Managing the Healthcare Crisis: The Career Narratives of Nurses

by

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Abstract

The aging population has created an increased demand of healthcare services in the United States that is expected to increase over the next four-years creating a heightened demand for medical services. While nursing is currently the largest employment sector within healthcare; there will be a shortage of nursing professionals to withstand the surge of patient medical needs unrelated to the national pandemic. This study aims to capture insights from male and female professionals within the Wisconsin healthcare system. Wisconsin is a state in the north central United States (Midwest) with a total population of 5,822,434 as of the year 2019. Wisconsin is the context for this hermeneutic phenomenological study and is compounded of 72 total counties with 23.3% of the state's population working in educational, health care, and social assistance workforce sectors. As of 2018, 10,356 LPN's, 80,000 RN's, and under 1,000 NP's renewed licensures to practice in the state of Wisconsin. This study discovered that organizational culture, mental and physical health opportunity costs, and nursing school rigor contribute to a larger shortage of nurses. Nurses who were interviewed shared lived experiences to illuminate factors influencing career choice and satisfaction, which is imperative to retaining and recruiting nurses to fulfill workforce labor demands.

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Chapter I: Introduction

Over a lifetime, an average individual works 90,000 hours in an occupation (Nelson, 2020). Mitch et al. (2004) state that occupation is defined as a person's principal line of profession, trade, career or job, which provides means to earn a living. According to Wrzesniewski et al. (1997), work constitutes for over 25% of an individual's daily waking hours; therefore, impacting quality of life (Wrzesniewski et al., 1997, p. 21). While the meaning of work-life balance varies per individual, evidence presented in the Journal of Research and Personality suggests that individuals view work as either: 1) necessity and financial means 2) promotional advancement opportunities or 3) fulfilling social duties (Wrzesniewski et al., 1997). These three factors are impacted by internal and external changes within the conceptual framework of the workforce. Several forces shift the nature of the workforce including the: 1) nature of work 2) content of work and 3) organizational, social, and institutional context. First, nature of work is characterized as an occupation or scope of work contributing to society's mode of production. Secondly, content of work includes the skills and techniques needed to full-fill job duties. Lastly, organizational, social, and institutional include the organizational culture and environment within an organization or industry. The nature of work, content, and organizational culture contribute to several aspects of an individual's standard of living, community relationships, self-esteem, and social status. However, external factors such as changing regulations and laws, globalization, and demographical variances contribute to changes in the nature of the workforce (National Research Council et al., 1999).

Demographical changes historically and currently affect the workforce. For example, over two million women were employed in war-time industries, previously unacceptable for women, during World War II. The United States' participation in the war, following the bombing

of Pearl Harbor, created a higher military demand and shortages of labor supply with an increased demand of military goods and services. Against societal norms, women entered unorthodox careers in manufacturing, transport, and auxiliary services to assist with the demographic shift of drafted servicemen. According to Milkman (1982), the shift changed the boundary of male and female career paths. The end of World War II, the return of the labor force, and a cultural code of familial roles reversed workforce demographics with layoffs upon return of the male workforce.

Wartime changed the perspective and attitudes of women and workforce participation of the silent generation, which then reflected upon the baby Boomer generation. Generations are defined as an individual group who share the same year of birth and social processes, beliefs and behaviors, based on participation of defining events (Ng et al., 2018). World War II for example was a defining event that shaped beliefs and behaviors of opportunities within the workforce for women. In fact, women's desire to join the workforce increased from 25% to 55% from the 1940's to 1985 particularly that of married women (Lichter & Costanzo, 1987). In fact, baby boomer's accounted for the majority of the workforce population in the 1980's following increased regulations surrounding educational movements and equal opportunity for generified, racial and diverse populations. New laws and regulations created additional educational opportunities, increased dual-career families, and diversified acceptance to a demographic of baby boomers. While Generation Y or millennials are currently the largest employed generational group, baby boomers were the largest generational group within the United States workforce until 2019 (Pew Research Center, 2020).

According to Pyöriä et al. (2017), millennials value the nature of work differently than prior generations. First, millennials value family and leisure work-life balance over higher

compensation. Secondly, personal growth and development opportunities are valued over employer loyalty and longevity. Additionally, millennials thirst for cultural influence and impacting social change. Lastly, millennials are technology natives born in an evolving digital and media era; therefore, workplace limitations are minimized through technological adaptability (Pyöriä, et al., 2017). Generational theories develop stereotypes. For example, one common stereotype is millennials are raised by helicopter parents. Justifiability, it's fair to argue that not all parents use a micromanaged parenting style (Costanza & Finkelstein, 2015). According to Nawabi et al. (2019) parental, lived experiences, and media perception play a vital role in career influence of children versus economic supply and demand of the workforce. In fact, adolescent career choice is less strategic and more about admiration. However, career aspirations become less fantastical and more realistic from adolescence into adulthood. From early stages of childhood, admiration and several underlying factors influence individuals to a specific career path. According to Olaosebikan & Olusakin (2014), societal norms gender, cultural, and religious belief impact occupational choices. In fact, career choice regularly mimics parental career choice or follows suit to social class or parental acceptance. Overall, the term career holds several meanings pertaining to both occupational experiences and total life experiences too. Thus, variables influence career exploration and vocational choice.

Choosing a career is a substantial decision that influences an individual's entire future. While many occupational opportunities exist; economic demands contribute to industry demand and sustainability. As discussed, prior, the nature of work and demographical changes creates a paradigm shift of careers to a marginalized group of the workforce. Amidst an already trialing year globally for the economy and workforce following a national pandemic, an aging population of baby boomers and increased demand for healthcare services are creating a new type of war, a

war against the marginalization of healthcare labor, particularly nursing. According to D'Antonio & Keeling (2019), nursing is considered one of the largest and most diverse of all health professions and is the number one recruited position in the United States.

Statement of the Problem

The aging population has created an increased demand of healthcare services in the United States. In fact, the United States has the highest number of people over the age of 65 years old today than any point in history. Over the next four-years within the United States, 55 million Americans will exceed 65 years old (Haddad, et al., 2020). The expected aging population includes 14.6% of current registered nurses within the country (Smiley et al., 2018). An increase in an aging population creates a heightened demand for medical services. Nursing homes are expected to grow at an annualized rate of 2.1%, which will create a consistent employment demand for medical services and long-term care options (Knickman & Snell, 2002). Employment opportunities in healthcare are expected to grow by 18%, creating 2.4 million new jobs from 2016-2026 (U.S. Bureau of Statistics, 2021a).

Nursing is currently the largest employed segment of healthcare professionals within the United States employing over 3.8 million registered nurses and has a projected growth rate of 203,700 positions created yearly through 2026 (United States Bureau of Labor Statistics, 2021b). However, there will continue to be a shortage of healthcare professionals throughout the country due to the aging population of the workforce, health and work-life balance, acuity levels, patient care, and career benefits such as compensation, growth opportunities, and environmental healthcare culture. Identifying factors influencing career choice and satisfaction is imperative in retaining and recruiting nurses to full-fill workforce labor demands and avoid a healthcare crisis within the United States healthcare system.

Purpose of the Study

The primary purpose of this study is to gain an understanding on influences and decisions to pursue a career in healthcare. It aims to capture insights from female and male nursing professionals employed within the healthcare system in the state of Wisconsin. The resultant findings aim to contribute to the literature by illuminating the lived experience of personas navigating gentrified occupations. Proactive verses reactive employability measures are necessary avoid a healthcare professional shortage. This research aims to identify factors within the scope of the nursing career field that affect career motivation and satisfaction.

Research Questions

The overarching research questions (RQ1 and RQ2) aim to determine factors that influence choosing a career in nursing:

RQ1. Research Question 1: How do study participants describe and justify their choice of nursing as a career?

RQ2. Research Question 2: How does experience in the field of nursing impact the practitioner's career narrative of their profession?

Significance of the Study

The research has the potential to make contributions in healthcare by providing factual and meaningful experiences of nursing professionals and the impact of personal perspectives in the healthcare industry. The study's goal is to positively impact the recruitment and retention strategies of nursing professionals through the emotions and real-life experiences of healthcare professionals. Presenting influential experiences will allow healthcare recruiters and organizations to 1) message nursing as a profession and career 3) identify organizational and

career cultures on nursing experiences 4) and comprehend reward packages impacting career and growth pathways to better bridge the upcoming gaps in employment.

Assumptions of the Study

In regard to this study, the following assumptions exist:

1. Lived familiar, socio-economic, societal and cultural norms, and educational experiences correlate to factors that influence a career in healthcare and transform into nursing.
2. Life stories shape career pathways: therefore, nurses create their own interpretation of career choice from those experience, which then informs practice.

Limitations of the Study

The study supports human perspectives by embracing social and cultural experiences and values, and interests of participants, which contribute to the research process. While the study design is advantageous in investigation of opposing ideas and conflict, existing limitations including rigor and time, limited generalizability, suggestive context versus definitive data, researcher and attrition bias, and reflexivity of introspection and intersubjective reflection reinforce participants' authenticity and honesty (Holloway & Galvin, 2017).

First, conducting one-on-one interviews provides the ability to expand insight on personalized lived experiences and meaningful data. Thus, the process of recruiting voluntary participants following a national pandemic, scheduling and conducting interviews, and transcribing descriptive voice-to-text content is a labor-intensive and time-consuming process (Creswell & Creswell, 2014). Attrition bias of participants creates additional time restraints to fulfill a sample size of interviewees within the interview process.

Second, the study is meant to identify the voices and phenomenon of participants within one segment of healthcare specifically the population of nurses. Within the segment of nursing, participants' specialty will vary based on organizational role, type of patient care (short or long-term), geographical location, and narrowed population. The fundamental dilemma of an interpretive process cannot be extended to a wider population and replicated with the same degree of confidence as study designs (Atieno, 2009). The study presents suggestive data, which is exploratory and inductive through detailed analysis and relies on the researcher as the instrument of study design, data recording, collection, interpretation, and analysis creating researcher bias. In addition, research impacts the study through reflexivity of the researcher through lived experiences and observations of the healthcare system; however, can be limited through transparency of the research processes (Walker et al., 2013). Lastly, the study utilizes a narrative analysis format to document participant's experiences; however, it is assumed that the participants' answers are creditable and honest. Organizational policies and ethical codes of conduct may prevent participants from sharing details of lived experiences. That trust of equality between the researcher and participant is the power to relationships and validity (Holloway & Galvin, 2017).

Definition of Terms

The terms listed in the following section will be used throughout the study. In order to provide transparency, a list of definitions for each term has been provided below.

Acuity Level

Patient to medical staff ratio or the level of attention a patient receives based on the severity of medical illnesses over a 24-hour period (Potter et al., 2017, p. 366).

Baby Boomer

Cohort of individuals born between the years 1946 to 1964 who grew up during the Civil Rights Movement and the Cold War (Pruchno, 2012).

Career and Technical Education (CTE)

Vocational training that prepares students for career readiness and pathways to high-wage, skilled, and industry demanded technical careers through practical and applied instruction within sixteen career clusters including 1) health science 2) business 3) finance 4) information technology 5) engineering and math 6) manufacturing 7) hospitality 8) government, 9) law, public safety, and corrections 10) agriculture, food, and natural resources 11) human services 12) marketing 13) transportation, logistics, and distribution 14) education and training 15) A/V technology and communications 16) and true about his or her personal (Stauffer, 2020).

Certified Nurse Midwife (CNM)

An Advance Practice Registered Nurse with advanced education and certification in gynecological, prenatal, and postnatal care including pregnancy, childbirth, and postpartum care of women (Zhou & Lu, 2018).

Coronavirus 2019 (COVID-19)

An extremely contagious virus resulting in severe acute respiratory symptoms. The virus first evolved in Wuhan China in December 2019 and has spread to 185 countries resulting in the World Health Organization (W.H.O.) to issue an international health emergency and declare a national pandemic ensuing closures of schools and all non-essential businesses (Sheposh, 2020).

Gender

A language relative to the cultural, behavioral, and characteristics associated with a personal sense of identity as being male, female, some combination of both, or neither/non-binary (Merriam-Webster, Incorporated, 2020).

Generation

A group of individuals defined by birth year and significant events in time such as wars, economic shifts, and technological advances (Smith & Nichols, 2015).

Generation Y/Millennials

Cohort of individuals born between the years 1981 and 1996 who grew up with technological advances such as cell phones, internet, and computers. (Pyöriä et al., 2017).

Generation Z/Generation M

Cohort of individuals born after the year 1994 and were impacted by historic events such as 9/11, terrorism, and Hurricane Katrina (Seemiller & Grace, 2018).

Generation X/Busters

Cohort of individuals born between the years 1965-1980 and grew up experiencing historic events such as the Vietnam War, aids outbreak, and explosion of the Challenger space shuttle (Betz, 2019, n.d.).

Hermeneutic phenomenology reduction

A research philosophy, initiated by Edmund Husserl, which lends itself to inquiry and informs and inspires a current method of thinking and practices. Hermeneutic phenomenology uncovers experiences and stories through textual analysis, traditionally through structured, semi-structured, and open-ended interviews, with individual participants or groups (McCaffrey et. al., p. 215-223).

Licensed Practical Nurse or Licensed Vocation Nurse (LPN)

Provides basic medical skills such as inserting catheters, checking blood pressure, and ensuring comfort of the patient. Educational requirements include a Diploma or Associates Degree Program in nursing (Potter, et al., 2017, p. 1316).

Long-Term Care

Medical services designed to meet patient's health and personal care goals (usually over several weeks or months) during a long period of time to allow people to live safely while receiving medical attention for everyday activities or treatment of chronic medical conditions (Potter et al., 2017, p. 245).

Nurse Practitioner (NP)

A nurse with post-graduate nursing education (master's in nursing) and has earned an advanced practice registered nurse (APRN) licensure. NP's typically work independency to establish provider-patient relationships and diagnose and treat simple to complex health needs, often using a more holistic approach than physicians, typically in ambulatory or community health settings such as clinics (Potter et al., 2017, p. 4).

Phenomenological Research

A qualitative strategy that allows the researcher to identify the nature of lived human experiences about a phenomenon described by the study participant (Creswell, 2014, p.249).

Qualitative Research

Scientific research used to comprehend the meaning of groups or individuals by developing questions and procedures, collecting, analyzing, and generalizing themes from data to make suggestive interpretations of the meaning behind the data (Creswell, 2014, p. 250).

Registered Nurse (RN)

A nurse who has completed a state approved Bachelors of Nursing course of study (behavioral, social, and physical sciences) and has passed the National Counsel Licensure Examination in the United States. RNs obtain the credentials to provide levels of patient care,

certain tests and procedures and are responsible for the supervision of certified nursing assistants and licensed practical nurses (Potter et al., 2017, p. 1320).

Short-Term Care

Medical services designed to meet patient's health and personal care goals (usually less than a week) during a short period of time following a surgery, injury, illness, or other medical ailment that is expected to improve (Potter et al., 2017, p. 245).

Silent Generation

Also known as Traditionalists, cohort of individuals born between the years 1928 to 1945 during the Great Depression and World War II (Enam & Konduri, 2018).

Wisconsin

A state in the north central United States (Midwest) with a total population of 5,822,434 as of the year 2019 (United States Department of Commerce, n.d.). Wisconsin is compounded of 72 total counties with 23.3% of the state's population working in educational, health care, and social assistance workforce sectors (USA.com, 2020). According to Zahner et al. (2019), 10,356 LPN's, 80,000 RN's, and under 1,000 NP's renewed licensures to practice in the state of Wisconsin.

Chapter II: Literature Review

The purpose of this study sought to advance research by illuminating lived experiences of healthcare workers employed as nurses. Research aims to capture insights from nursing professionals employed within the Wisconsin healthcare system. The following chapter comprises of both a theoretical and empirical review of literature on nursing as a career choice. Three theoretical frameworks are explored including the 1) Self-Concept Theory of Career Development2) Gottfredson Theory of Circumscription and Compromise and 3) Two factor Theory of Motivation.

Theoretical Framework

The Self Concept Theory shaped by Carl Rogers, can be defined as “the totality of a complex, organized, and dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his or her personal existence” (Purkey, 1988, p. 2). In context of career choice, individual’s self-concept changes over time and is influenced by three components including self-image, self-esteem, and the ideal self. All three components are influenced by developmental factors including developmental considerations, culture, and experiences of success, failures, illness, and traumas. Self-image is subjective and represents a reflection on how an individual perceives themselves. For example, a female nursing student may perceive herself as intelligent because she holds the role of valedictorian within the social context of her nursing cohort. If the same nursing student receives an award and praise for efforts on patientcare, self-esteem increases. If the student receives criticism or if the patients’ condition declines, self-esteem decreases. Self-esteem is the amount of self-value place on oneself and are sometimes unclear and unrealistic; therefore, perceived as coveted perceptions or ideal self. Self-esteem is usually highest during childhood and adulthood and lowest during adolescence and old

age. Therefore, an individual with low self-concept, may choose less satisfying career choices. However, other theories support career choice is affected by adolescent.

According to Cochran et al. (2011), Gottfredson's Theory of Circumscription and Compromise, developed by Linda Gottfredson in 1981, describes how childhood aspirations develop over four stages of development including the orientation of 1) size and power 2) sex roles 3) social valuation and 4) internal unique self. Stage one (3-5 years old) is considered an observatory age. Children view careers by what they observe from adults. Stage two (6-8 years old) is the age where gender roles within the household and careers are defined. Children begin changing career choice based on their own ideal view by stage three (9-13 years old). Adolescents begin eliminating specific jobs based on personal perceptions of gender roles, reputation, and respect within given career roles; however, with no consideration of personal skills, ability, or interest. Stage four (14 years old and older) is when adolescents begin taking their personal interests into account. However, interests are skewed before prior stages, which in relation to the Self-Concept Theory is also the age of the highest self-esteem. Overall, all four stages lead to formulation of career goals; however, other factors determine career motivation and satisfaction upon entering the chosen career field.

Designed in 1959, Fredrick Herzberg's Two Factor Motivation Theory acknowledges two intrinsic and extrinsic factors, motivation and hygiene, which sway job satisfaction and level of performance. Motivation is derived from an individual's attitude toward one's job role, which is affected by factors including recognition, achievement, responsibility, advancement opportunities, and job duties. Hygiene refers to environmental work factors such as organizational policies and culture, peer to peer relationship, mentorship and manager support, salary and compensation packages, working conditions, and job security and flexibility.

Herzberg's theory states that increased motivation factors create higher job satisfaction while increasing hygiene factors decreases job dissatisfaction. According to a study of 272 Saudi Arabian study nurses, hygiene factors were less important to job satisfaction compared to motivator factors (Alshmemr, 2016). In fact, the Two Factor Motivation Theory is a highly accepted and applicable model in healthcare for several reasons. First, healthcare employees hold higher educational requirements than blue collar workers. According to Herzberg's theory, less educated individuals have no need for achievement and hygiene factors are the only job motivators. Second, healthcare organizations employ larger groups of employees in fast-paced and rapidly changing environments; therefore, when applied to management approaches and organizational issues, increases productivity and efficiency (Bohm, 2012).

Motivational influences surrounding job satisfaction is in correlation with motivational factors too. The following literature presents an amalgamation of quantitative and qualitative research unique to the phenomena of nursing and are presented under several themes including shifting workforce and demographical fluctuations, societal "norms" and traditionalized views, generified roles, developmental and cultural considerations, familial and mentor guidance, and intersecting influences and scope of healthcare industry from history.

History of Nursing: Generified Roles and Traditional Views

For centuries, workforce demands were dictated by societal "norms" and traditional views of gender roles. Gender and social class defined career options and healthcare roles were generified. In healthcare, males were doctors and women provided matriarchal and parental support by assisting with births, nursing the sick, and providing support and care for the dying. Formal education or training was limited and segregated by social class, race, and gender. For example, traditional views of women were heavily tied to domestic duties and providing

essential hygienic and ill care, which was learned through practical application versus formalized training. The definition of a nurse is a person who cares for the sick or infirm (Merriam-Webster, Incorporated, 2020). Therefore, by that definition, all women in the 19th century and prior, were nurses without the official title or training. While education for nursing remained in infant stages in the 1830's, instructional guides promoting nursing education existed. Medical advocates such as Warrington (2018) authored instructional manuals promoting women in healthcare roles. The manual titled, *The Nurse's Guide Containing a Series of Instruction to Females who wish to Engage in the Important Business of Nursing Mother and Child in the Lying-In Chamber* provided an instructional guide in aiding in the delivery of newborns (Warrington, 2018). While the manual was used by some medical professionals on the east coast of the United States, nursing was considered a menial job for women and unfavorable for middle to upper social classes. Therefore, ironically the class of women with the literacy ability to read the manuals were the very same social class restricted from becoming nurses. In fact, many servants and housemaids were trained to practice in-home medical care for the middle and upper social class (Helmstadter & Godden, 2016). However, war shifted the practicing environment of healthcare treatment.

The American Civil War of 1860 changed the trajectory of medical care from home-based familial care to treatment in roadside hospitals, battlefronts, slave quarters, and on open plains. However, the nursing duties were still stereotyped as a female role and most nurses were untrained. Women, of all classes, involuntarily and voluntarily provided care to soldiers on battlefields or within their own homes by feeding, administering medication, and attending to hygienic needs of the injured and sick. Hospitals existed in highly populated urbanized areas; however, conditions and standards were much different from the sterile conditions that exist in

today's healthcare system. Conditions of hospitals ranged from very poor to good and it wasn't uncommon to witness rats and mice scurrying across hospital floors while nurses tended to ill patients (Rothstein, 1987). Due to the unfavorable conditions and despite increased industry demand, healthcare wasn't considered a career choice or a societal role for females.

Males avoided nursing careers due to existing traditional views and gender stereotypes of the femininity of the profession creating a perception that men entering nursing roles were heterosexual. Other stereotypes made nursing an unfavorable career choice including the notion that men had the inability to control sexual desire and only females could provide intimate care to other females (Cottingham et al., 2016). These perceptions of males in nursing roles created a gap in workforce demands, which were filled with a particular demographic of women; criminals were considered poverty stricken, accepting alcohol and money for sexual favors, and working for public hospitals as approaches to reduce jail sentencing. In fact, according to Judd and Stitzman (2014), nursing was considered a revolting career unfit for any respectful women. Nursing as a career choice was influenced by societal norms, social class, and urgency to meet basic needs to live. While many individuals may perceive the current 2020 pandemic as ominous times in healthcare history, the eighteenth and early nineteen centuries were considered the darkest of times in nursing due to traditional views of the profession (Theofanidis et al., 2015).

Nursing as a Profession: A Change in Perspective

During a time in history when religious movements and reforms, societal class, and gender dictated career and familial roles, nursing was still considered a menial and contemptuous career choice for wealthy women. In fact, nursing was a poor woman's job. However, against her father's wishes and in pursuit of her own religious callings from God, Florence Nightingale left England in 1851, to attend a Christian nursing school in Germany. In nursing school, she learned

the importance of cleanliness and patient care. Florence Nightingale's passion for providing quality skilled patient care with proper medical equipment and sanitary conditions, laid a foundation for what later led to a shift in nursing educational nursing standards and overall perception of nursing as a career field. Florence Nightingale, like many vocational educational training advocates in later years such as Booker T. Washington, changed the practical standards and perception of the career field. In fact, according to Shetty (2016), in 1860 Florence Nightingale transformed nursing from a domestic duty to occupation through organized learning after her efforts in aiding solders during the 1853 Crimea war between Turkey and Russia.

The theory of education for nurses was introduced by Florence Nightingale's first training program, "Nightingale Nurse's Training School" at St. Thomas' Hospital in London, England. Curriculum was structured around two principles, which involved structured hospital training and an individual's own moral value. The training stated nurses must develop applied training in hospitals. Secondly, nurses should live by a strict moral code of conduct and fulfill a respectable and altruistic lifestyle. With both principles in place, the caliber of individuals entering the nursing profession would provide a more positive perception of nurses. The curriculum empowered nurses to following Nightingale's vision of healthcare training through disease prevention, sanitation, hygiene, and nutrition. The concepts and policies promoted within Nightingale's training program are practices and frameworks still used today in healthcare and extend farther into improved facility conditions and affordable healthcare costs for patients.

Nursing Now: Levels of Nursing and Educational Requirements

Nursing duties and educational pathways has evolved over time since the era of Florence Nightingale. Nurses are a fundamental component of all healthcare services and oversee acute, critical, and long-term care in clinics, hospitals, emergency rooms, surgical wards, geriatrics, and

private practices. Based on educational training, skill variation, and specialized credentials, nurses can be categorized under an umbrella of three categories 1) License Registered Nurse (LPN) 2) Registered Nurse (RN) and 3) Advance Nurse Practitioner (APN). LPN's provide basic medical skills such as inserting catheters, checking blood pressure, and ensuring comfort of the patient. Educational requirements include a Diploma or Associates Degree Program in nursing and training at a community, vocational, or university. LPN requirements can be completed within 12 months, which is shortest route into nursing. RNs are nurses who has completed a state-approved associates or bachelor's in a nursing program of study (behavioral, social, and physical sciences) and has passed the National Counsel Licensure Examination in the United States. Program requirements often take two to four years. RNs obtain the credentials to provide levels of patient care, certain tests and procedures and are responsible for the supervision of certified nursing assistances and licensed practical nurses. Lastly, the APN requires advanced degrees including a bachelors and master's degree, which provide training and licenser to diagnose and treat illness and injuries. Programs can complete within six to eight years for both undergraduate and graduate degree completion. Similar to that of a medical doctor, some healthcare organizations require a minimum education level of a doctorate for APN, which requires additional post-secondary schooling beyond a master's degree. (Potter et al., 2017).

While the number of nurses pursing APN credentials increased by 10% from 2013 to 2017, APN's comprise of less than 4% of the nursing workforce within United States (Smiley et al., 2018). A surplus exists between the bachelor's and APN degree attainment amongst Wisconsin nurses to national nursing workforce. According to the Wisconsin 2018 RN Workforce Survey, 6.9% of nurses hold APN educational requirements compared to the 3.9% nationally (Zahner et. al., 2019). While Bachelor's Degrees are the most common amongst

millennial nurses and Diplomas and Associate Degrees are more customary to baby boomers; more 5.8% more Wisconsin nurses held bachelor's degrees compared to U.S. nursing population of 41.8% (Smiley et. al., 2018). According to Harrison (2019), disparity amongst degree attainment correlates with the demand for a more complex and diverse nursing skill set. Therefore, Wisconsin's greater number of bachelor's degrees correlates with the 1.8% higher number of elderly populations over the age of 65 years old compared to the US average of 17% (United States Bureau of Labor and Statistics, 2021a). The trend in increased degree attainment indicates a push toward a higher educated workforce, with increased skills, in response to demographic and specialty demands (Smiley et. al., 2018).

Specialties: The Opportunity to Respond to the Need

Nursing is an evolving career field that requires adaptability and docility with diverse patient populations and environments. If the COVID-19 pandemic of 2020 has taught nurses anything, it is the notion that flexibility and critical thinking skills save lives. Healthcare environments can be fast-paced such as an urgent care or an emergency room environment (E.R) where nurses provide medical attention to patients in need of immediate medical treatment to treat time-sensitive or life-threatening injuries. While age and gender of patients vary, types of illnesses and treatments are comparable. A steadier paced environment, which involves more patient and family interaction, includes a hospice center where patients (typically geriatric) receive palliative care plans. While type of illness and treatment influence medical urgency, nursing personality, interest in patient population, and environmental factors influence specialty.

According to Monti (2021), a medical specialty is defined as sub-fields within the comprehensive fields of medicine, which allow healthcare professional to focus on a distinct demographic of patients, diseases, skills, or philosophy. Due the increased demand for healthcare

services for the aging population and demand for intense medical care, the demand to fulfill nursing specialties positions exceeds the overall nursing shortage alone in the United States. While COVID-19 has marked uncharted territories for healthcare organizations globally, nursing education has responded to the pandemic by providing more online training options for secondary nursing programs, in addition to specialty training (Jackson et al., 2020). For that reason, healthcare employers reward employees for specialty training by means of promotion, additional job responsibilities, and compensation. For example, nurses with gerontology (study of aging) training and experience are more desirable to employers (Office of Occupational Statistics and Employment Projections, 2020). In fact, anesthesia is both the highest paid nursing specialty in Wisconsin and nationally (Smiley, 2018). According to Strom et al. (2013), anesthesia has a higher negative effect on the cognitive brain function postoperatively of elderly patients creating a higher specialty demand for nurses with credentials to care for that specific population of anesthesia patients. Additionally, according to Buerhaus et al. (2017), 55% of the nursing workforce will retire by 2030 leaving specialty creating gaps for nurses with additional certifications and credentials. The demand for specialties will increase particularly in higher trained specialties including Intensive Care Unit (ICU), geriatrics and home care, dialysis, neonatal, and oncology. Specialty training options are reliant on existing nursing degree credentials, skill-level and years of experience, and comfort level and interest with patient populations. Lastly, a proctored test is required upon completion. Materials and testing costs are incurred by the nursing student. Certifications cost both time and money. Many healthcare employers offer tuition vouchers or reimbursements to incentivize continued learning, growth, and advancement; however, time is a restraint due to voluntary and required overtime within departments for both seasoned and new nurses. According to Stimpfel et al. (2019), 13% of new nurses reported

working second jobs and predominately twelve hour shifts while 12% worked mandatory overtime, and over half worked voluntary overtime. However, organizations including the American Nurses Credential Center (A.N.C.C.) provide self-paced, online, and competency-based courses that are renewable every five years for costs ranging between $100-$1,000 per certification (2U, Inc., 2020). According to Agyepong and Okyere (2018), continued education is highly encouraged by employers because it allows nurses to expand their license and create versatility within scopes of practice. Adaptability of nursing duties has become increasingly evident amidst the 2020 pandemic and one million nurses will be needed in the year 2020 alone to meet healthcare demand (Haddad et al., 2020).

Workforce Demand

Shifting demographics, generified roles, global pandemics, and technological and medical advances impact supply and demand of all industries of the workforce, including the leading employment sector in the United States, healthcare (Dowell, 2020). In 2018, 91.5% of Americans held private or state funded healthcare insurance allowing the healthcare industry to steadily grow with a resilience to economic decline (Berchick et al., 2019). Healthcare expenditures are expected to increase from 2019 to 2026 by 1.8 trillion dollars from 3.9 to 5.7 trillion dollars due to increased demand for healthcare services particularly for the aging population (Berchick et al., 2019). Employment opportunities in healthcare are expected to increase by 15% creating 2.4 million new jobs from 2019-2026 making healthcare employment almost insuperable (United States Bureau of Labor Statistics, 2020b) The surge of healthcare opportunities is prevalent, and the workforce is adding 24,000 new healthcare jobs per month due to the demand of short and long-term care (Berchick, 2019). However, the aging population of baby boomers has created an increased demand of healthcare services and a reduced labor

pool of nurses. Therefore, 69.4% of those projected workforce demands include the backbone and largest segment of healthcare employment, nurses (The Center for Health Workforce Studies, 2012).

Within ten years, baby boomers ages 65 years and older will exceed the number of children; thereby, impacting nursing specialties. This may require a future evaluation of specialty nursing services. On a state level, the Wisconsin population of baby boomers will nearly double by 758,000 from 2010 to 2040. Additionally, the "silent generation," or elderly population 85 years and older, is projected to increase by 27,000 from 2010 to 2025 (Egan-Robertson, 2013). Emphasis on preventative and treatment care and medical advances in medicine, for once terminal diagnoses, results in longer life spans; therefore, patient longevity creates higher demands for more healthcare professionals. While the increase in aging population indicates a higher demand for healthcare services, nursing employment deficits don't accurately project patient census. For example, Japan has the highest elderly population of any other country with a maximum patient to nurse ratio of one nurse to every seven (1:7) patients. While regulated patient ratios vary per department and specialty; the United States' maximum patient acuity level (patient to nurse ratio) is one nurse to every five (1:5) patients. Therefore, if Japan will require an additional 260,000 nurses, by the year 2025, the country is expecting an increase in 37,142 elderly patients. However, the United States is projected to need 10,000 fewer nurses to meet the demand of 50,000 more elderly patients giving a skewed perception that the United States has higher acuity levels resulting in less quality of care (Hughes, 2008). However, acuity levels differ from clinics and hospitals to long-term care facilities including nursing homes. In fact, depending on the day, evening, and overnight shift; patient ratio increases from 5 (daytime), 15 (evening), and 20 (overnight) patients per every nurse. Despite higher nurse to patient ratios,

70% of the population ages 65 and older are reliant on Medicare. Therefore, 1.3 million due to the aging population is living in nursing homes across the United States and that number will increase due to the longevity of the aging population (Face the Facts USA, 2015).

According to the Centers for Diseases Control (2019), the national life expectancy will reach 79.8 years old, which is lower than the life expectancy projection in Wisconsin males of 81.5 years and 85.7 years for females (Agency for Research and Quality, n.d.). Due to increased life expectancy, 1.9 million Americans live in nursing homes with a larger number of elderlies in the Midwest and Florida. Wisconsin's elderly population will continue to live longer than the national elderly population creating a larger demand for nurses to provide health services to geriatric populations. The increased geriatric needs are creating shortages globally. Japan has the highest elderly population. Responding to the current demand of filling one million nursing positions, geriatric healthcare needs further complicates nursing care within the profession. Additionally, the current workforce demographic, perception of generified roles, and nurse burn-out both due to prior workplace conditions and current emotional and physical tolls of the 2020 pandemic further challenges meeting the need in the nursing profession (Haddad et al., 2020).

Demographic: Shifts Impacting the Nursing Profession

According to the Haddad (2020), the United States encompasses 7.5% of the 29 million nurses globally. While the United States is labeled the "melting pot" and the "land of opportunity," 92% of the national nursing workforce are educated within the United States indicating an employment and education gap of foreign nationals within nursing. Zahner et al. (2019) highlights that states should meet the national benchmark of diversity. However, Wisconsin fell 17.9% below the national benchmark. According to Aiken (2007), most nursing programs globally mirror the curriculum of the United States nursing programs; therefore, hiring

more foreign trained nurses would help bridge the shortage and steadily contribute to the existing nursing workforce.

According to Smiley et al. (2017), there are exactly 920,743 Registered Nurses (RN's) working within the United States. Hospitals employ 55.7% of RN's followed by ambulatory care (9.4%), nursing home and extended care (4.8%), and home health (4.3%). Of the 972,743 nursing home facilities within the United States, nursing homes/extended care facilities employ 37.1% of LPN's followed by home health (14%), and hospitals (9.6%). The differential of work environments from RN to LPN is consistent with educational and skill variations. Overall, the nursing workforce averaged an age of 51.5 years, which is higher than Wisconsin's average nursing age of 46.4 years old compared to Wisconsin's. Nurses ages 65 years old increased by 9.9% from 2015-2017 indicating a trend to work past retirement age, which has recently increased due to COVID-19 nursing shortages. In fact, in response to nursing shortages globally, countries are fast-tracking nursing re-registration options to allow retired nurses to assist with pandemic nursing shortage (Jackson et al., 2020). While the population of retiring baby boomers is creating an influx of unfilled nursing positions, traditional views and perceptions of generified roles creates an imbalanced generified workforce too. Lastly, males make up 9.1% of the nursing workforce while females account for 90.9% indicating gender disparities in employment. However, generified roles are influenced by societal and generational influences (Smiley, 2017).

Perception of Nursing Now: Gender Equity and Social Influence

In 1955, the first male nurse, Lieutenant Edward R. Lyon became the Army Nurses' Corporations first male nurse. However, while that moment marked a symbolic moment for males, over 65 years later; only 9.1% of the nursing workforce within the United States are male. On a state level, that number is even lower (Zahner et al., 2019). In fact, in Wisconsin, males

account for 7.5% of the nursing workforce indicating gender biases. Although the minority of the nursing workforce, males, earn $10,000 dollars more than female nurses per year nationally (Potera, 2015). Additionally, males make up 79% of the healthcare CEO, department chair, and division chiefs and medical officer leadership positions in healthcare overall (Rotenstein, 2018). Therefore, a *glass escalator* exists in nursing meaning men are given hidden advantages in a prominently female profession within the United States (Williams, 2016). However, countries outside of the United States have embraced male nurses at a higher rate for cultural differences. Twenty-three 23% of the nursing workforce in Iran are male. However, the 13.9% difference of male nurses is attributed to religious value and same gender nursing to patient preferences versus a larger social acceptance of male nurses. In fact, gender stereotypes, of nursing as a feminine role, and challenges deter males from entering the profession. According to the U.S. Department of Labor (2018), nurses should be gentle, compassionate, responsible, and detail oriented, of which, are viewed as feminine traits. Due to societal perceptions on gender roles, male nurses are often viewed as homosexual or feminine. The gender-bias and the term “male-nurse” versus “nurse,” is showcased and used as comical satire in movies and on television shows too, which heightens the fear of femininity. The perception of male nursing as female career role creates dissimilar nursing student interactions, clinical experiences, and educational experiences within the educational and career journey, which translates into career satisfaction and dissatisfaction. For this reason, male nurses divert to more masculine specialties such as anesthesia care or the emergency room.

According to Harrington et al. (2015), gender roles are a significant factor influencing millennial career choice. Although the demand of healthcare careers has increased, millennials have a fundamentally different career perspective than previous generations. In fact, to identify

career influence of millennials, an online survey and study was conducted on individuals between the ages of 22-35 years old with a minimum of two-year work experience at five large organizations within the United States, but with a global presence. The industries included the following: financial services, insurance, annuities, employee benefits programs, financial service provider, property and casualty insurance firm, and commercial and industrial property insurance company. The online survey was randomly sent via email and 1,100 employees across the five participated.

The study identified the perception of organizational culture and gender perception amongst employees and revealed that men felt more pressure than women to work longer hours and ensure less work-life balance. Secondly, career growth opportunities, salary, and work life balance were the most important employer criteria factors. While the healthcare industry is a patient driven industry that requires compassion, millennials were less concerned with finding meaningful careers that contribute to society than other generations. Lastly, millennials' number one reason for leaving an employer was to make more money, which translates into healthcare organizations offering competitive compensation and benefits to retain and attract employees. Contrast to females working in male dominated careers, males still earn a higher salary than women in the United States. In fact, male nurses earn 2.5% more than female nurses and are less dissatisfied with compensation. Despite gender or compensation, other factors inspire individuals to pursue nursing.

Permission Givers: Mentorship

In the recent months and in light of COVID-19, news channel stations have shared stories of healthcare workers' bravery and struggles during the pandemic. During those interviews, many nurses shared experiences of satisfaction or dissatisfaction within the current healthcare

system. However, despite the temporary conditions during a global pandemic, underlying factors or influences drive individuals to a challenging, yet rewarding, career in nursing. Like many career choices, influence and acceptance is driven by experiences and personal influencers. According to Dante Cordeiro et al. (2017), social influences such as gender stereotypes, cultural, and parental influencers played a larger role in students' choices of non-nursing careers in Asia and the United Kingdom. In fact, a descriptive survey was conducted of 2,376 people in Brazil. Of the students surveyed, 451 responded equating to a 52.7% response rate. The survey, which followed a 35-tem parallel Likert scale, was sent via email questionnaire to non-nursing healthcare students enrolled within the first seven courses of the Social Work, Psychology, Pharmaceutical Service, Dental Hygiene, and Healthcare Management programs.

Furthermore, according to Liaw et al. (2017), the purpose of the study was to identify the influencer and perceptions of nursing versus other healthcare careers. Several factors including personal interest attracted students to healthcare programs, the interest in nursing as a career choice was less about monetary influences and more about helping others, personal fulfillment, and job security. To determine the influencer of non-nursing healthcare careers, study participants were asked to rate the influencer of specific healthcare career choice by six influential factors including 1) personal interest 2) prior healthcare exposure 3) self-efficacy 4) job prospects 5) perceived nature of work and 6) social influences. Research was compared to a similar study of 59 nursing students.

A previous qualitative study revealed similar trends. In fact, parents in the United Kingdom discouraged children from pursing nursing careers because it was considered less scholarly and required more hygiene related job duties. In fact, non-nursing students declared a disinterest in handling the dirty work; however, nursing students stated that hands-on related

duties were a primary career influence. Additionally, survey results revealed non-nursing students preferred healthcare positions with more responsibility and decision-making rights.

Nursing students declared personal interactions with healthcare experience as an influential factor in career choice including secondary school activities and volunteer work related to nursing job duties. Additionally, the following career influencers were higher amongst nursing including 1) interaction with people 2) exposure to nursing careers through prior secondary school activities or care of a sick family member 3) challenging and hands-on work environments 4) job security and workforce demands and 5) positive career perception. However, the primary influencers of non-medical students included 1) monetary benefits 2) career advancement and 3) job duties not relating to hands-on hygiene care.

Overall, the study was developed and conducted to bridge the gap of future nurse shortages and also provided institutions and policymakers with tools to increase student interest and create a realistic perception of nursing careers. In fact, the study confirms that early exposure to nursing careers increases nursing enrollment in post-secondary institutions. Early exposure includes breaking gender stereotypes, gaining parental support, educating parents and students on the personal and professional benefits of nursing, and discussing the advancement opportunities of nursing including Nurse Practitioners, researchers, and educators (Liaw et al., 2017). However, the term “parental influence” has sundry meanings.

The median age for a grandparent is 54 years old. Additionally, over 13 million children across the United States live with their grandparents; therefore, parental influence for some families constitutes as grandparents. According to Crick et al. (2017), article, *Reflections on the influence of grandmothers on the careers of four nurses*, healthcare and their patient care perception and approach was driven by united values of admiration, courage, and listening skills

observed from their grandmothers Crick et al. (2017), presents the personal reflections of four nurses from different cultural and geographical locations. The article and study identify the influence of family and friends, particularly grandmothers, as a leading career choice factors in healthcare. In fact, Crick et al. (2017) reaffirms that many nurses have grandmothers that worked in healthcare or were employed as nurses. According to Crick et al. (2017), the purpose of the study was to identify the characteristics of grandmothers that influence four nurses' healthcare careers from the reflections of the following four female study participants: 1) Danielle 2) Jane 3) Michelle and 4) Nicky.

First, Danielle's experience during her grandmother's death inspired her to obtain her Master's Degree of Nursing and helped her understand the importance of respect and dignity during difficult times including death. Secondly, Jane's passion for working with elder care, within mental health settings, was driven by her observation of her grandmother's struggle with chronic arthritis. Crick et al. (2017), reflect on the battle of loneliness and depression due to medical conditions in elderly populations. Similarly, study participant Michelle, chose a career in elder care because elderly patients often are frail and physically or mentally unable to speak of concerns based on their own behalf. Per Michelle, speaking up for those who cannot, due to injustice, a trait instilled from her grandmother as a child. Lastly, Nicky reflected how her grandmother's patience, listening skills, non-judgmental character, and desire to ask questions helped her build better patient relationships and more efficient intake chart notes as a nurse.

Overall, the study identified that values including respect, courage, and listing skills, deprived from grandmother to grandchild relationships. These values and experiences are translated into similar values outlined code of International Council of Nurses code such as respect to people and co-workers. Nurses are expected to respect co-workers, patient families,

and patient rights. Courage is required to take action when ethical and medical decisions are addressed. Lastly, listening promotes a safe environment for a melting pot of patient population and cultural experiences and expectations (Crick et al., 2017). While factors influence entering the career field of nursing is influential, career satisfaction and dissatisfaction also contributes to the retention rate of nurses.

Career Outlook: Retention

While nursing provides job security and a median national income of $63,000, nurse turn-over rate is amongst the highest of industries within the United States. According to Zahner et. al. (2019), Wisconsin has a 3.7% turn-over rate in comparison to the national average of 17.1%. The highest turn-over present themselves in southeastern states. Nurses working in emergency care, behavioral health, had the highest turn-over in comparison to burn-units, pediatrics, and women's health departments all of which had the lowest turn-over rates amongst specialties. The nursing professions turn-over was reported based on environmental factors, higher patient acuity levels, required overtime and lack of work-life balance, and physical and emotional strain. First, healthcare facilities have written codes and procedures in place lifting patients alone. However, if acuity alignment is inadequate, nurses are placed in circumstances to lift patients which can cause injury to both the patients and staff. Secondly, while varied per department, bullying amongst staff is a concern affecting career and workplace satisfaction. Incidents of bullying from seasoned nurses and doctors, towards rookie nurses, has increased to 30% (Al-Ghabeesh & Oattom, 2019). In fact, according to a study conducted by Berry (2017), nurses without colleague relationships feel more isolated, get overwhelmed more easily, and are more dissatisfied with their roles compared to nurses with more colleague relationships.

According to Gatchel (2018), nurses were twice as likely to experience depression as individuals within other professions. The author also discussed increased nursing demands due to high burn-out and turn-over within the nursing profession. Although a high demand career field with job stability, there are several bio behavioral opportunity costs of nursing including 1) low back pain 2) stress and 3) depression. Nurses are also expected to tend to the opioid crisis with little training on the interpersonal and pain management demands of patients, which creates a high stress work environment resulting in faster burn-out.

According to Gatchel (2018), reviews a study of two suburban Midwest hospitals were conducted in an effort to reduce the number of opioid visits to the emergency rooms, which would then create a less stress-full working environment for nurses. In fact, the author stated that "nurses are less healthy than the general public," (Gatchel, 2018, p. 2). The author made recommendations on how nurses can better handle opioid patents, which included additional opioid and pain management training. In a 2016 burn-out study, 418 nurses completed a questionnaire using a seven-point scale. Specific qualitative data wasn't presented; however, an overview of data findings was presented to create better working conditions for nurses and bridge in the future nursing shortage.

The study revealed that depression and stress can create impaired judgement on work-related tasks, which can lead to medical errors. Therefore, Gatchel (2018) presented several solutions to solving the nursing shortage due to the aging population and high burn-out rate. For example, high burn-out is a result of high-demand and low resources such as wellness resources and training programs. Gatchel's study revealed that nurses working in hospice had higher levels of burn-out; however, burn-out could be avoided through additional programs to assist nurses

with mental-health and personal healthcare needs. The opioid crisis creates a similar need for nurses.

Overall, the healthcare industry continues to be a consequential component to the economy. The demand for healthcare amidst a pandemic, the increase options for healthcare coverage, and the aging population created a shift in the provision of care. The shortage of nurses, due to the aging population and COVID-19, have created misappropriated satisfaction levels of both patients and staff. The following research study, of Wisconsin nurses, will strengthen the nursing workforce by allowing healthcare organizations to identify career influences for recruitment initiatives and focus on employee satisfaction to build a quality workforce that will navigate the paradigm shift of the aging population and the changing healthcare system.

Chapter III: Method and Procedures

The purpose of this qualitative study is to gain insight on influences and prospect's decision to pursue a career in healthcare. This study aims to capture experiences and insights of nursing professionals employed within the healthcare system in the state of Wisconsin. The resultant findings aim to contribute to the literature by illuminating the lived experience of persons currently navigating nursing occupations. Two overarching research questions (RQ1 and RQ2) guide this study:

RQ1. How do study participants describe and justify their choice of nursing as a career?

RQ2. How does experience in the field of nursing impact the practitioner's career narrative of their profession?

Research Methodology

The research methodology for this study is directed by a qualitative phenomenology hermeneutic approach. The researcher has chosen a qualitative study for several reasons. First, qualitative research is exploratory; therefore, provides benefits to healthcare and clinic research. Secondly, qualitative paradigm supports human perspectives by embracing social and cultural experiences, values, and interests of participants, which contribute to the research process (Creswell, 2014). Additionally, qualitative research provides a systematic collection, organization and interpretation of textual information. Unlike quantitative research, which gathers codable numerical data; qualitative research provides non-numeric data. In fact, according to theoretical physicist, Albert Einstein, "Not everything can be counted counts, and not everything that counts can be counted" (Toye, 2015, n.d.). Lastly, qualitative research is strategic in nature and uses an inductive approach to generate insights into experiences that are difficult to measure quantitatively. According to Creswell (2014), qualitative research examines

the meaning of individuals or groups through inquiry methods including 1) emerging methods 2) open-ended questions 3) interview, observation, document, and audio-visual data, text and image analysis, and recurrent themes and pattern interpretations.

According to Mak and Elwyn (2003), phenomenology research focuses on the *how* and *what* of the research, whereas the hermeneutics focus is on the *why* of the research. Both *RQ1* and *RQ2* are designed to identify and characterize what, how, and why patterns and behaviors, group interactions, and individual perceptions impact the narrative of nursing professionals, which is coded through analysis of emerging contextualized themes. While human emotion and perspectives sway participant and researcher bias, the study provides richness and validity through consistent instrumentation, processes, and tools (Leung, 2015).

Validity and Reliability

Creswell (2014) highlights that validity ensures that findings are accurate from three perspectives of the 1) participant 2) researcher and 3) readers. Trustworthiness supports inquiry findings, through raw data, if theory-based categorization matrix is absent. However, several other measures support trustworthiness in qualitative research including data, collection, and analysis. Content analysis is conducted in three phases, which include 1) preparation 2) organization, and 3) reporting. First, the preparation phase involves the data collection method, which includes conducting a semi-structured interview for this study varied sampling methods including snowball and purposeful sampling. Secondly, the organization phase refers to categorization and abstraction of data. For example, this study utilizes a thematic reduction process to create themes and concepts of participants' ideas. To indicate trustworthiness, the researcher provided an example of the raw data table and reduction process, which transpire into themes and concepts. During this process, the researcher also ensured dependability by

describing and identifying the participants accurately. Lastly, the reporting phase involves presenting results and the analysis process. The researcher provided the content analysis in a clear way allowing the readers to conceptualize the research phenomena through common concepts ensuring validity.

Qualitative researchers' facilitation skills impact validity: therefore, effective interviews require relational focus, curiosity, and interviewing practice (DeJonckheere & Vaughn, 2019). To provide an engaged and relational focus with quality data, the researcher will avoid transactional questions-answers. While qualitative research unfolds as the researcher asks questions to the interview, the researcher will follow a semi-structured (open-ended) interview questions relevant to scope of the research. Organizational policies, ethical and patient confidentiality rights will be considered when developing guided questions to ensure that the interviewees' responses will not influence workplace and familial relationships, or levels of care provided. Although participant responses change the tone and trajectory of dialogue between the participant and researcher, the researcher will follow a guided instrument of core questions to optimize validity and authenticity.

According to DeJonckheere and Vaughn (2019), establishing rapport creates an additional awareness of relative or social factors that influence perspectives. Trust and rapport are established between the researcher and interviewee by providing the guided core questions and meaning of the research to the participants, in advance, prior to the interview. The researcher allotted the same standard of minutes for each interview to account for unplanned follow-up questions. Utilizing the same core questions and creating consistent-comparative methods decreased bias. Limiting time restraints allowed the researcher to initiate the interview, ask core guided questions, and obtain greater detailed responses while building credibility. Lastly, the

researcher transcribed and recorded field notes to identify both verbal and non-verbal ques from the participants. Once transcribed, common themes were captured, and a thematic analysis was generated.

According to Lichtman (2013), steps of gathering data involve four steps. First, the research gathers a large amount of data and pieces the data together like a puzzle. Secondly, the researcher categorizes and analyzes the data, which is called the reduction process. Third, raw data is captured, and unnecessary phrases and initial codes are reduced. Lastly, through shared phenomenological experiences, the researcher aims to identify resultant themes in reference to the two research questions regarding justification and lived experiences of an occupation in nursing.

Subject Selection and Description

The subjects of this study consist of a population of healthcare professionals currently licensed and employed as Nurse Practitioners (N.P.), Registered Nurses (R.N.), and Licensed Practical Nurses (L.P.N) within the state of Wisconsin. For the purpose of this study, a stratified selection approach was employed to meet a diversified subset of subjects based on the following criterion: 1) gender identification 2) roles within nursing, and 3) generational group. Employed stratified processes will include the following (see Table 1).

Table 1

Subject Selection and Stratification

Minimum n6	Goal n12	Subject Criterion				
1	3	Identify Female		Identify Male		Identify Other
2	3	LPN's	GenX	GenY	GenC/Z	Other
2	3	RN's	GenX	GenY	GenC/Z	Other
2	3	NP	GenX	GenY	GenC/Z	Other

Generating a sample size of six to twelve nurses allows for attrition of voluntary participants. Attrition is expected due to time restraints due to COVID-19 and current demands of health care workers amidst a national pandemic. Additionally, lack of incentive and relationship or rapport with the researcher may create less urgency and willingness to complete interviews. The researcher created a varied perspective of participants' lived experiences by interviewing a minimum of two males, one nurse practitioner, and subjects from two generational groups who hold a LPN or RN licensure. Due to the national COVID-19 pandemic and limited access into healthcare facilities, the researcher will utilize a chain-referral snowball sampling technique to recruit a sample population of nurses.

According to Brickman-Bhutta (2012), snowballing is a technique that accumulates data through existing social structures. Social structures include social media such as Facebook. Facebook increases web-based interactions particularly during a time of increased virtual workplace and social interactions due to the COVID-19 pandemic. Snowballing, utilizing Facebook has several benefits. First, the average Facebook user has over 225 friends; therefore, sampling extends beyond the user size and users can easily recruit friends. Secondly,

accessibility to indirect and direct communication is easy, quick, and cost efficient with no monetary cost to join. Additionally, interactions and messages occur on both private, public, or group walls allowing other users to view the contents of public and group message content (Brickman-Bhutta, 2012). All participants included referrals from the researcher's existing social media networks of colleagues, friends, and family. To avoid researcher bias, no family members or close friends were used. Participants did not have any prior relationship with the researcher. Due to COVID-19; there was an inability to recruit staff directly in a healthcare setting. Therefore, the researcher utilized existing contacts on Facebook (777 total friends) to gain access to a large enough pool to ensure a sufficient sample size of LPN's, RN's, and AP's for the study. A message was posted to recruit on social media using Facebook (See Appendix A). The researcher then recruited participants in private messages on social media (See Appendix B). If the participant was interested, the researcher confirmed a date, time, and asked the participant their delivery preference of Microsoft Teams or via phone. The researcher confirmed the date, time, and provided a consent form (See Appendix C) via email (See Appendix D) prior to the interview.

Instrumentation

Semi-structured interviews were conducted either virtually using Microsoft Teams or via telephone given the current national pandemic guidelines and health risks of meeting face-to-face. The researcher printed the semi-structured research guide for each participant's interview to use as a guide and provide space to write field notes or follow-up questions. Prior to the interview, all participants were emailed a consent form (See Appendix C), along with a confirmation of their appointment via email (See Appendix D), and the researcher's interview questions. Interview questions were open-ended, and any follow-up questions were designed to

allow the participants to fully engage in the process. However, the researcher had prompts for each open-ended question to ensure consistency throughout all interviews. The participants had an option to opt-out of specific questions if uncomfortable with discussing those circumstances. Additionally, the participants were provided a brief overview of the research purpose, potential healthcare impact, written information regarding the confidentiality of employee and employer names, and acknowledgement. All participants were advised that interviews will take sixty to ninety minutes. Each interview was recorded via tape recorder and transcribed using Microsoft Teams or Rev.com if opting for a phone interview.

Data Collection Procedures

In order to gain consent of each participant and ensure an understanding of confidentially and privacy of personal identifiers, all participants received a consent form via email upon finalizing a date and time of the interview with the interviewee. The interviewer sent an email (See Appendix D) confirming the appointment day, date, and time with an attached consent form (See Appendix C). The informed consent form included the participant's name, licensure, year of birth (to determine generation), and identified gender. Additionally, the consent form discussed the purpose of the study, procedures, risks and benefits of being in the study. Prior to each interview, the researcher printed a semi-structured research guide (See Appendix E) for each interview that included a scripted introduction of the researcher's name, the purpose of the research and research questions, the participant's name, and verbal consent to record the interview. According to (Muswazi & Nhamo, 2013), field notes allow an interviewer to identify continued or follow-up questions or conversations and stimulate writing of sequenced events and noteworthy topics. Therefore, the researcher used the printed semi-structured interview guide document to hand-write field notes and follow-up questions presented during the interview.

Data Analysis

Recorded interviews were stored on a secured, password protected, personal computer, before being transcribed on Rev.com. Rev.com is an online paid professional freelance transcription service that provides audio transcription of recorded files. Once transcribed, all transcribed interviews were stored in a file labeled “Interviews” on the researcher’s personal password protected computer. Additionally, all transcribed interviews were printed and stored, along with field notes, in a locked filing cabinet in the researcher’s personal home office.

All transcribed interviews were reviewed by the researcher to determine appropriate shared themes, which were then reduced to shared concepts. The researcher employed the thematic analysis reduction process to discover interpretations within the text analysis. First, the researcher reduced the data (raw capta) from the transcripts and removing all personal identifiers. While the researcher reviewed all raw data during the thematic reduction process, personal identifiers and privacy of the participants were stored using several methods including: The participant’s consent form included a written disclosure stating all organizational/employer and subject names will not disclosed.

1. Participants are labeled as Nurse Interviewee #1, Nurse Interviewee #2, Nurse Interviewee #3, and so on.
2. All transcripts of the interview were reviewed by the researcher to remove employer names.
3. The researcher ensured anonymity of the participants by using alias names. Additionally, no obvious descriptors regarding place of employment, dates, locations of incidents, nor were patient names revealed.

Secondly, the researcher eliminated extraneous words to clarify structural meaning and

reduce transition words. Third, the researcher categorized themes based on the original data otherwise known as raw capta. Lastly, the researcher presented the common themes which were then condensed into common concepts (Alhojailan, 2012). Figure 1 below illustrates the reduction process:

Figure 1

Thematic analysis description, process, and procedure

Raw Capta	Codes Reduction of Raw Capta	Categories Themes based on Original Capta	Concepts Declaring the Themes
The original transcripts raw text as presented via the transcription process. Nothing is removed. Purpose: helps the researcher move back and forth throughout the reduction in an effort to maintain the integrity of the participant's meaning. Maintained through to the end and becomes the source for direct quotes in support of the themes that come to show.	Eliminating extraneous words in an effort to clarify structural meaning. Purpose: reduces transition words and noise perceived as non-contribution to meaning. Allows the researcher to understand and see the meaning units. Sorted by *Meaning Units* in their entirety, includes the introductory and transition text. Can be likened to a paragraph structure. Maintained through to the end to assure integrity of the participant's meaning.	Captured from the meaning units are the phrases that present ideas or concepts Purpose: begins to present the participants narrative in a manner that can be understood as ideas / concepts which maintain their meaning when isolated from the context in which it came to present itself. Sorted by like Concept or ideas. Maintained through to the end to maintain the integrity of the participant's meaning.	Declaring themes requires maintaining the integrity across all previous steps. Themes are presented as statements written by the researcher in their own words yet tightly honors the participant's capta. Themes are never presented numerically. They presented themselves through meaning. There are likely fewer than 5 themes.

Adapted and informed by Giorgio (1997), van Manon (1984) and Lanigan (2013).

The researcher used the thematic reduction process above for each transcribed interview. A snapshot of a transcribed interview is available (See Appendix E). After all raw data underwent the reduction process, the researcher concluded that ten themes exist under four main concepts (Seem Appendix G). The ten themes will be discussed in Chapter four while the four concepts will be presented later in Chapter five

Limitations

Limitations to the study involve limited access to healthcare workers, inability to conduct face-to-face interviews, and the negative and positive media coverage of the healthcare system

due to the national COVID-19 pandemic. The current pandemic influenced the lived experiences of nursing professionals and their overall attitudes towards the profession of healthcare, particularly if personally impacted by workload or job duty changes triggered by the pandemic. Lastly, the researcher had no direct experience working in a healthcare setting. Therefore, extra interview time was required to explain medical terminology, acronyms, policies, or common practices within healthcare during the allotted interview time.

Chapter IV: Presentation of Findings

The purpose of this qualitative research study was to inductively explicate the lived narratives of Wisconsin healthcare professionals employed as Licensed Practical and Registered Nurses, Nurse Practitioners, and Director of Nurses. The findings present a systematic mean of justifying phenomenon through the analytical process of thematic analysis of human experiences. Thematic analysis involves several reduction steps before presenting final data including 1) analyzing raw capta 2) organizing and reducing raw capta 3) describing the themes based on original capta and 4) declaring and reporting emerging patterns and themes within the data (Nowell et al., 2017). The intention of the researcher was to ask open-ended questions, allowing for a free-form response, and actively listen to the eight participants' shared experiences to identify emerging themes (See Appendix D) across the participants' nursing narratives.

Interviewee Overview

The following section will provide a brief overview of the eight nursing professionals that participated in this study with corresponding personal identifiers such as Nurse Interviewee 1, Nurse Interviewee, Nurse Interviewee 3, Nurse Interviewee 4, Nurses Interviewee 5, Nurses Interviewee 6, Nurses Interviewee 7 and Nurse Interviewee 8. Nurses were given personal identifiers in chronological order based on interview date and time. A total of nine participants agreed to be interviewed; however, one interviewee canceled due to a scheduling conflict. Therefore, there was a total of eight participants. Participants are summarized below in terms of years of healthcare industry experience, current and prior departments and positions held within healthcare, licensures and educational degree attainment, generational identified gender, and generational group based on year of birth. Figure 3 below reflects the generational groups used this this study:

Table 2

Generational Groups by Generalized Type

Generational Group	Year of Birth
Baby Boomer	(1946-1964)
Generation X/Busters	(1965-1980)
Generation Y/Millennials	(1981-1996)
Generation Z/Generation M	(1994-2010)

Interviewee Profile

Nurse Interviewee 1 is a retired Licensed Practice Nurse (LPN), identifies as a female, and among the Baby Boomer generation. She has over forty-five years of healthcare experience both within direct patient care and nursing education. Prior to retirement in 2015, she held a License Practical Nurse licensure and worked as an LPN in Western Wisconsin where she also grew up and raised her children. She primarily dedicated her career to nineteen years in pediatrics, and several years in dialysis, working with Veterans, and nursing home environments, before becoming a Medical Assistant and L.P.N. instructor. Nurse Interviewee 1 worked as a full-time medical assisting program instructor and later an instructor for an LPN program for a technical college within Western Wisconsin.

Nurse Interviewee 2 is currently a Director of Nursing at a nursing home in Western Wisconsin, identifies as male, and is among the Generation Y generation. He has over twelve years of experience working in healthcare. Nurse Interviewee 2 holds an associate degree of Registered Nursing, Bachelors of Registered Nursing, and a Master's Degree of Arts/Servant Leadership. He worked as a Certified Nursing Assistant for two years, L.P.N. for one year, and

R.N. in Intensive Care (ICU) for four years before becoming the Clinical Manager in Critical Care for five years. Nurse Interviewee 2 then furthered his nursing experience by becoming a Professional Development Nurse for a medical specialty unit before taking on the role of Director of Nursing.

Nurse Interviewee 3 has been working for the last four years as a Registered Nurse in Allergy-Ambulatory Care in Western Wisconsin, identifies as female, and is among the Generation Y/Millennial generation. Nurse Interviewee 3 has over twelve years' experience working in healthcare overall and started her healthcare career and by working as a C.N.A. nursing home. Upon graduating with her Associates Degree in Licensed Practical Nursing, Nurse Interviewee 3 worked as a county L.P.N. for a county in Western Wisconsin before earning her Bachelor's in Registered Nursing (B.S.N.). Upon earning her R.N. licensure, she gained diverse nursing experience as a float nurse where she provided R.N. staffing support to departments such as family medicine and other subspecialities. Recently, in response to the national pandemic, Nurse Interviewee 3 has voluntarily picked-up extra shifts working on the COVID unit where she cares for COVID-19 patients and also infuses the new antiviral and monoclonal antibody to patients.

Nurse Interviewee 4 provides R.N. care in the birthing suites (labor and delivery unit) for a hospital in south-central Wisconsin, identifies as female, and is among the GenX generation. Nurse Interviewee 4 earned a Bachelor's of Science in Registered Nursing (B.S.N.), holds a current certification in patient obstetrics, and has over fifteen years of healthcare experience as a R.N. She started a healthcare career working in dialysis, during her post-secondary internship, and then transitioned to a medical-surgery unit upon graduating with her B.S.N. Working on the Medical Surgical Unit provided experience caring for patients within several specialties

including orthopedics, urology, and oncology. However, after 2.5 years working within the Medical Surgical unit, Nurse Interviewee 4 followed her childhood passion of working in labor and delivery. For the last fourteen years, Nurse Interviewee 4 has provided R.N. care in the birthing suites (labor and delivery unit) for a hospital in south-central Wisconsin.

Nurse Interviewee 5 works as a R.N. in a clinic in Western Wisconsin., identifies as male, and is among the GenY generation. He earned an Associates and a Bachelor's Degree in Registered Nursing and has six years of nursing experience. Upon graduating high school, Nurse Interviewee 5 started his career working for a nursing home as a Certified Nursing Assistance (C.N.A.). Realizing his passion for educating patients on diagnosis and providing physical care, he then worked in a Western Wisconsin hospital on the Medical Surgery Unit upon graduating with his Associates in Registered Nursing. To ensure diversification within his role, Nurse Interviewee 5 took several R.N. positions including several medical surgical units, the emergency room and intensive care unit, and Infectious Dieses Unit within a clinic setting before his current role in the clinic.

Nurse Interviewee 6 is a seasoned nurse with twenty-six years of healthcare experience, identifies as a female, and is among the GenX generation. She earned an associate degree in Nursing and a Bachelor's of Registered Nursing. As a military spouse, Nurse Interviewee 6 worked as a R.N. for six different states within the United States. She believes in a growth mind-set; therefore, spent her career mastering departments as a per diem float nurse in several departments including the Medical Surgery Unit, OB, postpartum, ICU, telemetry, cardiac and pulmonary, pediatrics, orthopedics, long-term care, spinal cord injury unit. Most recently, Nurse Interviewee 6 has spent the last several years working as a School Nurse for a school district in Eastern Wisconsin.

Nurse Interviewee 7 is an Advanced Nurse PR actioner (A.P.N.) in northeastern Wisconsin, identifies as female, and is amongst the Generation X/Busters. She has over twenty-one years' experience working in healthcare. Nurse Interviewee 7 started her healthcare career at the age of fifteen as a nursing home receptionist, earned a C.N.A. certification upon graduating high school, and then pursued a Bachelor's in Registered Nursing in 2000. Nurse Interviewee 7 started her nursing career working oncology on a medical surgery unit for several years before transitioning to pediatric oncology where she has spent fourteen years serving children battling cancer. Her passion for helping oncology patients manage chemo and the side-effects of treatments; led her to earning an Advanced Nurse Practitioner License in 2017.

Nurse Interviewee 8 is a Certified Nurse Midwife practicing in Western Wisconsin, identifies as female, and is amongst the GenX generation. She earned a Bachelor's and Master's Degree in Psychology, and through an apprenticeship, gained a passion for midwifery. She returned to school as a non-traditional student to earn a Bachelor's in Nursing, and upon graduation worked as a post-partum nurse for a hospital in Western Wisconsin while she earned an American Midwifery Certification. Upon graduation of the mid-wifery certification, Nurse Interviewee 8 worked as a full-scope mid-wife at a clinic in northwest Minnesota where she provided care for annual exams, women's health, and non-pregnancy related illnesses and concerns. She later moved back to Western Wisconsin where she took a position as a C.N.M. in a birthing center in Western Wisconsin where she provides pregnancy care, fetal growth monitoring, delivery of babies, and follow-up post-partum care to patients. Figure 4 reflects the total participants by personal identifier, identified gender, generational group, and current licensure held.

Table 3

Participant Identifiers by Gender and Nursing Licenser

Participant Identifier	Gender	Generation	Licensure Held
Nurse Interviewee 1	Female	Baby Boomer	L.P.N.
Nurse Interviewee 2	Male	GenY	R.N.
Nurse Interviewee 3	Female	GenY	R.N.
Nurse Interviewee 4	Female	GenX	R.N.
Nurse Interviewee 5	Male	GenY	R.N.
Nurse Interviewee 6	Female	GenX	R.N.
Nurse Interviewee 7	Female	GenX	A.N.P.
Nurse Interviewee 8	Female	GenX	C.N.M.

Thematic Analysis

According to Vaismoradi et al. (2016), the meaning of the word theme is a descriptor that organizes a group of individuals' repeated concepts and ideas within literature through a process of theme development. Theme development involves four stages including 1) initialization 2) construction 3) rectification and 4) finalization. First, initialization includes reading transcripts, coding through data reduction, and writing field notes. For this study, a total of seven hours and fifty-three minutes were transcribed amongst eight participants. Secondly, construction entails classifying, comparing, labeling, translating, and defining ten recurring themes. The researcher revealed four overarching concepts: 1) mental and physical opportunity costs 2) mentorship and early influence of healthcare 3) career demands of nursing and work/life balance 4)

career/organizational culture and 5) nursing school preparation and rigor, which will be discussed in chapter five. Rectification is relating the themes to the existing knowledgebase. Therefore, the researcher finalized ten themes to develop a storyline. The following storyline or themes are conveyed below in appendix item (Appendix E) and explored more deeply through direct quotations of the eight participants' responses to the following researching questions (*RQ 1*) How do study participants describe and justify their choice of nursing as a career? and 2) how does experience in the field of nursing impact the practitioner's career narrative of their profession?

Themes

The following narratives are comprised of ten themes, which are further discussed below:

Emotional and Physical Strain is the Nursing "Norm"

Participants stated that asking for help is a sign of weakness as a nurse. In fact, participants expressed that while nursing is a rewarding career field that provides job security and gratification, it is emotionally exhausting to work with patients suffering, patients' families, grieving, and dying patients. While all participants agreed that their mental health was impacted, they did not seek internal or external mental health services unless required in-person. Nurses often leaned on their peers for support versus utilizing Employee Assistance Programs (E.A.P.) or outsides counseling. However, nurses were more likely to utilize organizational resources for physical opportunity costs, which were inevitable. Nurses are more likely to use on-site physical/occupational therapy than mental health-services provided by their employer.

Nurse Interviewee 1[Female, Baby Boomer, L.P.N.]: Working in pediatrics was so gratifying. I just really enjoyed it. It was sad, too. There were a lot of times we had patients that passed away. We had a little boy that had leukemia. Yeah, that was really hard. We all got so

close to the family and everything. I think some people just say, "I just can't handle that." We had a girl that was in a car accident and she was still alive, but there was no way that she was going to make it. She had too many injuries. Another nurse and I had to clean her up for the family. We were both crying. That was terrible. But we were doing it for her family and that makes you feel good. It was tough. But a lot of time, it was just your colleagues that you worked with that you could talk to about things and that helped a lot.

Physically, it was hard too. I had to have both my knees replaced because I was on my feet so much. A lot of people had problems with their hips and their backs because you're on your feet so much and doing so much. I'd go through a pair of nursing shoes in six months. I have several friends that have had to have back surgery and knee surgery and different surgeries to relieve the pain. And, of course, it depends on what you do. You're standing in one place for a long period of time, so that doesn't help then, either. I think you need to make sure that you take care of yourself, like make sure you have good shoes and that you're using your body mechanics right and all that. But then there's times where you can't help that, you can't stay on task with it all the time. It depends on how you're working with a patient. You might have to be bending over for a long time while you're doing something or helping with something.

Nurse Interviewee 2 [Male, GenY, R.N.): I don't know how you could do it if you didn't have a good way to just compartmentalize, deal with it later. And then to also have good self-care practices as well. I've seen people that can't handle it, and they come in there thinking it's one thing and they realize the pace, the emotional taxation the expectation of what it is that we have to give, both emotionally and physically and mentally is just sometimes too much. And that's okay. Like, once again, the nursing profession is so just broad that if working in the ICU

doesn't work for you, there is another space within nursing that made that align with who you are as a person, or how you cope and stuff as well.

You hear the stories about like, "Oh, they don't get breaks and they don't ever go to the bathroom." "Nurses have to have like large bladders." Well, I don't know, if nurses have larger bladders. But I think the stories are based somewhat in truth is that there's lots of times where I look down at my watch and I've been like, "Oh, my gosh, I've been working for seven hours, and I haven't gone pee yet." Like, and you just don't realize that you haven't gone pee until you finally get a moment to think and your bladder's like, "Oh, hey, by the way, I'm here too. Can you help me out?" And I think when you're younger your body is more forgiving, obviously. But I think over time it does start to take its toll. I've seen nurses that had to transition into different roles because plantar fasciitis, just because being on their feet all the time and walking, walking, walking. And they tried to go to a podiatrist, they got orthotics and all that, but it just got to this point where it's they really could not stand more than a few hours anymore.

I know they offer EAP Programs, but I think it’s not used as much as they should. So primarily what nurses do is they lean on each other. And they lean on the experiences. So, the best way, so when we talk about mistakes, I think that most nurses get through that emotional roller coaster, making a mistake is when that senior nurse that you respect and you are pretty sure doesn't like you, comes to and says "Hey, I've had a minute or two." And they share that mistake and they kind of share in that pain a little bit and say, “This has happened you will learn from this and you won't do it again because I learned from mine and I never did it again."

Nurse Interviewee 3 [Female, GenY, R.N.]: Especially during this pandemic, it's been awful. But prior to that, you certainly go home and take the situations that you had at work with you. I think every nurse does. It's a stressful job. You're constantly multitasking and dealing with

a variety of ethical dilemmas and patient preferences and families, and work relationships. I mean, it's a stressful time. I know at my facility, there's employee assistant programs that are offered, that offer counseling, free resources and someone to talk to 24/7. That's virtual now, but there at least is things out there. I think prior to the pandemic, there was a variety of different programs offered that unfortunately now can't be. So, I think every nurses', mental health is affected right now.

It's tough on your body too. Not only are you standing most of your shifts, unfortunately in America, obesity has overcome. And wheelchairs and patients get heavier. The equipment's heavy. I think physically probably most nurses, their upper back is affected. we work with occupational health, or not occupational health, OT and they do classes on safe patient handling and things like that. And there are lifts that make our job easier, but there are certain situations.

Nurse Interviewee 4 [Female, GenX, R.N.]: So, well pre COVID, I mean sometimes nurses get hurt really bad and I've seen nurses get hurt at work, be unable... have the hospital stop supporting them and have them be unable to do labor and delivery anymore. And it's common for labor and delivery nurses to blow out their rotator cuffs because we're like lifting their legs back and forth, they're pushing and sometimes that's five hours that you're in there with no break. Of course, patients are getting heavier all the time so you're turning them a lot and they might be like 400, 500 pounds. I mean it's, I'm like really conscious of it because so many people I know have gotten really hurt and so I'm just a little bit more careful than some people. I do carry short term disability, I always have. We used to have to pay extra for it, now the hospital does cover that.

But post COVID it was mask wearing all the time and the shield and everything, I got terrible headaches all spring and summer, well like half the summer, and then just terrible the

day after working because you can't drink as much with the mask on obviously. And then you're also just more dehydrated wearing that. You have to talk louder and so then I figured out, okay if I bring a can of sparkling water, I drink that on my drive home from work and then I found this drink powder that's called liquid IV, and so I can put that in my water bottle and it really helps get more hydrated and then way better on the headaches. So that's much better but it's still more physically and emotionally draining with COVID.

We're just all in so much pain, it's just everybody has had to go on meds or should be on meds or increase their meds, like anxiety, depression. Even on my unit where we're not even really, really dealing with COVID, I mean we just feel terrible for the units that's all they do and the fear that they must have every shift is just terrible. Right, I could not do that and I know that, like I have, I'm starting to get PTSD and it's not even fully, I mean we've barely ever really have a COVID OB patient, but I mean my husband and I would be watching a show and we were watching some firefighter show and somebody had a respirator on and I just couldn't even think anymore. And I'm like, "Oh great, now I'm starting to get some weird PTSD from this situation."

My employer has some kind of Zoom thing that you can call in and I think it's supposed to be like a support group or listen to different ways to cope with it. But it's like, okay when I'm not at work I have three kids that I'm virtual schooling, so I don't really have the time to be calling in, I've written down different times of when these are and never once have I been able to make one.

Nurse Interviewee 5 [Male, GenY, R.N.]: I would say it's very mentally exhausting working in the hospitals, working 12 hour shifts and working between nights and day shift. I did not acclimate very well to the changes, but I would say over time, it really made me feel burned out, even though it wasn't physically demanding. But I think there are sometimes when I feel like

I do need a break or just always having to be on your toes mentally, is very exhausting. As far as I know, my organization used to have therapy. I sought them out a couple of times for something unrelated to nursing, but I think they still have those opportunities for employees that have therapists on site to talk to. But I feel those resources are highly unused. It's just, people don't want to inconvenience, either the inconvenience of having to go to talk to someone else or just the inconvenience of having to openly discuss it with somebody else.

I think it's because people just, they internalize their feelings and their stress to the point where they don't even want to go to work anymore. And once these nurses burn out and they leave for a short time, turns into that longer time and some of them don't even come back. It's not always necessarily related to one certain thing, but overworking is another thing. But burnout is a real thing. And once you hit it, it's hard to come back from.

Nurse Interviewee 6 [Female, GenX, R.N]: In New York, they were so busy that I think they had a hard time keeping nurses because they were overworked. I don't think they could catch up getting enough nurses to have job satisfaction there. And then from there we moved to Nebraska and I worked in Nebraska for... We lived there six years. They really tried to staff better. I liked the department managers. The two different managers really understood. Making sure that the nurses weren't... If you were stressed, they understood that we needed to care about our health as well, that we needed to take care of ourselves. To be a better nurse you have to be healthy physically and emotionally, and mentally. They just seem to be much more mindful of those things. I was there long enough and I worked enough that I... They sometimes would pull me up for little special projects. I felt they respected.

Nurse Interviewee 7 [Female, GenX, A.N.P.]: When I started working, I was very sensitive to meaner patients. I feel like especially the dialysis patients sometimes aren't the

nicest, and I'm a sensitive person, probably not as much anymore. I was very sensitive if people were mean to me. When I went on to oncology in pediatrics, obviously I loved it. I stayed there for a long time. That did not bother me as much. And people usually aren't mean in oncology in general. You're battling with them through this whole cancer trajectory. Yeah, is there rough patches? Sure. Can people get mad or upset about something? Sure, but generally you can smooth that over easier.

But it’s hard when kids die, obviously. It really kind of puts your own family into perspective as far as the little things and the big things. But over time, it sounds kind of harsh, but you kind of learn how to put that away and put a barrier up in a way to not be as affected by it, because if you became affected by it you wouldn't be able to do your job. You kind of learn how to get a little tough and become a part of it and buy it in both aspects. We do have E.A.P. programs. But, I think there's a little stigma associated and I never participated in them before. But I have a good support system at home too.

I know when I was in peds oncology, there was something that was really tough going on, for example we had several deaths every week. We had like five patients die once a week on a Monday. That was really hard on the staff, so they did bring in kind of a counselor and then we kind of sat down and debriefed as a group with the doctors and with the nurses, just to kind of talk about things because that's really hard. And that was kind of when I first started there, so I think they were worried about the nurses' emotions and things before personally I learned how to kind of manage that. So yeah, absolutely, I think in our world people are very cognizant of the emotional concerns that can arise from caring for these patients. I believe they my organization has an E.A.P. We also have pastoral care support, which is really nice. So, sometimes they'll just hold like a little vigil or different things for too, so that can be helpful.

Physically, I think with inpatient work, that's hard work. You're lifting people, you're doing things, so some people get injuries. What I do personally, I'm not doing... I'm more sanitary now as a nurse practitioner then I was as a nurse. I have definitely gained weight, so that makes me upset. But then too, I get the free buffet at work. I'm sure that's been a factor. So, that's also a problem. So yeah, I think there's a lot more stress. As a nurse practitioner, I'm a little bit responsible for a little bit more, so it's hard to lose weight. I'm heavier than I have ever been, so it impacts me that way. But we have an orthopedic sport building right on the hospital campus that I think they offer discounts too, to go in and do exercise.

Also, my whole family got COVID. They said to me, “Oh, by the way, you're the first family of five that actually came back all positive at the same time." So, I was the obvious vector. Actually, there was a patient exposure kind of thing, but it's hard to say it because there's community exposure. I mean, they're wearing their masks. Some people can't breathe with their mask on. People are tired of all the precautions. If someone even has a fever or any symptom, we have to isolate them if we have to bring them into clinic. And some patients we can't not bring into clinic, because they need transfusions, they need different things, so we have specific protocols to bring them right in, keep them isolated, and we have to worry about our PPE and stuff.

Nurse Interviewee 8 [Female, GenX, C.N.M.]: For a good three months, took a big pay cut and FTE reduction because the hospital lost so much money due to having to basically cut our surgical and our patient load way down for safety reasons. That was disheartening. That's the thing too, is I think I never realized that my salary or my job could be in jeopardy due to something like this. I had never really thought about it. It made me realize that yes, I probably can always have a job somewhere as a nurse or as a midwife, but that there are things that can

make that feel more tenuous. I hope that this pandemic will help us realize that we need to be doing more for our nursing staff than just buying them pizza when they're stressed out. We need to be paying more attention to mental health needs. We need to be paying more attention to family-work balance or life-work balance. We need to be doing something to make up for the sacrifices we expect nurses and healthcare providers to make because we sacrifice a lot. We sacrifice family time. We sacrifice holidays.

We sacrifice sleep. We sacrifice our health. If you look at shift workers, people who work third shift, even on a semi-regular basis, have a higher rate of death at an early age, higher rate of breast cancer, higher rate of diabetes. We're making all these sacrifices for a healthcare system that doesn't seem to have our backs sometimes. I hope that this will change that a little bit, whether it's changes that are initiated from the inside, out, or just nurses starting to say, “You know what? Screw this. We need to unionize, or we need more power.”

They cut our pay because they basically were like, “We don't have enough money to stay afloat if we don't.” It was terrible. It made me really think about leaving healthcare altogether. I was like, “Really? I'm risking my life at work, essentially, and dealing with all this extra stress and you're going to pay me less money?” It just was very frustrating. The public had this idea, “Oh, you guys are all getting hazard pay. You guys are this and that.” No. That's not at all what happened. We didn't get anything extra because of COVID, other than extra stress. We used to have local counselors that you could see for job-related stress or other mental health needs. They took those people away and now it's all virtual. A lot of budgetary cuts that have happened even prior to COVID took away some of those counseling resources. I think there is a certain level of stigma.

I think some people have used those resources, but I would say the vast majority of people I know haven't. Part of it is time. A perfect example, because of how many staff are out with COVID or COVID exposure or whatnot right now, all of the nurses at our local hospital are having to do an extra eight-hours paid period and they're having to float to other units. Now, you have these nurses who are already taxed. Many of them are trying to school children at home for the first time in their lives. How are they going to have time to even go do the stuff that they need to, to care for themselves? How are they going to have time to exercise? They maybe don't have childcare because the daycare is closed. They maybe can't drive for a counseling visit because they can't leave their kids alone at home. Mental health-wise, there really isn't anything locally anymore. That's the sad part. It's all through this remote program. I think they can have lots of in-person counseling services if they deem that necessary, but that's not on-site anymore. My husband's work has a clinic right on-site, that's free for employees. During your workday, that's considered health time and you're able to use that without having to schedule it outside of work hours. People take advantage of it all the time.

Honestly, it is challenging. Just lack of sleep is tough, physically. That's the first thing, I guess that comes to mind. We stay up 24 hours. That's not natural. The one thing that has become clear to me since I've been on surgical leave is how tired I am normally. I'm two weeks post-op and I feel better than I have in years and it's because I'm sleeping. I'm not having to stay up all night. That's definitely a big physical demand.

The other thing too is just working in labor and delivery. There's a lot of physical exertion. Whether you're holding a patient's leg or doing things during the birth to facilitate things, there's a lot of standing and turning or sitting and turning. It can be hard on your back. That kind of stuff. If there's emergencies, there's no way to take care of an emergency in an

ergonomic way. I might be jumping on the bed with my hand up someone's uterus, trying to keep them from bleeding to death. There are definitely some physical demands on that as well. That, I feel like we have more resources for. We've got occupational health. Say I get a needle stick or say I wrenched my back because a patient kicks me or something, I can go to occupational health and get evaluated for that and get treatment. There's been situations where a nurse has slipped on blood and broken an ankle. I did once get blood on me from a patient who had syphilis, so I had to do some testing. They did HIV, syphilis, hepatitis, all that screening on me and that was all free. Luckily, everything was fine. It is a physically demanding job.

Patient and Peer Needs Take Precedence Over Self-Care

Nurses are more likely to take on additional workload and stressors versus asking for help. In fact, three of eight participants agreed that nurses avoid asking for help because they don’t want to burden their peers with questions. New nurses, in particular, want to execute skill level confidence and feel a sense of belonging; therefore, seeking help contradicts that notion. New nurses do not want to be seen as uneducated or ill equipped to perform job duties. Lastly, nurses are so indulged in patient care and job duties that simple self-care routines, such as using the restroom and drinking water, is overlooked.

Nurse Interviewee 3 [Female, GenY, R.N.]: I feel like every nurse could be more hydrated. We certainly don't drink enough water on our shift, nor do we have time to think about using the bathroom.

Nurse Interviewee 4 [Female, GenX, R.N.]: Yeah, we could have never anticipated COVID. There is a stigma-ish, most people just handle it. Nurses are terrible at taking care of ourselves. We do nothing to take care of ourselves and everything to take care of everybody else.

Nurse Interviewee 5 [Male, GenY, R.N.]: It's taking a patient at a time. I mean, some people process stress differently. I tend to just shut down and not talk as much. So that's how my coworkers could see I'm stressed out, but I feel asking for help is something that people do not do enough of. They don't like their coworkers to complain about them, Say, "They always need help." I feel especially new nurses, a lot of them will not really ask for help. I think it's because they want to be as independent as possible. But I think they don't know how to go about asking.

Key Influencers Led Them into the Nursing Profession

In management, a common philosophy exists that leaders aren't born; they are made related to nursing too (Aline & Ramkumar, 2018). Based on six of eight participants' responses; the same philosophy falls true for nurses. Only one participant recalled an early childhood interest, due to parental influence. While many of the participants alluded to having a care-taker personality, six participants were introduced to nursing in high school and had no prior interest in healthcare until recommended by a guidance counselor or peer entering a similar program. Additionally, two participants sought separate post-secondary degrees and later returned for a nursing degree for career advancement and job security. All GenY participants were strongly encouraged by either a guidance counselor or friend to enter healthcare supporting literature of functioning under a micromanaged cultural society. Additionally, both GenX participants pursued degrees outside of healthcare as traditional students and later entered healthcare as non-traditional students for job security and growth supporting the notion that Gen X'ers are career minded and motivated by career transferable and job security (Ritter, 2014).

Nurse Interviewee 1 [Female, Baby Boomer, L.P.N.]: Well, I was in high school and I didn't know what I wanted to do, and a friend of mine was going to take the medical assistant program. I had been a candy striper and I babysat a lot as a teenager, and I thought, "Well, that

sounds interesting. Maybe I'll take that." So, I got in the program and we both went through the program together and I absolutely loved it.

Nurse Interviewee 2 [Male, GenY, R.N.): So, I knew I love working with people. But I wanted to be a teacher and I even thought about being a pastor at one point, a doctor as well. We were hanging out one evening, and just kind of talking through the whole predicament that I had found myself in. And my friend was like, "Have you ever thought about becoming a nurse?" And I was like, "What? No." Unfortunately, and I think this is more societal than anything was not in my purview; it wasn't in my periphery or anywhere in front of me as like an option as a career. So that wasn't something I'd ever thought about. And she was like, "Well, my mom's a nurse." And so she had some knowledge of what her mother did. And she was like, "I think you would be a fantastic nurse." And I was like, "What-" Basically she was like, "You're just so good with people." And she was like, "You have a really big heart and you really care about people." And so I think this would be something that you do. And you're really smart all that stuff. So, I was like, "Oh, okay." Well, then I went and researched it. And then as I was researching, I was like, "This is probably the perfect career for me." In that one there's a lot of options.

Nurse Interviewee 3 [Female, GenY, R.N.): I started my career in nursing when I was still in high school. I was a junior in high school when meeting with my counselor, trying to decide kind of which routes I plan to take with college. I really didn't have any idea what I wanted to do. And she had helped me come across a certified nursing assistant program that was based in Minnesota. [F]rom there went for the licensed practical nursing program, …then to the registered nurse program… and to the bachelor's program.

Nurse Interviewee 5 [Male, GenY, R.N.]: I first was introduced to the idea of doing PCT work back in high school. Yeah, the guidance counselor at my school referred me to it. There's a

lot of nursing opportunities in regard to different departments or different aspects. If you want to do management, or if you want to do specific departments, during the week from Monday to Friday hours. I feel there's a lot of opportunities to do what you want to do. You just have to seek out those opportunities.

Nurse Interviewee 6 [Female, GenX, R.N.]: I originally went to school to become an attorney. So, I went through high school planning to get a business degree, which I did do. I went to University of Wisconsin. And then I was going to apply and go a law school. Then I married my husband who happened to be commissioned in the army. We graduated the same year. So, I became an army wife and we moved to Southern Arizona. And I realized I will not be able to go to law school as an army wife… so I did some soul searching. Honestly, nursing school was something that when I was in high school, if I had to make a list of a hundred things. I thought I would want to do someday being a nurse would not ever have been on that list of a hundred. My family is, well, when I told my mom, "Hey mom, I think I want to go to nursing school," she was like, "Oh my gosh, you will never be happy changing bed pans for people." My parents did not, we didn't really have insurance. We didn't go and seek healthcare. I didn't have like any kind of healthcare background or experience because my dad was self-employed, and they were farm folks. And if you don't feel good, go pick some strawberries or put a band aid on it. So, it wasn't something I was familiar with. And I had two aunts who were nurses, and they would tell these really great stories when we had family functions, but it just didn't sound like it ever be anything that I would like doing. I was raised in a family that had kind of the mindset of growth. Like, your whole life should be a life of learning. That's how I was raised, that's how my parents are, especially my mom. So, I just have that mind. I feel like in nursing, there's always something more to learn. But, we were in Arizona and I knew we were going to be there at least three years.

since I didn't speak Spanish fluently as a second language, any job I called about they like, "Oh, no, thank you. We need somebody who can speak Spanish fluently as a second language." So I applied to Cochise College, which was a two year nursing program. Because I already had a bachelor's degree, I was just part-time. I went part-time for three years.

Nurse Interviewee 8 [Female, GenX, C.N.M.]: I had decided at that point that I was not going to go on and get my doctorate in that because I just wasn't feeling like that was the path I was supposed to take. I realized I wanted to do something in women's healthcare, and particularly, I wanted to work with pregnant women and childbirth, and sexual health, that type of stuff. I realized through chatting with some people and doing some apprenticeships that I wanted to become a certified nurse-midwife. In order to do that, I needed to get a nursing degree first. I already had a Bachelor's and a Master's Degree in Psychology, but I needed to go back and get the nursing portion. Then I had a BSN to be able to move on and focus on midwifery studies. At that time, I enrolled part-time as a nursing student. Over a course of a few years, I finished that education. Then I worked as a nurse for a couple of years, while I did my master's degree in order to become a midwife. For me, really choosing to become a nurse was part of the long-term goal of becoming a nurse-midwife.

Early Experience and/or Certificated in Nursing Assistant Led to a Professional Nursing Career

Healthcare has a clear a trajectory of growth opportunities. Certified healthcare positions such as Certified Nursing Assistants (C.N.A.) provide a high level of interest and stepping-stone for working in healthcare, which influences a choice of nursing as a career. In fact, five of eight participants gained early experience as a medical assistant or Certified Nursing Assistant, which created an interest to pursue a nursing degree. Participants with previous experience in

healthcare, prior to earning a nursing degree, felt much more comfortable with patient care. Participants without healthcare experience felt less prepared for the industry. Early experience in healthcare ensures realistic expectations of career rigor, career culture and dynamic, and growth opportunities. It provides a higher comfort level with patient care, a more diverse skill set, and experience with specialty care, particularly the specialty of geriatrics. 100% of all participants agreed that specialty care is introduced in nursing home settings, which would create a higher skill set and interest level working with geriatric patients, which are the very demographic of individuals creating a surge for healthcare demands.

Nurse Interviewee 1[Female, Baby Boomer, L.P.N.]: I graduated with my medical assistance degree and got a job in a hospital setting and I worked there for a couple years and I thought, "I'm going back to school." So, I enrolled in the LPN program and graduated and had a job at a military hospital. Because I had taken a lot of the basic classes in medical assistant, I didn't have to take as many in the LPN program. So that was a lot easier for me and I just loved it. I got good grades and I just was really looking forward to working. After graduating, I got a job in pediatrics and I worked there for 19 years".

Nurse Interviewee 2 [Male, GenY, R.N.): Nurse Interviewee 2 [Male, GenY, R.N.): I had worked on cardiopulmonary for nine months as a CNA, and then was hired into critical care. I feel students should have six months experience in healthcare because you can tell a very real difference between a nurse that has been a CNA, and a nurse that has not worked as a CNA. I did get my CNA and I started working as a nursing assistant while I was in school. So, I worked at a local skilled nursing facility for two and a half years. So, I was going to school and working at the same time. So, I worked straight nights. We had had a kid too. So, there was many times where I was writing out a paper with a baby on my lap.

Nurse Interviewee 3 [Female, GenY, R.N.): I guess my career in nursing started off with completing the CNA program. And then for the licensed practical nursing program, and then to the registered nurse program. However, I knew that wasn't probably going to pay the bills. And I knew that a career in healthcare was always going to be out there. There's always going to be sick people. There's always going to be people that need help. So, when that opportunity presented itself and I survived the nursing assistant program, I knew that I would always be secure in that position, but I think in general, working as a CNA, up to an RN position, I think it just makes you a better nurse.

I think had I not had my counselor reach out and push me towards doing the certified nursing assistant program, I don't know what I maybe would have gone to school for. And I think that should be utilized more, whether that's just a job shadow or an observation time versus doing a program. So, getting started early in high school, I think it's huge to give kids that opportunity to see what they like and if it's not nursing, what else can you do in healthcare? It's huge. And until you're out there working in it, you have no idea.

Nurse Interviewee 5 [Male, GenY, R.N.]: I feel you can see a difference and certain aspects in terms of overall patient care, willingness to help out other team members. I first was introduced to the idea of doing Patient Care Tech or C.N.A. work back in high school. So, I ended up taking the class and I ended up going on because I realized that I do have a love for learning. And I also want it to be able to be more of an assistance to people just past doing physical care. Getting to the bottom of certain diagnoses and being able to educate patients and things of that nature. I ended up going back for my Bachelor’s about three years ago, and I have a little more in-depth research ideas on how to properly educate patients going forward. But I would say most of it just comes from my love of just helping people. I started at a nursing home

and of saw it's a very short road, because there's not a whole lot of differences you can do with nursing homes unfortunately, in my opinion.

Nurse Interviewee 7 [Female, GenX, A.N.P]: When I was about fifteen, got a job at a nursing home. I really enjoyed it. I was actually a receptionist. From there, I decided after graduation, from those experiences that kind of fostered me wanting to become a nurse caring for people. And so then, after graduation I became a CNA and then I enrolled in a nursing college.

Gender Stereotypes Impact Gender Equity in Pursing Nursing as a Profession

While societal "norms" have changed over time to a more diversified workforce, gentrification within nursing still exists. In fact, seven of eight participants agreed that nursing is a female driven career because of stigmas and stereotypes associates with nursing as a female and maternal role. While males don't necessarily avoid nursing due to stereotypes; the career is still seen as a maternal role; therefore, males don't consider nursing first when considering a career in healthcare. Baby boomers witnessed a more scarcity of male nurses than Gen X, and Gen Y participants. While participants reported working with at last one male nurse, all agreed that male nurses are more valued and provide a balance of drama and bicker associated with working within a predominantly female workforce. Lastly, one participant agreed that more males within the nursing profession increase female's nursing wages alluding that a wage gap exists as well.

Nurse Interviewee 1[Female, Baby Boomer, L.P.N.]: Well, there weren't any male nurses when I started. It was all females. It was mostly young. We were all young out of high school and everything. It was totally different when I left nursing. There were male nurses, there were male RNs, there were male charge nurses, and nobody thought anything of it. I liked working with male nurses and healthcare workers. But I enjoyed working with them more. It was

interesting how the doctors were, because the female doctors would go to the female nurses and the male doctors would go to the male nurses.

Nurse Interviewee 2 [Male, GenY, R.N.): I was one of six guys in a class of I think we started out with 90 by the time we graduated with 60. But because as you are aware nursing school can be very difficult. Some instructors feel like maybe part of their job description, even though I know it's not but to like weed people out as well. I only had one instructor where I felt singled out for being male. It just felt like everything was extra scrutinized. There was always this feeling of like... I'm trying to think I want to describe it. Within that specific class and that specific instructor, it didn't feel like I belonged.

Yeah, so males tend to go to, ER, so emergency services or critical care, like ICUs. And then surgery. For whatever reason, guys tend to be fixers. And that is the whole, where I think sometimes issues when people have to go to couples counseling or stuff like that, it's like the communication is usually, it's not that the guy doesn't want the same things or whatever. It's just like, "Why talk about it when I can just fix it?" And I think that's kind of what is presented, that might be the attractive piece of working in an ICU, or an ER, or surgery is because there's a lot of fixing. ICU has a lot of communication, because there's a lot of family care. And even I would say in the ER too, surgery, not so much because they're just knocked out. But yeah, I think that's probably why men are more attracted to it.

Nurse Interviewee 3 [Female, GenY, R.N.]: I've honestly only worked with a few male nurses and just the things that I've observed, it's like male nurses are more prized probably because there's not very many of them. And by prized, I don't know how to explain it. Maybe their opinions coming to light and being more acknowledged. Maybe being acknowledged verbally more often.

Nurse Interview 5 [Male, GenY, R.N.]: I know I am one of the only male nurses. I've noticed a lot more joined in as of now, but I haven't really noticed much more discrepancies. I would say it's probably societal gender roles. People don't see males as nurses. It's a very female predominated field such as doctors used to be. And now female physicians are starting to really climb up the ranks to even out the difference in number of male doctors. It's hard to say. I mean, I could say that working with a few more males on the unit can sometimes calm down a little bit of the, how can I say it, the talk, or the drama. It doesn't really matter if you're male or female. I don't think there's a whole lot of changes with discussions if you're male or female. I think it just depends on how well you know the provider.

Nurse Interviewee 6 [Female, GenX, R.N.]: Well, the demographic was different depending on where I lived. In Arizona... Well, I was just at a nursing school. I was mid-twenties, so I was fairly young as a nurse. In Virginia, I was a minority as a white woman. As a Caucasian, I was the minority working there. Most of the nurses were black or African. I worked with a lot of Somali and Ethiopian nurses who I really liked working with. A lot of the doctors were middle Eastern or Indian, and sometimes I would have to translate to English. A doctor would say, "Nurse, nurse, nurse. Come. Tell her." So, I would have to translate his English to an Ethiopian nurse's English. It was very odd because they were both hard to understand, but they could not understand each other at all speaking English. So that was my least favorite place I ever worked. It was very stressful. At that particular hospital, there definitely was a racial thing. So I was one of the few nurses who was white. Most of the CNAs were black women. When you have a nursing assignment... I'd be assigned six patients, and they'd say, "Well give three of your early morning baths, changing sheets, that sort of thing, give three of your patients to one of the CNAs, then you have to do the other three." "Okay. That's fine." Towards the end of my shift my

patient would be like, "Ah, sweetie. I really could use a bath, can you help?" I was like, "Oh, nobody, was in here to give you a bath?" When I asked the CNA, she would just ignore me. I'm like, "Excuse me." It was terrible. So it took a couple of weeks for me to figure out like, "What the heck is going on here? Am I not communicating this well? Am I supposed to be communicating it some other way?" And then one of the other nurses he's like, "Oh sweetie, they're not going to do any of your baths for you, they take care of..." It was a racial thing. They would probably do all the baths for the black nurses and they wouldn't for us white nurses.

When I worked in Arizona, I worked with probably the highest percentage of men, male nurses. And I think it's because we were in a military community and a lot of them were prior military. Exactly. I remember a time when I was working, I was charge nurse actually. And I was the only female nurse because they would all come to me like, "Hey, can you put in a Foley catheter for me?" Find a woman. Sometimes we would trade things. Men and women would trade things if we didn't want to do like, "Hey, if you put the Foley catheter in my male?" We would trade jobs. There are more men in the military, and so a lot of them were in healthcare. And then they left the army after, four years, eight years, and they stayed in the town and ended up in nursing school. I think like 20% of the nurses, more than 20% were male nurses. We had a really high percentage of male nurses in our program. Some were prior military. Most of them were non-traditional, they weren't right out of high school. We had one person in our nursing program who was right out of high school. All the rest of us were non-traditional. I was one of the youngest and I was, I had just finished a four-year degree, so I was 22 and I was one of the youngest people in my nursing program. Most were older. It was like their second career. Some of the guys were, they had been EMTs and they decided to go back to school for nursing school. A couple of them had been teachers, like science teachers, and decided to try nursing. I really

like working with male nurses. And quite honestly, I think they've helped increase the wages in nursing. The more men who've gone in to nursing, whether that's like a systemic or societal thing, they've; I think having more men in nursing has improved the pay rate for nurses. Then, when I was in Madison, I don't know if any of them were prior military. Lots of them were gay. I've worked with a lot of gay nurses.

I honestly think some men don't enter nursing because there is a stigma attached to it. I had an experience that happened with my oldest son, that I still, it still just chaps my hide. So, when my oldest son was a senior, he played football and was a very good football player. And they had this big football banquet at the end of football season. And their quarterback, we knew their family. The dad, he was a flight, what was he, a flight nurse? He was a flight nurse. So, I knew that the quarterback's dad was a flight nurse, and I knew that their son wanted to go into nursing. At this football banquet, the coach was announcing, "Oh student's name, he is going to go to University A, and he's going to study engineering," and clap, clap, clap.

And then, "So-and-so, they're going to go to University B and they're going to study biology," clap, clap, clap, clap. The quarterback of the team comes up, he's going to go to wherever it was, "University C" and he's going to study nursing." And the snickering, even from parents, and I was like, "What in the heck?" I was so mad that this obvious kind of negative snickering, kind of like that, "Oh my gosh, he's going into nursing." I was so mad and I thought, "Okay, that kind of attitude that makes, that's going to prevent any other guys or any younger brothers who are this banquet, they're never going to want to say they're going to nursing school because they're going to have 30 or more fellow players and parents snickering and laughing because they're going to nursing school."

Nurse Interviewee 7 [Female, GenX, A.N.P.]: I think there's a stigma that nursing is a female profession. On ninth floor when I worked for that for years initially, a few males, but really overall female. Usually, the males go for the more masculine roles too, like the ER nursing, but we do have a few in oncology that work. So, there may be a higher percentage in ER or surgery, because I feel like a lot of them do also go into nurse anesthetist roles, so there's a definite track that they kind of lead. You don't see a lot in OB, for example. ER, surgical kind of routes and then they become like nurse anesthetists or different things like that. I feel like definitely PA has a strong male role, so there are a lot of physician assistants that are male. NP is probably more female I would probably say, at least 90-95%.

Nurse Interviewee 8 [Female, GenX, C.N.M.]: For us, it was all women on our floor. We didn't have any male nurses at the time, both in labor and delivery or on postpartum and in NICU. When I came back to my organization as a midwife, eight years ago, we had one male nurse in the NICU, but he was really doing that just to get enough critical care experience for him to go to anesthetist school. I think especially in maternal-child nursing, there is a really strong bias for women to go into that because I think if you look traditionally at birth, it has been something where women have accompanied other women all through history. It doesn't mean that men haven't been involved in that, but it has largely been women's realm. If you look back to the days before we had even official midwives and before doctors were delivering babies and whatnot, it was basically women helping other women have their babies. We had some in the village or town, that was experienced. Maybe she had 10 kids herself and just casually helped a lot of the people in the area have their babies, but I think that that's traditionally been a thing.

I think that there is a certain draw and empathy of women for other women in terms of trying to help with that huge life transition. It doesn't mean men can't be good at it. There are

men midwives and men labor and delivery nurses, but it's pretty rare. I think if you were to ask the patients themselves, they would probably tell you they feel a lot more comfortable having a woman support them through that maybe than a man. I think it's a really intimate experience that obviously can be very personal. Your private body is exposed.

You're pooping in front of people, all kinds of stuff. I think oftentimes, women feel more comfortable with women. It's traditionally really drawn a much higher percentage of women to that field, especially that area of things than I think all the others. If you look at, say ER nursing, flight nurses, and stuff, you have a higher percentage of men in those areas than you are in other areas of nursing, but as a field, I think we do need more men. I think that there's a certain perspective that they can bring to the table, that's really good too.

Structure of Work Scheduling Affect the Nurse Work-life and Family-life Balance

A career in nursing requires long hours, weekends, and holidays. All participants have sacrificed their work/life balance including missed holidays, dinners with their children, and school and family events. All eight participants felt their children and families have sacrificed for their career and for those reasons; would not recommend nursing as a career to family and friends. Of the eight participants, seven have children. Without familial support and help with childcare, half of participants wouldn’t recommend a career in nursing due to the inflexibility of scheduling and shift options particularly night shifts for rookie nurses.

Prior to COVID-19, research reflected that turn-over has increased due to higher patient acuity levels, and emotional strain. In fact, nurses were twice as likely to experience depression as individuals within other professions particularly during times of higher demands (Gatchel, 2018). Fast forward to the year 2020, seven of eight participants are still employed and have underwent voluntary and involuntary schedule changes since COVID-19, which have impacted

their physical health and work life balance particularly time spent with family. COVID-19 has created a higher demand for involuntary over-time and longer shifts. Nurses are being asked to work more hours in one shift versus more days during a week. When comparing participants' work life balance, float nurses and nurses working eight-hour shifts had a healthier work life balance than nurses working twelve-hour shifts. Participants working 12 or longer hour shifts reported lower morale and a higher likelihood of malpractice or mistakes due to physical and mental exhaustion. Supporting earlier literature, longer hours create trigger depression and depression can lead to impaired judgment and high burn-out and turn-over rates (Gatchel, 2018).

Nurse Interviewee 1[Female, Baby Boomer, L.P.N.]: Well, it did impact us negatively a lot of times because before we had our kids, my husband worked the day shift, and I worked all different shifts. We got used to it, but then, of course, right after we had our kids, we had to readjust everything. If I worked the early shift, he would have to get them off to the babysitter or school or whatever, and so it's a lot of extra planning and everything. But we made it through even though it was hard.

Nurse Interviewee 2 [Male, GenY, R.N.): And so you miss Christmases, you have to plan things differently, you have to do a lot of juggling with schedules too. If you wanted to be at this one specific thing that your kids in, you can ask, but once again, it's a lot of support. So you're all in it together. And so one of your peers will be like, "Well, hey, I'll work that for you. So you can be at your kid's thing if you can just pick up this shift for me over here." There's a lot of that. I think that's the other piece, a lot of nurses sometimes they feel torn, because they feel like they want to be there for their patients, but they also know that they have to be there for their families. And even now more so like with virtual schooling, and like all of this. We've had people even just in my short time, they're like, I really, really don't want to do this, but I have to support my

family, like I have to step away for a while. And because they're like, "I have to take care of my family. Make sure my kids are going to do okay, and stuff." And so like people are making sacrifices right now, on all sides when it comes to like the nursing profession. Either they're sacrificing their profession, which has meant so much to them for so long, because they have other priorities, and they have their family that they have to take care of. Or there are others that they're sacrificing their time and their energy to work the double shifts, because to be there for their patients to support their peers that maybe need to go home to be with their kids. So there's a lot that's being asked of them.

Nurse Interviewee 3 [Female, GenY, R.N.]: Nurses are Exhausted and tired. Everybody is expected to work their full FTE and then one shift on top of that. So, no matter if you work a 1.0 and you're 80 hours a week, you're going to work 88 hours a week. I mean, people are just exhausted. You are expected to work that.

Nurse Interviewee 4 [Female, GenX, R.N.]: Also, our obstetricians they used to be 24 hour shifts at the hospital, so they were tired. We have, like a few of us have been talking about it lately too because as these younger nurses are coming up, they're the kind of generation that's, you know they don't necessarily, they won't work as hard as we worked which is fine. Like we shouldn't have been working as hard as we worked and for years, we would often not even get a break at work. Now we do get, I mean I can't even, maybe once or twice a year we might be so busy that I don't get to eat, but the charge nurse everyday she doesn't get a break until like 3:00 or 4:00 PM.

Right, you need to show up for work. I mean I, so I'm an eight-hour nurse and I was like, okay, my kids don't have, they don't have any Zoom meetings on Wednesday, so I've been scheduling myself, like when we put our requests in for our schedule I request Wednesdays to

work a 12 so then I'm, so I'm working 12s on Wednesday and then Friday, Saturday, sun for my weekends. So it has been, I have been home a little bit more than normal because of that so that's been helpful and nobody was mad or sad anything about it. I know there was that CARES Act, but I think that healthcare workers were exempt from things in the CARES Act. No, like the leaves for childcare and stuff like that. I don't think that, there's a bunch of things that healthcare workers were not able to get and that was written into it.

And I think, I don't know, and now it's pretty much, like when I started most nurses were eight hours or at least half and half were eight and half were 12. And now most nurses are 12, so that's I think much more intense to work seven P to seven A. Yeah, I do feel way more tired towards the end of the 12 and the next day I'm more tired too. Even when we're not super busy, so it is concerning to me that way, but people like it. They don't want to be there as many days. I think, I don't know if that's been studied but our 12-hour people, they have to work a three-shift weekend, so they work Friday, Saturday, Sunday. So, I figure how are there not more mistakes Sunday evening than any other shift of the week. There's got to be because everybody's super tired. The decisions that we make are life and death, often. If we're tired, we're more likely to hang the wrong medicine and kill someone and it happens.

I know so many nurses who left nursing because it's so inflexible and they treat us so poorly and they were just like I can't take it anymore. And they're photographers now, they're stay at home moms. I mean some people do think that they can be there more for their family when they work nights, and some people do love night shift and I did love night shift when I was... I worked night shift for five years and I loved it and I thought I would never go off night shift, but then when I had my twins I was like, oh, I can't do this anymore. But I mean if we just had one baby at a time I don't know if that would've been the difference, probably not. Then once

I started working days I was like, "Oh my god, I can't believe how much better I feel." I had no idea I felt that bad for that many years.

Nurse Interviewee 5 [Male, GenY, R.N.]: My schedule is different now since COVID. I don't have any children, I just have a dog and a wife, so it's easy to move that stuff around a little bit. But if I had children, I'm sure it'd been a more difficult story. So they gave us the date and they said you're at the disposal of the schedules in the hospital and what they need. It was involuntary. I also work holidays.

Nurse Interviewee 6 [Female, GenX, R.N.]: I floated, I was a per diem float nurse. I worked either eight or 12 hour shifts and sometimes it would be split. Sometimes I'd work four hours in one unit and then four in another. If I worked 12 hours, they would try not to split it into three, because that's... It's super hard. They normally would try to keep me eight hours somewhere and then four hours somewhere else. I would fill in the gaps. I would show up for my shift and I went to our per diem office and I'd look and see where I was assigned. I floated the 10 different units. I never knew the... I might be eight hours on the orthopedic unit. And then I'd be four hours on the spinal cord injury unit. So, I never knew where I'd be.

Then, when I worked at university hospital, that's where I think I saw the most forced overtime. You might work a 12-hour shift and you're exhausted. And if a nurse is working some back-to-back shifts and they're like, "Hey, can you stay another four hours till we find another nurse?" After 12 hours you're exhausted, you're hungry, you're thirsty, you're exhausted. And so I as a per diem nurse, there was times I would be asked if I would stay, and I probably did. There were probably times that I stayed a couple more hours while they tried to move some people around or find another nurse. But I would never be forced to stay because I was a per diem float nurse. So, I was the most expensive nurse on the floor.

Nurse Interviewee 7 [Female, GenX, A.N.P.]: If I looked back initially at my nursing career, inpatient was hard, working nights was really hard for me. I did get depressed. I cried a lot. I had to switch. It was just too much. I didn't even have kids at the time; it was just the night shift. I think part of was the stress of working on the floor understaffed. So, you're working really hard, you might have to work longer. We were working 12 hour shifts and it's definitely more than 12 hours generally by the time you give report and do your charting and get out of there. So, that was really hard.

Nurse Interview 8 [Female, GenX, C.N.M.]: When we moved, I took on as a full-scope physician. Then I was now working on call and delivering babies and doing all that stuff. That was a big adjustment because I went from having a really nice four-day a week, eight-hour a day schedule to doing 24-hour call shifts. Being up all night and working holidays again, and working weekends again, all that kind of stuff. On the flip side, I'm so much happier about how much time I had to spend with patients.

If I'm honest, the hours are hard and it's difficult. It depends on how much sleep you've gotten. A 24-hour shift doesn't necessarily mean that I'm off that whole 24 hours and that I'm working straight, that full 24 hours. If there's time to take a nap or to sleep overnight, I certainly do that because we have a sleep room, but there are times on occasion where you don't get to lay down at all or you are really, really busy and it's one patient after another, after another. You have to have a really good self-awareness of how safe you are because we have an obligation to provide the patient at hour 23 and a half the same level of care as that patient during your first hour, but that's hard to do.

You're tired and so sometimes your brain is a little fuzzy. I'm trying to figure out, where are my weaknesses or where are my possible areas that I know I need to make sure I'm extra

safe? Then how do I ensure that? For me, what can happen a lot of times at the end of a shift is I don't feel like I make bad decisions. I feel like my decision-making is still really sharp, even when I'm tired. My ability to relate to the patient is still really strong at that point, but where I struggle is just remembering the little details. For instance, I might be like, “Oh my God. Is this patient in room three or room four?” or “What time did I break her water?”

For me, what I do is I write those details down because then I have all of it in front of me. It's easier to not get caught up on those little things because that's important. If I go in and I put a bunch of orders in for a patient who's just had a baby and I put it in on the wrong chart, that's a huge hassle. I got to go in and get everything. It's potentially a safety issue if you didn't catch it. That's where I tend to make my mistakes. Luckily, it's not big stuff. To be honest, they don't care how tired you are. If there's an emergency, you wake up fast. I think that you do have to have a really honest self-awareness and there's some people that don't function well that way. They need to realize then that maybe that's not the job for them or maybe they need to do 12-hour shifts. The saving grace for me is that the midwives at our practice always have post-call day off. If I work a 24, I always get to go home and sleep right afterwards, and I don't have to go to clinic.

But it's tough. We are very lucky in that we have seven midwives. On average, I'm only doing one of those 24-hour shifts a week. Now, it varies week to week. I might have a week where I have to call shifts and two clinic days, so I'm not around a lot that week, but then the next week I might only have two clinic shifts and no call. In a seven-week period, I have seven call shifts. Especially when your kids are little, you miss tucking in your two-year-old. There’re times have had to miss birthdays or Christmas or family weddings or whatever the case is. Usually, we can switch stuff around for the really important things, but we all have to take our fair share of holidays. That's a big one. I have to say I don't feel like I could do it without a

supportive spouse. My husband is extremely supportive. luckily had a husband who has been very supportive of my goals and everything and is a great dad. He takes over and does a great job when I'm out of the house. I think it was hard at first for the girls.

My youngest, she is nine years old, doesn't remember much else because she was a year and a half old when I started doing births again. She actually adjusted pretty fast. My older daughter is 18 now, but she was a fifth grader at the time that we moved back here. It was hard for her. I remember she would text me from her iPad and be like, “How dilated is the patient? Are you coming home?” Back then, we actually could take calls from home. That changed only about a year after I started working back here. That was tougher for her because she wasn't used to me be gone.

I definitely like being able to check-in. If I'm sitting in waiting for someone to dilate, I like that I can sit at the nurses' station and text my daughter or child and husband or whatever the case is. It's nice. It makes the time go faster and it makes me feel a lot more connected to home, I guess, to be able to do that. It's interesting. I feel like COVID, and this is a strange dichotomy, but it has made me realize, number one, how much we're valued as healthcare workers, but secondly, also how much we're taken for granted. It's really frustrating to see this pandemic, how it is affecting hospital systems and how it's affecting staff, and how it's affecting families.

Dissonance Between Organizational and Nursing Ideology Impacts the Nurse’s Self-Efficiency

Working in healthcare is similar to working in the hospitality sector. In fact, three participants shared that healthcare is like working for a hotel because it’s about the patient star rating, influx of customers versus the time spent with the patients. Several participants are frustrated that healthcare organizations have moved toward a focus on metrics, insurance claim

amounts, and patient satisfaction rates only. Those metrics create an increased pressure to see more patients and perform unnecessary procedures creating lower employee morale. This deems true particularly for providers working on commission only or towards a healthcare bonus. The pressure to meet with more patients interferes with the ability to personally connect with patients and creates a lack of comradery between nurses and providers. Nurses are less likely to lean on one another for emotional support or ask questions in fear of inconveniencing their peers, which creates a distraction from adhering to metrics and goals.

These top-management decisions create a separation between nursing staff and staff in upper management roles. Nurses are frustrated with the direct impact, of upper-management decisions based on key performance indicators, that directly impact nursing job duties. Changes made without communication or input create a negative organizational culture, which impacts nursing satisfaction, turn-over, and burn-out rates.

Nurse Interviewee 2 [Male, GenY, R.N.): I found myself constantly in this position of always, and I'm going to use the word fighting but it's just struggling. You're struggling to ensure that things are done in a way that aligns with where the organization is trying to go, but you're also struggling to ensure that things are done in a way that still takes into consideration the people that are a part of it's happening to.

Nurse Interviewee 4 [Female, GenX, R.N.]: We have this year, we have 12 obstetricians and six of them left. No, we need that many, the doctors just got really angry because the hospital, like it's just so corporate, they aren't even letting the doctor’s practice how they want to be. So it's like there's always like these improvements which aren't really improvements, and they just, you know we'll get an epic upgrade but it'll be really a downgrade and then suddenly we have to chart more, and more, and more, and more. And now we're doing billing, and now

we're doing cleaning, and now we're doing... you know it's just like constantly more little, tiny tasks upon us and the same is starting to happen to doctors. So, I mean at some point, I don't know why we haven't, nurses in general in this country haven't been like, "What the hell. We refuse to work under..." You know, I don't know if this is going to come out when COVID ends".

We also used to have the triage nurse, so they would do like any patients that comes in and thinks, "Did my water break, am I in labor, I'm bleeding, something's wrong." They would take care of those patients, and now often we're not allowed to have one because we can only have the exact number of nurses for the patients. So, we're always, because we have to be productive, we have this productivity tool and so the charge nurse is calculating that. Sometimes the charge nurse has several patients and we're still not productive and it's like, who made this tool. And there'll be unsafe assignments sometimes because, sometimes it's because we don't have enough staff because a lot of people have left. Not anything, even pre COVID, just because it's so intense.

Nurse Interviewee 4 [Female, GenX, R.N.]: Hospitals, it's kind of like a hotel now. So we have to be fancy and we have to treat the patients, they have their satisfaction scores and that determines how much money the hospital gets by how satisfied by the patients are. So when you get those surveys of like how did your doctor treat you, if you give the doctor poor, like say, "Oh I wanted a warm blanket and nobody answered my call light." Because maybe they were coding three patients next door, that determines how much money the hospital gets which determines how much money doctors get. So, then they get reprimanded when they don't get good scores. So, if you're a patient and you're like, "I want antibiotics for this sniffly nose." And you don't get your antibiotics because that's inappropriate, then you give that doctor a bad score, then they get

yelled at from administration and also the hospital doesn't get as much reimbursement. Yeah, so it's just like constant pressure.

Nurse Interviewee 5: [Male, GenY, R.N.]: I would say it's going to be very similar to what it is now, but it's going to be run by managers and people expecting it to be a certain way. I feel like everything now is going towards the ideal of getting people in and out. Getting them the best possible rating, like a hotel. I think once they get the number of patients through the door, they expect the staff to give them the best possible experience. I would say especially now they try to get more in. Whereas I feel a couple of years ago, it wasn't so much solely based on that. But now it's because insurance reimbursements have changed that they really want the best outcome for them as possible. So, it's very similar to a hotel because they're expected to do everything possible, but they want the best possible experience. So, for instance, if they want certain things handed to them, then if they give us a bad review, it's because they know they can get the same care if they go across town.

Nursing Interviewee 6 [Female, GenX, R.N.]: One of my goals when I worked in New York was if I could just come into a room and if I could just look at my patient and have a conversation. Cause I normally had so little time, it was like, "Okay, my goodness. I got to do this. I got to do this. I got to plug in this antibiotic and I go to do that and then I got to do this, and I've got to get a drink. And then I've got to give them their two meds." It was so busy. I was so busy. I had so many patients that I thought, "Oh my gosh." I wasn't able to be a nurse that I wanted to be. So, one of my goals was to at least when I was asking them questions to look. It probably sounds really pathetic, but it was like, when I asked a question, I need to look at my patients and actually have a conversation looking at them. I was so busy doing procedures,

"Unplug that and change that, and I change the sheets..." I was just so busy that one of my goals every day was to have a conversation, even if it was really short, by looking at my patient.

Nurse Interviewee 8 [Female, GenX, C.N.M.]: I worked with a group of physicians at that first job, that were not very supportive. They really saw nurse practitioners and nurse midwives as being physician extenders. We also need management that understands that sometimes family has to come first before work. I think we need an easier way of allowing nurses time off when they feel that they need it. I think that that's a direction we really have to go because the thing is, bringing cookies up in the night or ordering pizza for day shift, okay, those are nice gestures, but that really feels like spit in the face. We need some real changes within this.

Healthcare Job Function, Level, and Practitioner Generation Hierarchy Impact the Work Satisfaction of the Nurse

The nurse's moral and ability to perform job duties is impacted by nurse, provider, and upper management hierarchy. In fact, all nurses interviewed experienced hierarchy, lack of support, or harassment within their employment setting.

Nurse Interviewee 1[Female, Baby Boomer, L.P.N.]: When I worked in the dialysis unit, we had a man that was old, and he had dementia and he was there three days a week and he decided that one time he was done and he pulled his needle out. Well, it's hooked to a machine and the machine is pumping the blood through him and cleaning the blood through the machine, and so I heard a noise and I walked in the room and here's the needle and it's in the air and it's squirting blood everywhere. So, then I took a compress and put it on his fistula so it would stop bleeding. He didn't even know what was going on, he was so out of it. And I'm yelling for help and the head nurse, who was absolutely useless, walks in and screams and walks out. I'm like,

"OMG." So, then somebody else did come in and shut the machine off and helped me. I had blood in my hair, I had it all down my back. I mean, it was just awful. Well, my manager thought that her idea of being the head nurse was to sit in her office and that's not my idea of being the head nurse, but that was here idea. She didn't last very long. There were so many complaints about her. She was only there a couple years and they moved her to a different department. She was not interested in, I mean, helping patients and stuff. She didn't even go in and talk to patients when they were there. Running out of the room when this patient had pulled his needle out, it's like, "Really? Put some gloves on and help."

I had some experiences like that, but that was the worst one. I was holding a little girl's hands and he was taking the stitches out. I can't remember if they were in her head or her arm or what. But, I was just talking to her, "Just look at me and we'll talk about something else while they get your stitches out. It's no big deal. Let's talk about ..." I said, "Do you like animals?" We were talking about things like that and finally he looked at me and he had the stitches out and he looked at me and he said, "And now will you shut up?" in front of the mom and the little girl. And I looked at him and I said, "I was only trying to keep her calm for you," and he went to the head nurse and he said, "That was awful." He said, "I was trying to concentrate, and she was talking to the little girl." And our head nurse told me later, she said, "You were in the right. He was in the wrong. He shouldn't have done that. He shouldn't have told you to be quiet. That's terrible." Doctors just want to do their job and get it over with. They don't care about relations with the patient or anything. Well, that's half of your job, is working with the patient and making them comfortable and making them feel like they're going to get taken care of, not being so bad or saying things or rolling their eyes.

Nurse Interviewee 2 [Male, GenY, R.N.): Some of the earlier stuff, which kind of resulted in some later things as well was what felt the lack of support from those that were not at the frontline. So upper management, I would say. And so being as the manager, so clinical manager of the ICU, what's expected of you is really because there's all these policies and stuff, and they're asking you to push these forward and make things happen. And here are these goals and these metrics and these outcomes that we want to achieve or your unit to achieve. Which is not saying they're bad. But sometimes the reality of what that looks like it as you roll things out into the daily work of the staff. And once again, as a nurse when you're putting forth all of who you are. And it's not saying it's wrong or right. But when someone else comes in and says, "Oh, you need to do that differently now." Or "We're going to change this up." Or "We're going to reduce the number of staff." Or "We're going to do these types of things." That even though it's not meant to be personal, it can at times be taken personal.

Nurse Interviewee 3 [Female, GenY, R.N.]: I've developed so many great relationships with a variety of different coworkers. That just makes your day fun because you have such a great team. I've had negative experiences also. I did have an incident where a provider was being inappropriate and kind of harassing me over, gosh maybe a year in which after multiple times of asking him to stop and other coworkers asking him to stop. That finally was observed by management and things were turned in, an investigation was done. And fortunately, he was terminated, but it was just kind of a cruddy place to be for me because although I didn't enjoy that, I don't like conflict.

Probably, experiences that you have with other departments and coworkers. If you come onto a department and you're treated poorly because of whatever reason, because your brand new, because you're young. I don't know. I've had situations like that where as a float nurse,

you're there to help and be of help in any way that you can and overlooked because of I don't know. I think providers overlook float nurses quite a bit and they go to look for their comfort team, their go to people when you're standing right there and available and they'll go out of their way to avoid you instead of asking for help.

I also think certain nurses could just get set in their ways. They're not adaptable to an ever-changing career, whether that be in documentation or just this pandemic, change is happening every day. I don't know how those nurses hold up. Some nurses, I feel like work harder to get out of things than to physically do it, whether that just be their confidence level or their skillset. But, to those nurses that I've witnessed, it doesn't do them any good by not doing those things. If you're not comfortable in doing a certain task, because you haven't done it in six years, then speak out, use your resources and reteach yourself and try it again because we're all capable of doing that.

Nurse Interviewee 4 [Female, GenX, R.N.]: We're really lucky now to have great doctors. When I first started labor and delivery it was pretty bad. Some of the doctors really bullied me from the-get-go just because I'm quieter. I'm better now at standing up for myself, but I really was not then. Things have drastically improved. That would not be acceptable now. A different generation of doctors, those doctors have all retired. And now, I mean it was starting to be, some things were kind of being cracked down on, I'm sure it's policies too because I feel like if a doctor was doing that now I would be like, "Hell no, I'm not doing that." And I'd write them up. But back then it was like, "Well, okay, yeah, they're probably just tired." The anesthesiologist was super mean too but most of those really mean ones have left. But they'd say things like, like the epidural wouldn't work and back and they'd be like, "Well, the patient has taken a birthing

class." And you're like, "Yeah, but now we're past that, maybe your epidural should work when you put it in."

Also, a main part of a nurse's job is to be a patient advocate. I've had a door shut on me by a doctor, a pediatrician wanting the patient to unlatch the baby when she just got the baby latched for the first time ever. That time I was like, "We're not unlatching this baby." And this old man pediatrician like shut the door on me and stormed out and I did write that one up, that was right before he retired but I was like that's not acceptable. And the patient, it was right in front of her, she was upset.

Nurse Interviewee 5 [Male, GenY, R.N.]: I feel like right away, I was thrown into a situation where the other staff had a wolf kind of a thing, which I'm not a fan of. I've heard about it happening and not just at our facility, but a lot of facilities people getting jobs. I don't know what it is, but new people are the easiest targets for nurses. And I know I've done reports to a lot of nurses having almost bullying or harassment type situations where it causes them to leave nursing entirely.

Also, sometimes the staffing was terrible. But it's not always the department manager's fault or the hospital's fault. If it's flu season and two nurses call in sick and they can't find any subs, then you're short-staffed. So, it just really varies. If the census is low, you might all have four patients. If the census is really high and the nurse is out having a baby or is sick, then you might have seven patients. There are suggestions for nurse patient ratios. But as far as I know, unless some states have passed some of those types of laws, I think that would be a state-based law. Not anywhere that I ever worked, did they have any type of law like that. They do have some laws about forced overtime and that sort of thing, but I don't think there's any kind of law about nurse patient ratios.

Nurse Interviewee 6 [Female, GenX, R.N.]: Most departments have a quality improvement team or there's some kind of other nursing leadership type positions. Per diem float nurses were always just stuck in a hole somewhere, wherever they had a shortage of nurses. So I often didn't know who the other per diem nurses were. But if I went back to certain units... I really liked the orthopedic unit. And I think the manager would often request me. We got along well, and I like orthopedics. I knew several of those nurses fairly well. I ended up working there, I don't know, maybe a quarter of my hours, I worked maybe in orthopedics. So I did have some friends. I had some friends that I would like, "Oh, hey, I'm glad you're working today." And when you're a per diem float nurse, most people are like, "Oh, hooray." They're happy to see you because they know that you're going to make their shift easier because I'll be taking some of their patients.

So, most people are always happy to see a per diem nurse, and I got along well with people. I'm trying to be a personable person. I have no interest in getting involved in any kind of gossip or like none of that. I'm just not that kind of person. Sometimes nurses their taking care of a patient the shift after, or the day after somebody else does. And they might be like, "This person does... And I don't think they changed their sheets." Or, "They did a terrible drafting change yesterday." There's all that kind of... It's easy to judge a person's work because you can see it or a patient might complain. It's easy to judge each other's work. I think for the most part, most nurses know that we're working our butts off. And if you didn't get to something or you didn't do a great job of something, there's probably a reason why. You were too busy or you were slammed. Yeah, I think most nurses understand because, you're all just hoping to get a drink of water and get to go pee at least once in eight hours. You all know. Everybody knows that everybody's working really hard.

Nurse Interview 7 [Female, GenX, A.N.P.]: New nurses so, there's always this old catch how older nurses eat their young. So, some of the older nurses can be really mean to new grads. I've had a few nurses that work where I currently work, that I have talked about that actually, like that people were really mean to them. One of them, personally she's a great nurse, but I don't know if something just didn't sit where people weren't nice to her at all. I think the nurses sometimes don’t want to deal with it. I always get the picture in my head that they're obviously older, the older ones getting ready to retire kind of thing. They don't want to deal with newer nurses not knowing sometimes. I personally take the stance that you've got to learn and grow with these people, they're going to be our future, so you've got to really invest in trying to let them learn and do these things.

Nurse Interviewee 8 [Female, GenX, C.N.M.]: My first midwife job, I worked in a clinic-only position. I would say most midwives work what's called full scope, meaning they work in the clinic, seeing scheduled patients, but then they also work in the hospital, delivering babies and taking care of women that have just had their babies, et cetera. I quickly realized I was miserable. When they hired me, they made it sound like it was going to be a lot more reproductive health and it ended up being 80% family health. A different position opened up and I was able to mov, but I worked with a group of physicians that were not very supportive. They really saw nurse practitioners and nurse midwives as being physician extenders. One of the terms that I absolutely hate that you hear a lot is the mid-level providers. It's not intended on being a derogatory term, but it definitely feels that way to many of us because it's like we're not providing a mid-level of care. We're providing a top level of care at the top of our licensure. It's just that there are certain things that are not within our scope of practice, that are for a physician. For instance, I don't do C-sections, but there's also a lot of things I might be skilled in, that

maybe a physician isn't. That was a frustrating environment to be in because I felt not very well supported, not very well valued. Any big decisions made about the practice as a whole were made by the physicians, without really much input from the Advanced Practice Nurses. That was the other big part of the reason that I really didn't feel very happy there. They also really focused on production. I would say on average, in an eight-hour day, I would see 20 patients.

The more patients you see, the more money the clinic makes. They look at empty appointments as a wasted opportunity to make revenue. It's very much a revenue-driven practice. I was salaried, but then I also got a bonus once a year, based on how productive I was. Definitely, there was this idea of the busier you are, the better. The more patients you can cram in, the better. They didn't care about the quality of care, but they really cared about the volume of care. Then our physicians were paid 100% on production. It was messed up. Their salary was 100% based on how much revenue they brought into the clinic. For instance, say they had 100 patients that needed birth control. If they put IUDs in 70 of them, they would make more money than if they put IUDs in 20 of them because an IUD would generate more revenue than obviously sending in a birth control prescription.

I do think so because I think that there were a few physicians that were so concerned about production that they may be made decisions they wouldn't have otherwise made. We had one doctor. I hate to say it, but she was super sneaky. She was like, “Oh, she checked her cervix at 37 weeks. Oh my God. Guess what? She broke her water on accident.” That would happen multiple times. We were like, “You're totally breaking her water on purpose so that you can go deliver her and make the money for the birth.” The C-section rate was out of control there. There was a 50% primary C-section rate when I was at the practice. If people walk through the door of that hospital in labor or as a pregnant patient, there was a 50% chance you were going to have a

C-section. In comparison, our current C-section, primary C-section rate at my organization is 17%. Luckily, my bonus depended on how busy I was, but not my salary. I never cared about the bonus.

Education and Training of Nurses Impacts the Nurses Perceived Preparedness

Despite nursing school preparation and rigor, five of eight participants felt unprepared for all specialties due to lack of clinical and hands-on experience. Study and prep for courses impacts the ability to work full-time while in school; therefore, discriminating against working non-traditional students with children or family commitments. Non-traditional students were able to pass nursing school due to familial and childcare support. Nurses with a background in Certified Nursing Assistance felt more prepared and comfortable with the nursing curriculum, working with teams, and interacting with patients. All study participants started their career in medical surgery unit units upon entering nursing; however, did not stay within that department. While nurses receive some clinical experience (maximum of three months) while in school, no participants were given any sort of specialty interest survey to determine departments of interest creating department turn-over shortly after entering nursing.

Nurse Interviewee 2 [Male, GenY, R.N.): I think it's one of those things that, in reflecting, when you look back retrospectively, you're like, "How did we do that?" Like, how did we make it through that period of time? Because now if you told me like, "Hey, I need you to work a job, go to school, work nights and actually go to class after school and also take care of your baby and buy a house and all that stuff." I think it was the support at home from my wife. Additionally, at work I worked straight nights, the other CNAs I worked with, they were probably all 30 years my senior. But they wanted to see me succeed as well. So, they would like after we would get our rounds done at night. They would say "Okay, all right, you have a test

tomorrow. So, you study for your test we'll get your calls down your hall." So, it was just, I think, just in reflecting, it was because of the people around me in big ways or small ways that supported me, that allowed me to be able to do the things that needed to get done just to be successful in my schooling. And so, I think in this case, what I realized was just like, "I just need to prove myself." I just had to prove that I belonged to be here, just like anybody else. And so, I just applied myself, I studied harder than anybody. I'm somewhat competitive. And there were some other students. And students, my peers, there was never any issue of being a guy, or not being. And we had really good relationships, and supportive because it's hard.

Nurse Interviewee 3 [Female, GenY, R.N.): The nursing program was tough. The first thing you have to complete, and pass is a pharmacology dosage calculation exam. And you need a hundred percent on it. And if you didn't, then you were out. And there was plenty of people that didn't pass that. And nursing school, like the exam, I think like an 85% on anything was graded as a B. And I mean, it was pretty tough. When I was in my RN program, I got married and had my oldest daughter, Cameron. And then I took probably a year, maybe one-to-two-year break and I was working and then had Reese, my second daughter. And then I went back to get my bachelor's after working. I just don't feel like there was much of a family life. I mean, you do what you can to get through it, but nursing school is tough. I mean, between classes and clinicals and exams and studying, it just doesn't leave much time even to work. I know that they you have to get your clinical time in, but I think offering different hours, especially for people who have kids, because most of the clinicals are day shifts. And that doesn't leave much time for parents to be a parent or involved or to even hold a career during it.

Nurse Interviewee 4 [Female, GenX, R.N.]: Sometimes the phone just never stops ringing and they have to just be answering questions as they're doing surgery. The nurse line might need

to ask the doctor a question or because we have a NICU, so we get a lot of referrals in of people, sick, pregnant women from small hospitals. So, they have to talk to our doctor first, they can't just send them without getting the approval because what if we were full. Sometimes I just have to answer the phone for them, like they're doing surgery, they're doing a C-section and the phone's ringing so of course they can't answer the phone so then literally hands are in someone's uterus and then I'm answering the phone and it's some ER, it's like somebody with some weird question and I have to take down the message or hold the phone up to the doctor. It's so mind blowing, the number of times the phone would ring. Nurses working the nurse's hotline would benefit from specialty training, but I just wouldn't want that responsibility. There's no way they could know all the different specialties and the problems that people could be calling in with. So, we don't necessarily blame them, but it's frustrating sometimes.

Nurse Interviewee 7 [Female, GenX, A.N.P.]: There's a lot of classwork mixed with clinical. Honestly, I think they need more clinical experiences. Now they may have changed things, this was 1996 to 2000 that I did it. Because, when I got out; I felt like a fish out of water. And I'm sure everyone does in some sort of way. But you learn quickly. Initially when you get a job you get a preceptor for several months. They don't just throw you into the fire, per se. I like to know what I'm doing so that was a little scary. But my transition from Registered Nurse to Nurse Practitioner, with all the experience behind me, went really [well].

Now, we also deal with a lot of technical college nurses in clinicals, and they're very well prepared. And they have a lot of clinical. It will be interesting to see with COVID how this impacts people because they're graduating the nurses a little bit early now and also, they're not able... the clinical scenario is very... we're limiting people obviously with our patients, so I don't know what they're doing with clinicals right now. So, I think they're relying very heavily on

simulations, which is newer to me because I didn't have simulation when I went to nursing school. So, that will be really interesting to look at in the future here.

Nurse Interviewee 8 [Female, GenX, C.N.M]: They don't have a lot of non-traditional students. Here I was in my late 20s, early30s, going through this program with a bunch of 19-year-olds. It was a little unusual in that I think I stood out a little bit like a sore thumb in terms of not quite fitting in. I had already done a master's degree. For me, it wasn't easy by any stretch, but I was experienced. Just maturity level wise, I was really different. I felt like it was very intense. I felt like half-time nursing school was almost the equivalent of full-time in another program. If I compared it to my nursing studies, I would say the amount of effort I put in for half-time was almost as much as I had put in full-time as a psych student. I remember thinking, "Oh my God. I couldn't have done this full-time and worked a job. Then, I got a job as a postpartum nurse, while I did my online midwifery degree.

I think there's a lot of women or men who later in life are like, "You know what? I think I'm going to go back to school for nursing and become a nurse." I feel like at the time, most new nurses were young well behind the years, fresh out of school. I felt a little different in that regard, but I feel like that really helped me. I hit the ground running as far as maturity was concerned. I remember my orientation preceptors being just really happy and impressed with where I was starting out as far as maturity, as far as communicating my needs and asking questions, that type of stuff as well.

School-based Learning, Clinical Placement, and In-Field Skilling Impacts the Nurse's Self-Efficacy

Six of eight participants started their career on the medical surgery unit; however, still felt unprepared for patient care upon entering the workforce. All participants felt that nurses

should receive more clinical hours prior to graduation. Several participants agreed that students are receiving less clinical time and more simulations, which aren't a true representation of patient care. Since the pandemic, nursing students are completing less clinical time in the clinics and hospitals and spending even more time conducting simulations which will ultimately impact nursing skills and overall patient care and satisfaction.

Nurse Interviewee 2 [Male, GenY, R.N.): So how nursing has changed? What I've seen as like nurses are coming out of school still is that the heart is still there. I think more and more is being called up and expected of nurses. And I don't know if that's always what is the narrative that they're getting when they're being prepared for this in school of life of how much it.

Well, I think it's just that taxation of like your mind and your body that is called into. The tasks are the same, like how to spike an IV, how to administer a medication and stuff. But it's like, how do you deal with the families? How do you deal with a patient that says, "No, I don't want to do it."? Like these aren't things that come in textbooks and lesson plans. And it's not that these new nurses are coming in, and they've been coddled or anything. But I just think the reality of what it is that we do sometimes, it's messier than a sim lab.

And you try to get it through clinical, but I think, unfortunately what's happening right now is that there's a lot of nurses that aren't getting clinicals. So not only were they maybe not getting as much of that before, but they're also getting even less of it now. Because they're doing the clinical hours and simulation and it's not the same. And the hours, when we talk about the taxation, again, everything that's put out there and on the line with COVID, it's so much more. So, through clinical, you might get like, "Oh, you get a week here. And you get a week there. And you get a week." So, you might do a week like in OB-GYN? Not everyone gets to do

weekend critical care or ER, but if you do, maybe you get to do that. Everyone does a week in like a med surg unit. But no one does, like a week in clinics.

Nurse Interviewee 3 [Female, GenY, R.N.]: Had I gone into the hospital I think I would have been prepared. But I didn't go to the hospital. I came to ambulatory outpatient care. And I used my skillset that I had for that. But some of it, like the paper side of nursing, always taught clinicals and patient experience that way and procedures and things like that. But gosh, when I went into the ambulatory care setting, I've had no idea all the Medicare requirements. I had no idea what a prior authorization for a medication was. So, one that piece of nursing, I didn't feel prepared at all. That's something that we never even talked about.

Nurse Interviewee 5 [Male, GenY, R.N.]: You really can't tell what specialty you like until you start working. I've had multiple people say they really wanted to go do a labor delivery. And then after they get into the job, about a week or two in or a month, they absolutely hate it. So, it's hard to say even through school, some things can certainly catch your eye, but I feel you can't really make that determination until you do it first-hand. When it comes to the job, things are a lot different than what they tell you in school. So, it takes about an average of around nine to 12 months, to be able to feel like you know what you're really doing. The orientation process is about three months.

I would say everybody wants you to have experience, but as a new nurse, it's very hard to get experience when everybody wants you to have experience. So that's one of the reasons I went in the route of a nursing home. However, what I have noticed is that, when I've had two different interviews at my same job to move to different departments and you get asked the same exact questions, whether or not you've been a nurse for 10 years, or you've been a nurse for 10

minutes. And I feel like there's some questions on there that you can't really answer because you haven't been exposed to it yet and experience to it yet.

Nurse Interview 6 [Female, GenX, Nurse]: Nursing school was hard. It was very, very hard. But my friends in the nursing program were helpful. The army community was very supportive, my church friends were supportive. I feel like lots of things in my life helped. It just helped that it, that I could do it. I feel like I grew a lot as a person during that time. I learned that I can do really, really super hard things and make it. It was hard. I typed a lot of papers and I did type, like it was before the internet, before email. So, I'd have my baby on my lap and late at night trying to finish papers and it was hard.

Nurse Interviewee 7 [Female, GenX, A.N.P.]: I liked helping care for people. I actually worked nights a lot, so as far as the interaction goes, it was probably a little less than a person that works on the day shift. But I just liked helping people and helping care for them, so I kept doing it through college, through my education at Bellin. After I graduated, I began working at the ninth floor at St. Vincent Hospital, and that's actually like an oncology/general medical floor. I worked night shifts there also. That was hard. It was hard being a new grad coming out of school. I felt like I didn't know a lot. I think being a nurse and having empathy and caring for people gets you through it, but it was very hard. I worked night shift and I worked there full time for about three years. And then, I transitioned to a clinic setting but it was in pediatric oncology. That's where, by then I figured out that my niche is kind of oncology, and I really enjoyed taking care of the cancer patients. And what's really unique with that is, the longevity of getting to know people. I also actually really enjoyed the hospice pediatrics and the caring for families and dying people. So, everyone says it takes a really unique person to go that way, but I have that empathy portion that really helps me with that. So then, I transitioned to pediatric oncology and I was

there for 14 years. I really enjoyed that. But by then, I started feeling like, as you grow as a nurse I feel like, you get more of that leadership under your belt and become more seasoned, and I felt like I needed to learn more. So, I went back to school for nurse practitioner. And that's a little late in the trajectory actually. I feel like a lot of people actually go back a lot sooner. I felt like a lot of people in my class graduated nursing school right away and wanted to become an NP. Unlike my classmates coming straight out of nursing school, I could draw from personal experiences a lot more. So, that was interesting. And that took me three years.

You generally need a little experience before you kind of jump into oncology. A lot of nurses in clinic work have worked already worked in an oncology type setting, in patients before they come to us. So, they have a little experience under their belts. It would be very, very overwhelming to come into our clinics as a new nurse graduate.

But, overall, I think there is a very strong liking for the field because of all the different things you can do with it. It's pretty good pay too, not that people go into it for that necessarily. It's a vigorous program. You've got to know your stuff and be able to do it. So, I think that helps to weed out the people that are like, "Oh I'm just going to do this to do this.". I know that sometimes there's a shortage in educators, so that's always a big push too is to get people into the more education side of it. Educators need extra schooling. I think they pay pretty well, so I don't think that that's an issue as to why. But it does take you away from the patient care aspect too. I mean, it's a little different ballgame as far as, I mean, you probably can get that emotional sense from your students maybe, but it's hard work too. I mean, education is tough, dealing with people and grades.

Nurse Interviewee 8 [Female, GenX, C.N.M]: It was good to get that experience while I was studying for the midwifery stuff, but on the other hand, it was also nice to not come into

learning to be a midwife with a ton of nursing experience under my belt because I didn't have to unlearn all the nursing skills or the nursing perspective in order to see things as a provider. I had seen some of my classmates struggle with that. They were like, “I've been a labor and delivery nurse for 15 years and I don't know how to not think like a nurse.” For me, it was a little bit easier transition.

There were also a lot of people in the midwifery program, who had worked as a labor and delivery nurse for a long time and then went back for midwifery after that. That was definitely a different nursing school experience because there were women all the way from 25 years of age to 60s, going back to be a midwife.

Nurse Interviewee 8 [Female, GenX, C.N.M.]: I do work with new nurses. I think some are surprised and discover like, “Oh, I don't like this” or, “I don't like this department.” We've had some nurses that quit during orientation because they're like, “I do not like doing C-sections” or, “I do not like postpartum care” or whatever the case is. They're not usually like, “Oh, I hate being a nurse. I'm leaving nursing.” It's more like, “I need to find a different department that works better for me.” The nice thing about nursing is there's such a variety of ways to be a nurse. As a student, you get exposure to all different areas, but it's only a little bit here and there. I just think you get a good taste. Most people come out of nursing school going, “Okay. I know the stuff I hate. I know the stuff I like,” but sometimes once you get into the nitty-gritty of it, it's maybe not what you expect. I would say I think we're lucky to have a couple of really strong nursing programs in the area, but I feel like the new nurses we get, especially if they're trained locally, have a pretty good idea of what to expect because they've already been doing their clinicals.

Chapter VI: Discussion, Conclusion and Recommendations

This qualitative research gained insight on influences and decisions to pursue a career in healthcare. Specifically, the study aimed to capture lived experiences from female and male nursing professionals employed within the healthcare system in the state of Wisconsin. Nursing is the largest employed segment of healthcare professionals within the United States employing over 3.8 million registered nurses. Nursing has a projected growth rate of 203,700 positions created yearly through 2026 (United States Bureau of Labor Statistics, 2021b). However, within ten years, baby boomers ages 65 years and old, will exceed the number of children creating a surplus of healthcare demands and a deficiency of nurses both nationally and within the state of Wisconsin. On a state level, the Wisconsin population of baby boomers will nearly double by 758,000 from 2010 to 2040 (Zahner et al., 2019).

The message nursing as a profession, the researcher employed a narrative of factual and meaningful experiences of nursing professionals and the impact of personal perspectives within Wisconsin's healthcare system. The study's goal was to positively impact the recruitment and retention strategies of nursing professionals, through the emotions and real-life experiences of healthcare professionals. Illuminating the eight participants narratives and identifying common themes across all semi-structured interviews, answers to the research questions *RQ1) how do study participants describe and justify their choice of nursing as a career?* and *RQ2) how does experience in the field of nursing impact the practitioner's career narrative of their profession?*

Discussion

This following four conclusions are discussed further within four concepts, which were condensed from the previous ten themes presented in Chapter 4:

Concept 1: Mental and Physical Opportunity Costs

Participants described their nursing career in terms of mental and physical opportunity costs, which concluded that a career in nursing will undoubtedly have an emotional and physical impact despite generational groups, identified genders, and licensures. Prior literature presented by Gatchel (2018), suggested there are several bio behavioral opportunity costs of nursing including 1) low back pain 2) stress and 3) depression, which supports participants frustrations of increased job demands creating a larger exhausted nursing workforce. All participants alluded to physical opportunity costs associated with standing for long periods and caring for an increased number of obese patients. One participant stated, *"Physically, it was hard too. I had to have both my knees replaced because I was on my feet so much. A lot of people had problems with their hips and their backs because you're on your feet so much and doing so much."* Additionally, participants are experiencing more mental health concerns, due to increase patient loads. This finding aligned with prior research presented by Gatchel (2018) on increased turn-over being attributed to environmental factors, higher patient acuity levels, and physical and emotional strain. Participants agreed that nursing as a career requires a higher emotional capacity due to patient care variances. However, the national pandemic has created a higher level of depression due to increase acuity levels and lack of work-life balance. As one participant stated, "*We're just all in so much pain, it's just everybody has had to go on meds or should be on meds or increase their meds, like anxiety, depression. I'm starting to get PTSD."*

All interviewees supported that increased nursing demands amongst all departments is creating higher levels of depression and burn-out. All employed participants agreed that emotional strain has only worsened amidst the pandemic creating an exhausted nursing workforce and continued mental health concerns with no outlet for mental health services. While

the pandemic demands may decrease over time, the increase in the aging population will create another healthcare surge. While not the extent of the pandemic, participants agreed that nurses are exhausted and burn-out and the workforce cannot afford to lose nurses for mental health concerns that are preventable. While nurses are aware of mental health services offered by employers or employee assistance programs (E.A.P.), participants suggested these services are highly unused because of time restraints and convenience, virtual delivery methods, and personal pride. Despite Gatchel's (2018) research that mental health programs prevent burn-out, reluctancy to utilize mental health services could certainly be a contributing factor to why nurses are twice as likely to experience depression than other professions. Participants preferred to lean on their peers and fellow nurses for emotional support versus using mental health services supporting that nurses without colleague relationships feel more isolated, get overwhelmed more easily, and dissatisfied with their roles compared to nurses with more colleague relationships (Berry, 2017).

Concept 2: Mentorship and Early Influence

Contradicting earlier literature findings by Crick et al. (2017) that family, particularly maternal role models, are the leading influencers or permission givers for choosing a career in nursing; only one of eight participants were introduced to healthcare by a maternal family member. In fact, most participants discouraged their own children from entering healthcare due to lack of work-life balance and emotional and physical opportunity costs. Determent of a nursing career aligns with a previously shared United Kingdom study where parents discouraged children from pursing nursing career because it was considered less scholarly and required more hygiene related job duties (Liaw et al., 2017). While the reasons for avoiding nursing were different, overall parental perception of nursing as a career choice are similar.

Most participants shared early exposure to healthcare by a high school guidance counselor or while working as a certified nursing assistant while in in secondary and post-secondary school. One participant shared, *"I think had I not had my counselor reach out and push me towards doing the certified nursing assistant program, I don't know what I maybe would have gone to school for."* Early exposure to healthcare created an interest in healthcare. For example, another participant shared, "*When I was about fifteen, got a job at a nursing home. I really enjoyed it. I was actually a receptionist. From there, I decided after graduation, from those experiences that kind of fostered me wanting to become a nurse caring for people. And so then, after graduation I became a CNA and then I enrolled in a nursing college."* Liaw et al. (2017) previously suggested that personal interactions with healthcare experiences are an influential factor in career choice. Therefore, supporting this study's findings that participants' choice of nursing as a career supports that personal interactions with healthcare experiences and secondary school activities create a higher are primary influencers of positive career perception.

Despite societal advances and increased secondary exposure to healthcare, all participants still agree that nursing is a generified role and female saturated. Cottingham et al. (2016) suggested that males avoid nursing for three reasons including 1) traditional views and gender stereotypes of the femininity of the profession creating a perception that men entering nursing roles were heterosexual 2) men had the inability to control sexual desire and 3) only females could provide intimate care to other females. Two of those three assumptions were discussed by participates as contributing factors with the exception of male nurses with military affiliation. One participant shared, "*There are more men in the military, and so a lot of them were in healthcare. And then they left the army after, four years, eight years, and they stayed in the town and ended up in nursing school. We had a really high percentage of male nurses in our*

program." While the perception of male nurses creates a generified gap in the labor force, participants also shared that male nurses are diamonds in the rough meaning more valued and paid higher wages than female nurses. One participant shared, *"Quite honestly, I think they've helped increase the wages in nursing. The more men who've gone into nursing, whether that's like a systemic or societal thing; I think having more men in nursing has improved the pay rate* for nurses."

Concept 3: Career and Organizational Culture

Nurses are exhausted and mentally strained from working overtime and longer shifts particularly to meet the demands of medical care and the pandemic. Healthcare workers are not only sacrificing time with their families, but they are risking their lives and risking exposure to deadly illnesses such as COVID-19. As one participant shared, *"We need to be paying more attention to family-work balance or life-work balance. We need to be doing something to make up for the sacrifices we expect nurses and healthcare providers to make because we sacrifice a lot. We sacrifice family time. We sacrifice holidays. We sacrifice sleep. We sacrifice our health. If you look at shift workers, people who work third shift, even on a semi-regular basis, have a higher rate of death at an early age, higher rate of breast cancer, higher rate of diabetes. We're making all these sacrifices for a healthcare system that doesn't seem to have our backs sometimes."* Another participant shared, "*I know so many nurses who left nursing because it's so inflexible and they treat us so poorly and they were just like I can't take it anymore."* supporting research by Zahner et. al. (2019) that turn-over has increased due to environmental factors, higher patient acuity levels, required overtime, lack of work-life balance, and physical and emotional strain.

Participants shared that healthcare organizations' approach to creating a better work-life balance is requiring nurses to work longer shifts less days per week. However, arguably longer shifts create more room for error. Particularly, 12-hour shifts create more room for exhaustion leading to malpractice. One participant shared, "*The decisions that we make are life and death, often. If we're tired, we're more likely to hang the wrong medicine and kill someone and it happens."*

Nursing participants stressed that healthcare organizations are more concerned about financial outcomes than safety of patients and staff. In fact, healthcare was described as a hotel focusing on a five-star rating versus patient safety or employee satisfaction. Nurses shared that metrics dictated patient outcomes and organizations are more concerned with quantity over quality. In fact, organizational metrics even dictated treatment plans. One participant shared, *"The more patients you can cram in, the better. They didn't care about the quality of care, but they really cared about the volume of care. Then our physicians were paid 100% on production,"* and *"...breaking her water on purpose so that you can go deliver her and make the money for the birth."* Organizational metrics have created a more stressful environment with less synergic teams amongst a group of peers already dealing with hierarchy between upper management and employees. As one nurse shared, *"Nurses are frustrated with the direct impact, of upper-management decisions based on key performance indicators, that directly impact nursing job duties. Changes made without communication or input create a negative organizational culture, which impacts nursing satisfaction, turn-over, and burn-out rates."* Not only do nurses feel unsupported within their role by upper management, they are dealing with bullying (verbal abuse) and in some cases sexual harassment creating lower career satisfaction and organizational moral. Another nurse shared, *"I've had a door shut on me by a doctor, a*

pediatrician wanting the patient to unlatch the baby when she just got the baby latched for the first time ever. That time I was like, 'We're not unlatching this baby,' and this old man pediatrician like shut the door on me and stormed out and I did write that one up, that was right before he retired but I was like that's not acceptable. And the patient, it was right in front of her, she was upset." Overall, organizational culture and upper management support directly impact career satisfaction, which impacts departmental retention and patient care.

Concept 4: Nursing School Preparation and Rigor

Nursing school is rigorous and time consuming. Participants shared that working full-time while in nursing school was unmanageable, without family and childcare support, creating little flexibility for non-traditional students with family commitments. As one participant stated *"...between classes and clinicals and exams and studying, it just doesn't leave much time even to work. I know that they you have to get your clinical time in, but I think offering different hours, especially for people who have kids, because most of the clinicals are day shifts. And that doesn't leave much time for parents to be a parent or involved or to even hold a career during it."* However, participants that pursued nursing school as non-traditional students felt more prepared and comfortable with patient care based on life and career experiences similar to students with healthcare experience as certified nursing assistants.

Participants with prior healthcare experience felt much more comfortable with patient care and working in teams than students without prior experience. Despite experience, all participates shared that nursing students do not get enough clinical hours, Medicare and insurance process knowledge, and specialty experience. As one participant shared, *"I came to ambulatory outpatient care. And I used my skillset that I had for that. But some of it, like the paper side of nursing, always taught clinicals and patient experience that way and procedures*

and things like that. I've had no idea all the Medicare requirements. I had no idea what a prior authorization for a medication was." While most participants started their careers on a medical surgery unit, nurses transfer to different specialties before finding a department that meets interest and day/evening shift preferences. Earlier research revealed, increased demand for healthcare services for the specialty of geriatrics exceeded the overall nursing shortage alone in the United States (Monti, 2021).

Conclusions

While the intent of this study was to bridge healthcare demands of the aging population through nursing narratives, this study revealed that the healthcare system in Wisconsin was already in crisis because nurses are in desperate need of self-care. Prior to COVID-19, organizational culture was impacting nursing retention and turn-over. While nurses were emotionally impacted by everyday job duties; colleagues relied on each other to push through the mental exhaustion. However, organizational changes that push for quantity versus quality have negatively impacted those peer relationships. Synergy and respect are lacking amongst colleagues because of organizational pressures to meet financial goals.

Post-COVID-19, nurses are struggling with mental health to the point of being prescribed medication or considering leaving the industry entirely. The nursing code of conduct shares that nurses hold care-taker qualities; however, nurses are better at caring for others than themselves. While mental health resources and employee assistance programs exist, those programs are completely underutilized. Also, lack of support of a healthy work-life balance and scheduling needs have taken a back seat to the monetary needs of the organization. Nurses feel disposable and are resentful for lack of work life balance. They are craving camaraderie within the

workplace, creating quick turn-over within departments until a family dynamic environment is found.

Lastly, positions cannot be filled fast-enough because nursing school schedules align for a more traditional student discriminating against a pool of demographic of students needing to work full-time or adhere to family commitments. Despite the rigor of nursing school, nurses still feel unprepared upon entering the career field due to lack of clinical and specialty experience. While career readiness can be combatted with previous healthcare experience as a certified nursing assistance, it takes six to nine months to feel comfortable within a specialty or department.

Recommendations for Key Stakeholders

The following five recommendations are directed for healthcare organizations particularly for the human resources department and educators:

- First, to gain a better understanding of cultural shifts, professional interactions, and organizational gaps, healthcare organizations would benefit from annual employee engagement and exit surveys of current and previous employees. Conducting a market analysis, by an objective third-party vender, would allow employees to freely discussed organizational issues creating organization and job dissatisfaction such as scheduling barriers or any other factor placing the organization at risk for lapse in compliance or malpractice.
- Secondly, while new nurses receive a preceptor during the orientation period, new and current nurses may need emotional and skill-support beyond the organizations' orientation period. Therefore, considering a peer mentoring program would provide

new nurses with an assigned peer mentor to discuss skill or job-related questions beyond the orientation period.

- The third recommendation is a potential solution to high turn-over amongst departments due to unrealistic expectations within departments. Adding a specialty interest questionnaire, within the hiring or application process that addresses patient demographic, skill set demands, common procedures, and shift options, may prevent internal department turn-over.
- The fourth recommendation is to incentivize mental and physical health programs to increase usage or employee assistance programs, gym memberships, and other mental health services. This study also confirmed that nurses are more likely to enter healthcare if mentored within secondary school, within another healthcare position civilian and military.
- The fifth recommendation is collaborating with high school guidance counselors, nursing homes, and veterans' affairs, to offer school-to-work and scholarship programs, to increase interest in healthcare related fields for both males and females. Lastly, the final recommendation is to provide non-traditional nursing school options for students with families. Non-traditional routes could include part-time enrollment options or evening courses for busy working adults, which is a demographic of nurses that could full-fill workforce demands.

Recommendation for Further Research

Further research is also recommended to explore 1) why nurses leave healthcare, 2) why males enter masculine healthcare roles, and 3) what contributing factors impact nursing school retention rates.

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Appendix A

Social Media Participant Recruitment Message

Dear Facebook Friends, Family, and Colleagues,

I'm writing my dissertation on the career narratives of nurses. I'm looking to interview Wisconsin healthcare workers on their experience in nursing. If you know a LPN's, RN, and/or NP who may be interested in being interviewed, please comment with their name and email in a private message via Facebook. Please let them know that I'll reach out, in a private Facebook message, to discuss the opportunity more in detail. If they do not have Facebook, please provide me with their name, phone number, and/or email in a private message. Thank you for all your help and support. Stay healthy and safe.

Appendix B

Participant Referral Message

Hi (*participant's name*),

First and foremost, thank you for your effortless commitment and dedication to serving Wisconsin patients during such a critical time in healthcare. My name is Rachel and I'm a (*relationship: friend, family, or colleague*) of (*referral's name*). I know (referral's name) may have told you I'd be reaching out. (*Referral's name*) said you're a dedicated nurse and that I should reach out to you. I am a Career and Technical Education-doctoral student at UW-Stout. I am currently conducting a qualitative research study to better understand life experiences and narratives that influence nursing careers. Participation in this study will involve a virtual meeting that will be recorded and later transcribed. The interview will take approximately 60 – 90 minutes. We can meet virtually via Microsoft Teams, secured cell phone line, or via secure cell phone line using Facetime. Please choose an option more convenient and comfortable for you. You will also receive the interview questions in advance. Your responses from the interview will be kept anonymous. No participants' name, patient, employer, or colleague names will be shared to adhere to employer and healthcare patient confidentiality guidelines. Interviews will be held between November 27th, 2020 through December 13th, 2020. Please reply with the date and time that works best to discuss your nursing journey. I look forward to hearing from you.

Sincerely,

Rachel Krueger, Doctoral Candidate in CTE

University of Wisconsin – Stout

Appendix C

Consent to Participate in UW-Stout Approved Research

Project Title: Managing the Healthcare Crisis: Career Narratives of Nurses

Description:

The purpose of this qualitative study is to gain insight on influences and prospect's decision to pursue a career in healthcare. This study aims to capture insights from nursing professionals employed within the healthcare system in the state of Wisconsin. The resultant findings aim to contribute to the literature by illuminating the lived experience of persons currently navigating nursing occupations. The study addresses the following research questions:

1. How do study participants describe and justify their choice of nursing as a career?
2. How does experience in the field of nursing impact the practitioner's career narrative of their profession?

Risks:

There is minimal risk associated with this study. However, you might recall some unpleasant life or career memories. The benefit to participate is that you might enjoy sharing your experience. Questions have been prepared and reviewed for participants to share their life experiences and narratives of nursing.

Benefits: The benefit to participate is that you might enjoy sharing your experience. Questions have been prepared and reviewed for participants to share their life experiences and narratives of nursing.

Confidentiality:

The records of this study will be kept private. In the research finding and dissertation, I will not include any information that will make it possible to identify you. I may receive help from

someone to transcribe the recording of the interview. That person will be instructed to keep the information confidential.

Future Use:

Any information collected for this research project will be stripped of identifiers and will not be used in other research in the future.

Time Commitment:

Due to COVID-19 restrictions and safety measures, participation in this study will involve a virtual meeting that will be recorded and later transcribed. The interview will take approximately 60-90 minutes. You can choose to meet virtually via Microsoft Teams, secured cell phone line, or via secure cell phone line using Facetime.

Right to Withdraw:

Your participation in this study is entirely voluntary. You may choose not to participate without any adverse consequences to you. You have the right to stop the interview at any time. However, should you choose to participate and later wish to withdraw from the study, there is no way to identify your anonymous document after it has been turned into the investigator.

IRB Approval: This study has been reviewed and approved by The University of Wisconsin-Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding this study, please contact the Investigator or Advisor. If you have any questions, concerns, or reports regarding your rights as a research subject, please contact the IRB Administrator.

Investigator:	**Advisor:**
Rachel Krueger	Dr. Urs Haltinner
Kruegerr17261@my.uwstout.edu	haltinneru@uwstout.edu

Statement of Consent:

By signing this consent form, you agree to participate in the project titled "Managing the Healthcare Crisis: Career Narratives of Nurses"**.**

_____

Print Name

_____

Nursing Licensure (LPN, RN, or AP)

_____

Date of Birth Identified Gender

_____

Signature

Appendix D

Confirmation Email with Consent

Attached is the consent form needed for my research.

You can send it back via email. I look forward to our chat via phone on Tuesday, 12/8/2020 at 6:00PM CST. It will take no longer than 60 minutes.

Based on your request via Facebook, I will call you using my secure cell phone. My phone number is: [redacted].
We'll chat for a few moments before I ask you permission to record. I'll be asking two main questions, which are listed below. The first question is more of a get to know you better...

1. Describe me to how you got into your nursing career…
2. Tell me about your experience in nursing and how it has impacted you…

Thanks again for helping me with my research. It means a lot.

Appendix E

Semi-Structured Research Guide

Introduction:
My name is Rachel Krueger, and I'm a UW-Stout student conducting doctoral research on what underlying factors influence a career in nursing. My research aims to answer the following two research questions:
RQ1: How do study participants describe and justify their choice of nursing as a career?
RQ2: How does experience in the field of nursing impact the practitioner's career narrative of their profession?

Today, I have the pleasure of conducting a semi-structured interview virtually via _____ with _____ regarding her experience in nursing.
_____, before we get started do I have your permission to record this interview?

RP1: **Describe me to how you got into your nursing career…**

- Tell me more about…
- You said… Can you tell me more about…
- I noticed you didn't say anything about… Can you tell me more about…
- Re-direct based on RQ1 as needed
- Add prompts as needed
  - Family Life (work-life balance)
  - Educational Background
  - Positions Held
  - Years working in the field

RP2: **Tell me about your experience in nursing and how it has impacted you…**

- Tell me more about…
- You said… Can you tell me more about...
- I noticed you didn't say anything about… Can you tell me more about...
- Re-direct based on RQ2 as needed
- Add prompts as needed

_____, thank you so much for your time and commitment to the heal

Appendix F

Working Thematic Analysis Example

Raw Capta	Codes Reduction of Raw Capta	Categories Themes based on Original Capta	Concepts Declaring the Themes
Yes, you do. I first was introduced to the idea of doing PCT work back in high school.	introduced to the idea of doing PCT work back in high school.	Participants entered the field of healthcare due to mentorship in secondary school.	Emotional and physical strain is what becomes the norm.
CNA or Patient Care Tech at a local nursing home.	CNA or Patient Care Tech~~.~~ ~~At a~~ local nursing home.	Career as a Certified Nursing Assistant (C.N.A.) led to a career in healthcare.	Key influencers led them into the nursing profession.
So I ended up taking the class and I ended up going on because I realized that I do have a love for learning. And I also want it to be able to be more of an assistance to people just past doing physical care.	~~So I ended up~~ taking the class ~~and I ended up going on because I realized that~~ I do have a love for learning. ~~And I also want it to~~ be able to be more of an assistance to people just past doing physical care.	Students with Certified Nursing Assistant (C.N.A.) experience felt more prepared than students without C.N.A. work experience.	Early experience and/or certificate nursing care led to their professional nursing career. Healthcare job function, level, and practitioner generation hierarchy impact the work satisfaction of the nurse.
Getting to the bottom of certain diagnoses and being able to educate patients and things of that nature. I ended up able to educate patients and things of that nature. I ended up going back for my Bachelor's about three years ago, and I have a little more in-depth research ideas on how to properly educate patients going forward. But I would say most of it just comes from my love of just helping people.	~~Getting to the bottom of certain diagnoses and being able to educate patients. I ended up going back for my Bachelor's about three years ago, and I have a little more in-depth research ideas on how to properly educate patients going forward. But I would say most of it just comes from my love of just helping people.~~		

Appendix G

Working the Rough Themes to the Enduring Themes

Concepts	Rough Themes	Rough Themes (N=Nurse Interviewee)	Enduring Themes
Concept 1: Mental and Physical Opportunity Costs	Theme 1: Participants agreed that their role in nursing was mentally and emotionally tolling (pre and post COVID-19); however, did not seek personal mental health resources.	N1, N3, N4, N5, N6, N7, N8	- Emotional and physical strain is what becomes the norm - Patient and peer needs take precedence over the needs of self
	Theme 2: Participants agreed that it's easier to care for others than themselves.	N1, N3, N4, N5, N6, N7, N8	
	Theme 3: Participants are aware of their organization's Employee Assistance Program (EAP), however, do not utilize their organizations' program.	N3, N4, N5, N6, N7, N8	
	Theme 4: The physical demands of nursing create physical strain and health problems.	N1, N2, N3, N4, N5, N6, N7, N8	

Concepts	Rough Themes	Rough Themes (N=Nurse Interviewee)	Enduring Themes
Concept 2: Mentorship and Early Influence of Healthcare	Theme 5: Participants entered the field of healthcare due to mentorship in secondary school.	N3, N5, N7	- Key influencers led them into the nursing profession
	Theme 6: Participants were influenced by a family member or friend to enter nursing career field.	N1, N2, N4	- Early experience and/or certificate nursing care led to their professional nursing career
	Theme 7: Career as a Certified Nursing Assistant (C.N.A.) led to a career in healthcare.	N2, N3, N5, N7	- Gender stereotypes impact gender equity in pursuing nursing as a profession
	Theme 8: Career as a Medical Assistant (M.A.) or Licensed Practical Nurse (L.P.N.) led to a career as a Registered Nurse (R.N.).	N1, N2, N3	
	Theme 9: Participants agree that nursing is still generified, and males do not consider nursing as a profession when entering healthcare.	N1, N2, N3, N4, N5, N6, N8	

Concepts	Rough Themes	Rough Themes	Enduring Themes

		(N=Nurse Interviewee)	
Concept 3: Career/Organizational Culture	Theme 10: Inflexibility of shifts and required overtime creates a lack of family/work-life balance.	N1, N2, N3, N4, N5, N6, N7, N8	- Structure of work scheduling affect the nurse work-life and family-life balance -
	Theme 11: Length of shifts create unsafe environments for patients and puts providers at risk for malpractice.	N4, N8	- Dissonance between organizational and nursing ideology impacts the nurse's self-efficacy - Healthcare job function, level, and practitioner generation hierarchy impact the work satisfaction of the nurse
	Theme 12: Nurses feel unsupported by leadership, seasoned peers, and management.	N1, N2, N4, N5, N6	
	Theme 13: Participants argues that healthcare organizations are more concerned about financial outcomes and meeting organizational patient quotas versus employee and patient safety creating a negative organizational culture.	N4, N8	

Concepts	Rough Themes	Rough Themes (N=Nurse Interviewee)	Enduring Themes

Concept 3 Cont'd: Career/Organizational Culture	Theme 14: Participants expressed that colleague communication, relationship, and respect, amongst doctors and nurses, varied between generational groups, gender, departments.	N1, N2, N3, N4, N5, N6, N7	
Concept 4: Nursing School Preparation and Rigor	Theme 15: Nursing school is rigorous, yet nurses still feel unprepared upon entering the career due to lack of hand-on clinic or hospital experience.	N1, N2, N3, N4, N8	- Education and training of nurses impacts the nurses perceived preparedness. - School-based learning, clinical placement, and the in-field skilling impacts the nurse's self-efficacy
	Theme 16: Nursing school provides little flexibility for students with families or non-traditional students.	N1, N3, N6, N7, N8	
	Theme 17: Students with Certified Nursing Assistant (C.N.A.) experience felt more prepared than students without C.N.A. work experience.	N1, N2, N3, N4, N5, N7	

Concepts	Rough Themes	Rough Themes (N=Nurse Interviewee)	Enduring Themes

Concept 4 Cont'd: Nursing School Preparation and Rigor	Theme 18: Participants' first department upon graduating nursing school, was the Medical Surgery floor.	N1, N4, N5, N6, N7
	Theme 19: Participants did not have hands-on experience in specialty areas or take a specialist interest assessment in school or upon being hired.	N1, N2, N3, N4, N5, N7, N8