

Professional Socialization of Nurses

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Paper Title:

Professional Socialization –The Key to Survival as a Newly Qualified Nurse

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Ijnp reference IJNP-2005-00044

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Mooney Mary :International Journal of Nursing Practice 2007; 13: 75–80

Professional Socialization – The Key to Survival of Newly Qualified Nurse

Abstract

The impact and prevalence of professional socialization in nursing has been written about extensively. Despite the many positive developments that have taken place in nursing within the past decade, the role of professional socialization remains heavily weighted and is of particular significance to those nurses who are newly qualified. The account given by newly registered nurses in this study demonstrates that their ability and willingness to become professionally socialized determines their ease of survival at clinical level. Twelve newly qualified Irish nurses, from two separate cohorts, were interviewed to ascertain their perceptions of becoming newly qualified nurses. A grounded theory approach was used and data were analysed using thematic analysis. A category that emerged was linked very strongly with professional socialization. The respondents did not refer to professional socialization per se, but through the coding process this emerged as the linchpin of the discussion.

Key Words:

socialization, holistic nursing, stress, professional power, qualitative research

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Introduction

The professional socialization of nurses has been the subject of discussion for several years. This term refers to the process through which novice practitioners are merged into the profession to become professional practitioners¹. Within this system newcomers are instructed in the ways and attitudes of the organization and gradually adopt the attitudes, values and unspoken messages within the organization². The newly qualified nurses, who were individually interviewed for this study, provided lively descriptions of ritualistic practices, hierarchical attitudes and strict observance of rules. These accounts were reflective of the six processes associated with the socialization of nurses into nursing identified by Melia³. These included learning the rules, getting through the work, learning and working and passing through. The problems associated with the transition of nursing students to professional nursing practice have been acknowledged as being traumatic and stressful^{3, 4, 5, 6}. The majority of nurses in this study felt frustrated, vulnerable, stressed and disappointed post qualification. While all twelve respondents supported the taught practice of holistic nursing and evidence-based care, only one nurse actually witnessed it in practice. As newly qualified nurses, the participants felt unable to exert any influence over the ward ethos in their clinical areas. The findings of this research study, together with the literature, suggest that professional socialization in nursing continues to contribute significantly to the enduring problems faced by newly qualified nurses.

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Ethical Approval

Prior to commencing the study ethical approval was granted from the research ethics committee in which the study took place. The researcher ensured that the correct procedures were undertaken concerning informed consent, autonomy, anonymity and the maintenance of confidentiality.

Methods

Collection and Analysis of Data

A grounded theory approach was chosen as a framework for this study. The inductive approach, which is intrinsic to this method, allows the real issues in the study to emerge. This is assisted by the simultaneous collection and analysis of data. Individual in-depth interviews were held with twelve newly registered nurses, from two separate cohorts, who were qualified between six and ten months. Eleven of the twelve nurses agreed to have their interviews recorded and all twelve interviewees consented to note-taking throughout the interviews. The interviews were typed verbatim. The notes from the unrecorded interview were re-written immediately following the interview so that no valuable information would be lost or forgotten. These notes were also included in the analysis process.

A feature of grounded theory is the simultaneous collection, coding and analysis of data. The only occasion on which data were collected in isolation from the other procedures was during the initial interview. Thereafter the process of data collection and coding, theoretical sampling and data analysis were concurrent. Theoretical sampling, which was employed in this study, involves sampling on the basis of the emerging concepts that emerge from the preceding interview. This necessitated systematic and detailed record-keeping. It was through the employment of theoretical sampling that the deviant case became so apparent. The sample size is

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normally determined by data saturation, which refers to informational redundancy. The researcher had considered that data saturation had been achieved after ten interviews. It is interesting to note however that the deviant case emerged at the eleventh interview. A limited time frame precluded more than twelve interviews.

Data were analysed throughout the interviews and during transcription. The analysis was assisted by actively listening when interviewing, exploring phenomena to which the participants referred and use of memos taken during the interviews. Data were handled manually using index cards, notes and charts. Line by line analysis was used to develop the open codes and subcategories, while main categories were developed through axial coding. This timely and rigorous process yielded exclusive categories, which when closely scrutinised, appeared to fit the yielded data. Data were revisited several times and changes were frequently made. This ensured that all data were included.

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Rigor

As the researcher is the research instrument in qualitative research, it was essential that careful attention was paid to the maintenance of accuracy throughout the study. Sandelowski delineates four aspects of trustworthiness within the naturalistic paradigm⁷. These include credibility, consistency, confirmability and applicability. These issues were addressed in this study. Credibility is enhanced when the readers can identify with the experience. In order to maximise credibility, all interviews except one, were recorded. Detailed notes were taken during, and rewritten following, the unrecorded interview. This reduced the chance of losing important information. Data and interpretations were presented to three participants who were asked to verify the appropriateness of the findings. Two meetings took place between the respondents and the researcher. An initial briefing was held prior to each interview. These meetings were considered essential to overcome any potential barriers or threats that the researcher may pose to the respondent. Each interview lasted at least forty five minutes. Such prolonged interaction with the respondents provided the researcher with an increased understanding of what was being said.

In terms of consistency, a clear decision trail was provided. One peer assessor was provided with the interview notes and asked to trace the audit trail to ascertain the enquiry process. This cross-checking of data provided new insights and clarifications.

The use of a reflective journal assisted with the establishment of confirmability. A lengthy dialogue took place with the peer assessor who challenged the researcher's assumptions and provided clarity in some aspects of the study.

In an effort to achieve applicability, the researcher aimed to have a representative group involved in the study. It is acknowledged that those people who are less vocal tend to participate less in qualitative studies. To overcome this possibility, a strict inclusion criterion was set out for

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involvement in the study, clear details about the study were provided in advance and a briefing meeting was arranged before all interviews. This time was used to answer questions and get to know the participant. Data are presented in this article in the form in which they were derived, which further enhances the assertion that trustworthiness was preserved.

Findings

All twelve nurses who participated in the study had been in the same research site (hospital) as undergraduate nurses and were employed there afterwards as newly qualified nurses. One nurse, whose stories differed from the rest, described her clinical area as one that fostered change, encouraged questioning and had a patient-centred approach to care. The presence of a deviant case such as this enhanced the trustworthiness of the findings and enriched the study. The remaining eleven participants recounted stories and post qualification experiences, all of which were aligned with the presence of professional socialization in nursing. The category which was related to these descriptions was entitled “Old Habits Die Hard”. This title was chosen as it described the ritualistic and rigid behaviours that dispirited the enthusiasm of the eleven newly qualified nurses in the clinical setting. The category emerged from two sub-categories called “Set in Stone” and “Without a Voice”.

Set in Stone

This sub-category related to the ritualistic clinical practices and routines, which the newly qualified nurses found frustrating. The participants found it difficult to reconcile themselves to ward routines in the clinical area. Respondents had considered that they would be able to change these practices when they qualified and were determined to do so initially. Some of the nurses tried to make changes at ward level but got no encouragement from staff or clinical managers.

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The drugs that are prescribed for 2pm are given at 12md, which I thought was ridiculous. I said it one day; why can't we just give them at 2pm. The response I was given [from the ward manager] was that it has always been done this way. That's the way it's done on this ward.

The work was portrayed as being ritualistic and non-patient focused. From the interviews it was apparent that the newly qualified nurses had difficulties with tasks taking precedence over other aspects of care and they took exception to the way work was organised in the wards. The newly qualified nurses felt less pressurised at work when the manager was not there, as everything was more relaxed in his/her absence. While routines were still maintained by senior staff, it was to a less extent of rigidity than when the manager was present. One participant told a story about how she and another nurse had being reprimanded by the ward manager because they went ahead and made some beds while they were waiting for the bathrooms to become vacant. The ward rule was however that all washes had to be completed before the beds were made.

We are supposed to get all the washes done in the morning and all the beds made in the morning and the washes have to be done before the beds. It's such a nightmare trying to get everything done.

In relation to the difficulties associated with routines, the nurses expressed disappointment and disturbance at the negative attitudes of some staff towards psychological care. Participants felt that talking was seen as not working. They were keen to "fit in" with the ward routines and not cause trouble for themselves so soon after they qualified.

I am forever hearing people say she [the ward manager] won't bother you if you look busy. You have to make sure you run around constantly and you'll know she won't come near you and she won't give out.

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The deviant case did not identify with these findings. Conversely, she felt that the ethos on her ward was one of patient and staff centeredness. She felt that she had time to talk to patients and that while the ward was busy, the workload revolved around the patients' needs.

Yeah, we are really busy most of the time but we are always allowed to talk to the patients. The ward sister X [named] talks to them herself. X is not fussed about beds and tidy wards. I am delighted I got back to X ward for staffing.

Participants described how "fitting in" meant you would be highly thought of by other members of qualified staff.

There could be one person that you don't get on with but they can make life very difficult for you. I think that people expect you to try to fit in.

Eleven of the twelve participants spoke of a desire to make changes and some tried with little success. All eleven nurses eventually conceded that the rituals and routines were set in stone and would not change. They expressed that as students they were somewhat unaware of the implications of routines, but as staff nurses, this awareness had a profound effect. Respondents felt frustrated and disillusioned by the ritualistic practices and the reluctance of others to change.

Without a Voice

This sub-category referred to the vulnerability and powerlessness experienced by the newly qualified nurses. Although they had transcended a period of insignificance as students, they were now the most junior of those who were significant. They were collectively known as 'the juniors' and accentuated the supremacy of being senior while highlighting the prevalence of hierarchy.

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Some of the nurses talked about how they resented that only junior nurses were sent to help out on busy wards, if their own ward was not busy.

She [the ward manager] says there has to be perks (benefits) for somebody that's ten or twenty years qualified

Respondents felt they were blamed disproportionately and distrusted when things went wrong.

One respondent spoke about four separate occurrences of drug errors on the ward. One error involved a junior nurse while the remainder involved senior nurses. The problem of “juniors” making drug errors was highlighted at the staff meeting. There was no mention of the errors made by the senior nurses. It was agreed at the meeting that junior nurses should do drug rounds with a senior nurse at all times.

I was the only junior on [duty] at the staff meeting and I was made to feel like this tiny speck of dust on the carpet and I just felt so small

Eleven of the twelve respondents described how the nurse manager holds the reigns of professional nursing power within clinical areas. One example, which was given repeatedly, was related to the assumption that the newly qualified nurses would cover the night duty rosters over Christmas and New Year. They felt discriminated against, as this was an automatic, autocratic decision. Respondents felt they were not heard when they argued their point and all too often they gave up and conformed.

I feel like I can't speak up that much because I am only newly qualified. I don't have the same voice as if I was ten or twenty years qualified. I don't think they would listen to anything I had to say

Participants told of ward managers who admonish staff in public. This accounted for respondents being stressed and frightened during handover of care. The newly qualified nurses felt that senior

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staff should speak up for junior staff, but nobody ever did. The importance of learning to survive and making life easier was transparent. The twelfth nurse, who presented as the deviant case in this study, reported feelings of security and equality as a junior staff nurse. She discussed how she was assigned to a preceptor when she went to the ward initially and spoke of how effective and reassuring it was to have someone to rely on.

I know from hearing the others (newly qualified nurses) that I am lucky to have been placed where I am. It helped a lot that everyone on the ward knew I was the junior who had just qualified. I depended on that for survival. I am really happy and well looked after, but all the staff on x ward seem really happy.

It is evident from these contrasting descriptions by newly qualified nurses that support and contentment levels are dependant on the ward to which the nurse is allocated.

The category called “Old Habits Die Hard” represented participants’ descriptions of stress, powerlessness and disappointment post qualification. Despite a desire to challenge structures and ward routines, participants identified that as newly qualified nurses they exerted minimal impact at ward level. The junior status of these nurses was reinforced through hierarchical rules and attitudes, with distrust of junior nurses on some wards. Within the first ten months post qualification, eleven participants in this study admitted that they had conformed to ward rules and routines. The newly qualified nurses valued knowing the “ward rules”, as this information made their lives easier as registered nurses.

Discussion

A study by Philpin described incongruence between the personal values of newly qualified nurses and the values set by clinical areas⁶. Hunt suggests that within clinical areas there are two sets of values. The first and official set comprises of the explicit statements such as policies, mission

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statements and other important documents. The second set of values is unspoken, implicit and virtually silent, yet known to those who are exposed to them². It has been shown that newly qualified nurses have an interest in providing holistic, patient-centered nursing care but quickly become socialized and conform to ward cultures^{8,9,10}. This has been referred to in the literature as learning how to play the game within the organization². Treacy demonstrated that talking did not constitute working and highlighted the importance of appearing to be busy, in an effort to conform to such ward cultures¹¹. Participants in the current study acknowledged the prevalence of this ethos but were personally opposed to it. Jackson proposed that newly qualified nurses today may possibly uphold the division of tasks and routines as a means of organizing their own workloads and providing patient-centered care, through care planning, as opposed to simply fulfilling tasks or maintaining rituals¹². This suggestion was not however supported in this study.

The impact of professional socialization in nursing has been addressed in The United States⁵, The United Kingdom³ and in Ireland¹¹ and the presence of hierarchical structures in clinical environments has been recognized as an important component of this process^{13,14}. It has been advocated that socialization experiences are determined by the scope and ability of the qualified nurse, which impacts directly on the quality of patient care^{12,13}. Hierarchical structures are cyclical and tend to be perpetuated through example and role modeling of senior staff within the midwifery profession¹⁵. It has been suggested that it is primarily the ward manager's preferences that are most frequently met^{3,13}. In this study, those newly qualified nurses who initially challenged issues of concern became quickly discouraged when neither defended nor supported by their senior colleagues. The adherence to ward managers' preferences, by the majority of qualified nurses, provided little scope for these newly qualified nurses to introduce change or use initiative. It has been shown that nurses are often subjugated to the values of others in their work environments¹⁶.

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Participants in this study described feelings of powerlessness and vulnerability following registration. Six to ten months after qualification, many felt that they had not developed sufficient skills of assertion, although most were more assertive than they had been as students. Some nurses described negative sanctions against them, as a result of their junior status, while others reported fears about asking questions. Professional socialization has been linked with the development of self-esteem¹⁷. Self-esteem tends to be generally low among nurses and midwives¹⁸. The way in which professional socialization is imposed upon nursing professionals may account for their low levels of self-esteem and their failure to be assertive, questioning and challenging. Valentine found that nurses adopted behaviors such as avoidance, to deal with conflict, which is associated with people who have reduced confidence and skills of assertion¹⁹. This finding is reflected in this research study and in other research studies^{6, 8, 20}.

Some studies have shown however that some newly qualified nurses are forthcoming, assertive and fearless in admitting limitations^{10, 21, 22}. Nurses who display assertiveness skills may originate from clinical areas where questioning is fostered and supported, which was the situation with the one nurse in this study who did not support the above findings. This is an interesting aspect that may be researched in the future but was not addressed in this study. If nurses are subjected to domination and powerlessness, then the cycle of oppression will continue, which has implications not only for newly qualified nurses but for those patients in their care. Professional socialization is an inevitable consequence of entry to any profession and plays an important role in the development of a professional identity. It assists practitioners with the development of decision-making abilities and the promotion of working relationships^{18, 23, 24}. However, its value, meaning and context can all too easily become obscured by professional power, domination and hierarchy.

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Conclusion and Recommendations

This study set out to ascertain the perceptions of newly qualified nurses of their transition to becoming registered nurses, using a grounded theory approach. However, the information that unfolded with the simultaneous collection and analysis of data related to issues surrounding the professional socialization of nurses. The descriptions in this study of ward routines, task-focused care and powerlessness were supported in the literature^{8, 10}. This can result in frustration and resentment towards the hierarchy, whose needs are frequently met^{3, 13}. Due to countless reasons, many nurses avoid challenging those issues and philosophies with which they disagree and instead conform to the accepted ward culture through the process of professional socialization. While nursing, as a profession in the twenty-first century, has progressed via the improvements in education and increased opportunities, many newly qualified nurses remain restrained in their daily practices and continue to work within confined limitations. If nurses fail to develop skills of assertion, reflection and critical thinking, then the goals of evidence-based practice and holistic care cannot be fulfilled. The implications of the negative experiences associated with professional socialization include stress in nursing, a reduction in the quality of patient care and dissatisfaction among nurses generally. It would appear therefore that the issues surrounding professional socialization in nursing are multifaceted and have the potential to disenfranchise nurses as autonomous professionals.

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