of this study.

A difference in espoused and embedded values in the nursing profession was revealed in this study, which lends support to two additional studies. One is Ulrich’s (1987) research, which described differing values that surfaced between nurse executives and educators who teach graduate nursing administration students. The other was the findings of Leininger (1995), which reported that nurses may face culturally-related

conflicts as they assume differing roles in the nursing profession. The findings revealed in Ulrich's and Leininger's research relates to the findings of this study as differences were found to occur in the values of the three cultures examined.

*Values in the culture of the academic discipline of nursing.* Valuing their love of teaching, valuing autonomy, and valuing integrated scholarship were the values espoused by study participants as related to the academic discipline of nursing. Interestingly, the values most often mentioned by faculty participants were not aligned with the values identified by AACN, the national organization which oversees the accreditation of most baccalaureate and graduate nursing programs in the country.

The seven essential values identified by AACN (1986) included altruism, equality, esthetics, freedom, human dignity, justice, and truth. The difference between the values espoused by nursing faculty participants and the primary values identified by AACN that have been integrated into most nursing curricula, suggests that professional statements may have little impact on the values that actually exist in the culture of the academic discipline of nursing.

Empirical studies related to values inherent in the academic discipline of nursing consistently reported that nursing faculty were in agreement that the values identified by AACN were representative of the values of professional nurses. This is in stark contrast to the discoveries of this study. This disparity in findings may be explained by the fact that all of the previous studies involving comparison of AACN values with faculty values (Eddy et al., 1994; Elfrink & Lutz, 1991; Schank & Weis, 1989; Thurston et al., 1989; Weis et al., 1993) were based on quantitative research methods, primarily through the use of survey data. The qualitative method of design used in this study, may have

contributed to the differences between the previous research and what was discovered during this study because, not only were espoused values reported, embedded values were revealed, which would not surface within a quantitative survey.

Valuing the “science” of teaching over the “art” of teaching was identified through this study as the primary embedded value related to the academic discipline of nursing. While all the participants received formal education in the art and science of the nursing profession, none of the participants had been formally prepared for a career as an educator. This lack of instruction in pedagogy emerged as a significant contributor to participants’ difficulty throughout their transition to a faculty role. Participants reported the importance of maintaining clinical competency but feared losing their clinical skills because their immediate focus was on learning the technical skills of teaching. No studies were uncovered that corroborated the existence of this embedded value primarily because limited qualitative research related to the culture of the academic discipline of nursing exists.

*Values in the culture of the academic professorate.* The primary espoused value identified by participants related to the academic professorate was the value of research and scholarship. Interestingly, faculty members consistently stated that the value of participating in funded research was the most important value shared by the professorate, even though none of the participants identified research as the primary espoused value in their own faculty role.

Numerous studies in the literature (Becher, 1987; Bowen & Schuster, 1986; Clark, 1987; Kuh & Whitt, 1988; Morrill & Spees, 1982; Ruscio, 1987) revealed three primary values embraced by most academics; creation and dissemination of knowledge,

professional autonomy, and collegiality. Knowledge can be created and disseminated in several different manners in an academic setting. Participation in funded research leads to the creation and dissemination of knowledge among the professorate and teaching is a method of passing on knowledge to students. Therefore, the primary professorial value identified in this study, research and scholarship, is consistent with the professorial values uncovered in the literature review.

Valuing funded research over both the art of nursing and the science of teaching was identified as the primary embedded value related to the academic professorate. Valuing research and scholarship over teaching was also noted throughout the academic literature (Bowen & Schuster, 1986; Boyer, 1997; Kuh & Whitt, 1988). Of particular interest is that the findings in this study revealed a mismatch in the values participants stated to be important to the professorate and the values that guided their behavior in their faculty role. While the literature reported that faculty often work in institutions with cultures that match their own professional values and beliefs (Bowen & Schuster, 1986; Boyer, 1987), the participants in this study worked within an institutional culture with differing values from their own. The actions of participants were guided primarily by values related to the art of nursing and the science of teaching, rather than values related to research and scholarship, although the participants all reported that research and scholarship was the most important value in the university setting in which they worked.

*Difference in values between cultures.* Not only did the primary espoused values differ from the embedded values within each culture, differences existed in the embedded values between the three cultures. The notion of differences between values inherent in each of the cultures was not uncovered in the literature review. Although conflict among

nursing faculty related to the faculty role has been reported in the literature (Crane-Roberts, 1998; Fain, 1985; Mobily, 1987; Sienty, 1988), the concept of nurses experiencing dissonance between the values of the three different cultures examined, had not been previously reported.

Of particular importance is that the embedded values between all three cultures were conflicting. This is a key finding because when a nurse assumes a faculty position in a CON, he or she is affiliated with all three roles; nurse, nursing faculty, and the professorate. As values differ between roles, it is difficult for nurses who have been acculturated into the values orientation of the nursing profession to function within three differing values systems. Findings from this study indicated that members of the academic discipline and members of the academic professorate value research and scholarship more than clinical competency. This is in stark contrast to the nursing profession where clinical competency is valued the most. This difference in values led to a reversal of the priority values in each culture, which had not been reported in prior research.

*Conflict in values and rewards.* In addition to the difference in embedded values between the three cultures, a conflict between what was valued in each of the three cultures and what was rewarded in each culture was discovered. The existence of conflict between values and rewards between the differing cultures examined in this study was not previously reported in the literature.

A key finding of this study was that the reward system that existed in the CON was not aligned with what faculty members valued in their prior nursing or current faculty roles. While clinical competency was not identified as a value in the culture of the

academic discipline or the academic professorate, clinical competency was identified as the most important espoused value in the culture of nursing. In the academic discipline, valuing a love of teaching was identified as the most important espoused value. In sharp contrast to either the values of clinical competency or love of teaching, participation in funded research was the primary avenue for reward within the CON. This espoused and embedded value on research in the professorate was intricately tied into the reward system of the university setting, even though most faculty members did not identify research as an espoused value in either their clinical role or faculty role.

Valuing clinical competency varied between the different levels of faculty in the CON. Clinical faculty valued competency in the clinical instructor role but reported that senior faculty had lost touch with the clinical component of teaching. This conflict in values and rewards was very apparent throughout the findings of this study, which raised an important question of how do values relate to what is rewarded in different professional cultures?

#### *The Effect of Culture on Nurses' Transition to a Faculty Role*

The second research question explored in this study was: How do cultural similarities and differences affect the transition of individual nurses from a clinical nursing role into a faculty role? The effect of culture on the transition process of new nursing faculty is presented in a discussion of faculty socialization, transition factors, and changing student culture.

*Socialization of nursing faculty.* A consistent finding of this study was related to the fact that none of the participants were prepared during their graduate programs for a future faculty role. This is a particularly important finding when reviewing the extensive

literature that demonstrated the close relationship between culture and the socialization process of students and faculty members.

Kuh & Whitt (1988) stated that socialization is the process through which individuals learn the values that are inherent in a particular culture. Numerous studies supported the notion that anticipatory socialization of faculty occurs during graduate school (Bess, 1978; Corcoran & Clark, 1984; Freedman, 1979; Tierney & Rhodes, 1994), and organizational socialization occurs during the promotion and tenure process (Tierney & Bensimon, 1996, Tierney & Rhodes, 1994).

While all participants of this study attended either a masters or doctoral program, none were prepared for a faculty role following graduate school. The educational preparation of nurses at the baccalaureate and masters level cultivates the values of the nursing profession, while doctoral preparation cultivates research as the primary value. The graduate programs attended by most study participants focused on clinical practice, not teaching or research; therefore, the socialization experiences that each received were more related to the profession of nursing. Additionally, the majority of participants in this study were also not being socialized into their faculty role through the promotion and tenure process because most participants were clinical faculty who were not on the tenure-track. Mobily's (1987) study suggested that limited anticipatory and organizational socialization experiences contributed to increased role strain in nursing faculty, particularly in faculty without doctoral preparation. Mobily's findings, coupled with the findings of this study, might explain role strain in nursing faculty related to the difference in values orientation between the differing cultures.

The faculty members who participated in this study were all socialized into the nursing profession during their undergraduate and graduate nursing education and clinical nursing practice, but they had limited socialization experiences related to either the academic discipline of nursing or the academic professorate. Therefore, it should not be surprising that a dissonance in values between the cultures surfaced. This finding concurs with Infante (1986) who described a conflict in values between clinical nurses and nurse educators.

*Transition factors.* The concepts of Schlossberg's (1995) adult transition model that were of particular importance to this study were the factors related to the situational transition of the participants. The majority of participants in this study were prepared for advanced clinical practice at the masters level of nursing. Additionally, study participants reported being very strong clinical practitioners in their previous nursing role. This concurs with the literature reporting the hiring of masters-prepared clinicians for faculty positions in schools of nursing (AACN, 2003; Hinshaw, 2001; Krisman-Scott & Thompson, 1998).

The primary situational factors that facilitated the transition process of participants were (a) having precepted students in a past clinical role and (b) having prior management experience. All participants had served as preceptors to nursing students and three participants had previous experience in nursing management. Although all participants had a strong clinical background, which may have been a factor in the overall transitioning process, clinical expertise did not appear to help or hinder participant's ease of transition, while previous experience working with students in a preceptor role did.

Having prior management experience was the most significant facilitator of transitioning into a faculty role, as the three participants who reported a fairly easy transition had worked previously in nursing administration. In contrast, the two participants who reported having the most difficulty with transitioning had no prior administrative experience. Having had management experience in a clinical role helped new faculty members transition into an educator role primarily related to their experience in working with employee issues (e.g., performing employee evaluations, dealing with conflict). This finding lends additional support to the results of the qualitative study by Schank et al. (1996) that demonstrated that prior professional experiences affect the values orientation of individual nurses.

Interestingly, while every participant reported, that as advanced practice nurses, they could make significantly more money in clinical practice than in a nursing education role, none of the participants stated they would leave teaching because of the limited financial compensation. Of the two participants who were returning to practice positions at the end of the academic year, wanting to do what they were educationally prepared for, not increased pay, was cited as the reason they were leaving. This finding highlights the importance these participants held on the need to be educationally prepared for the faculty role in which they practiced.

The two faculty members in the moving out stage longed to practice clinical nursing. Interestingly, they initially chose to join the faculty ranks, but after several years of teaching, decided to leave the CON to return to a clinical practice role. Nurses with strong clinical expertise are recruited for faculty positions, but the practice of hiring clinical nurses for faculty positions puts new faculty in completely dissonant roles. The

value system of clinical nurses is a better match for what they were educated to do, practice nursing, and a mismatch with the values found in a faculty role.

*Effect of changing student culture.* The literature supports the presence of a dominant student culture within institutions of higher education (Kuh & Whitt, 1988; Van Maanen, 1987). In this study, the concept of changing student culture had a definitive effect on how faculty members transitioned into their new role, which supports Kuh & Whitt's research that student culture has a strong impact on the overall institutional culture.

In this study, faculty members related that what students valued, what students expected from their education, and how students behaved were different from what faculty members expected students to value, and the manner in which they expected students to behave. This difference in expected and perceived student culture was closely related to the difficulty participants experienced during their faculty role transition.

Participants described the majority of students in the CON as being competitive, high achievers, and accustomed to getting As. According to Kuh & Whitt (1988), programs that are highly selective contribute to academically-oriented subcultures among students in those programs. Teaching in a difficult and demanding program increases the pressure for success on both students and on faculty members. In this study, dealing with students who were angry and mistrustful created a stressful educational environment for faculty, which made transition into the faculty role more difficult. This finding concurs with the literature reporting that the existence of student cultures often results in powerful consequences within the institution, including an effect on student/faculty relationships (Kuh & Whitt, 1988).

In conclusion, the primary findings of this study focused on the differences between the espoused and embedded values identified in the nursing profession, the academic discipline of nursing, and the academic professorate. A difference in the values inherent in each of the cultures, identified by this study, has not been previously reported in the literature. As demonstrated in this study, nurses who have been acculturated into the values orientation of the nursing profession experienced difficulty when attempting to function within three differing values systems during transition into a faculty role. A reversal of the priority values in each culture was found to exist, which greatly expands the knowledge of research related to role conflict in nursing faculty.

Several important findings were presented related to how cultural differences affected the transition of nurses from a clinical practice role into a faculty role including, socialization of nursing faculty, transition factors, and changes in student culture. One key discovery revealed by this study was that limited socialization experiences of new nursing faculty to the academic discipline of nursing and the academic professorate contributed to the cultural dissonance experienced during transition from a clinical practice role into a faculty role. The findings presented in this study add considerably to the limited research that previously existed specifically related to the culture of the academic discipline of nursing.

#### *Limitations of the Study*

Limitations of the study were related to the qualitative nature of the study design (e.g., small sample size, generalizability), which was described previously. An additional limitation that arose during the study was that only two participants held doctoral degrees. While two study participants were enrolled in doctoral programs, the majority

of participants held masters degrees in nursing as their highest educational preparation. Furthermore, because the institution in which the study was conducted limits tenure track faculty to those holding terminal degrees, the majority of participants were not tenure track faculty. Although every attempt was made to encourage participation from the two tenure track faculty members who declined to take part in the study, having more than two doctorally-prepared participants may have revealed values different from those discovered in this study.

Another limitation to arise during the study was that I was not able to observe a committee meeting with four participants because they were not involved in any CON committees that met during the data collection period of the study. Additionally, because the study was limited to one academic term, I was unable to observe one participant in any setting beyond the two formal interviews.

A final limitation was that the depth of data analysis may have been limited by my decision not to use a qualitative software program. Even though data were analyzed extensively through coding and recoding, additional themes may have emerged or surfaced in a different organization if a computer software analysis program had been used.

#### *Implications for Policy and Practice*

A conflict in the values between the culture of the nursing profession, the academic discipline of nursing, and the academic professorate was revealed in this study. This cultural dissonance is at the heart of the conflict in roles that has been noted in previous literature (Fain, 1985; Mobily, 1987; Sienty, 1988). One participant said that when she came to the faculty role, “all the rules had changed.” The findings of this study suggest

that what changed for her was the value system in a faculty role compared to the value system in a clinical practice role. The ultimate question becomes: “What can administrators and faculty members in institutions of higher education do to ease the transition between the nursing profession and academe?” In answer to this question, a discussion of suggestions for practice and policy are presented.

### *Implications for Practice*

*Expectations for a faculty role.* First and foremost, new nursing faculty must become aware that the values of the cultures are unique and different and that cultural dissonance exists between the clinical nursing and faculty roles. Additionally, this research demonstrated that the realities of a faculty role did not match the expectations for faculty members involved in this study. Differences existed between the skills for which faculty were hired, the skills for which faculty were judged, and the skills for which faculty were rewarded. The dissonance found to exist between what is expected, judged, and rewarded in a faculty role was not uncovered in the review of the literature; therefore the existence of differences between cultures was an important finding of this study. Clinical nurses transitioning into the academy must be clearly informed of the expectations, the values, and the rewards inherent in a faculty role. Clear expectations of all facets of a faculty role will improve the process of transition and help new faculty survive and thrive in an academic position.

The findings of this research demonstrated that when clinical nurses who transition to a faculty role hold on to the values that guided their behavior in clinical practice, the transition process may be difficult and potentially unsuccessful. Studies related to nursing faculty workload (Crane-Roberts, 1998; Locasto & Kochanek, 1989; Sienty,

1988; Williams, 2000), nursing faculty job satisfaction (Cavenar, 1987; Esper, 1995; Fain, 1985; Johnston, 1988), and balancing the traditional faculty components of scholarship, teaching, service, and practice (Charron, 1985; Lambert & Lambert, 1993; Pappas, 1988; Rapson, 1980; Steele, 1988; Tolve, 1997; Wold, 1994) support the difficulties nurses experience in faculty positions, although the previous literature did not focus on a dissonance between the cultural values. Nurses who have difficulty transitioning into a faculty role often return to clinical practice, which contributes to the ever growing shortage of nursing faculty; a major issue facing nursing programs nationwide.

An implication for practice is for nursing administrators and senior faculty members to ensure that new faculty are made aware of what is expected in a faculty role. Administrators must also increase the awareness among all nurses considering a faculty career that cultural dissonance exists between the cultures. Senior faculty members, as well as administrators in CONs, each have a part to play in making sure that new faculty are aware of the differences between the cultures. In addition, senior faculty members need to assist new nursing faculty in developing the skills they can use to cope with this cultural dissonance. New nursing faculty must receive very clear role expectations that focus on the cultural dissonance between clinical practice and a nursing faculty role.

Interestingly, just having the knowledge of the values difference between the cultures is not enough to help clinical nurses successfully transition into a faculty role. One participant was raised in a very strong academic family; her father and several other family members were tenured professors. Despite this knowledge of the differing values of each culture, she still had difficulty transitioning, although she described her transition

as being easier than the transition of some of her colleagues. Therefore, providing a clear awareness of the differences between the roles is a critical step in easing the transition process of new nursing faculty, although it is not sufficient as the only method of assuring an overall understanding of the differences in cultures.

*Programs of nursing education.* Adding to the dissonance between cultures, this study demonstrated that the lack of educational preparation for a teaching position made it even more difficult to achieve a smooth transition between roles. Combining the differences in values and rewards between cultures with the lack of teaching skills, it is a wonder faculty members even survive the transition process into academe. While clinical specialization of advanced practice nurses remains an important focus for America's health care system, the training of nurses is of utmost concern to higher education administrators, in an attempt to improve the national nursing shortage (Kelly, 2002). Without qualified, committed nursing faculty, there will be no one to teach our future generation of nurses (AACN, 2004; Hinshaw, 2001; NCES, 2002).

The findings of this study clearly indicated that having no formal preparation for an academic career was one of the most serious issues faced by newly transitioning nursing faculty. Not being educationally prepared for a teaching role resulted in participants doubting their abilities as an educator, which led to lowered self-confidence related to their teaching role. The need to increase the availability of and accessibility to graduate programs that are specifically focused on the education of future nursing faculty is a key practice implication to arise from this study. New faculty members must be taught how to be nursing educators.

Having nurses attend graduate programs specifically focused on the values inherent in a future faculty career would abate some of the cultural dissonance experienced by new faculty through the anticipatory socialization process of graduate education. This would lessen the isolation felt by new clinical instructors and would potentially decrease the number of new faculty who chose to return to clinical practice positions, whose focus is on the values they are most familiar with, the nursing profession.

The findings of this study suggest that institutions of higher education must work on the development of nursing faculty early in their nursing career. Certainly we must cultivate future nurse educators through the development and support of graduate programs in nursing education, but we might want to introduce students to the idea of pursuing a future faculty career, even at the undergraduate level. Students could be socialized into the culture of the academic discipline of nursing throughout their entire nursing education, not just during graduate school. This socialization process to the academic discipline of nursing must begin early if we are to address the issue of the nursing shortage at both the clinical practice and faculty levels.

There is agreement that clinically-sound practitioners of nursing are needed in light of the nursing shortage being faced in this country (Hinshaw, 2001; Krisman-Scott & Thompson, 1988). But educationally-prepared nursing faculty are also needed to teach the future generation of nurses. Not all nursing students are enthralled with the idea of a lifetime of clinical practice. As one participant in this study reported, "I knew I didn't want to work in a hospital after my first clinical experience in nursing school."

Nursing educators should provide opportunities for undergraduate students to experience role modeling and be introduced to skills needed for a potential future faculty

role. Certainly, nursing theory and clinical experience must be the primary focus in undergraduate nursing curriculum, but as we train students in the clinical skills they will need to practice nursing, we might also provide an introduction to skills they would need in a future faculty role. This is particularly appropriate in RN to BSN completion programs, where the focus on learning clinical skills is not as much of a priority as it is for pre-licensure nursing students.

The vast majority of baccalaureate nursing programs include coursework in nursing management (AACN, 1986). This study supports the development of management skills in nursing graduates, as administrative experience was reported by participants as having helped in their faculty role transition. Interestingly, while the three participants of this study who had management experience reported that management experience helped in their transition to a faculty role, none stated that their strong clinical expertise prepared them for a faculty role. While education in management is an important aspect in the preparation of future nursing leaders, this research demonstrated that it is equally, or even more important to prepare graduate nurses for future positions in teaching.

*Role models in nursing education.* This study emphasized the importance for faculty to have access to role models in nursing education. New faculty members would especially benefit from having a formal connection to observe other faculty in all settings including clinical, lab, and theory classes. Practice implications to increase access to faculty role models are focused on obtaining institutional support for the development of formal mentoring programs in CONs. While this study focused on a colorless population, the provision of role models of color is an important consideration.

Faculty members not only need access to role models in nursing education, they also would benefit from learning about all aspects of the academy (Becher, 1981; Kuh & Whitt, 1988; Ruscio, 1987). This education includes not only the acquisition of teaching skills, but a specific focus on how new faculty members can contribute to the research and service missions of the institution.

Clinical nurses transitioning to a faculty role must be involved in a formal mentoring program and be provided with the opportunity to model effective teachers. Because of their lack of teaching education, it is imperative that new nursing faculty are provided with the opportunity to learn the skills of pedagogy; not through the “trial and error” experiences as noted by the participants in this study, but through formal programs developed at the university level.

*Resources for clinical instructors.* Resources and support must be made available and accessible for all faculty to improve their skills in a faculty role. Especially important is the provision of resources for clinical instructors who, based on the data from this study, struggle the most with their new positions. Implications for practice include improving the access to resources related to teaching skills, evaluation methods, and clinical instruction. Support for the teaching role should be available to all faculty members, but providing a specific pool of resources for faculty in clinical roles, who are the most isolated faculty in CONs, must be assured.

#### *Policy Implications*

While the preceding practice implications will lead to a reduction in the dissonance experienced by new nursing faculty, implications related to changing policy in higher education institutions would have an equal, if not greater, impact on decreasing

dissonance in newly transitioning nursing faculty. The findings of this study revealed a conflict between the espoused values in the CON and the embedded values that were found to exist. While the CON espoused the values of teaching and clinical practice, noted throughout the document review, obtaining funded research surfaced as the primary embedded value of the institution. The CON, through its stated mission of advanced clinical practice and hiring nurses with strong clinical expertise, essentially put nursing faculty into a value structure that did not match what was espoused to be valued.

Tierney and Bensimon (1996) described academic socialization as a “bidirectional process” (pg. 37) and suggested that the potential exists for faculty members to change the inherent culture of the institution, just as the cultural norms of the institution may change the values of faculty. A key implication to arise from this study is that the academy must seek out ways to adopt values inherent in professional nursing culture. Most importantly, the academy must change its reward structure to value the clinical nursing role and the clinical expertise that nurses bring to the faculty role. Instead of expecting new nursing faculty to adapt totally to the culture of the institution, policies must be enacted within the university structure that will reward the values inherent in the nursing profession.

The policy and practice recommendations presented in this study will increase a faculty member’s likelihood to survive in his or her new role. Additionally, if these implications are instituted throughout CONs and universities nationwide, faculty members will not only survive and endure, they will have an increased chance of thriving and growing in their faculty positions to be able to mentor the next generation of faculty.

### *Conclusions*

The process of transitioning into a faculty role from a clinical practice role is interwoven with the values that nurses hold in their faculty role, which differ from the values inherent in their clinical nursing role. The overarching conclusion from this research is that cultural dissonance exists between the values nurses hold in a clinical role and the values held by nurses in a faculty role. The ensuing discussion will center on the following conclusions: (a) the impact of cultural dissonance on faculty transition, (b) the importance of mentoring faculty values, (c) the importance of education and socialization to the faculty role, and (d) the need for institutional change to better match the culture of the faculty member.

#### *Cultural Dissonance in New Nursing Faculty*

Cultural dissonance clearly exists in new nursing faculty as nurses adjust to a faculty role based on the values they bring from their former clinical practice role. The concept of cultural dissonance is the incongruity that clinical nurses' experience when transitioning into a faculty role in a CON. New nursing faculty are caught between a set of values sustained in the culture of the nursing profession and a differing set of values endorsed by the academic discipline of nursing and the academic professorate.

Dissonance occurs because the values that guided their behavior in a clinical practice position differ from the values important for their success in a faculty role.

Added to the values conflict experienced by new nursing faculty is that the rewards inherent in an academic setting focus on an entirely different set of values than the rewards found in clinical practice. It is no wonder that new nursing faculty have

difficulty with transitioning into a system where, “all the rules have changed,” due to this disharmony between values and rewards of clinical practice and academe.

Guiding values are what makes a profession unique (Becher, 1981). Altering a person’s guiding values can change one’s whole being. The unique challenge related to cultural dissonance in newly transitioning nursing faculty arises as they begin to question which value system they will follow in their new role; the nursing profession, the academic discipline of nursing, or the academic professorate. Prior to this research, this question has not only never been asked, it most certainly has not been answered.

*Impact of cultural dissonance on faculty transition.* Cultural dissonance creates conflict in new nursing faculty that profoundly influences the transition of nurses from clinical practice into a faculty role. Additionally, some of the challenges in retaining nurses in faculty positions may be attributable to the cultural dissonance that exists. Nursing faculty are recruited into faculty positions because they have strong clinical skills and are experienced clinical practitioners. Although clinical expertise is essential to be successful in a clinical nursing capacity and is highly valued in the nursing profession, being an expert clinician does not equate to being an expert teacher. And while faculty members want to preserve their clinical expertise, not only is it difficult to do so, clinical competency is not held as a key value in either the academic discipline of nursing or the academic professorate. The dissonance between what is valued in the different cultures makes faculty transition even more difficult because the new organization (e.g., university) does not hold the same values as those that were held in the clinical organization. Ultimately, new faculty may return to clinical practice where the values they are most familiar with are supported and rewarded.

Most nurses new to faculty positions come from an institutional structure in which they are highly regarded, both for their clinical expertise and their educational achievement. With the minimal entry into nursing practice being an associates or bachelors degree, nurses holding a masters degree are the “top dog” in the hospital setting. Unfortunately, while an MSN is highly valued in the clinical organization, it is not valued in educational organizations, as many institutions of higher education require a doctorate degree as the minimal entry into a faculty position. Transition to a faculty role is more difficult when the values of the clinical practice role and academe do not match.

Not only are the values different between organizations, new nursing faculty have lost the respect they formerly held in their clinical practice role. Participants suggested that senior faculty had lost touch with clinical issues, they did not value the clinical expertise of junior faculty, and they demonstrated an overall lack of respect for clinical faculty. Administrators and faculty in CONs must demonstrate a renewed respect for the clinical expertise that clinical instructors bring to the role to enable them to be successful and remain in academe.

*Mentoring faculty values.* Having access to faculty mentors would facilitate the transition of clinical nurses into a faculty role. Of importance is that the faculty mentor must have a clear understanding of the cultural dissonance that exists between the culture of the nursing profession and the culture of the academic discipline of nursing. Additionally, the faculty mentor should share a similar value system with the newly transitioning nurse.

Experienced nurses have learned to model good practice in their clinical roles, but most nursing faculty have not been able to carry on the same level of role modeling in their faculty positions. Because faculty roles are usually practiced in isolation from other faculty, there is less opportunity to model exemplary teaching practice. And when coupled with the changes in student culture, mimicking what their teachers did for them does not always work for clinical nurses who are transitioning into a faculty role.

Nursing faculty who serve as mentors must understand the uniqueness of the shift in values from a clinical practice role to a faculty role. This understanding of the difference in values will ensure that faculty mentors will be able to assist new nursing faculty in the transition from the value orientation of the clinical practice role to the value orientation of the academic role. This may lead to new strategies for the development of formal mentorship programs for all new faculty in CONs.

*Importance of education and socialization.* Cultural dissonance can be improved if nurses receive formal education to prepare them for a faculty role. Due to a decline in enrollment in masters programs and the increased emphasis on clinical specialization during the past 20 years, most nursing faculty have not been educated for a career in the academy (Krisman-Scott & Thompson, 1998). As a result of this lack of formal preparation, new nursing faculty struggle to learn the basic skills necessary to become effective teachers while transitioning into their faculty role.

Although new faculty members feel confident with their clinical ability, they lack the same degree of confidence in their teaching ability. This overall lack of self-confidence in teaching performance is dismal. As nursing educators, if we continue to rely solely on

clinical practice and education in a clinical specialty area as the most important precursor to a faculty role, the risk of faculty attrition in CONs will persist.

Additionally, cultural dissonance experienced by new nursing faculty would be decreased if nurses were socialized into the academic discipline of nursing during their educational experience. Coming directly from a clinical practice role, new nursing faculty have learned the values inherent in the professional nursing culture, not the values of either the academic discipline of nursing or the academic professorate. Furthermore, as nurses continue their educational journey by attending clinically-based masters programs and research-based doctoral programs, anticipatory socialization to a faculty role and transmission of the values inherent in faculty culture are essentially non-existent.

The elements of socialization that are most important to new nursing faculty are those that help nurses move from the value orientation of the clinical practice role to the academic role. Socializing future nursing faculty to the values inherent in a faculty role, before they actually transition into the role, would ease the difficulty with cultural dissonance faced by new nursing faculty.

*Change in institutional culture.* While providing socialization through the formal education of nurses to the faculty role will reduce the dissonance found in new nursing faculty, educational programs alone will not address the issue of dissonance related to the reward structure of the university. Formal educational programs in teaching addresses one dissonance that is related to participants' teaching ability, but it doesn't address the other dissonance in the university value system, which is the value of research over teaching and clinical expertise.

Changing the culture of the institution to better match the values of the nursing profession is a critical step toward reducing cultural dissonance in nursing faculty. Not only does the nurse need to adapt to the values of the institution, the culture of the institution must change to reflect the values of the faculty member.

This study demonstrated that conflicting values prevailed between the cultures of the nursing profession, the academic discipline of nursing, and the academic professorate. The dissonance between the skills for which faculty were hired, the skills for which faculty were judged, and the skills for which faculty were rewarded can only be improved if cultural changes occur throughout the CON and the overall institution. The values of the academy need to match the values and skills for which nursing faculty are hired, judged, and rewarded, if the issue of cultural dissonance is to be improved.

Although this study focused only on nursing faculty, a similar dissonance in other disciplines within the academy may also exist. Other academic disciplines (e.g., education, medicine, physical therapy) hire faculty to assume clinical positions that have practice experience but no teaching experience. Although additional research in cultural dissonance needs to be conducted in other academic disciplines, the findings from this study suggest that the conclusions presented for nursing faculty may be applicable to newly transitioning faculty within the overall academic institution.

#### *Recommendations for Future Research*

This study described similarities and differences between values inherent in three cultures, the nursing profession, the academic profession of nursing, and the academic professorate. The study was limited to the perceptions and experiences of seven faculty members in one CON. Understanding that cultural dissonance exists in new nursing

faculty, additional research that would focus specifically on how faculty members cope with this dissonance and how cultural dissonance affects their continued transition into their faculty role is important to explore.

Second, because this study was conducted at a large research university, the study should be replicated at an associate degree nursing program in a community college setting. Because the focus of community colleges is generally geared toward teaching rather than research, it would be important to determine if a similar dissonance existed among faculty teaching in associate degree nursing programs.

Third, future research on cultural dissonance should be done with faculty who have been in the faculty role longer than the three year criterion of this study. A study of nurses with more than three years of faculty experience would increase the likelihood of having more doctorally-prepared faculty as participants. Since this study identified differences in the values and beliefs of new faculty members, a study of faculty members who were pursuing tenure would provide an understanding of whether cultural dissonance increases or decreases in nurses who have been in a faculty role more than three years. A study of more experienced faculty members would also provide a better understanding of values specific to the nursing professorate.

Fourth, a similar study with faculty from other professional disciplines (e.g., physical therapy, education) would be important to conduct. Since the concept of cultural dissonance was found specifically in nursing faculty through this study, it would be of value to determine if differences also exist in other professional disciplines.

Fifth, research must be conducted with nurses who have left their faculty positions to return to clinical practice. In light of the current nursing shortage, it is extremely

important that higher education administrators understand how cultural differences affect nurses' decisions to leave their faculty role and return to clinical practice.

Sixth, this study was conducted with a limited ethnic population of white nursing faculty. Future studies should focus on seeking out faculty participants of color to determine their unique transitioning experiences.

Finally, the issue of changing student culture emerged strongly from this study as a factor that affected faculty transition. Change in student culture became an emerging theme that was not originally anticipated in the initial design of this study. Future research to explore the changes that are occurring in nursing students' values and behaviors, and the effect changing student culture has on faculty teaching in CONs is definitely warranted.

#### *Summary*

Similarities and differences were found to exist between the three cultures examined, which affected the transition of nurses from a clinical role to a faculty role. Differences in the espoused and embedded values related to the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the academic professorate resulted in an overall cultural dissonance in nursing faculty who had recently transitioned from a clinical practice position.

Cultural dissonance in nursing faculty can be equated to the adage of trying to fit a square peg into a round hole. The edges of the square peg can be envisioned to represent the values, beliefs, and assumptions that are unique to the culture of nursing with the round hole representing the values, beliefs, and assumptions related to the academic discipline of nursing and the academic professorate. A square peg is not able to fit into a

round hole unless the edges of the peg or the curves of the hole are altered. Novice nursing faculty need to be acutely aware that the previous values that have defined their prior nursing career differ from what is valued in a faculty role, as they try to assimilate into this new academic culture. To reduce the cultural dissonance experienced by new nursing faculty, policies must be enacted at the institutional level that promote the values and reward structure of the nursing profession and of other professional disciplines within the academy.

Knowledge of the existence of dissonant cultures will provide higher education administrators valuable information to improve faculty recruitment and retention in CONs. An awareness of the difficulties faced by newly transitioning nursing faculty will assist faculty and administrators in higher education institutions to adopt strategies and implement policy change that will support faculty in this new culture, which will improve the current nursing faculty shortage by increasing the numbers of nursing faculty nationwide.

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## Appendix A

## Initial Telephone Screening

**Demographic Information:**

Name \_\_\_\_\_

Faculty rank \_\_\_\_\_

Availability: Spring \_\_\_\_\_

Preferred contact method: Email \_\_\_\_\_ Phone \_\_\_\_\_

**Lay summary will be presented verbally and will include:**

1. Who I am and a brief description of the study.
2. What I will do with the study results.
3. The criteria for inclusion into the study. Where I obtained their name.
4. Possible benefits and risks and the assurance of confidentiality to the participant.
5. The number, length, and timeframe for the interviews and observations.
6. Request to record observations with field notes and to audiotape all interviews.

**Criteria for participation:**

1. Full-time faculty appointment in the CON.
2. Ph.D. or MSN.
3. Transition to faculty role from clinical practice within last 3 years.
4. Number of years in current faculty role: \_\_\_\_\_

**Consent to participate in study:**

- Formal informed consent will be obtained prior to beginning the initial interview, at the time of the scheduled interview.
- Establish time and place for initial interview.

## Appendix B

### Initial Interview Guide

**\*\*Note:** Specific questions to be asked are numbered 1-6. Bulleted questions will serve as probes for the interviewer and will be used only if needed to strengthen the interview process.

#### **General Information:**

1. Tell me a little about yourself. Where are you from? What brought you to teach at this college?
  - Describe a typical day for you at the college. What do you spend most of your time doing?
  - What do you enjoy about working at this college? What is important to you as a faculty member in the CON? Which committee do you enjoy serving on most?
  - What things do you dislike or have difficulty with here? What are your primary concerns with your current faculty role?

#### **Values, Beliefs, and Assumptions related to Professional Nursing:**

2. Tell me about your experience as a clinical nurse, before you became a faculty member.
  - What has been your professional nursing experience? Where have you worked in the past and in what capacity?
  - How you would describe nursing to someone that is not a health care professional? What is it like to be a clinical nurse? Describe a typical day for you in that role.
  - What was important to you as a clinical nurse? What did you spend most of your time doing? What were your main concerns while working as a clinical nurse?
  - How did you learn what it means to “be a nurse?” What was the influence of other nurses and/or nursing faculty on how you perceived the profession of nursing?
3. Tell me about a value that was important to you as a clinical nurse.
  - Give me an example of how you demonstrated this behavior in your own professional clinical practice.
  - What do you think are the professional values held by other clinical nurses?
  - In what way have you seen these values demonstrated by other nurses in the clinical setting?

#### **Faculty Role Transition and Socialization:**

4. Tell me about your transition into your current faculty role.

- How were you oriented/socialized to your current position? How did you learn what it means to be a faculty member in the CON?
- What has been the influence of other faculty on you during your transition to your current role?
- What do you do to help ease or cope with your transitioning to a faculty role?
- Tell me about an event that has helped you move through the transitioning process. How will you know when you have fully transitioned?

**Values, Beliefs, and Assumptions related to the Academic Discipline of Nursing:**

5. Tell me about a value that is important to you as a faculty member of the CON.
  - When I was looking at \_\_\_\_\_ CON document, the value of \_\_\_\_\_ seemed to be important. What do you think about my interpretation of that document?
  - What do you think are the key values held by other nursing faculty at this college? Tell me how the values held by other nursing faculty here are similar or different than yours?

**Values, Beliefs, and Assumptions related to the Academic Professorate:**

6. Tell me about a value that is important to faculty at this university who are not associated with the CON.
  - When I was looking at \_\_\_\_\_ CON document, the value of \_\_\_\_\_ seemed to be important. What do you think about my interpretation of that document?
  - How are these values similar to or different from the values held by nursing faculty? How are these values similar or different to the values held by nurses in clinical practice?

Are there other documents that you think I should look at to understand the values, beliefs, and assumptions associated with nursing, faculty, or professorial culture?

What other documents would help me understand your transition better?

Is there anything else that I didn't ask you that you would like to talk about today?

**\*\*At end of interview:**

- Ask for copy of vitae.
- Set up participant observation dates and times:
  - CON committee
  - Class or clinical conference

## Appendix C

### Informed Consent Form

You are being asked to participate in a qualitative doctoral study exploring how cultural differences and similarities affect the transition of nurses from a clinical nursing role into a faculty role in a College of Nursing. The purpose of this study is to identify and describe the similarities and differences of three distinct cultures, the culture of the nursing profession, the culture of the academic discipline of nursing, and the culture of the professorate. This investigation will help provide a better understanding of how cultural variations affect the transition of nurses into faculty roles.

An examination of the cultural influences of individual nurse's experiences during faculty role transition may lead to the development of administrative strategies that will contribute to improving faculty recruitment and retention in Colleges of Nursing. Study results can be used to assist higher education administrators in their support of new faculty during the transition from clinical practice into a faculty role and is of special importance due to the escalating shortage of nursing faculty throughout the country.

Your involvement in this study will include two formal interviews, with the possibility of a third interview with your consent, to occur at your convenience during spring quarter, 2004. The interviews will take approximately 60 minutes each and with your permission I will tape record the interviews. The taping will allow me to focus on our conversation and to better represent what you tell me. You will be free to end the interview at any time and to request that I do not use the interview or any reference to it in any way.

I am also requesting your consent for two observations associated with this study. I am requesting your permission to sit in on one class or clinical conference that you teach and one committee meeting that you attend during spring quarter, 2004. You will choose the time and place for the observations. If at any time during the observation you feel uncomfortable or think your students feel uncomfortable with my presence, I will leave immediately. I will also be observing one general faculty meeting during spring quarter and will be reviewing College of Nursing documents that have been provided to me by the Associate Dean of Research. I will be asking you for any additional documents that you believe will assist in answering the research questions of this study. In addition, I will be asking you for a copy of your vitae. You may decline my request for your individual document without consequence.

The information that is obtained during this study will remain confidential and will not be shared with anyone associated with The Ohio State University or the College of Nursing. To assure confidentiality, pseudonyms will be used in the final write up of the results of this study and no identifying quotations will be used. Dissertation committee members will have access to non-identifying data. Upon request, the findings of this study will be shared with you. If you have any questions or concerns, you may reach me at 419-865-8088, or my advisor Dr. Penny Poplin Gosetti at 419-530-5570.

Sincerely,

Cheryl L. Schriener, MSN, RNC, CNS

If you are willing to participate in this study, please sign this consent form acknowledging that you understand the following:

Your participation is entirely voluntary; no coercion of any kind has been used to obtain cooperation. You may withdraw your consent and terminate your participation at any time during the study.

You understand that interviews will be taped and transcribed.

I grant my permission for the interview to be audio taped:      Yes \_\_\_\_\_      No \_\_\_\_\_

You have been informed of the procedures that will be used in this study and understand how I will be using future interviews, observations, and review of documents.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## Appendix D

### Second Interview Guide

#### Member Checking:

1. This is what I heard you saying at our last interview \_\_\_\_\_. Is my understanding of what you said, correct? What areas do you feel that I need further clarification in to best understand your transition into your faculty role?
2. During our last interview, you talked about \_\_\_\_\_. I would like to explore that area a little more with you to help me more fully understand your perception of \_\_\_\_\_.
3. In talking with other faculty on campus, I've heard \_\_\_\_\_. What is your experience with this area?

#### Document Review:

4. When I was reading your vitae, I noticed that your research/teaching/service/practice interests are \_\_\_\_\_. How do you view research/teaching/service/practice in your current faculty role?
5. Tell me what your understanding is of the CON mission statement? Can you explain the College's mission statement to me? What do you believe is the most important point in the College's mission?
6. At our last interview, you suggested that I look at \_\_\_\_\_ document to better understand the culture of/transitioning \_\_\_\_\_. My interpretation of that document is \_\_\_\_\_. What are your thoughts concerning that document and culture/transitioning?

#### Participant Observations:

7. When I was sitting in on your class/clinical conference, I heard you say \_\_\_\_\_. Can you tell me more about \_\_\_\_\_ and my interpretation of this?
8. When I was observing the general faculty meeting, I noticed that you \_\_\_\_\_. Tell me more about my understanding of \_\_\_\_\_.
9. When I observed the \_\_\_\_\_ committee meeting, I heard you say \_\_\_\_\_. Tell me what you meant by that/or how those ideas/concepts fit into your faculty role/values.

Is there anything else that I didn't ask you that you would like to talk about today?

- Determine if there is a need for a third interview.
- Thank participant for his/her time and sharing of information.
- Ask where he/she would like a copy of study results sent if requested.

## Appendix E

## Document Analysis Questions

How are the documents written, by whom, when and for what purposes?

How are the documents read, by whom, when and for what purposes?

What is the relationship between the writer and the reader?

What kind of information is included in the document? What kind of information is omitted?

What values or beliefs are evident in the document?

Are the documents associated with particular occasions or events?

What is the outcome of the document being produced and used?

What does the writer seem to take for granted about what the readers believe or know?

What do readers need to know in order to make sense of the document?

Is this document part of a tradition?

What are the symbolic relationships noted in the document?