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Nursing Professionalism: The View from the Starting Line

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by

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Abstract

Professionalism in nursing is about nurses striving to understand what is expected of them as members of a regulated and licensed profession; and moreover, what their work then looks, feels, and sounds like to themselves, and to those they encounter while in practice.

A focused ethnography was conducted over a four month period, with the purpose of discovering how nursing students understood and then defined, nursing professionalism. Eight key informants shared their knowledge of professionalism through one to one interviews, shadow observations, and one focus group discussion. Data collection and analysis were conducted simultaneously, examining for emerging patterns, descriptions, and relationships that held meaning to these student nurses. The study findings suggest that the experience of professionalism for these informants can be thematically expressed as relationship based: relationships with self, with patients and families, with colleagues, and with the public.

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Finally, I extend my gratitude to the eight student nurses who so bravely and openly participated in this study; sharing their insight and experiences about what it means to be a nurse, and do nursing work. Their understanding of the importance and impact of their nursing work on those around them, exemplifies their commitment and passion to the discipline of nursing.

Table of Contents

Chapter One: Arriving at the Question: How Do Fourth Year Nursing Students Describe Nursing Professionalism?

Professionalism has always been the cornerstone of my nursing practice, providing the foundation for collaborative practice, ethical clinical decision making, and implementation of competent and confident nursing care at full scope of practice. Moreover professionalism in practice is an expectation of the College and Association of Registered Nurses of Alberta (CARNA, 2006). Professional value and behavior development is essential for nurses working within the current health care system in which complex patient care situations and ethical dilemmas are encountered with increasing frequency. According to the Canadian Nurses Association (CNA) the acquisition and internalization of values adopted by the nursing profession are central to professional development and provide a common framework upon which expectations and standards can be developed (CNA, 2008). Shared values such as altruism, trust, and dignity become the standard by which all nurses conduct their practice; and are used to evaluate the integrity of the individual nurse, health care organizations, and the profession of nursing. In this chapter I will present the purpose of this research study, explore the assumptions and theoretical background that helped me determine the research question, and outline the justification for a cultural exploration of student nurses' professionalism. I will then discuss the need to better understand the perspective of new nurses just beginning to develop their professional practice. Finally, I will outline my current understanding of nursing professionalism. In summary, I will provide the framework for the development of my research question and the subsequent choice of research methodology.

Background

My interest in nursing professionalism, and subsequently my understanding of it, was born from my personal and professional life journeys: my experience as a patient, reflection on my own clinical practice, observing the practice of nursing colleagues, conducting literature reviews, and mentoring the practice of nursing students with whom I have had the privilege to work. It was through continued reflection and inquiry that I came to know and take pride in the powerful potential nursing has to impact the populations we serve. The impact can be positive, offering supportive guidance and physical care to persons (often at their most vulnerable) resulting in their increased health and wellbeing. Or the impact can be negative, leaving patients to feel scared, lonely, and confused; the legacy of which could be an emotional scar lasting long after the physical body has healed.

The View from the Other Side of the Bed

When I was 27 years old (I had been a nurse for five years) and 23 weeks pregnant with my first baby I became severely ill: jaundiced, sharp right upper quadrant stomach pain, and intractable vomiting. My pregnancy up to this point had not been an easy one, continuous morning sickness wouldn't even allow me to take in fluids most days. I was already exhausted and scared before even being admitted to the hospital. My husband took me to the emergency department where it was discovered that I had a septic gallbladder full of stones that had to be removed as soon as possible. Over the next 48 hours I was told that the operation posed a grave risk to my baby and I should prepare myself for the worst. Not only was I in substantial physical pain (not wanting to take opioids for fear of what they would do to the baby), but now I was an emotional wreck (lots of tears) reeling with the uncertainty of 'our' outcome. Not one nurse

asked me how I was coping or if I needed support. No one even acknowledged that there were two of us in the bed-it was as if I was no longer pregnant.

Both of us came out the other side of the surgical experience, but it remained a cold, scary and isolating experience. I was moved three times within the first few hours after leaving the recovery room. I felt as if no one wanted to care for me. The excuses I overheard for why the staff couldn't manage my care included: because I was pregnant, because I had surgery, or because I had a patient controlled analgesic pump. When I eventually found a place that I could stay to recover, I didn't feel settled or safe. In addition to a typical postoperative recovery, I had to deal with preterm labor contractions, mandatory bed rest and painful steroid injections to mature my baby's lungs (to increase her survival chances) should she arrive early. I was asked to count and document my baby's movements hourly, and my obstetrician ordered twice daily fetal heart rate monitoring to ensure she continued to cope in utero. Consequently, I did not feel as if things were going to turn out very well. I was anxious and scared and became even more so when the nurses routinely forgot to arrange the fetal heart rate monitoring-a nurse had to come up from the labor and delivery department with the equipment. I felt as if I was a bother to the nurses when I called to request the fetal monitoring, as I heard exasperation in their voices, and saw frustration on their faces. During my ten day hospital stay, I rarely encountered a nurse. The nurses came into my room infrequently and spent only minutes with me; to check my vital signs, manage my intravenous infusions, and occasionally to administer medication.

This experience had a profound impact on how I recovered from both the surgery and the preterm labor experience. It took me a very long time to recover physically and emotionally, and to regain my trust in the health care system and the profession that I called my own. As a result,

I experienced substantial tension in my nursing work. I realized that I had to take a long hard look at my own practice as well, and many questions emerged. How am I contributing to my patients healing and their understanding of their illness experience? What does my practice look like to others? What impact does my nursing practice have on me and those around me (patients, families, colleagues)? What is going on in the work environment and in the practices of those around me that is affecting my practice? My experience as a patient changed my nursing practice and how I understood it (purpose, significance, and impact); and my practice continues to evolve through self-reflection.

Accordingly, I have come to understand how delicate maintaining a high level of nursing professionalism can be when working within highly stressful, emotionally and physically exhausting clinical situations and or work environments. In my work as a nurse educator I have observed student nurses, new and experienced nurses struggle with what it means to be a professional nurse.

Jane RN: A True Story

Jane (pseudonym) is a newly graduated registered nurse (RN) and a recent hire onto a fast paced, high acuity surgical unit. She received several weeks of dedicated one to one unit orientation and mentorship, followed by regular 'check-ins' with the clinical nurse educator (CNE). The 'check-ins' included asking her about her patient care plans, encouraging critical thinking, and offering guidance and or assistance. Upon seeing the CNE approach, Jane would turn red and giggle nervously. When the CNE asked about her patients (attempting to engage her in critical thought) Jane would giggle and say "they are fine". When asked if she needed assistance, Jane would say "no everything is fine, busy have to go". Jane's behavior was not

reassuring to the CNE or Jane's nursing colleagues. One of Jane's colleagues reported to the CNE that Jane was experiencing "difficulties in her nursing practice", and that she was concerned about patient safety. The CNE decided to investigate further. The first issue she discovered was that Jane did not adjust her patient's epidural infusion per the physician's order until two hours after the order was entered. The second issue the CNE uncovered was that Jane did not administer an ordered preoperative antibiotic to one of her patients. When the CNE spoke to Jane about these incidents, Jane laughed and said "oops I can't believe I forgot to give the antibiotic" and did not have an explanation for the delay in altering the epidural infusion. Moreover, Jane did not appear to understand the significance of delaying ordered changes to treatment regimens or omitting one altogether. The CNE reported that Jane had no insight into the impact of her care on the patients in question. Both the delay in providing care and the lack of insight into how this impacts her patients and the ordered plan of care are demonstrative of unprofessional conduct (CARNA, 2006).

Professional practice issues, like this one, are not uncommon, as evidenced by the disciplinary section [pages] of the monthly CARNA magazine. These professional practice issues often have significant ramifications for the individual nurse, their team or unit environment, and most importantly, the patients in their care. The question remains: why do we continue to struggle with professionalism (the manner in which we practice) despite education, regulations and standards? I think nurses need to keep thinking about, talking about, and researching professionalism as it relates to the discipline of nursing and nursing training. My personal and practice reflections on nursing professionalism instigated a detailed literature examination of what nursing professionalism is, why it's important, and to whom. Before

initiating further research, I needed to more completely understand how nursing professionalism was being discussed and defined within the nursing literature.

Review of the Literature: Nursing Professionalism

A systematic literature search was conducted using CINAHL, Google Scholar, and PubMed utilizing the following search terms: professionalism, nursing professionalism, professional values, professional culture, nursing culture, professional behavior, professional environment, significance of professionalism, and professional practice in different combinations. The search was limited to studies carried out from 1993 through 2013. Studies conducted in the 1990s and studies on physicians were included due to the diminutive number of research studies conducted on nursing professionalism to date. I established the following search limits: English-language articles published in scholarly journals that had been peer reviewed and described research regarding nursing professionalism. Further, I conducted an additional search based on the references cited in selected papers. Twenty two articles (out of 37) appeared to meet my criteria based upon titles and abstracts. After thoroughly reading each article, two were discarded for one or more of the following reasons: (1) the construct being examined was professionalization (2) the population studied was outside clinical nursing or medicine (3) the article did not describe research.

Professionalism and the Discipline of Nursing

For nurses, professionalism is far more than a definition, a notion, or a label. Professionalism is the image and essence of nursing that then becomes known by nurses, patients, families, colleagues, the media, and the public. Moreover, it becomes what nursing gives of itself to itself and to the populations we serve (Turkoski, 1995). How we understand our nursing work and subsequently how others understand it, is predicated on the fundamental goals

of a professional nursing practice. Nursing professionalism is foundational to achieving the primary goals of nursing practice: optimal patient outcomes, optimal patient satisfaction, and effective collaborative practice within health care delivery teams (AHS, 2008; CARNA, 2006; CNA, 2008).

Additionally, professionalism described in the current literature, as values and behaviors, has been identified as a core and expected competency by licensing boards, nursing associations, and health care agencies (AHS, 2008, 2010; CARNA, 2006; CNA, 2008). These three agencies (Alberta Health Services, College and Association of Registered Nurses of Alberta, and Canadian Nurses Association) are consistent in their expected attributes of a professional nurse that are then stipulated in their written practice and professional standard documents. To list a few: possess humanistic intent, practice ethical reasoning, demonstrate competent [safe and knowledge based in scope] practice, be a respectful communicator and an effective collaborative partner.

Moreover, professionalism has been incorporated into required learner outcomes within undergraduate nursing program clinical evaluation tools: "Students are prepared for the discipline and profession of nursing and its commitment to an ethical/social justice perspective and by way of this education program, develop particular skills, dispositions, and competencies to meet the standards of professional practice" (University of Calgary, 2013, p. 4). These learner outcomes provide guidance and support to our future colleagues in nursing as to what is expected of them when registered as professional nurse.

Professionalism and Patients and Families

Patient respondents to a study done by Coulon, Mok, Krause and Anderson (1996) described excellence in nursing as the patient being the center of concern. Further, this concern was grounded in practice delivered competently, humanistically, and collaboratively wherein professionalism comprehensively exemplified excellence in nursing care. The caliber of nursing care is the measure of the profession. Clarke (2007) found that the profession of nursing is further developed through its caring practices and that nursing professionalism is therefore exemplified in the different aspects of nurses 'caring practices; specifically, authentic and purposeful communication, focused attention to safe nursing practice; and being attentive and supportive of the physical and emotional needs of patients. "The professional act of caring is not only about what can be verified. It is also about the attachment of the carer to the human condition, to a philosophy of both the individual and the collective" (Drummond, 2003, pp.65).

Collaborative practice is emphasized in healthcare delivery models. AHS (2008) stipulated that the Registered Nurse (RN) works as one member of the health care team, collaborating to deliver comprehensive care that meets the needs of individuals, families and communities. Additionally, AHS expects that the RN collaborates and communicates effectively and respectfully with patients, families, and interdisciplinary team members in a manner consistent with the mission statement of the institution. The mission statement articulated by AHS utilizes the word culture to describe in detail the requisite values and behaviors essential to the organization, and therefore its ability to provide the best possible care to all in need of it. Furthermore, AHS expects that the values of respect, accountability, transparency, engagement, safety, continual learning, and a commitment to high performance standards guide all aspects of each employee's work. Therefore, when these values and behaviors are actualized in AHS

practice settings by AHS employees they become what the other (patients, families, the public) know the professional structure of AHS to be: the professionalism of AHS.

Professionalism and Nurses

Professionalism in nursing is predicated on continued competence in practice. Attention to continued practice competence is an ongoing component of professional practice (CARNA, 2006). CARNA (2006) defines competence as the ability of a nurse to integrate and apply the knowledge, skills, judgment and, personal attributes (attitudes, values and beliefs) needed to provide safe and ethical care. Furthermore, a necessary component of professional nursing practice is the personal accountability of nurses for their learning and continued practice competence; including the requisite knowledge, skills, attitude, and judgment to meet client needs (CARNA, 2006; CNA, 2000). According to Richards and Potgieter (2010) professionalism relies on nurses' ability to respond quickly to changing care conditions, client needs and to the influence of government or agency policies. Moreover, professional nurses are encouraged to embrace change and foster innovation (Richards & Potgieter, 2010). Therefore, new skills and knowledge (necessary to maintain practice competence) are essential tools for the nurse to adopt in order to achieve personal, professional, and organizational success. Albeit an important one, competence in performing the skills embedded in a nursing practice is only one element of professionalism, but an element that is continually included in the varying definitions that exist in the current literature.

Effective continuing competence education initiatives have been linked with raised staff morale and staff retention. Reasons given by nurses for engaging in continued competence education include; enhancement of professional knowledge, advancing professionally, providing

relief from routine, improvement of work relationships and increased self-esteem (Richards & Potgieter, 2010). Additionally, continuing competence education in nursing is accompanied by the development of leadership skills evidenced by the nurse's increased ability to: inspire others, effectively question, promote confidence in self and others and accept constructive critique (Ehrat, 2001 & Eustace, 2001). According to Smith and Topping (2001) continued competence education empowers nurses to stay effective in their jobs. Conversely, it could be posited that nurses who are not able or willing to maintain practice competence might feel helpless and potentially defeated. Nursing deals with complex human problems and as a professional discipline, should not limit itself to a bounded body of knowledge. The ongoing quest for knowledge is critical to the development of the profession; and subsequently the professionalism demonstrated by its members. The constantly changing features of nursing work and the environments in which it is completed, requires that nurses continually investigate existing knowledge and participate in new knowledge development (Richards & Potgieter, 2010). Further, Hoban (2005) suggested that neglecting continued professional development will inevitably result in a decrease in nursing credibility. It is clear from the literature, that professionalism is a large construct that is being used as an 'umbrella term', meant to capture and cover many other instrumental (and individually defined) concepts within the work of nursing.

Nursing professionalism is intimately connected to achieving the fundamental goals of a professional nursing practice: optimal patient outcomes, optimal patient satisfaction, and effective collaborative practice within health care delivery teams (AHS, 2008; CARNA, 2006; CNA, 2008). Subsequently, the professionalism of nurses is understood by nurses and others as

the essential and expected values and behaviors that are integral in the conduct of an effective professional nursing practice. Values and behaviors articulated as essential to and shared by a group of individuals can be understood as a culture (Suominen, Kovasin, & Ketolla, 1997; Thorne, 1997). Therefore, I propose that we need to consider nursing professionalism from a cultural perspective.

Culture of Nursing Professionalism

Culture is a construct that is defined and expressed in numerous ways depending on time and context. In nursing, culture finds expression in the learned and shared behaviors, values, language, practices, dress, and rituals of those who belong to the profession (Holland, 1993; Suominen, Kovasin, & Ketolla, 1997). In addition, a culture exists and perhaps evolves over time and in response to environmental changes. According to Assad (1986), nursing can be seen as a structure that is passed down from generation to generation that then becomes a shared history. Therefore, nursing professionalism can be understood as a cultural phenomenon because the construct of professionalism is comprised of and currently represented as shared value and behavioral attributes. I have chosen to discuss the current literature by thematic categorization: professionalism described as a combination of values and behaviors, behavior based professionalism, and value based professionalism.

Professionalism described as a combination of values and behaviors.

Several studies focused on identifying the values and behaviors associated with professionalism. Coulon, Mok, Krause, & Anderson (1996) conducted a qualitative study to explore the meaning of excellence in nursing care, utilizing a self-response questionnaire comprised of open ended questions. The sample consisted of 156 undergraduate and graduate

nurses living in Australia. Themes emerged within the data: professionalism, holistic care, and humanism. Further, the fourth theme comprised three sub-themes of enabling personal qualities, nurse patient relationships, and nurse-health team relationships. The overall conclusion of the study was that the patient or client is the central focus of excellent nursing care (Coulon, Mok, Krause, & Anderson, 1996). Excellent nursing care is described by these authors and others (Clarke, 2007; Drummond, 2003) as exemplified by: 1) the authentic and engaged presence of the nurse; 2) the safe, efficient, and competent completion of nursing tasks; 3) respectful and consistent communication; and 4) care that is organized and conducted effectively within collaborative teams.

Another qualitative study conducted by Ohlen & Segesten (1998) was designed to elucidate the concept of the professional nurse identity to promote theoretical clarity and examine implications for nursing practice. The authors conducted semi structured interviews with eight Swedish informants: six female and two male registered nurses. Comparable to Coulon, Mok, Krause, and Anderson (1996) the data collected by Ohlen and Segesten yielded similar findings concerning professional values. Ohlen and Segesten found that professional values such as compassion, confidence, conscience, commitment, and courage contributed positively to the behaviors of nursing competence and professional role socialization.

A quantitative study conducted by Baumann and Kolotylo (2009) aimed to develop and test a questionnaire intended to determine key personal attributes and key environmental attributes that influence the professionalism of Canadian nurses in practice environments: The Professionalism and Environmental Factors in the Workplace Questionnaire (PEFWQ). The PEFWQ is an 82 item 5-point Likert Scale instrument containing several subscales generated by

the researchers, after consultation with experts, and a thematic analysis of the literature. Results indicated nurses believed the behaviors that influence nursing professionalism are autonomy, knowledge, competence, accountability, advocacy, collaborative practice, and commitment to practice (Baumann & Kolotylo, 2009).

Behavior based professionalism.

A number of studies focused on discovering the behaviors associated with professionalism. Miller, Adams, and Beck (1993) described the development of an evaluative behavioral inventory based on Miller's Model for Professionalism in Nursing. The Professionalism in Nursing Inventory (PNI) was mailed to 1,600 randomly selected RNs working in eight western United States, resulting in only 515 usable inventories. Results indicated that the majority of respondents demonstrated professional behaviors by participating in continuing education activities, quality assurance initiatives, community service, and by implementing a theory or evidence based nursing practice (Miller, Adams, & Beck, 1993).

Kim-Goodwin, Baek and Wynd (2010) quantitatively studied professionalism among Korean American RNs using Hall's Professionalism Inventory (HPI) scale: a 25-item scale that includes five subscales with possible scores ranging from 25-125. The authors utilized a convenience sample of 221 Korean American RNs living and working in the United States. Behavioral factors found to be contributory to professionalism were membership in professional organizations, current nursing employment, certain work settings, nursing experience, location of final degree attainment, and duration of nursing education in the United States.

A study conducted by Adams and Miller (2001) investigated behaviors indicative of professionalism in nurse practitioners. 1,624 nurse practitioners representing all of the United

States and the most common specialties of nurse practitioners completed the Professionalism in Nursing Behaviors Inventory (PNBI), while attending a national conference. The PNBI is a forty-eight item instrument adapted by the authors for use with Nurse Practitioners in 1998. Educational preparation, regular publication of work, conduction of research, membership in professional organizations, participating in community service, maintaining competence, adherence to the Code of ethics, autonomous practice, and engagement in evidence or theory based practice were articulated as professional behaviors .

Value based professionalism.

In Weis & Schank (2009) the research objective was to examine the psychometric properties of the Nurses Professional Values Scale- Revised (NPVS-R) utilizing a random sample of student nurses and practicing nurses. The NPVS-R is a 26-item Likert-scale format instrument ranging from 1 (not important) to 5 (most important) derived from the American Nurses Association (ANA) Code of Ethics for Nurses. Each item in the NPVS-R is a short descriptive phrase reflecting a specific ethic within the ANA code of ethics and all items are phrased in the positive direction with none reversed scored. Weis and Schank utilized a sample of 782 subjects including baccalaureate nursing students (n = 404), graduate nursing students (n = 80), and practicing nurses (n = 298). Results of this study indicated that student nurses and RNs valued caring, activism, trust, professionalism, and justice.

Fagermoen (1997) conducted a two phase comprehensive mixed method study on a nurse population to answer the question: What are the values underlying nurses' professional identity as expressed through what is meaningful in nurses' work? The randomly selected sample was comprised of Norwegian nurses with one, five, and 10 years of nursing experience. The survey

questionnaire and one short answer question were mailed out with data collection points in 1980, 1985, and 1990. According to the author 731 responses were received and included three cohorts: nurses with one (n = 245), five (n = 251) and 10 years (n = 235) experience in nursing. The second phase investigated the impact of identified professional values on the meaning of nursing work with data obtained from a convenience sample of six nurses. In-depth semi structured interviews were conducted to elicit patient care narratives (Fagermoen, 1997). Survey results demonstrated alignment across the cohorts on two specific values: other-oriented values or moral values, self or work oriented values. According to Fagermoen, human dignity and altruism were the most prominent moral values and intellectual and personal stimulation were the most significant self or work values. Furthermore, Fagermoen concluded that the other values of hope, trust, privacy, security, autonomy, personhood, and humanity were linked to human dignity either by arising from it and/or being aimed at preserving this basic value. Narrative data revealed that all six nurses consistently approached their nursing practice in a creative, flexible, and patient responsive manner valuing the importance of trust building, attentive listening, sensitivity, presence, and reassurance. In addition to these interactive strategies, professional value-actualization took place through the work of nursing: delivery of safe, competent, and comforting care.

Nursing research indicates support for the proposition that nursing professionalism can be understood as a culture comprised of shared values and behaviors. From the current literature we know that the shared values most articulated and agreed upon by nurses are altruism, trust, advocacy, and dignity. Further, we know that nurses articulate professional behaviors such as respectful communication, maintenance of competent skill performance, effective collaboration,

and involvement in professional organizations with the most frequency. Therefore, an examination of how nurses as a group understand and demonstrate nursing professionalism in practice is warranted.

The View from the Starting Line

I believe that the best place for me to begin an examination of nursing professionalism is with our future nursing colleagues. Fourth year nursing students have just spent the most concentrated and comprehensive amount of time focused on understanding what it means to be a nurse. Additionally, this group is about to transition into independent practice, with the expectation that they do know (at entry to practice level) what it means to be a nurse and do the work of nursing (AHS, 2008; CARNA, 2006). However, this time of transition to the professional role of the registered nurse is often described as highly stressful. According to Boychuk-Duchscher (2009) the new graduate nurse experiences a transition period that can include negative sequelae ranging from mild anxiety and discouragement to marginalization and even transition shock. Moreover, Boychuk-Duchscher stated that educational preparation and the culture of the work environments that new graduate nurses' transition into are important predicting factors for success or struggle. Another significant reason for studying the experience of student nurses is to uncover what professional values, attitudes, and behaviors they are going to exhibit and teach in their future professional lives. Additionally, helping them to describe their experience of professionalism can be an early step in identifying potential problems and eliminating them. Therefore, the fourth year student's experience of nursing professionalism is relevant in both timeliness and significance; however, an examination into what is already known about student nurses and professionalism is required.

Students and Nursing Professionalism

I searched the CINAHL, Google Scholar, and PubMed databases using the following search terms: student nurse professionalism, student professionalism, professionalism and student nurses, and learning and professionalism in varying combinations. I established the following search parameter: research conducted with student nurses, English-language articles published in scholarly journals that had been peer reviewed and described research regarding nursing professionalism. The search yielded eight articles outlining research endeavors conducted between 1997 and 2013.

Several quantitative studies focus specifically on student nurses and professionalism. Weis and Schank (1997) conducted a quantitative comparative study of 80 randomly selected American and 50 English first year student nurses to determine if professionalism could be understood across cultures. To accomplish this they utilized the Professional Values Scale (PVS), a 44-item instrument with a Likert scale format. The PVS is based upon the 11 value statements found in the American Nurses Association (ANA) Code for Nurses that focus on professional issues such as patient rights and nurse responsibilities, and social issues such as responsibilities of the profession (Weis& Schank, 1997). These authors found that overall, American and English students were similar to each other in identifying the importance of professional values reflected in the ANA Code for Nurses.

A confirmatory factor analysis (CFA) was conducted by Çelik, Karadağ, and Hisar (2011) to confirm the identified factor structure of the Instrument of Professional Attitude for Student Nurses (IPASN) developed by Hisar et al. (2010). The IPASN is a 28 item Likert scale format questionnaire grouped according to 8 different factors: contribution to research,

autonomy, cooperation, competence and continuous education, participation in professional organizations and professional development, working in committees, community service, and ethical codes and theory. CFA was performed using 1039 voluntary students from 23 randomly selected nursing schools in Turkey. The IPASN was found to be theoretically and statistically appropriate for measuring student professionalism, and consequently it is recommended that this tool could be used for future Turkish research, or adapted for use in other cultures (Çelik, Karadağ, & Hisar, 2011).

A study conducted by Lui, Lam, Lee, Chien, Chau, and Ip (2008) aimed to discover student nurses' perceptions about the Code of Professional Conduct for Nurses in Hong Kong. They mailed out a self-administered survey questionnaire to a convenience sample of fourth year nursing students, two hundred and sixty-three were returned. The questionnaire consisted of four parts: in part 1, respondents were asked to prioritize the eight aspects of the professional code of conduct; in part 2, respondents rated their perceptions on the importance of each of the 39 items of professional conduct using a 6-point Likert scale, in part 3, they rated the degree of difficulty in achieving each item using a 6-point Likert scale, and in part 4, their demographic data such as age and gender were collected (Lui, et al., 2008). These researchers found that providing safe and competent care to clients was the most valued item of the code, while fostering a therapeutic relationship with patients and families was one of the least valued items.

Additionally, there have been several qualitative studies focused on student nurses and professionalism. To understand the student nurses' lived experience of nursing education in the northern United States and identify educational practices that support students' professional formation, Del Prato (2013) conducted phenomenological interviews with 13 participants. Del

Prato discovered that Faculty incivility including demeaning behaviors and language, subjective evaluation, rigid expectations, and targeting or weeding out practices inhibited student learning, lowered student self-esteem, and consequently hindered the students' ability to formulate a professional identity.

A phenomenological study was conducted by Keeling and Templeman (2013) to explore fourth year nursing student's perceptions of professionalism in the United Kingdom. These researchers conducted a focus group and five one to one semi structured interviews with ten study participants. Through thematic analysis Keeling and Templeman found that student nurse's perceived vulnerability, symbolic representation, role modeling, discontent, and professional development as elements that informed their professionalism. Moreover, they found that being able to observe the behaviors (both positive and negative) of registered nurses in clinical environments was significant to student nurses in the development of their own sense of professionalism.

Anderson and Kiger (2008) conducted a qualitative study in the United Kingdom to discover the experiences that ten student nurses in their final year had while working on their own in community placements, and what these experiences meant for them. Their findings revealed that students experienced the role of a 'real nurse' and this enabled them to build confidence, develop professionalism in relationships, learn how to manage care, develop knowledge and insight, and feel included and supported within the discipline.

The current literature also includes ethnographic study of student nurses and professionalism. Lundberg and Boonprasabhai (2001) utilized ethnographic interviews and observation to uncover the meanings of good nursing care among twenty female last-year

undergraduate nursing students in Thailand. Findings revealed six categories: 1) compassion; 2) competency; 3) comfort; 4) communication; 5) creation; and 6) courage (Lundberg & Boonprasabhai, 2001).

Williams, Spiers, Fisk, Richards, Gibson, Kabotoff, McIlwraith and Sculley (2012) conducted a focused ethnography to understand how new graduate nurses in Alberta, Canada, describe the contribution of their education experience to their professional practice development utilizing the Problem Based nursing technique. The researchers conducted one to one interviews and focus groups with 45 participants, revealing that graduates described themselves as self-aware and self-directed critical thinkers, patient advocates, holistic practitioners, and effective members of collaborative teams.

All of these studies are relatively current and have examined different facets of student nurse professionalism, either quantitatively or qualitatively. Consequently, we know that student nurses are thinking and learning about professionalism, and nurse researchers are beginning to ask questions concerning this knowledge. However, there is more to uncover about how student nurses define or more comprehensively describe nursing professionalism.

The Gap

All of the quantitative studies detailed above utilized instruments that provided the participants with the professional values and behaviors under investigation. Subsequently, the students did not have to describe professionalism using their own language, ideas, or experiences. Moreover, these quantitative studies did not analyze how the particular environments in which participants learn and work in might influence their responses. Finally,

of note is that all of the quantitative studies presented above were conducted outside of Canada, within the context of diverse health care and educational systems.

The phenomenological studies I have outlined were all conducted outside of Canada. Studies conducted in the United Kingdom by Anderson and Kiger (2008), and Keeling and Templeman (2013) yielded rich descriptions of how student nurses lived the experience of professionalism and role socialization. However, they did not give us insight into professionalism as a culture within Canadian environments in which nursing work is learned and practiced. Del Prato's (2013) study findings focused on the educational barriers to a positive lived experience of nursing professionalism for student nurses. I agree with her inclusion and analysis of the environmental impact on professionalism, but what is missing is a description of how students experience nursing professionalism as a collective.

Williams et. al, (2012) conducted a recent Canadian ethnographic study evaluating the impact of a particular method of providing nursing education on professionalism. This is an interesting study about the import and impact of teaching methodology, but not specifically informative about the students experience of nursing professionalism or how they came to understand professionalism.

The results of Lundberg and Boonprasabhai's (2001) ethnographic study are of particular interest to this research. However, they language their findings as 'good' nursing care not professionalism or professional nursing care. This could be because this study was conducted in Thailand, where the term professionalism may not have any meaning while in fact we may all be talking about the same thing. Subsequently, we cannot know this for sure.

In summary, the majority of studies investigating student nurses and professionalism have taken place outside of Canada. Moreover, a good number of the studies were quantitative in nature, providing participants with defined parameters of professionalism rather than seeking the participant's descriptions. The qualitative studies that have been conducted do provide abundant data regarding certain facets of professionalism. However, none of the included studies have specifically focused on uncovering a description of the culture of professionalism experienced by fourth year nursing students within the context of western Canadian education and health care systems.

The Research Question

In response to the gap in research identified above, I conducted research to discover how fourth year nursing students at the University of Calgary, Canada describe and experience nursing professionalism. A second objective of my research was to determine if persons about to begin their professional nursing practice understood nursing professionalism in a shared manner; and if so, how they came to share this knowledge. To effectively achieve these objectives, I initiated a cultural examination of nursing professionalism with fourth year nursing students who are just beginning to explore the role of the nurse and experience the professional socialization process. The overarching question I wanted to answer was: How do fourth year nursing students at the University of Calgary describe nursing professionalism, and how was it learned and shared within the context of classroom and clinical practicum environments? Additionally, I examined how the classroom and clinical practicum contexts affected the student nurses' experience of professionalism. It is important to note that I was not able to account for the

difference that gender, race, age, or varying economic status may have made to my study findings because my eight informants were all female, were of similar age, and economic status.

Nurses as members of a recognized and regulated profession form a collective group, expected to conduct themselves at specific and articulated standards. Moreover, the CNA (2008) stipulated that nurses are evaluated by shared and internalized professional values, behaviors, and beliefs. This then substantiates a cultural examination of nursing professionalism when defining culture as human experiences, beliefs, patterns, and ways of living or being (Thorne, 1997). Ethnography is a qualitative research paradigm centrally concerned with the cultural meanings humans develop and utilize to comprehend and experience the world in which they live (Aamodt, 1991). Ethnographic history, philosophy, and methodology are congruent with my research question, and therefore my chosen method of inquiry.

My Understanding of Nursing Professionalism

Prior to discussing the research I conducted and my subsequent findings, I need to be clear about the conceptualization of nursing professionalism that my personal experiences and professional inquires have given rise to. I believe that nursing professionalism is an umbrella term, as suggested in the literature. It is a 'catch all' concept aimed at including all of the professional practice standards, and expectations of licensing agencies and health care delivery organizations. I do agree that nursing professionalism can be understood as shared values and behaviors. However, I don't agree with all of the values, behaviors, concepts, and practices that have been included in the definitions/understandings of nursing professionalism that currently exist in the literature. I think these vast and ambiguous definitions of nursing professionalism lead to confusion, and overwhelm nurses when they try to demonstrate professionalism in

practice. Instead, I have come to realize that nursing professionalism can be understood more simply. Nursing professionalism is about what a nursing practice means to a nurse-how they conduct their practice, and what it then looks like and feels like to those around her/him.

Chapter One Summary

In chapter one I have outlined the background supporting my research question, discussed the current understanding of nursing professionalism reflected in the literature, and substantiated a cultural examination of nursing professionalism as described by fourth year nursing students, and outlined my current understanding of nursing professionalism. In chapter two I will present my method of inquiry, and discuss how ethnography best enabled me to explore how fourth year nursing students understand and demonstrate nursing professionalism. In chapter three I will introduce the reader to the study environments, the key participants, and present an understanding of how fourth year nursing students understand and demonstrate nursing professionalism. Chapter four is dedicated to discussion of my findings, how they fit within the current literature, and the new knowledge they contribute. In closing, chapter five will include a discussion of the limitations of my study, and a presentation of my recommendations for nursing practice, education and research.

Chapter Two: Researching the Question: How Do Fourth Year Nursing Students Describe Nursing Professionalism?

Exploring student nurses' understanding of nursing professionalism and its demonstration in clinical practice has been a rewarding and enlightening experience. To robustly describe their understanding of professionalism and best learn how their understanding evolved, choosing the most appropriate research method was profoundly important. I present ethnography as an appropriate research methodology for understanding fourth year nursing students' experience of nursing professionalism. Ethnography, a qualitative research methodology, not only allows the researcher to discover a group's shared values, meanings, behaviors, and attitudes, but yields rich and complex data. A focused ethnographic inquiry, asking " How do fourth year nursing students at the University of Calgary describe nursing professionalism, and how was it learned and shared within the context of classroom and clinical practicum environments?" revealed cultural values and beliefs that serve as a guide for practice. This chapter begins with an outline of ethnographic methodology, including the data collection methods, ethical considerations, the setting, the participants, and techniques for analysis. Additionally, I will discuss maintaining trustworthiness and the writing of an ethnography.

History of Ethnography

Ethnography is considered to be the oldest of the qualitative research paradigms. According to Roberts (2009), ethnographic methodology has been used since ancient times when the Greeks and Romans wrote descriptions of the cultures they encountered. Within the literature, it is argued that Herodotus is the first Greek ethnographer who wrote the first ethnography; The History (Willis & Trondman, 2002). Herodotus (Trans. Greene, 1987) said

when referring to his own work, "so far it is my eyes, my judgment, and my searching that speaks these words to you" (p. 171). Other authors also recognized the contribution of the Roman Tacitus and his detailed ethnographic work on the ancient Germans and Gauls: Germania (Gudeman, 1900; Rutledge, 2005). One problem that ancient ethnographical accounts present is that there is often no way of verifying the accuracy of the information. At times, only archaeology can confirm or deny what ancient ethnographers have claimed (Willis & Trondman, 2002).

The contemporary historical roots of ethnography lie within the disciplines of anthropology and sociology. Since the advancement of ethnography by Malinowski in the 1920s, with his dedication towards describing the natives' point of view, ethnography has become the foundational research method for anthropologists (Payne, Dingwall, Payne & Carter, 1981). Early anthropological ethnographies, emphasized "the neutrality and authority of the ethnographers gaze from a distance" (Hammersley & Atkinson, 1993). Today ethnographers seek not only to describe, but understand what is occurring culturally, by immersing themselves in the study environment. Ethnography emerged within Sociology in the early 1920s and was known as the 'Chicago School'; an influential subgroup of sociologists who wrote several ethnographies of social scenes within the urban context of Chicago (Short, 1971). The 'Chicago School' sociologists were greatly influenced by the theory of symbolic interactionism; a process for studying human group life and human conduct (Blumer, 1969). Today, sociologists continue to utilize ethnography in various ways depending on their philosophical perspective; phenomenology, ethnomethodology, and symbolic interactionism to name a few (Mackenzie, 1994). The history of ethnography identifies the foundational disciplines from which it emerged.

Exploration of the philosophical perspectives underpinning these disciplines and therefore ethnography is necessary prior to applying the method to a study of nursing professionalism.

Philosophical Foundation of Ethnography

All research is based upon philosophical beliefs about the world. Philosophy is comprised of epistemological and ontological claims regarding the central concern of a scientific discipline (Fawcett, 2000). Epistemology articulates what is considered truth or knowledge and how this is known, whereas ontology deals with what is considered 'real' and how this 'reality' is understood by members of a particular scientific discipline (LoBiondo-Wood & Haber, 2009).

Ethnography is largely understood as an interpretative qualitative method, grounded in the methodological framework of naturalism, and is concerned with describing how people respond to, live within, and interpret their social world-their specific culture and environment (Aamodt, 1991; Hamersley & Atkinson, 1983; Schmoll, 1987). Since the central precept of interpretivism is that people are constantly in a cycle of interpreting and responding to their changing environments, interpretivist researchers believe that people construct their social worlds (Williamson, 2002). Constructivists believe that reality is ever changing and that in fact, multiple realities exist (Denzin & Lincoln, 1994). The aim, then, of constructivist research is to develop a humanistic perspective of how realities are formed by the population. That is to say, 'truth' or knowledge is constructed by individuals within the population. Further, constructivists seek to understand how these realities are influenced by social, political, cultural, economic, ethnic, and gender values (Denzin & Lincoln, 1994). Ethnographic techniques (interviews, focus groups, observation, and document exam) are well suited to constructivist frameworks as they afford the researcher the opportunity to elicit the perceptions, meanings, behaviors, and

experiences of key participants and provide rich descriptions of them (McGregor & Williamson, 2005; Williamson, 1997).

Ethnography, like anthropology is centrally concerned with studying the concept of culture from both the emic and etic perspectives. The preferencing of one view over the other depends upon the philosophical framework guiding the ethnography. Emic (insider) is defined as the insider or native's view of the world, whereas the etic (outsider) view is created by the researcher during observation of and participation within the environment (Lobiondo-Wood & Haber, 2009). In the midst of conducting my research, I became aware that the situations I was observing and participating in were neither completely foreign nor familiar. Resultantly, my perspective and application fluctuated between the etic and emic views, and so did my status as an insider or outsider within the different study environments. I suspect this shift was directly correlated to the fact that I too am a nurse, observing the work of other nurses.

Culture is defined in numerous and widely divergent ways within the current literature. For this research, I subscribed to the definition that culture is comprised of the values, beliefs, and behaviors shared, understood, and organized by a group of people in a specific setting (Goodenough, 1976): students in an undergraduate nursing program. Symbolic interactionism theory created within the field of sociology shares common philosophical perspectives with ethnography. The theory of symbolic interactionism is complex and is centered on; the meanings people give to 'things' encountered in everyday living, how these meanings affect behavior, and how these meanings change over time (Blumer, 1969). Ethnography is also centrally concerned with meaning and the lived experience of it; cultural meaning. My personal nursing practice philosophy is congruent with ethnography's philosophical perspective. I too am

constantly looking for meaning in the beliefs, values, and behaviors of myself, patients, families, and colleagues.

Health researchers use ethnography to produce knowledge with the goal of improving practice (Holloway & Wheeler, 2002). I shared this goal as I moved forward with my ethnographic study of professionalism. Exploring the philosophical foundations of ethnography afforded me a deeper understanding of the knowledge I sought; a shared understanding of professionalism that could be taught and learned within undergraduate nursing programs and then ideally carried forward into workplace environments. To conduct a meaningful and purposeful ethnography, I first needed to understand and appropriately apply ethnographic methodology.

Methodology of Ethnographic Research

It is easy for the novice researcher to confuse methodology with method. Methodology is commonly organized around the inherent philosophy and is often articulated as foundational characteristics for how researchers obtain the knowledge they seek (Roberts, 2009). The emphasis of ethnographic methodology is obtaining cultural knowledge. The literature includes numerous studies identifying cultures within health care. To illustrate, Tutton, Seers and Langstaff (2008) conducted a study that identified and described a professional nursing culture on a trauma unit. Therefore, ethnographic methodology is well suited to my research inquiry focused on whether nursing professionalism could be understood as a culture. I will outline several foundational characteristics of ethnographic methodology, the essence of which is to gain an understanding of how people experience their culture, world, or working environment from the emic perspective. However, to uncover the emic view, the etic perspective is utilized. A

fundamental methodological characteristic of ethnography is the concept of researcher as the primary research tool, intimately involved for varying lengths of time within the research field. Interviewing, observation, construction of field notes and examination of cultural artifacts are ways that researchers become the instrument (de Laine, 1997; Streubert & Carpenter, 2011). Ethnographic researchers become immersed within the group under investigation in order to identify, interpret, and analyze the cultural elements from the insider's or emic perspective (Varcoe, 2003). An important research objective for ethnographic field work is to examine the effect of context or environment on the native's cultural understanding and behavior (Murphy & Dingwall, 2007).

Another essential characteristic is the ethnographer's primary concern for culture and the nature of culture. The focus of ethnography is not on isolated individuals; the focus is on individuals in relation to their world, home or work environments, and unifying culture (Clark, 2000). This then allows for an understanding of the values, meanings, and behaviors of a group within a cultural arena, such as students within an undergraduate nursing program. Studying culture is cyclic in nature. The answer to one question leads to another question and therefore an ethnographic researcher is engaged in an ongoing process of data collection, interpretation, and analysis (Streubert & Carpenter, 2011). Consequently an ethnographic study is never fully complete because all cannot be known about a culture. It ends due to limiting constraints such as time and money.

A final fundamental methodological characteristic is the presence of reflexivity, a term having a widely divergent range of connotations. Essential elements that comprise the term reflexivity are: understanding that the researcher's subjectivity is embraced and exploited, this

subjectivity affects the population studied and the interpretation of the data, and recognition that the researcher will be affected by immersion in the study field (Allen, 2004). According to Roberts (2009), reflexivity is the struggle an ethnographic researcher endures when managing the contrary realities of immersion within the field and the objectivity needed to establish trustworthiness and validity of the research findings. Adopting a reflexive approach enables participants and the researcher to explore together the meaning of what was observed. Consequently, I was continually mindful of my own experiences, beliefs, and values and how they could potentially influence my ethnographic study of professionalism. Moreover, I adopted a critical stance and open attitude during data collection; the purpose of which was to challenge my assumptions about nursing professionalism and to guard against unconsciously influencing data collection and/or analysis. The philosophical and methodological frameworks of ethnography presented above, became the foundation for my focused ethnographic inquiry into nursing professionalism.

Focused Ethnography in Nursing Research

In the last decade focused ethnography has been increasingly utilized in nursing research. It is of particular value to nurse researchers who explore a distinct phenomenon within a specific context, wherein the study population is a small group of people living within a larger community (Roper & Shapira, 2000). In my study the smaller group was comprised of undergraduate nursing students at the University of Calgary, who functioned within the larger communities of all student nurses and registered nurses in the city of Calgary. According to Roper and Shapira (2000) focused ethnography uncovers the meaning that members of a

subculture or group assign to their experiences and enables researchers to study the practice of nursing as a cultural phenomenon.

Focused Ethnography

Ethnography can be applied to healthcare issues in numerous ways as there are differing forms of this investigative approach. Masters level research is limited by time and resources such as money and personnel. Therefore, conducting a focused ethnography was the appropriate methodology to respond to a thesis question aimed at uncovering the shared experience of nursing professionalism held by fourth year nursing students. According to Spradley (1980) the scope of an ethnographic study can range along a continuum of macro- ethnography to micro-ethnography (cited in Woodgate, 2000 p.198). Micro-ethnography, known as focused ethnography, is less intensive, occurs over a much shorter period of time, fewer ethnographic methods are used, and focuses on a distinct topic of inquiry within a single social context (Spradley cited in Woodgate, 2000, p.198; Streubert & Carpenter, 2011). Further, Muecke (1994) described other characteristics of focused ethnography including: 1) conducted from the conceptual perspective of one researcher; 2) involves a limited number of participants; 3) episodic participant observation rather than complete submersion; and 4) used effectively within academia and health care services. Important to note that since focused ethnography is born of classic ethnography, it shares the same history and guiding philosophical and methodological frames described earlier.

The research process.

Method comprises the procedural steps for data collection and data analysis (Brewer, 2000). The researcher begins by selecting the participants for the study. In ethnographic

language, participants are referred to as key informants: individuals having extensive knowledge and experience with the subject matter (Woodgate, 2000). Before I entered into data collection with my key informants, I obtained ethics board approval and informed consent from each study participant. The notion of informed consent for ethnographic studies is complicated by the nature of the emerging, often evolving research focus and consequently the research design (Murphy & Dingwall, 2007). Therefore, I continually re-established the consent of my key informants during the data collection phase.

I incorporated the following ethnographic data collection methods in my focused ethnography of nursing professionalism: one to one interviewing, a focus group discussion, observation with field notes, and examination of pertinent curriculum documents.

Recruitment and Sampling Plan

For ethnographic research it is recommended that researchers choose a small number of participants who have "first-hand experience with a culture, social process, or phenomenon of interest" (Speziale & Carpenter, 2007, p. 29). A common sampling procedure for qualitative inquiry is a combination of purposive and convenience sampling methods. Purposive sampling identifies individuals who share common experiences, understandings, and particular knowledge about a specific phenomenon, occurrence or event. Moreover, purposive sampling is an iterative process designed to elicit data that is rich in description (Lobiondo-Wood & Haber, 2009 & Loiselle & Profetto-McGrath, 2011). Convenience sampling is a widely used, inexpensive nonprobability sampling strategy that uses the most accessible persons as study participants (Lobiondo-Wood & Haber, 2009 & Loiselle & Profetto-McGrath, 2011). Since I was interested in 'beginning at the beginning' with my examination of nursing professionalism, I sought entry

into a fourth year undergraduate nursing seminar and clinical practicum course. As a Masters student at the University of Calgary, I had convenient access to engaging and working within the undergraduate nursing program. My sample plan was purposive in nature because I believed that student nurses share the experiences, understandings, and cultural knowledge of nursing professionalism that I endeavored to uncover.

Before beginning recruitment I obtained approval from a Research Ethics Board (REB) and permission from the Faculty of Nursing (see Appendix A) to conduct research with students enrolled in the undergraduate nursing program. With the assistance of my faculty advisor, I was introduced to one of the faculty mentors, who would be guiding a group of fourth year nursing students through their final practicum. After meeting with her and outlining my research, I arranged to attend her next on-campus seminar session with her student group. During this session I was introduced to the group of 12 students. I was given time to present my research, outline the informed consent procedure, and request their participation. I successfully recruited eight fourth year students by the end of the seminar session, held in early January, 2014. All participants received information about the nature of the study and I obtained informed consent from each individual prior to initiation of data collection (see Appendix B). Each participant was informed of their right to withdraw from the study if they saw the need to do so. Moreover, informed consent included disclosing to all participants that I intended to discuss and write about the data obtained; however, the privacy and confidentiality of all participants would be strictly maintained. I disclosed that I would secure data in a locked or password protected environment and that once my work with the data concluded, it would be confidentially disposed of or deleted. I also made it clear that declining to participate, or withdrawing their participation

would not impact an individual's evaluation, academic grades, or employment. Additionally, the consent form detailed the risks and benefits of participating and what would be required of each participant. The inclusion criteria for my study were: 1) must be registered as a full time undergraduate nursing student; 2) must be fluent in English; and 3) must be enrolled in both seminar and clinical practicum courses. Conversely, anyone not meeting these inclusion criteria was excluded. I also obtained a signed informed consent form from the Faculty Advisor working with my participants in the final preceptorship seminar course (see Appendix C).

Prior to observing study participants in clinical environments (units) within Acute Care Hospital settings, I obtained permission from the management of each unit (see Appendix D). An information sheet was provided to unit management and posted on the unit when I was present observing the study participant (see Appendix E). This document outlined the study objectives and made it explicit that no data would be collected about unit staff or patients. Additionally, the information sheet detailed that verbal consent would be obtained from unit staff and patients prior to observations that included them.

Ethical Implications

An important aspect to be considered regarding ethnographic interviews is the intimacy shared between interviewer and the key informants. Key informants often reveal sensitive information face-to-face that they would not have revealed in an anonymous environment (Sorrell & Redmond, 1995). Ensuring sufficient time for rapport development and maintenance is an important responsibility of the interviewer. According to Sorrell and Redmond (1995), allowing information sharing at the beginning of and during the interview is a technique frequently utilized to establish rapport and provide a comfortable interview environment.

Closure at the end of the ethnographic interview is another important consideration. The researcher must ensure that time spent with key informants and participants within the studied culture, comes to a deliberate and thoughtful ending (Labaree, 2002). Moreover, the researcher must ensure that, if needed, key informants have access to support services as difficult emotions surface during the research process research process (J. Rankin, University of Calgary, Nursing 683 lecture, March 7, 2011).

Another potential ethical issue that I was mindful of was the potential for the participants to fear or experience negative social or evaluative repercussions from their nursing colleagues and professors, as a result of the content and contexts of their responses. Management of this potential issue would require diligent preservation of each participant's privacy and strict confidential maintenance of all data. To avoid this issue, I continually re-established the informed consent of each participant including disclosing how the data would be protected, utilized, disseminated, and eventually disposed of. Moreover, participants were told that they could withdraw from my study at any time without recrimination. One participant chose to withdraw late in the study, due to personal circumstances; I did however retain the data she had already provided with her knowledge and consent.

It was also a possibility that while observing within clinical or classroom environments I might witness a participant of my study or someone outside the focus of my study engaging in unethical or questionable behavior. According to Spradley (1980) researchers should first protect the rights and interests of their study participants. Subsequently, if the safety or wellbeing (physical, emotional, or otherwise) of my study participants was being compromised, I would have disclosed the incident to my advisory team. However, no such circumstance arose

during the conduction of my research. As an RN I am ethically bound to report unprofessional and or unsafe practice (CNA, 2008). Therefore, if during participant observation in clinical settings, I had witnessed a study participant conducting themselves in an unsafe or unethical manner, I would have reported it to their Faculty Advisor. In addition, if the study participant's actions impacted patients or staff within the clinical area, I would have reported it to the unit management as well. Additionally, if during participant observation, I observed a staff member engaging in unsafe or unethical behavior, I would have reported it to the unit management. Thankfully, none of these unfortunate circumstances occurred.

Preparing to Enter the Field

I felt both enthusiastic and apprehensive about beginning my thesis research. My uncertainty stemmed from diminished confidence associated with feeling like a 'stranger in a strange land', with an agenda to accomplish. Through self-reflection I asked and sought answers to the following questions: 1) How do I increase my confidence about fitting into the culture of fourth year nursing students I am interested in studying?; 2) How do I develop the necessary trust with my study participants, and further the unit staff of the clinical placements assigned to my study participants?

The following quote perfectly and quite eloquently outlined my concerns about the research I was about to conduct: "I wondered whether they would regard me as an outsider who might have difficulty understanding their situations and experiences and also whether they would perceive what I was trying to achieve as worthwhile" (Sword, 1999, p.272). This quote brought me great comfort to know that I was not alone in my concerns and apprehensions. Gaining access to or entry into a culture under investigation is primarily about the researcher gaining the

trust of the persons within the culture, and their acceptance to be among them (Labaree, 2002; Sword, 1999). To successfully gain entry it is imperative to engage participants and begin developing trust and rapport right from the beginning. Strategies I employed to accomplish this task included: 1) being authentic and honest about who I am as a person and nurse-sharing my experiences and knowledge, 2) being transparent about my research purpose, 2) conveying authentic interest in the lives and experiences of my study participants, 4) initiating all interactions with casual conversation (Sword, 1999 & Kowalsky et al, 1996). Gaining access during qualitative inquiry is a human process; one in which humanity, its uniqueness and unpredictability, must be respected and preserved. Consequently, the "be yourself" advice offered by Kowalsky et al, (1996), was my predominant focus when working with my key informants in the field.

Additionally, I was concerned with what impact I would have on my key informants, after I was invited into a place of acceptance and trust. Ethnographers are interested in unearthing the emic perspective, the way in which the key informants understand the phenomenon of inquiry (Lobiondo-Wood & Haber, 2009). As such I needed to protect the emic view from contamination with my own values, behaviors, or views. I paid particular attention to how I was phrasing questions, how I was responding to their questions, and to how I behaved during shadow observations. I found that keeping myself removed (observer, not participant) was a challenge, and fatiguing at times. It required a great deal of focused thought and restraint to not voice my ideas and opinions.

Data Collection and Analysis

Ethnography is a research process of learning about people by learning from them. Ethnographic data collection methods enable researchers to obtain rich and comprehensive information about worldviews, feelings, values, behaviors, attitudes, rituals, and shared patterns of a particular group of people (Leininger, 1985).

The ethnographic interview.

Ethnographic interviewing is aimed at describing the cultural knowledge of the informant (Sorrell & Redmond, 1995) such as the cultural knowledge nursing students have regarding professionalism. A skilled ethnographic interviewer acts as the instrument through which data is collected. The interviewer uses techniques such as probing and clarification and a highly trained ear for themes within the participant responses to guide the interview (Sorrell & Redmond, 1995).

Ethnographic interviews are typically semi structured and consist of descriptive, structural and contrast questions. Interviews should be guided by a tentative outline as questions for ethnographic interviews are usually introduced in sequence (Westby, Burda & Mehta, 2003). However, the researcher must allow for flexibility and alteration in format and order of questions as becomes necessary to guide the interview. It is recommended to begin the interview with descriptive, open ended or grand tour questions, broad in nature and aimed at eliciting a large quantity of experiential information. For example, in my study I began by asking: What is your understanding of nursing professionalism?

Beginning with descriptive questions enables the researcher to listen for repeated words, phrases or issues, which then become important categories or themes within the data (Sorrell & Redmond, 1995; Westby et al, 2003). Once categories have been identified, the interviewer

begins asking structural questions. There are three main types of structural questions: strict inclusion, rationale, and means-ends question (Westby et al, 2003). Strict inclusion questions aid the interviewer in gathering more data regarding specific categories; means-end questions attempt to generate information regarding identified behaviors, and rationale questions seek the reasons for the identified behavior (Westby et al, 2003). An example of a strict inclusion question I asked is: What professional behaviors have you seen in the nurses you work with? I asked this means –end question: In what ways do your unit leaders or teachers let you know what professional values and behaviors she/he expects? A rationale question that I posed was: What is the importance of demonstrating professionalism in your clinical practice? Finally, contrast questions aimed at discovering the meaning of words used by the key informants to describe the culture of interest are proposed (Sorrell & Redmond, 1995). See Appendix F for the list of questions I used to guide the one to one interviews.

The one to one interviews were held in a variety of clinical environments, dependent upon where each key informant was completing their final student practicum. A quiet private place was found within each clinical setting. In responding to my questions and relaying their experiences, the participants exhibited a range of physical and emotional responses from tense uncertainty to passionate enthusiasm. In most interviews the key informants would begin the interview very unsure of what I was asking and consequently unsure of their responses. Moreover, I could sense that many of them felt and thought that they were not knowledgeable (or knowledgeable enough) about nursing professionalism; and subsequently several of them appeared uncomfortable and even embarrassed. It was at these moments that I offered reassurance saying "that their confusion and knowledge deficit was precisely why I was

conducting the research". In addition I rephrased or reframed the questions that I was asking, and occasionally offered examples to help them understand what I was asking. Occasionally during the interview process I had to prompt key informants to either clarify their response, or offer more support of it. Amazingly I noticed that a transformation (of sorts) was occurring for many of the key informants from the beginning of the interview to the end: their understanding and ability to articulate what nursing professionalism is, increased. The transformation was visible due to a change in the fluidity of their responses and in their positive and passionate facial and body language. These emotions and their physical manifestations stemmed from their love and dedication to developing meaningful relationships with their patients while providing them the highest possible quality of care. Additionally, their emotions enabled them to deeply connect with and then articulate the purpose of their nursing practice, and to describe how they conducted their work.

The atmosphere of the majority of the interviews was calm and focused in nature. However, during one interview experience, memories of negative experiences regarding how her professionalism was evaluated were triggered. The key informant became visibly upset. Her voice trembled, and there were tears in her eyes as she described how she felt punished for feeling vulnerable and uncertain during certain clinical experiences. She described feeling overwhelmed and alone, with no one to turn to for support, despite indicating that she had sought it from her clinical instructor and nursing faculty. I would assert that this key informant felt betrayed by the actions/inactions of faculty (meant to mentor nursing professionalism) and subsequently became distrustful- not only in the faculty, but in her decision to become a nurse. It was clear in her remaining interview responses that she was desperate to learn how to be a

professional nurse (theoretical foundation of which is, arguably, the development of genuinely caring relationships) but unfortunately, and ironically she did not experience this type of relationship with her particular faculty mentors.

Although the conversations were focused on their experiences, I felt as though I was involved as well because I was intensely interested in their stories and their understandings, from the personal (previous patient), professional (active RN), and researcher perspectives. Additionally, several of my key informants expressed gratitude to me for shedding light onto the topic of nursing professionalism and helping them to find their voices (courage to speak) and the specific words to express their ideas. This was extremely validating for me as a novice researcher.

At the conclusion of each interview session, I came away feeling privileged to have heard the key informants' stories and their unique understandings about nursing professionalism. Furthermore, the interviews with each participant added substantive detail and description to the study. The enthusiasm and authenticity of each participant was a tangible presence as each of them described their understanding of what it meant to be a nurse, and do the work of nursing.

Participant observation.

Participant observation is another primary method of data collection for ethnographers and is the experience of 'being there' within the study population for a period of time watching and listening to what is occurring (Thomson, 2011). In a focused ethnography observation is often de-emphasized or becomes sporadic in nature, due to the limited length of time in the field. Observation encompasses the use of all five senses and exists as a continuum ranging from complete observer to complete participant (Spradley, 1980). For ethnographic research to yield

rich and descriptive data, a researcher needs to immerse oneself in the studied culture; however, must decide what degree of observation is appropriate. The primary determinant of which is the understanding that the primary role of a researcher is to remain detached enough to collect and analyze data relevant to the research question (Baker, 2006). I adopted the role of 'observer as participant'. This role encompasses more observation than participation but allows the researcher to engage more actively with the key informants when warranted or assist them when needed (Gold, 1958; Pearsall 1970). Additionally, the researcher's identity and presence becomes better known to the key informants and participants, assisting the researcher in gaining access or entry into the study culture (Baker, 2006). Ethnographers who practice participant observation are cautioned against what has been coined "going native". This term refers to the threat of a researcher becoming so immersed that they lose their objectively; no longer are they studying the culture, but become a member of it (Spradley, 1980). As a novice ethnographic researcher I was consistently mindful that I existed (to a degree) within two different cultures simultaneously: the culture under study and the culture of the academic community (Baker, 2006). However, I was surprised at how easily I was able to gain the trust of my study participants. They eagerly welcomed me into their classroom and clinical settings and were both intrigued by and excited to participate in nursing research related to professionalism. During the observation phase of data collection, I did not encounter any tension between my role as participant observer and registered nurse. Important to note that at no point during data collection did I feel as if I was losing my objectivity, largely due to the short period of time I spent as an observer.

My key informants were fourth year nursing students completing their final clinical practicums in varying healthcare environments within Alberta Health Services (AHS). I observed each individual key informant for one eight hour shift in their designated clinical environments, and I observed the eight key informants as a group during their seminar class and focus group discussion. Prior to each observation shift, I met with the unit manager of the specific area to inform them of my study and obtain their consent for me to be present on the unit/in the area. Each of the eight managers I met with was interested in and supportive of my research on nursing professionalism. Moreover, many articulated the concerns they regularly encounter regarding the professionalism of their staff and the lack of resources they have for addressing them. Observing the key informants while they were actively engaged in the practice of nursing enabled me to assess for cohesion between what they articulated as professionalism during their interviews and focus group discussion and what they demonstrated or showed to others while in practice. This was of particular import to me given the professional practice issues nurses continue to have within the context of an environment that supposedly provides education and expectations for a high professional nursing standard.

At the beginning of each observation I explained who I was and what my research was about to the unit/area staff nurses and any patients or family members with whom I came into contact. I obtained verbal consent from the unit nurses, preceptors, patients and families to observe interactions that involved themselves and one of my key informants. Further, I made patients and families aware that my primary role was to observe but that I may participate as necessary, for example, in turning or transferring an individual.

Before and during the first few shadow observation experiences, I felt mildly nervous. Predominantly my nervousness stemmed from worry that I would not be able to capture all the details, or conversely that I would get so caught up in trying to write detailed field notes, that I would miss what was actually going on. Each key informant also expressed some level of nervousness prior to completion of the shadow observation. To combat this I focused on my goal of collecting not only a quantity of data, but quality data. This process began with establishing trust with the key informants by first developing a rapport. I built rapport through conversations about who I am outside of this research project, and enquiring about who my key informants are outside of nursing school. We discovered common ground, shared experiences and interests. This helped us all to relax and enjoy the time spent together, and moreover helped alleviate everyone's nervousness. I wrote field notes during the shadow observations, quickly jotting down shorthand notes. Only occasionally did I need to leave my key informant's side to write down and/or make sense of my thoughts and impressions about a significant encounter or experience. Conducting observational research was exhausting at times, both physically and mentally, and there were a couple of times that I recognized that I was not able to remain focused. This level of fatigue occurred because the key informants and I got so caught up in the work that we missed our rest breaks. I did have to stop and take a break to eat and drink, encouraging my key informant to do so as well. Upon completing each shadow observation I reflected back over it, adding more detail and depth to my field notes.

Writing field notes.

The use of field notes during participant observation is paramount to ensuring that all experiences encountered in the field are captured as data. Informal notes are written in the field

to capture the moment and then written up more formally when the researcher is away from the field (Thomson, 2011). It is imperative to begin writing field notes immediately when conducting observations because the first moments in the field can be the most significant; the researcher is seeing things for the first time as a 'visitor' with no preconceptions or biases. Writing and then processing my field notes immediately after each shadow observation was crucial to capturing what was actually going on: my interpretations of what I saw and experienced (O'Reilly, 2009). I collected and analyzed the data simultaneously. This allowed me to uncover new questions and then to seek out the answers while still actively working with my key informants. I immediately organized the field note data on each key informant into categories: relational behaviors or skills and competencies. Then as I read through the notes, I paid particular attention for the formation of patterns and relationships between what I saw and heard in both the one to one interviews and the shadow observations. Questions I asked myself included: 1) is what I saw the participant *do* in practice congruent with what I heard them *say* about their practice? And if not, why; 2) is what the participants say they value about their nursing practices evident in the way in which they carry out their work; and 3) what more do I need to explore? The second phase of field note analysis occurred after the completion of each subsequent observation shift, a new set of field notes added in each time. Consequently, I was able to compare the sets of field notes to each other to see if the same patterns and relationships emerged. Very soon themes became apparent and I tracked these by coding and naming the different themes. After I completed the shadow observations and preliminary analysis of my field notes and transcribed interviews, a few items needed further clarity. To gain further insight into my lingering questions, I conducted a focus group with my eight key informants.

Focus groups.

Human beings rarely exist in isolation and as such human interaction shapes the way we see and know the world. The focus group interview uncovers participants' attitudes, perceptions, and opinions related to a studied phenomenon, that are developed through and influenced by group interaction (Krueger, 1994). In addition, this definition illustrates the principal justification for the utilization of focus groups, which is to take advantage of the interaction amongst group members that tends to elicit robust experiential data. According to Webb and Kevern (2001) participants within a focus group help each other to explore and clarify views, which are not accessible options in one to one interviewing. Further, according to Crang and Cook (2007), it is essential for ethnographers to understand how people come to know or feel about a particular topic while engaged in a social context; how interpersonal interactions impact learning, perceptions, reactions, consensus, or resistance. Therefore, conducting a focus group was an important format for studying the impact of culture (being a member of a group-i.e. fourth year nursing students) on individual participant's ideas, feelings, and behaviors.

I conducted one focus group discussion towards the end of the data collection phase with all eight key informants, with the assistance of a focus group moderator. The moderator was a nursing colleague. Her purpose was to take notes during the session about what the participants said, how they said it, and how they behaved. The moderator's presence enabled me to focus on asking the questions, responding to the responses, and ensuring everyone's participation. Informed consent was obtained from the moderator prior to the focus group date, ensuring that she understood her responsibility in relation to confidentiality. Prior to beginning the focus group I verbally reconfirmed informed consent, introduced the moderator and her purpose, and

reminded the participants that the session would be audiotaped. The focus group discussion occurred on the University Campus in one of the rooms within the Faculty of Nursing. Questions were focused on filling in the gaps that I noted while conducting one to one interviews and shadow observations. See Appendix G for a list of the questions that I used to guide the focus group discussion.

The researcher promotes group interaction by encouraging participants to talk with each other: asking questions, sharing stories, and commenting on each other's comments (Krueger, 1994). Interaction is the key to the focus group method, thus affording this data collection method with a high level of face validity (Krueger 1994) because what participants say can be confirmed or contradicted by other group members during group discussion. With this in mind, I opened the focus group discussion by posing a general engagement question: What is or are your favorite things about being a nurse? This question helped settle and refocus everyone onto the topic of nursing professionalism. Generally the key informants responded to the questions happily and enthusiastically. The moderator documented that the participants' had relaxed facial expressions and body postures when responding to most questions. However, when I asked the question: "What opinions do others (patients, families, colleagues and the public) have about nursing work?" the moderator noted that several of the participants "guffawed sarcastically, or groaned". I believe this was indicative of their frustration with the negative image they believe others hold of nursing. Their responses to this question were entirely negative, "If there is a mess, we clean it."

The focus group discussion was robust at times; noticeably more so at the beginning of the session and when discussing the attributes valued in the nursing practice of others and the

impact of the work environment on nursing professionalism. There were two key informants that contributed a vast amount to the discussion, several who contributed a moderate amount, and a few who only spoke if I called upon them directly. I wanted to hear from all key informants so at times I did single specific key informants out. This may have made them feel a little uncomfortable, but not enough to stop them from contributing a response. Additionally, my intention was to allow the group discussion to develop and flow organically, but there were significant lulls necessitating that I keep the conversation going by asking a prompting or clarifying question.

Document examination.

Historical artifacts such as statues and ancient manuscripts have been included as cultural data since the emergence of ethnography. More recently photographs, videos, policy documents, and any other relevant information source regarding the study population or purpose are now considered cultural data. Dicks, Soyinka and Coffey (2006) stated that "ethnography is now situated within a world saturated by multimedia technologies" (p.77) therefore, inclusion of these information sources within ethnographic data analysis is warranted. For my study of nursing professionalism documents of import were CARNA practice standards, CNA guidelines and expectations, AHS policies and protocols, and University of Calgary nursing curriculum pertaining to the seminar class that supported the final preceptored practicum experience. Further, as a participant observer, I attended the weekly on campus seminar class related to professional clinical practice in which my eight participants were enrolled. I wrote field notes on what was taught and discussed, and how the participants responded (their manner and behavior). Analyzing these documents and curriculum elements helped me to better understand the key

informants and assisted in the corroboration of my observational, interview, and focus group data. Specifically, I was most interested in knowing whether any of these documents described nursing professionalism in cultural terms, and how these documents were being interpreted by fourth year nursing students within the context of their experience of nursing professionalism.

Analysis of Ethnographic Data

Data collection and analysis for ethnographic research are cyclic in nature and occur concurrently. The cycle begins with initial data collection followed by analysis for themes or categories then more data is collected and the cycle is repeated until all the established categories can explain the data (Schmoll, 1987). Data collection yields an enormous amount of material, which requires further analysis to focus in on what knowledge was discovered. This yields the characteristic "funnel" shape seen in written presentations of ethnographic research (Mackenzie, 1993). An inductive process is applied to narrow and focus the data into conclusions or hypotheses by analyzing the data for interrelationships between two or more categories, inconsistencies and contradictions (Mackenzie, 1993; Scholl, 1987). Ethnographer's conclusions can lead to further study or can be developed into theory (Schmoll, 1987).

After each interview I listened to the recording in full and wrote down my immediate thoughts including the overall content of the interview, gaps or ideas I wanted to explore further, and key words or phrases that were repeated by the key informant. Analysis continued as I transcribed all eight interviews. The transcription process took approximately 24 hours to complete, during which I was began to identify the unifying themes emerging within all eight interviews. After transcription, I reviewed the transcripts, focus group transcript, and field notes and began the process of coding the data. Codes are labels assigned to units of meaning

(Germain, 1993; O'Reilly, 2009), and can be names, categories, concepts, or theoretical ideas. Units of meaning were identified in individual words, phrases, and occasionally paragraphs of raw data. Open coding and subsequent memo writing (to further evolve an idea) involved a degree of generalization (O'Reilly, 2009) because I moved from broad coding to more focused coding of the data. I sorted and funneled the data down into more specific thematic categories (Mackenzie, 1993). In and between the transcribed interviews I noticed words and phrases that were repeated by the key informants describing the internal and external attributes of nursing professionalism. At the end of the data collection phase the list of individual words was very long. Consequently, I began to develop thematic groupings or categories by using the previously mentioned words as headings.

As analysis continued categories were developed or reframed until major thematic categories were identified, leaving only a few words or outliers that did not appear to fit within any one category. I did not discard this data, but rather used the words to test the rest of the data, or strengthen my understanding of the prominent categories. Throughout the process of collecting the data, I explained to key participants that, if needed, I would ask for their verification that the data I was collecting was appropriate and accurate. I did need to verify data several times with a particular key informant, to ensure I had accurately heard and understood exactly what she was saying about nursing professionalism. This process enhances the validity of the researcher identified thematic categories (Hammersley & Atkinson 1983; O'Reilly, 2009). In addition to discovering how fourth year nursing students understood and enacted nursing professionalism, I wanted to analyze the impact of the environment or context (classroom and acute hospital units) on the professionalism of fourth year nursing students. I posed analytical

questions such as: How does the environment(s) support and or constrain professionalism? In what ways does the environment contribute to the development, understanding, and enactment of nursing professionalism? In addition agency documents such as curriculum outlines, course content, and clinical practicum evaluation tools were utilized as required to provide further support of the thematic categories.

During ethnographic data collection and analysis, considerable attention is devoted to ensuring the reliability and credibility of the process. The degree of validity and reliability directly corresponds to the degree of generalizability of the findings to a larger population (Barton, 2008). Generalizability, as a measure of validity, is largely understood as a quantitative consideration. However, it is the language used in the literature to describe evaluating the caliber of ethnographic work. I am less concerned with the generalizability of my findings, and more concerned with the transferability of them, within nursing and outside of the discipline. Meaning, that I hope that my research resonates with a wider audience; that others find a measure of meaning, a degree of truth, or potential applicability in what my key informants have shared (Leininger, 1994; Lincoln & Guba, 1985). According to some authors, validity is the primary criterion of 'good ethnography' (Germain, 1993; O'Reilly, 2009). In ethnographic research, validity is understood as how accurately the researcher is able to describe and portray the observed reality. Triangulation is a process used during analysis that involves the comparison of data collected from two or more sources; this increases the reliability of ethnographic findings (Denzin, 1970). I collected data from individuals working across different settings using more than one method, and from the group in a focus group format. In my research I endeavored to uncover and interpret the cultural meanings fourth year nursing students

ascribe to nursing professionalism. The ethnographic researcher's job is to report and then interpret the perspectives offered by the key informants as objectively as possible. However, there is a subjective element inherent to ethnography as the researcher is immersed in the culture under investigation. As the researcher listens, observes and records data they becomes a part of the cultural scene and thereby assumes a reflexive character: being a part of, rather than separate from, the data. The researcher must be aware of their own internal state and how it could affect both data collection and analysis: reflexivity (Hammersley & Atkinson 1983; O'Reilly, 2009). Reflexivity was a constant focus for me during the cycle of ethnographic data collection and analysis. When working with data in any capacity, the researcher must maintain objectivity while simultaneously acknowledging their influence on the data and the process (Barton, 2008). Ethnographic researchers are encouraged to keep a reflective journal that includes their thoughts, ideas and values which can then be incorporated into the analysis (S. Raffin, University of Calgary, Nursing 683 lecture, January 31, 2011).

During data collection I remained focused on the potential impact I was exerting on the key informants. I endeavored to keep my level of participation during observations to a minimum, and to ensure that my facial and body language remained neutral during interviews, shadow observations, and group discussions. My goal was to remain impartial and not encourage or discourage any type of response or behavior. However, there were times during the data collection process, that it was impossible not to offer a word of encouragement or a nod of recognition. Ethnographers need to be concerned with reflexivity, the impact they potentially have on the conduction of the research and on the knowledge generated (O'Reilly, 2009). To become a reflexive researcher I recorded my own feelings, thoughts, and ideas within my field

notes. Journaling about my experiences as a novice researcher helped me to make sense of my fluctuating emotions that ranged between excitement and weariness. Further, spending time in reflection assisted me in retaining or regaining the perspective of the stranger, guarding against 'merging with' versus 'immersing in' the culture under study; otherwise known as 'going native' (O'Reilly, 2009). Moreover, according to O'Reilly reflection also has an analytic function, alerting the researcher to emotions, ideas, or behaviors that our key informants may well share thus providing the opportunity for integration of the objective and subjective. When reflexivity is effectively managed, the researcher is able to understand and describe the lived experience of the study population to a larger audience (Barton, 2008). My desire was to describe the lived experience of nursing professionalism that fourth year nursing students have, and not my own.

Credibility in ethnography is predicated on whether the findings are believable or representative of the 'real world' of the participants (Boyle, 1994). I checked the credibility of my findings during the data collection and analysis phase and at the conclusion of my study. I met with my faculty advisor and thesis committee members to review my findings and thematic analysis and obtained their opinions regarding my data interpretation and identification of final categories. I sought to ensure that I was not reading more into the data than what was there, nor leaving anything pertinent out. This technique, known as 'member checks' (Morse, 1991), was also performed with some of the key participants (during data collection) following interviews and shadow observations to ensure that I was capturing their true intent and or meanings.

Another measure of ethnographic reliability is its transferability or fittingness, which occurs when findings fit other contexts or when readers find the report meaningful in terms of their own experience (Germain, 1993). In this ethnographic report, detailed description and

verbatim quotations from the key informants will hopefully enable other student nurses to recognize the value, importance, and meaning that the study participants have given to nursing professionalism; moreover may resonate within their own emerging practices. The knowledge generated in this study provides exemplars of nursing professionalism that add clarity, complexity, and/or challenge the assumptions about nursing professionalism currently presented in the literature. Ultimately, the knowledge generated from this research will lead to a renewed appreciation and understanding of the complexity of these student's experiences of understanding, developing, and enacting nursing professionalism in practice.

Writing an Ethnography

Ethnography literally means 'writing about peoples' (O'Reilly, 2009). I quickly became aware that writing is inherent to ethnographic fieldwork as I jotted down field notes during observations, made notes during interviews, or wrote down my reflexive reflections as I worked through the iterative-inductive cycle of data collection and analysis. However, there came a time when I had to move from writing things down to writing my ethnography in a format that could be shared with others. For me the writing process began as I conducted and interpreted the data, sorting and coding it into thematic categories, and compared my findings to what is currently written in the existing literature. I then polished my immediate and roughly recorded insights into a coherent story describing what nursing professionalism is to fourth year nursing students. The description of nursing professionalism is enhanced and supported by exemplars of rituals, behaviors, values, and critical events. The ethnographic story in this report is organized around the following five major thematic categories: 1) The Primary Relationship; 2) The Essential Relationship; 3) The Collaborative Relationship; 4) The Long Distance Relationship, and 5)

Relationship Obstacles. Several of the major thematic categories also have subcategories. I have chosen to write up my research in this way because I believe it will afford readers the opportunity to more wholly experience the journeys these eight student nurses' have taken to discover, describe, and demonstrate nursing professionalism.

Chapter Two Summary

In this chapter I have outlined and discussed why focused ethnography was the method best suited to study what professionalism means to fourth year nursing students, and looks like in their practices. I described the research process from the beginning point of obtaining study participants to the end point of writing up an interesting and accurate account of my ethnographic excursion. Finally, a discussion of maintaining trustworthiness and writing the ethnography was presented. In the next chapter the presentation of the study findings begins.

Chapter Three

Nursing Professionalism: The Significant Relationships

Nursing professionalism, understood in this work as the manner and caliber of how a nurse conducts her regulated nursing practice, is foundational to the delivery of competent, compassionate, and ethical patient care. Moreover, I have always thought it a privilege to be a nurse and do the work of nursing; to be in relationship with fellow nurses, health care colleagues, and with patients and family. However, providing safe and optimal care to patients and family during their times of illness is not always simple or straightforward. Overcoming individual, systematic, and environmental barriers can be a daily struggle for nurses. This struggle exacts a toll on nurses and can negatively influence the caliber of the care they deliver; subsequently negatively impacting the health and wellbeing of patients and families.

The purpose of this chapter is to present my findings concerning how a cohort of fourth year nursing students understood and demonstrated professionalism in their novice nursing practices. I begin this chapter with a discussion of the study environments, followed by an introduction to the enthusiastic and dedicated student nurses who were my key informants. I will then present my findings thematically, substantiating each theme with portions of interview conversations (the key informant's words verbatim) and inclusion of pertinent notes I wrote during observational field work.

The Study Environments

My key informants were fourth year nursing students in the process of completing their final clinical practicums. Consequently, observational data collection occurred within seven very diverse health care delivery environments: two acute inpatient care units, three outpatient

clinics located within acute care hospitals, a cancer screening clinic, and one occupational health office. In ethnographic research, analyzing the impact the environment has on the participants and the subsequent data collected is imperative. A robust discussion of the environmental impacts on my research findings will occur in a later chapter; however, below is a brief introduction to each of these environments.

A Post Anesthetic Recovery Room

The post anesthetic recovery room (PARR) is the first environment a postoperative patient is exposed to upon leaving the operating room theatre. It is here that the patient awakes from their anesthetic and begins their post-surgical recovery. The immediate recovery process for patients often includes varying degrees of discomfort, uncertainty, and anxiety. Additionally, significant and potentially life threatening complications can arise within this time frame. Consequently, registered nurses (RNs) in this environment require the ability to quickly identify and manage their patients' concerns and complications calmly and competently. This particular PARR unit is one large open area organized into twelve sections each furnished with a stretcher, supplies, and monitoring equipment. This layout enabled the RNs to collaboratively provide efficient care to twelve patients while simultaneously monitoring their recovery status. During the short time I spent on the unit, I observed that the momentum and flow of this environment transitioned and fluctuated between periods of quiet emptiness (no patients) to organized but hectic busyness (when full to capacity). Subsequently, I witnessed behavioral changes in the nurses and my key informant as they worked to adjust to this environmental shifting.

An Inpatient Medical-Surgical Unit

One of my key informants was assigned to an inpatient medical-surgical unit at one of the Acute Care Hospitals. This unit utilizes a primary nursing care model, wherein each RN or Licensed Practical Nurse (LPN) is assigned four to five patients and is responsible for all care delivery within their scope of practice. This particular unit is organized into 36 private patient rooms and one four bed patient room; consequently encompassing a vast geographic area. Subsequently, I noticed that nurses, including my key informant, had to spend a good amount of time walking to find assistance or obtain supplies. Another issue resulting from the spread out nature of the environment is that patient call bells were not answered in a timely manner, often sounding for greater than five minutes. The negative impact on staff is the pollution of their work environment with additional, persistent, and stress inducing noise. I wonder what impact this noise has on how they complete their work. Moreover, the delay in responding to call bells that are sounding impacts patients and families similarly and can result in patient safety issues when patient needs are not addressed expeditiously.

According to the unit manager, the vast majority of patients are admitted for medical reasons, with only half a dozen or less surgical patients admitted at any one time (Personal communication, Veronica Henkel, November 21, 2014). The overall acuity of the unit is impacted by the compliment of medical to surgical patients, and by the individual and often fluctuating severity of illness each patient experiences. Consequently, the nursing workload changes, and there are well defined expectations of AHS and CARNA that nurses adjust to meet their patient's needs. However, 'how' a nurse adjusts and what that looks like and feels like to others is much less clear and ambiguously defined. I did observe differences in how nurses and

my key informant managed changes in their workload that I will more directly link to nursing professionalism in the discussion chapter.

A Cancer Day Treatment Unit

The cancer day treatment unit has an outpatient focus (for patients not admitted to the hospital) and is located within Calgary's Tom Baker Cancer Treatment Centre. It is subdivided into three separate but connected treatment areas, wherein chemotherapy is the predominant treatment provided to treat a wide range of cancer diagnoses. Having no experience with cancer treatment, I was amazed at the high volume of patients that required lengthy courses of daily, weekly, or monthly chemotherapy treatments. Subsequently, the patients were well known to the nursing staff, which was demonstrated in the closeness of their interactions. They knew and addressed each other by name with smiles and exchanges of personal experiences, during the initiation of treatment. Interestingly, after this initial exchange, I did not observe the nurses regularly reconnecting with or re-engaging with their patients during a typical two to four hour stay in the area. Potential explanations for this phenomenon could be that 1) the majority of patients had a family member or friend with them, (somehow negating the need for nurse-patient relationship), 2) the workload and patient volumes did not allow time for the nurse-patient relationship, or 3) the geographic layout of the unit (nursing station in the center with view of all patients) may not necessitate physically checking in.

Prior to stepping on to this unit, I made the assumption that it would be a sad and ominous environment to work in, given the nature of treatment provided. However, the opposite was true. Patients and staff exhibited an optimistic attitude towards receiving and providing chemotherapeutic treatments, and evaluating the impact of the chemotherapy on the patient's

quality of life. Moreover, I noticed that patients, family members, and the nurses were all very knowledgeable about cancer diagnoses and treatments. Also of note is that the physical environment-many big windows and beautiful photos on the wall and ceilings-may exert a positive influence on the moods and behaviors of persons working and receiving treatment in this clinic. Both of the key informants who had their clinical placement within this environment appeared comfortable and happy to be there. They approached their patients and the area staff with engaging smiles and confident communication.

An Epilepsy Outpatient Clinic

This environment is set up like a family physician's office: several small examination rooms, two office spaces, one for nursing staff and one for the physician, and a waiting room for patients. Patients attend appointments to follow up with a neurologist specializing in seizure disorders at varying intervals, depending on severity of illness. I found the demonstrated role of the nurse in this environment to be narrow, repetitive, and removed from providing any measure of direct patient care. The nurse and or my key informant would collect the patient from the waiting room, escort them to an examination room, and complete a prescriptive questionnaire comprised of approximately ten questions. In my time observing in this environment, the nurse and or my key informant spent ten or less minutes with each patient and family. During this time, I did not witness attempts by nursing to develop or further enhance a nurse-patient relationship. Upon completion of the questionnaire, patients and family (if present) were left to wait for the physician behind the closed door of the examination room. This environment was efficient and productive, functioning much like an assembly line. However, the genuine and

empathetic concern for taking the time to connect with the human condition was noticeably absent.

A Hematology Outpatient Clinic

The Hematology outpatient clinic is set up along a narrow corridor located within the day treatment area of the Tom Baker Cancer Centre that is the home to two different outpatient clinics. This particular clinic specializes in the organization and follow-up assessment of treatment for patients with blood cancers. The clinic space covers a small geographic area and includes three small examination rooms and one shared documentation space. Spending eight hours in this environment was overwhelming and over stimulating for me. There were so many people attempting to work in such limited space that there was little ability to respect personal boundaries. I often found myself plastered up against the wall in order to avoid touching another person. Moreover, the volume of conversations was consistently loud, and the content of which was predominantly of a personal nature. My key informant shared that she often felt distracted and overwhelmed within the physical confines of this clinic. The nursing workflow was similar to that of the Epilepsy outpatient clinic described above, the casualty of which was once again making time for the nurse-patient relationship. However, the difference I noted was that this clinic did not operate efficiently and the care provided was not well organized. I observed lengthy delays for patients, many of whom were physically weak and unaccompanied. Additionally, several patients and family members became visibly upset with the lack of flow through the clinic.

An Occupational Health Office

This environment is located in an office building and divided into cubicle work spaces and meeting rooms. Three occupational health nurses and my key informant were working during my observation time. Their nursing responsibilities included the conduction of phone interviews with clients (staff members) off on paid leave due to injuries sustained at work. Interview content included follow up on doctor's appointments, required paperwork, and return to work discussions and procedures. Additionally, I observed the nurses and my key informant participate in a two hour meeting wherein each client's case was reviewed and updated. A nurse working in this environment has no direct contact with patients or families. The time I spent in this environment went by extremely slow. I struggled to stay awake and focused as the majority of my observation time was spent sitting alongside my key informant as she completed paper work. I did not feel engaged or connected to the discipline of nursing during my time in this environment.

A Colon Cancer Screening Clinic

One of my key informants was assigned to a preceptor working in a colon cancer screening clinic. Nurses in this environment are responsible for: 1) preparing patients to undergo a colonoscopy procedure, 2) assisting the Gastroenterologist during the procedure, 3) providing support to the patient during the procedure, 4) monitoring the patient after the procedure, and 5) discharging the patient safely home. This environment is set up similar to a day surgery unit with stretcher beds separated by drapery, wherein patients are admitted pre-procedure and recover post-procedure. Adjacent to the stretcher area are the procedure rooms. I noticed that this allowed for expeditious and efficient flow of patient care; which appeared to be a priority concern for the nurses working in this area. After I made an observation that not much time was

spent talking with/ being with patients, I was informed that there was an expectation set by management as to the number of patients per day that needed to move through the environment. While shadowing my key informant in this environment, I was aware that I did not feel relaxed at any time. Nor did I have the time to talk with patients or family members. The eight hours went by very quickly and I didn't feel as if I or my key informant connected or had the opportunity to connect with any of the patients we came into contact with.

The Key Informants

Nine fourth year student nurses fulfilled the recruitment requirements and voluntarily consented to be key informants in this study. All nine students participated in the focus group discussion; however, only eight participated in the one to one interviews and shadow observations. All of my key informants were young women ranging in age from 21 to middle-thirties. One of my informants was married, a few were in committed relationships, and none had children yet. To simultaneously protect their privacy and honor the personal nature of the research that we embarked on together, I have given each key participant a pseudonym. I am only able to briefly and somewhat superficially describe each individual as I only had a limited amount of time with each of them.

Alice

This young lady is in her early twenties and seems to me, a lovely contradiction. At times she presented a person who is confident, outgoing, and positively minded. Other times she was more reserved, hesitant, and less optimistically inclined. The contradiction could be the result of the tension she experienced between wanting to be authentic to who she was in her personal life and who she was working to be in her professional nursing life

Betty

Betty is in her early twenties and appeared to be quietly confident in who she is in her personal life and in her role as a student nurse. She was somewhat reserved and spent more time reflecting and listening than actively speaking in class. However, she demonstrated interest in the study topic and shared strong opinions about the work of nursing during our one to one conversations.

Charlotte

This young woman is in her early twenties, but carried herself in a sophisticated, precise, and elegant way. She was very soft spoken, and appeared to keep to herself. Despite her quiet demeanor, she had very clear opinions on what it means to be a professional nurse.

Dana

Dana is a young woman in her early twenties who exuded quiet confidence. She had an engaging demeanor and calming presence that put those around her at ease (staff, patients, myself). Dana was easy to speak with and was genuinely interested in discussing nursing professionalism.

Evelyn

This young woman has had a little more life experience, being in her middle thirties, married, with nursing not being her first career. As such, she comes across grounded and secure in who she is and who she wants to be as a professional nurse. Evelyn was very open and confident about her opinions and shared them easily and articulately.

Fanny

Fanny is a friendly and approachable young woman in her early twenties. She usually had a smile on her face, and always spoke in a soothingly soft voice. Her outlook towards building a professional nursing practice was positive and enthusiastic. Fanny enjoyed our discussions about nursing professionalism and shared that she was learning a lot from them.

Gabrielle

This young lady is in her early twenties and was the only participant for whom English was not her first language. Gabrielle always appeared happy and interested in discussing nursing professionalism. It was obvious that she worked very hard at her studies and wanted to make positive contributions to group discussions.

Harriet

Harriet is a gregarious young woman in her early twenties. She shared her thoughts and opinions freely and spoke with confidence during seminar discussions and one to one conversations. Harriet typically appeared self-assured; however, during my time observing her in practice, I glimpsed vulnerability in relation to not exactly knowing who she was as a becoming professional nurse.

Now that I have provided a sense of who my key informants were, you (the reader) can link each to their specific contributions in support of the findings I will now present. I have organized the findings thematically into major categories and subcategories.

Findings

The framework and significance of nursing professionalism presented earlier were easily written, can easily be stated or cited in practice documents, and can even be easily accepted as

theoretically valid. Realizing professionalism in divergent and challenging clinical practice environments, however, is not nearly as straightforward. Professionalism in nursing aims to achieve the best quality of care delivery for patients and families. Living the reality of enacting a professional nursing practice in the face of knowledge deficits, educational barriers, financial constraints, and unsupportive and/or negative work environments remains the challenge. However, in spite of these difficulties, nurses are rising to the occasion and not only demonstrating nursing professionalism, but mentoring it in their nursing colleagues and student nurses. Student nurses are particularly motivated to enhance their knowledge and understanding of nursing professionalism, because it is an academic expectation of them in the present, and a future expectation of the CARNA. However, before they can actualize professionalism in practice, they first need to understand what it is and what it means to them. What follows is a detailed description of how my key informants understand and define nursing professionalism; a description I derived through ethnographic analysis.

Ethnographic analysis was outlined in detail in an earlier section. However to summarize the analytic process: 1) I repeatedly read through all the interview transcripts and field notes to identify emerging patterns; 2) I coded sections of patterned data into thematic categories; 3) I further coded categories into sub categories by included terms; 4) I named each category and sub category based upon key terms/repeated phrases within that section of data.

My analysis of all the data collected on the understanding fourth year nursing students have of nursing professionalism revealed the existence of five major themes or categories. Each category has several subcategories. The names I assigned to each category are:

- The Primary Relationship

- The Essential Relationship
- The Collaborative Relationship
- The Long Distance Relationship
- The Relationship Obstacles

The data revealed that these key informants understood nursing professionalism through the lens of relationships; their relationship with 'the self', and the relationships they worked to build with those they interacted with during their nursing practice. It is important to note that the first three categories are relatively interconnected and are to a certain degree dependent on each other. Not one of these relationships could survive or thrive alone, nor is one more fundamental than another. The fourth category describes a relationship that is more removed and indirectly impactful on the work of nursing. It is the combination of all four relationships that comprised the key informants' understanding of nursing professionalism. A fifth category that emerged is distinctly different from the other four, as it describes the obstacles to the building and maintenance of the four relationships. These obstacles were discussed and experienced so much so, that it became part of the key informants' fundamental understanding of nursing professionalism.

The Primary Relationship

Several of the key informants described their struggle with staying true to themselves, and their unique personalities, while learning how to be a professional nurse. They felt as if the two identities were at odds; that they could not be who they were outside of nursing school, or how they envisioned themselves in the role of nurse. A few informants described feeling pressure to conform to a regulated, prescriptive, and detached definition of what it means to be a nurse. What was being taught did not feel natural to these particular student nurses. During

interviews and shadow observations, it became apparent to me how important it was to the key informants to first truthfully know themselves as individuals and then, as nurses. Their identity as a nurse and therefore their ability to demonstrate professionalism in practice was directly tied to knowing and being their authentic selves.

Knowing Your Values

To truly know and be yourself, the key informants felt that you must reflect on your history; how you were raised, who and what influenced your ideas, values, and behaviors. This belief was articulated at different times during data collection. They understood that their personal history directly influenced who they had become as young adults, and that who they are in their personal life is intimately connected, if not identical to, who they will be in their professional nursing role. To illustrate, when asked who had most influenced their understanding of professionalism, *Charlotte* responded "I would say that would be my mom. My family is extremely meticulous, first impressions are a key aspect". Charlotte was raised to value the way in which she presented herself to the world and the importance of doing everything the best that one can. In my field notes I wrote 'Charlotte's appearance is flawless: hair artfully pinned, flawless makeup, neatly pressed blouse and skirt, and functional but fashionable kitten heeled shoes'.

Due to the nearly indistinct line these key informants see between a nurse's personal and professional selves, I was interested in uncovering what it was that they valued. During the one to one interviews, I asked each of my key informants what they valued most about their nursing practice. *Alice* responded "Connecting with people. I love hearing people's stories. I think everyone has something to share." Near perfect echoes are *Charlotte's* words "the one to one

contact, assisting people in major transitions in their life" and *Fanny's* when she stated "I've always wanted to help people, be able to care for them, make sure they are happy, remain positive". During the shadow observation, I noted that 'Fanny appeared genuinely interested in listening to her patient's stories, always asking more questions to get a clearer understanding'. Similarly, both Betty and Harriet valued the ability to communicate with their patients the most; both to build trust and demonstrate empathy for their patients. When I spent time with Betty in her practice, she spent twenty minutes sitting and talking with a patient who wasn't eating. After their conversation had ended, I observed Betty bringing her tea and toast. It was clear that the building of the nurse-patient relationship was highly valued, and considered by this group of students to be a defining aspect of nursing professionalism.

Consequently, in so highly valuing the relationship with the patient, nursing work becomes about much more than merely completing the required work or task competently… it becomes about *how* you complete it. The following story told to me by *Evelyn* illuminates that nursing professionalism speaks about the manner in which a person conducts their nursing practice and becomes a reflection of who they are personally and professionally.

> I was on unit 36 at Foothills, which is a very busy acute unit and I was just starting my third year. There was this one patient who was really depressed about her health condition and had those MPR chartings about these negative things-patient is demanding, patient is difficult. This one nurse did not see the patient through those eyes at all. Every time she walked into the room… she would… you bring the energy that you want that patient to feel: you bring the energy into that room. She didn't say these words but she was like that to watch in action. She walked in and she was so pleasant, she [said] 'good

> morning, let's get these curtains opened up, let's get you sitting up'. It was so professional and she just created this cozy atmosphere for this depressed patient and even though the patient grumbled and mumbled, [she cooperated] she kept a smile on her face. I realized a smile is one of the best tools that you can have.

Evelyn went on to describe the resultant relationship that was established between this particular nurse and the patient, as a successful one. For the remainder of the shift the patient appeared relaxed, was cooperative and participated in her care, and communication was respectful and effective. Further, this story is an exemplar of the impact the *way* a nurse completes her work has on her patients, and *how* one's behavior can positively and memorably impact others who witness it. *Evelyn*, a beginning nurse was greatly impacted. I wrote in my field notes that when she told this story, she appeared proud and in awe of what was possible in nursing. Additionally, I could see her attempting to live out what she had learned from this story, in the way she held her patient's hand and rubbed her back while a painful endoscopic procedure was conducted. Moreover, in the story, how this particular nurse completed her work illustrates the high caliber of her personal and professional character. Specifically, she had exhibited empathy and chose to ignore the negative judgments her colleagues were sharing and writing about this patient; proceeding instead to develop an unbiased relationship with this patient, through the use of positive energy and enthusiasm. For my key informants, having the ability to freely be your authentic self was a defining feature of nursing professionalism.

Being your Authentic Self

Nurses care for patients and families at their most vulnerable moments: during times of pain, illness, incapacity, and death. Historically it has been a struggle for nurses to separate

themselves, keep themselves somehow apart from the suffering of others. This idea of 'keeping apart from' has frequently entered into the discussions about nursing professionalism that I have had in the last four years. Can and/or should a nurse be two separate people: one person outside of work and another when in uniform? Several key informants mentioned the importance of being allowed to be their true selves while in the role of nurse. In a conversation with *Alice*, she shared the following:

> I think when we go into practice we think we have to be a certain way in terms of how we talk, how we act, how we communicate with patients and I feel that we think that we have to hold back…and we can't have self-expression and we can't be our own person with that patient.

The 'we' Alice refers to are the various academic faculty and clinical instructors she encountered during her undergraduate nursing program. It is clear that she did not feel safe to be her true self while in clinical practice, and she could fathom no other way to practice. Why did she feel unsafe to be herself? Alice feared academic reprimand or punishment: "I got the idea that professionalism is being a certain way to someone… [With instructors] if you said something that wasn't what they wanted to hear…it was unprofessional". A similar opinion was expressed by *Betty* in sharing that "you want to be talking to them [patients] in a professional manner, not crossing any lines, any personal lines…but at the same time you can't keep it strictly focused on their prognosis, you can't always keep it straight nursing". In reading this statement aloud, I can hear Betty's confusion and concern over crossing 'the line'.

Other key informants were able to share an alternate view. In their clinical experiences with those who taught and mentored them, they felt more comfortable being their authentic

selves. Moreover, each nurse is a unique individual who possesses different attributes and strengths that can be used to support their nursing practice. *Dana* stated that "I'm still able to joke around with them [patients] and interact with them at a very casual level where they feel comfortable". She utilized a strength she has always had, the ability to make people smile or laugh in a therapeutic manner; understanding when humor would benefit the patient. *Harriet* spoke about how she came to have a deeper personal understanding of nursing professionalism.

> You get kind of an understanding in your nursing classes, what you should think about nursing. But it's only in your practice that you really understand what you believe professionalism is rather than what people tell you it is. Professionalism is loving what you do, portraying that to the people around you, show your patients that you care. If you give happiness then you get happiness. If you give negativity then you get negativity.

Nursing professionalism as described above is not something that could be feigned or demonstrated discriminatingly in one's practice. This data excerpt describes an authentic and positively toned connection to nursing practice that would require the individual to possess intrinsic motivation and dedication to maintain over time. Additionally, in my field notes about this particular interview, I had written that when Harriet spoke she was visibly excited and proud of the opinions and ideas she was sharing.

Passionate Energy

The positivity and visible excitement exhibited by the key informants during many of the interviews and shadow observations prompted the realization that having a passionate energetic approach to practice was a dimension of nursing professionalism. Not only was their passion for

nursing visibly evident but audibly present in the words they used to express their understanding of the role of nurse. When asked to describe the role of a professional nurse, *Betty* responded:

> A lot of people just think that nurses just take your vitals, give you your pills. But I think it is important to tell people that nurses do a lot more than that…nurses are there when its peoples' worst day and help comfort them…are willing to do whatever it takes to improve their quality of life.

Betty's words also reflect that others are impacted by how a nurse chooses to actualize their role; it becomes what others know and understand about our work. Patients and families formulate ideas and have feelings about the individual care they receive from one or even a handful of nurses that could morph into a judgment about the discipline of nursing as a whole. Through demonstrating professionalism, nurses can influence how others view us. An example of this is how *Harriet* was influenced by the following recollection of watching nurses work.

> You are on the unit and you've got up to seven patients and you see that nurse who takes that time out of her day to sit down with a patient, talk with them, when you know that they are running like crazy and that they took that five minutes just to sit with that patient. I am always inspired by those nurses, they aren't just task oriented. They are so passionate and still want to influence the patients.

During the focus group discussion further insights were shared by a few key informants and then agreed upon by the entire group. "I really like the energy and the enthusiasm from different nurses and how they project that onto the patient and what they do. I think that plays a really big role". After this response was given, I asked the group what they thought the significance of demonstrating energy and enthusiasm in practice was.

> There is a big significance… it's almost like they [nurses] are the face of the hospital…you walk in and you see a nurse. This is your first interaction and your first interaction often shapes the lens through which you view your whole experience. So it's a huge responsibility, just that piece, let alone the knowledge that we bring forward.

Additionally, the group agreed that having your passion and positivity validated would reinforce the behavior and prevent it from fading out over time "if you don't get any acknowledgement, you can only maintain your own 'up-beatness' for so long… you need that support to keep you motivated, when you feel like you can't motivate yourself anymore". The focus group discussion made it clear that for my key informants, utilizing their personal energy and enthusiasm is an important and significant aspect of nursing professionalism. The last phrase from the above quote, "let alone the knowledge we bring forward" introduces the last subcategory in the category 'The Primary Relationship'.

Practice Competence

Seven of my eight key informants directly stated that having the required nursing knowledge was a dimension of nursing professionalism. Specifically, they each mentioned the importance of knowing and abiding by the policies and procedures of health care organizations and to the standards set by CARNA. The ability to monitor one's own knowledge is an intimate relationship that requires willingness, objective insight, and strength. A nurse needs to be aware of what they know-to utilize it in their practice, and of what they do not yet know-so they can access the appropriate knowledge resource. For *Dana*, competence was ensuring her own understanding, "having a rationale for what I do and why I do". Similarly, *Evelyn* worked to ensure that she didn't act beyond her capabilities "evidenced based policy is really

important…and [don't do] anything you're not comfortable [with] or that you don't understand". Further *Evelyn* stated that "I do research in advance, so that I am prepared when going into practice... [and] asking for help". Ensuring knowledge competence was equally important to *Harriet,* "I like to think that I portray the image of someone who is a keen learner… because in nursing you never know everything". Harriet lived out these words in practice, I witnessed her continually ask questions throughout the shadow observation.

Additionally, for these key informants, action without knowledge and preparation was considered unprofessional and a direct violation against the sanctity of the nurse-patient relationship. "I don't feel that the patient is getting the best care, they [nurses] are not really following policy and procedure guidelines". *Fanny* was speaking about unprofessional qualities she has observed while in clinical practice. An aspect of an effective nurse-patient relationship is information sharing. This was important to *Betty* and something I saw her doing in practice*:*

> If I don't know something, if I don't know how to explain it[to my patient], then I always go on the computer and research how I could explain it in terms I can understand as well as my patient can understand.

In summary, the first thematic category 'The Personal Relationship' has four subcategories: 1) knowing your values; 2) being your authentic self; 3) passionate energy; and 4) practice competence. The ability to know yourself (through relationship with the self) enables you then to behave in a way that is consistent with your core values, both in your personal and professional lives. From here then it becomes possible to develop and maintain resilient and effectual relationships with those living and working around you.

The Essential Relationship

This category describes the relationship of primary import to the key informants within the context of their professional nursing role: the nurse-patient relationship. All eight key informants agreed that a core component of nursing professionalism was the focus on building and maintaining an effective and genuinely caring therapeutic relationship with their patients.

Genuinely Caring Connection

In twenty years of nursing practice, I have recognized the patient outcomes of a truly effective nurse-patient relationship: trust establishment, preservation of dignity and respect, occurrence of healing, reduced suffering, knowledge acquisition, and the assurance of safety. Each key informant was able to convey how they or other nurses effectively connected with patients. The key building blocks identified were spending time with patients, listening to patients, demonstrating genuine care and concern, sharing knowledge, and flexibility.

> I value being able to talk to the patients the most…patients always have something interesting to share with you about what they've gone through, their experience and I also enjoy learning about them and learning about how they are coping.

Dana not only enjoyed the time she spent with her patients, but was able to utilize the knowledge gained to effectively create and inform her nursing care and discharge plans for her patients. For *Alice*, spending time with her patients, and being accountable when making plans with them enabled her to build effective relationships "integrity is being your word and I think it is important in nursing practice especially to build that trust with patients".

Some may argue that completing required nursing work efficiently and competently does not necessarily require that a genuinely caring relationship exist between a patient and nurse.

However these key informants argued that it was a fundamental component of their understanding of nursing professionalism-the way in which they completed their nursing work.

> I think connecting with them [patients] and building relationships with them helps you gain confidence in your work…those relationships and what you bring to them and what you bring to their healing and their health…that makes practice meaningful…this has helped me shape my identity within nursing because I can be that for other people.

This is a powerfully emotional quote from my interview with *Alice*. It exemplifies the depth to which she genuinely cared about the relationships she developed with her patients and the positive and formative consequences to her nursing practice. I wrote in my field notes that 'during this interview, Alice's sincerity and passion for serving others was like a palpable presence in the room'.

Effective care delivery within the context of the nurse-patient relationship depends on each party having and understanding the same information. In her recent clinical work *Gabrielle* dedicated a significant amount of time to teaching her patients, "they would appreciate the way I [tried] to explain things and would tell me…that was really helpful or how they learned something". Her patients expressed appreciation for the time she spent educating them about their illness and treatment courses; Gabrielle in response was inspired to continue dedicating time to educating her patients. Consequently, this cycle of dedication and appreciation facilitated strong nurse-patient relationships.

In conversation with *Charlotte*, it became apparent that flexibility and adaptability were key tools in constructing the nurse-patient relationship "listening to the patient's concerns and modifying your interventions accordingly…really adapting to your population of focus". The

relationship with each patient is unique, and therefore nurses need to be fluid in the completion of their nursing work to meet the needs of their patients. Doing the hard work required to be a 'chameleon' in practice, to care about and be what your patients need, is an expression of genuine interest in and concern for both your patients and your nursing practice. Evident are the benefits of the nurse-patient relationship for patients; however the relationship can be equally advantageous to nurses.

Reciprocal Transformation

Several key informants reported demonstrating nursing professionalism requires that they reflect on all aspects of their clinical experiences; evaluating the nursing care they delivered, and considering the effect their care delivery had on everyone, including themselves. For example, the relationships *Alice* developed with her patients helped her to create and communicate how she would actualize the role of nurse in her clinical practice. Furthermore, there are benefits that one yields in providing care to another person: opening yourself up to other perspectives, increased pride in self and your nursing work, increased personal and professional satisfaction, and motivation to maintain a highly professional practice. *Charlotte* was proud of and visibly changed by the partnerships she created with her patients, "assisting people in major transitions in their life…being a key role in that, it's extremely rewarding…it's not just a profession…it's more a way of living". The relationships *Betty* had with her patients helped her to dedicate more time to improving her confidence and competence in her communication skills.

> I used to be very shy, not a big talker… I think it just helps me to know that I've done something good for my patients and I may have made a difference in helping them let out

their emotions… thinking that I made a difference in someone's day or that person finally opened up and I must have been a big part of that.

As a result of the motivation derived from her relationships with patients, Betty was able to increase her communication confidence and competence in a way that was meaningful to her. This was evident in her practice, as I had written in my field notes that 'Betty always had a smile for her patients and easily engaged them in conversation'.

Learning to be open and accepting of new and divergent perspectives is an important life skill that can be a very useful tool in a professional nursing practice. It can be a challenge for nurses to care for the wide variety of people who enter the health care system, particularly if nurses close themselves off to ideas and beliefs that differ from their own. "People have lived this incredible life and have so much to share with you, and give to you, that I think you can take a different approach to life after hearing from those people". *Alice* derived both personal and professional transformative growth through the relationships she built with her patients.

The theme of transforming through the nurse-patient relationship was also present in the focus group discussion. When discussing the professional relationship between nurse and patient, a key informant commented "I like the process of being able to connect with them [patients] and help lower their anxiety, reassure them-that's fulfilling to me". This comment instigated the most lively and animated discussion focused upon the positive benefits derived from relationships with patients, prompting another key informant to share that "knowing that you make a difference at the end of the day is a huge aspect of why I love nursing…I go home and feel I helped someone today". To leave work at day's end, *loving* your profession, is

indicative of how powerfully significant the nurse-patient relationship is to how a nurse feels about themselves and their practice.

In summary, the second thematic category 'The Essential Relationship' has two subcategories: 1) genuinely caring connection; and 2) reciprocal transformation. The ability to develop and maintain relationships with our patients is of primary import to having a successful nursing practice. However, of equal importance is a nurse's ability to build effective relationships with their colleagues in health care.

The Collaborative Relationship

Providing safe and comprehensive care to patients in today's health care environments necessitates the involvement of numerous disciplines in the physician ordered plan of care. Patients have complex physical, emotional, mental, and social issues that can extend beyond the interventional comfort level of nursing. These issues require the specific knowledge and expertise held by the disciplines of social work, physiotherapy, transition services, and occupational therapy to name a few. It becomes imperative to the work of nursing that collaboration occurs.

In Practice

Betty spoke about the importance of being able to effectively communicate with other health care professionals, "things can get lost in translation and then you have no idea where something went wrong…need to build trust with others…if you can't trust other people than it's difficult to approach [them] when you need help". She identified the import of collaboration to herself; being able to go to another team member for assistance or guidance, and working within a clearly defined and understood care plan. Moreover, she identified the risk to the patient;

confusion or omissions in their care plan could lead to significant patient harm. *Dana* was in agreement and understood nursing professionalism as the ability to "communicate with colleagues and the interprofessional team…in a very respectful manner".

Collaboration with other colleagues in health care was also a theme of the focus group discussion. A key informant commented, "We [nurses] aren't considered specialists, we are generalists". To which another informant added, "You [the nurse] have to find the resources, need to find the answers, or delegate it to who needs to deal with it". The group realized that their professional work depended upon the caliber of the relationships they developed with their interprofessional colleagues. In addition, the group had a discussion of how they thought their nursing work was viewed and understood by their colleagues outside of nursing. One informant felt dismissed and unappreciated by a physician colleague " It's that feeling, that nurses are disposable, nurses are a dime a dozen-get me a good one…like if you can't do the skills up to par, then get me someone who can". An opposing view was then offered by another informant,

> When I went into nursing, I thought doctors looked down on nurses and didn't think they were that useful…Once I got into nursing, doctors go out of their way to say-I don't know what I would do without you guys…you are the connectors.

This sentiment was echoed in another informant's comment "in the palliative setting, the doctors really value the opinions of nurses, because they are the person that the patient really trusts and talks to a lot".

The discussion then turned to focus on what other disciplines within the allied health group thought of nursing work, physiotherapy in particular. "I don't think they understand how much nurses do…I have a friend in physiotherapy and she has the view…you just clean people,

that's all you guys do." All key informants agreed that while this may be but one view, it is not less valid and needed to be reflected upon. Nurses have a responsibility to understand how other disciplines understand our work, and a further responsibility to work towards changing negative or false judgments. Through continued discussion, the group did come to agreement that individual factors as well as divergent clinical environments impact the development and caliber of interprofessional relationships. Nevertheless the group agreed that the continued dedication towards building interprofessional relationships was a fundamental component of nursing professionalism.

Another equally important collaborative relationship is the one that develops between nurses. All eight key informants acknowledged that their understanding of nursing professionalism had been predicated upon the relationships they created with nurses they met during their clinical practicums. *Harriet* shared "the nurses I've experienced on the unit…you get to see what you admire about their work and what you don't admire, and I guess I base my professionalism on that". *Gabrielle* expressed a nearly identical view,

> The nurses I am shadowing…they are really professional in communicating and teamwork and all their standards of care…there are some others that I don't think are professional…to stand outside [a patient's room] and talk about a patient within earshot.

In *Dana's* experience, nursing professionalism was actioned in clinical settings: "seeing something done through the other nurses and putting into practice her in the setting…that really makes an impact". Additionally, three of the key informants explicitly mentioned the importance of mentorship within collaborative relationship amongst nurses. In *Alice's* experience, "they [nurses] have been supportive…always willing to teach you…to show you

things that you've never seen, or always there to lend a hand". There was general consensus among the key informants that mentorship within intradisciplinary relationships is an instrumental aspect of nursing professionalism, evidenced in *Evelyn's* words "one part of professionalism…is just being willing to teach the next generation that comes after you…the nurses that appreciated their role in teaching…I think that was really professional of them". Moreover, an effect of the development of intradisciplinary relationships is the consequences of role modeling. If you are constantly around a certain behavior (positive or negative), or exposed to certain ideas, you will to varying degrees, embrace those ideas and assimilate those behaviors. A belief articulated by Charlotte, "the mentor relationship is quite key…to engage or follow that image, it's something to aspire to".

These nurse-nurse relationships occurred within the context of health care delivery environments, wherein student nurses are learning how to be, and what it means to be, a professional nurse. For the key informants, their ideas and beliefs about professionalism did not develop in isolation, but through interactions with others in varying clinical environments. Additionally, the informants discussed the effectiveness and impact of the collaborative relationships they had with faculty members and clinical instructors, within the context of 'learning to be a professional nurse'.

In Learning

Learning how to be a professional nurse also occurs within classroom settings. To become a registered nurse, one must first successfully complete an undergraduate degree in nursing. In undergraduate nursing programs, the teaching and evaluation of professionalism, is an included component. I attended the on-campus seminar sessions, a required component of the

final practicum course, along with my key informants. These seminars were theoretical, the foci of discussion aligned with the required learner outcomes of the final practicum course. Topics discussed included: therapeutic relationship, collaboration, communication, and leadership. However the word 'professionalism' was never used or linked to these topics, or the work being done in clinical settings. Consequently, what professionalism is or is not was also not discussed. This knowledge prompted me to ask my key informants how they were learning nursing professionalism in the classroom or practicum setting, from their academic and clinical teachers. The group was nearly equally divided in their responses, but everyone shared the opinion that this particular collaborative relationship (with faculty and instructors) shaped, to varying degrees, their understanding of nursing professionalism. Some had considerably deleterious experiences, others had equally affirmative ones, and a few had both.

The positive.

Several key informants expressed that the faculty members and clinical instructors that they interacted with were supportive and impactful in relation to teaching them how to be a professional nurse. *Fanny* voiced that they demonstrated support in the following ways, "answering questions for us…they advocate really well for us…kind of ensuring that you get the most out of your learning experiences…approachable". *Betty* also spoke about how her instructors and professors supported her by being open and available, " they would give us extra resources…sit down with us to go over a test…making sure we understand it…explain it in terms that you could understand." This greatly impacted *Betty*, for she brought this forward into her nursing practice; always ensuring her patients had the resources needed and that they

understood their plan of care. *Evelyn* had a particularly positive relationship with one of her clinical instructors:

> I had some other things going on in my life and she didn't just kind of push it aside and say you better perform. She sat me down and talked to me about them and I realized the value of that. How that made me feel and that made me open to wanting to share with her. I think about that every time I am working with a patient…I want to find out how I can best support them.

Evelyn, like *Betty*, took what she learned through collaborative relationship and implemented it into her nursing practice.

The negative.

Each individual student interacts with a wide variety of professors and instructors during their four year undergraduate journey. For a variety of reasons, some people you experience along the way will influence you positively, helping you to better understand the nursing practice you are building. Others will not. *Evelyn* shared another story with me about a time she truly struggled in her relationship with a clinical instructor. I wrote in my field notes 'Evelyn had difficulty telling this story, the tone and cadence of her voice changed, it appeared she really didn't want to recount it'.

> It's about turning patients into objects of science…I felt that was what we were doing…the instructor said everybody this person has this case… it had to do with the woman's chest and she [instructor] just completely put the gown down and exposed this woman's chest. So this woman was bare…with eight students crowding around her

> bed…and she [instructor] is like everyone come take a turn listening to her chest. I didn't even want to do it. This is terrible…we didn't preserve her dignity.

Further discussion with *Evelyn* revealed that she attempted to speak with her instructor about her feelings of moral and ethical distress, but her concerns were dismissed. Despite not being able to resolve the situation, *Evelyn* learned a powerful lesson: how she would never conduct her own practice. Her understanding of professionalism was formed in this circumstance in response to what she identified as unprofessional practice.

Alice reported only having undesirable relationships with her clinical instructors and professors, "never felt that I could go to them, they weren't a mentor to me…wasn't creating an environment that was safe and open". *Alice*, like many other students, experienced difficulties in learning how to enact the professional role of nurse. Contributing to her difficulties, she did not feel equipped to go to her instructors or professors for help, "I felt like if I had questions, or if I had emotions…they were used against me…there was no advice…it was more like you are wrong". Unfortunately because *Alice* was unable to resolve these relationships, she subsequently began to feel "vulnerable and helpless". Furthermore, even though *Alice* was now able to identify and demonstrate positive attributes of nursing professionalism, she had internalized these negative experiences for a significant amount of time:

> I would say a huge part of my journey in nursing…and not liking it…had to do with faculty members and how they presented a model for what nursing is and who nurses are…I didn't want to be part of that, I didn't want to identify with that, so I always used the faculty as an excuse to hate nursing.

In my field notes I had written, that by the end of telling this story 'Alice's eyes were beginning to fill with tears'. So I brought the conversation to a different place at this point.

For other key informants, it wasn't that the relationships with instructors and professors was negative or harmful, they just didn't exist. *Harriet* stated, "The faculty…I feel like it's almost intentional that they try not to make a connection with you". She realized that connecting with 150 students may not be a reasonable expectation but any attempt would have contributed to her understanding of professionalism, "they model a professionalism that almost seems out of their scope… it's hard to relate". With regard to the in classroom teaching of professionalism, *Dana* demonstrated agreement with *Harriet*, "In lecture they don't consider everything that happens in the clinical setting". These informants identified a distance or disconnect between the theoretical teaching of professionalism, and the enactment of professionalism within the realities of today's health care environments. Consequently, this became a barrier to 'relating to and trusting in' this particular collaborative relationship. Therefore, I question how much of what was taught about nursing professionalism was believed by, and then incorporated into the practice of our future colleagues in nursing.

In summary the third thematic category 'The Collaborative Relationship' has two subcategories: 1) in practice; and 2) in learning. The subcategory 'in learning' was further divided by the headings 'the positive' and 'the negative'. The ability for student nurses to develop supportive and accessible relationships with their collaborative partners, in both practice and learning environments, was identified as a primary aspect of nursing professionalism. Both successful and unsuccessful relationships were experienced, each having consequences to the understanding and demonstration of nursing professionalism. The consequences of nursing

professionalism extend beyond its impact on patients, nurses, or our collaborative health care colleagues.

The Long Distance Relationship

Alberta nurses' function within the government controlled and publicly funded health care system, and as such is subsequently accountable to the public. Public opinion can influence government policy and the strategic operations of health care organizations, including how nurses are utilized within it. Moreover, nurses have an inherent relationship and connection to the public. At any given time, a member of the public can become a patient. Therefore, it is necessary for the discipline of nursing to have an understanding of what the public believes about nurses and the work we do. With this knowledge, we can then work to change what doesn't fit with how we know and understand our work. *Charlotte* echoed this statement, "if we want to change the role we have or the voice we have in the health care system…how we present ourselves…is extremely crucial...professionalism would be a changing force for the role we do have in health care". A similar view was expressed by *Dana*,

> Throughout the years nursing has been pictured in a different way to the public and the media portrays nursing-as a very dirty job…and it isn't…so it's important to show professionalism, so we can change the image of nursing.

I asked each of the key informants to discuss the significance of nursing professionalism. *Alice* believed that how others view us is dependent upon how we first view ourselves, "It's [professionalism] important, not only for us to know what we stand for and what we are as a profession…what we can do and have the ability to do…also what we are to other people and how we are viewed" . *Alice* lived her idea in practice, I wrote in my field notes '*Alice* presents

herself to patients and colleagues in a genuinely caring and knowledgeable manner'. Several other key informants stated the import of professionalism was its influence on how the public and media view us. *Gabrielle* stated "It's hard to have a solid definition of what is it to be a nurse…different perceptions from media and public…I think it's better if we get a voice for ourselves…then present ourselves to the public". *Gabrielle* is speaking to the confusion that exists within our own discipline as to what nursing professionalism is; and subsequently, how difficult it becomes to convey who we are and what we do to the public. *Gabrielle* also argued that nurses should care about what the public thinks because, "I feel like we deserve more recognition…it would really encourage...good behavior…instead of we will not be burn out that easy. If we can be looked at more positively and if people appreciate what we are doing".

A dialogue regarding the relationship nurses have with the public and media was raised during the focus group discussion. I asked the group the question: what opinions have you heard or think the public has about nursing work? Individual responses included, "you do the dirty work", "you change diapers, do bed baths, empty urinals…if there is a mess, we clean it", "we are kind of smart", "but not smart enough to be a doctor", and "they think we are like the nurses on Grey's Anatomy". From here the conversation morphed into what our response, as nurses, should be to these misguided notions. "Now that I have a lot of skills and have a lot of knowledge, I am fine to say…you are wrong. Nurses know a lot of things, this is what we do… this is what my day looks like". Another key informant added that, "it's hard for people to understand without actual contact with them [nurses]. So I think its exposure". The key message, being the importance of demonstrating professionalism in practice, so others can see and experience what the true work of nursing is.

In summary, the fourth category 'The Long Distance Relationship' refers to the relationship that nurses have with the public; a relationship prominently influenced by the media. The key informants identified they had a responsibility to shape the understanding the public has of nursing work; and that this could begin to be accomplished through demonstrating professionalism in practice.

Relationship Obstacles

This category of findings outlines the main barriers identified by the key informants to their understanding and demonstration of professionalism in practice. These barriers to professionalism have actually shaped what they know of professionalism, and how able they are to demonstrate it in practice.

Professionalism: What's that?

All key informants had difficulty articulating their understanding of what nursing professionalism was. During interviews, significantly lengthy pauses and expressions of confusion occurred, after I questioned them as to how they would describe or define nursing professionalism. The responses, eventually given, were generally vague and included the word professional, to define professionalism. "I never really thought about nursing professionalism, but nursing as the profession, I think is being professional", is how *Alice* framed her response. *Betty* was equally ambiguous, "I guess it's not necessarily…I mean I know a lot of people say it's about being professional with our patients… I think it's just how you portray yourself". In my field notes, I wrote that *Charlotte* and *Dana* had the most difficulty in responding to this question, "Um…It's not just one's attire…it goes beyond that into your breadth of knowledge…it's tough…hard to describe", and "It's definitely hard to define, I can't really

define it, it's more I have a picture of it". During interviews, it typically became necessary for me to either prompt the key informant (with an example), or creatively rephrase my questions to help them understand what I meant by nursing professionalism.

In addition, there was general consensus amongst the key informants that the language of 'nursing professionalism' and discussions about what it is, it's significance, and how to incorporate it into practice, were not themes of discussion in their academic classes or clinical sessions. "I don't think I learned it through instructors…just the five 'P's of professionalism...I don't actually know what they are", was *Alice's* response to how she had come to her understanding of nursing professionalism. Similarly *Betty* responded, "They tell you every semester about the five 'P's…like being prompt and stuff…but I don't recall…that they went in depth into what the whole professionalism of nursing means". *Charlotte* struggled to clearly or assuredly identify what she had learned about nursing professionalism, or how she learned it:

> I would say it's very much tacit…we don't really vocalize it necessarily… I would say we discussed it… touch on it in class…tie it into learner outcomes…we tie it into everything that we do...but I'm not too sure how I'm fully aware of when I'm picking it… and when I'm using it.

When I asked *Dana* how and when nursing professionalism had been spoken about in nursing classes, she responded, "I think in terms of…how to approach a patient…can we get back to that one?". There appears to be a correlation between the key informants' lack of clarity regarding the term 'nursing professionalism', and their actual or perceived lack of formal education regarding it.

Interestingly, none of the key informants reported having a clinical instructor incorporate discussions on nursing professionalism into their pre or post conferences. These conferences were spent discussing pathophysiology, pharmacology, or as *Betty* informed me, "they were all about what you are going to do for your patient…but nothing to how you are going to portray professionalism with your patients, or the nurses you are working with". I do not debate the validity of these discussion topics, only wonder at the exclusion of discussion and/or use of the terminology 'nursing professionalism'.

I only had access to the curriculum taught and curriculum documents used in one course entitled 'Nursing Practice NURS599: Integrating Nursing Roles and Practices VI: Transition to Nursing Practice'. Therefore, I cannot comment on what 'was or was not' taught regarding nursing professionalism in any other undergraduate academic or clinical course. Nor can I comment on the individuality that occurs in the teaching styles and topic selection from one professor/instructor to the next. In reviewing the NURS599 course outline, I found that the objectives of the course were designed to contribute to each student's professional development. Further, the course objectives and learner outcomes were directly correlated to the CARNA (2006) framework and standards for 'entry to practice level' nurses. Additionally, the outline specified that a certain number of hours were to be committed to attending on-campus seminar sessions, led by a Faculty Advisor. The purpose of these sessions was cited as: "to provide a forum for students and Faculty Advisor to establish a community of learning and teaching; focused on creating a space for reflection to share understandings and experiences encountered in nursing practice" (University of Calgary, 2014, p.4). This objective is inexplicit, leaving

individual Faculty Advisors a great deal of freedom in deciding upon the content and direction of the sessions.

Upon examination of the learner outcomes document associated with this course, I found that one section related specifically towards evaluating a student's ability to work to the full scope of professional practice. Within this section, the words 'professional' and 'professionally' are utilized to describe what is expected of students in order to successfully complete this portion of the course. "There was so much emphasis from instructors…but it was always related to time…being on time and having the ironed scrubs and your hair pulled back…it wasn't about how you actually conducted yourself in the setting". This was *Alice's* understanding of how her professionalism was evaluated, an opinion that was shared by other key informants. Therefore, I am not convinced that merely stating different representations of the word 'profession' is enough to ensure that students understand what is expected. Certainly, it had not assisted these eight key informants in defining or articulating what is expected of a professional nursing practice: also understood as professionalism.

Professionalism Doesn't Live Here

Nurses are customarily required to work in teams, within specialized health care delivery environments; such as emergency departments, operating rooms, medical/surgical inpatient units, or outpatient clinics. A culture develops amongst nurses working inside of a particular work environment. The culture becomes and then represents the group's ideas, beliefs, and accepted behaviors. This representation becomes the norm, or the expectation of all who work within or enter the environment. The culture of a particular work environment may contribute to and support nursing professionalism; however, the key informants recognized that other cultures

were a barrier to them feeling able to demonstrate professionalism in practice. "You go onto a unit and you see something that is not professional, but the unit accepts it as professional…they try to rationalize it and try to change your mind about it". *Dana* struggled with this experience, felt ethical distress, as she did not feel equipped to confront the nurses working in this environment. *Betty* found that some work environments did not appear to value teaching and mentoring, "when we had little to no skills, the nurses essentially looked down on you, thought that you were just…in their way…they didn't want you to be there". Correspondingly, *Evelyn* felt "more than not…like I was a burden to them [nurses] or like I was in their way…especially when I didn't really know a lot of skills…they are like- what can you do?". Furthermore, *Evelyn* struggled with wanting to fit into her current clinical environment, but feeling in doing so, she would compromise her ethics: "People talk about their sex lives, when the patient is just there on the table…It's just really troubling to me… and I wonder what my boundaries are… to be able to say anything about that." Another example of a difficult work culture comes from *Fanny*,

> A lot of times, even if they [nurses] know we are watching and relay all to our instructors…they will tell me…just don't tell your instructor…they know it's wrong…they know it's not the best practice that they are doing that.

During a shadow observation, I witnessed *Dana* experience a similar situation when she was told by a nurse to lock a peripheral intravenous line with heparin solution. I could see that *Dana* was unsure of how to proceed, but that she was getting ready to do as she was asked. Knowing that this was not the correct action, I decided to intervene by asking the nurse a few questions about the particular patient and his case. In the end, after reviewing policy, saline was used to flush the

peripheral line. Undoubtedly these key informants experienced significant tension in wanting /needing to fit into what they identified as, an unprofessional work culture.

In addition, the group postulated as to why these deleterious nursing cultures had developed within certain work environments. During the focus group discussion, the key informants agreed that heavy workloads, poor staffing, and budget constraints were causative factors. Further, the group discussed the impact that negative work cultures/environments have on nursing professionalism. "Therefore, you end up…unfortunately… you are forced to cut corners, or are forced to take out certain aspects of care that are actually really essential…you end up getting rid of the holistic aspect of nursing". Another informant added, "The environment is very conducive to the quantitative end of things…because that's how they measure results –productivity…that's why you focus on the tasks". Subsequently, their experiences led these key informants to believe that certain work environments were not conducive to learning about or demonstrating nursing professionalism.

In summary, the fifth category 'Relationship Obstacles' has two subcategories: 1) Professionalism: What's that; and 2) Professionalism doesn't live here. These obstacles have become part of how they define and describe nursing professionalism, because they have played a role in shaping both their understanding and ability to demonstrate it in their practices.

Chapter Three Summary

In this chapter I have presented the findings of my research wherein I asked the question: How do fourth year nursing students at the University of Calgary describe nursing professionalism, and how was it learned and shared within the context of classroom and clinical practicum environments? In answering that question, I had the privilege of working with eight

bright and engaging nursing students. They described their understanding and demonstration of nursing professionalism in relation to four fundamental relationships they work to build while in practice: 1) The Primary Relationship; 2) The Essential Relationship; 3) The Collaborative Relationship; and 4) The Long Distance Relationship. Additionally, the key informants understood and demonstrated nursing professionalism within the context of several barriers to developing the four fundamental relationships. This category was subsequently named 'The Relationship Obstacles'. Numerous insights have been generated from these findings and the major themes need to be examined for their fit within, and contribution to the current literature on nursing professionalism.

Chapter Four: An Evolved Understanding of Nursing Professionalism

"The knowledge of all things is possible"
~Leonardo da Vinci~

In this chapter I will discuss how the ethnographic research conducted with fourth year student nurses, within the context of their final clinical practicums, has led me to an enhanced understanding of what it means to be a professional nurse. As I reflect on all that I have learned it has become apparent that my core assumption about nursing professionalism has been affirmed and strengthened by this study; that foundationally, professionalism in nursing is about the manner in which nursing work is conducted. My data has also revealed that professionalism in nursing is predicated upon the development and maintenance of effective and authentic relationships with the self, patients, families, and interprofessional colleagues. Consequently, my understanding of nursing professionalism, how it is actioned in practice, and then known by others has evolved. Additionally, I have gained more clarity regarding the barriers to actioning professionalism in a nursing practice. I will present how my thinking has evolved by discussing relationship based professionalism and its barriers in detail. Moreover, I will compare and contrast my data with what is currently known in the literature. The following questions will serve as a guiding framework for this chapter: 1) how has this ethnographic inquiry fostered a deeper understanding of nursing professionalism; and 2) how has my understanding of nursing professionalism been transformed by this work?

Relationship Based Professionalism

Ethnographic inquiry has afforded me the honour of walking (for a short time) in the practice of my future colleagues in nursing; to come to know and explore with them their

understanding of nursing professionalism. I was able to observe, as well as understand from interviews, their commitment and dedication to their nursing work exemplified through embodied relationships with patients, families, and colleagues. "Relationship based professionalism" is the term I have chosen to describe the key informants' understanding of nursing professionalism that emerged through the iterative process of ethnographic data collection and analysis. After I completed analysis, it was clear that several relationships were significant and fundamental to the informants' understanding and description of professionalism: 1) the relationship with self; 2) the relationship with the patient/family; 3) the relationship with their colleagues; and 4) the relationship with the public (the image held of nurses). The imperative of relationships to nursing professionalism is a novel and intriguing proposition. Currently the concept of relationship is not being used to describe and define nursing professionalism in the existing literature. However, there is an abundance of writing dedicated to patient centered care; a construct predicated on the concept of caring. Additionally, a new 'joined-up' concept of patient centered professionalism entered the nursing literature in 2014. These two concepts contribute to, and share similar attributes of the concept-relationship based professionalism described by my key informants. I will now outline each briefly, commenting on the features shared with and divergent from relationship based professionalism.

Patient Centered Care

Several theorists have developed models for enacting a caring nursing practice predicated upon patient centered care and the development of a nurse-patient relationship (Peplau, 1952, 1997; Gadow, 1998; Leininger, 1988; & Watson, 1985, 2011). Peplau's (1952, 1987) theory of interpersonal relations proposed the necessity for nurses to develop authentically caring nurse-

patient relationships, to assist patients in the work necessary for regaining their health. Further, Peplau discerned three phases of this relationship: orientation, working phase, and termination. Each phase has definable characteristics and specific work that needs to be accomplished. Grounding Peplau's theory is her belief that the nurse-patient relationship is the fundamental way of providing nursing care. Similarly, Leininger (1984, 1997) defined care as the essence of nursing and a distinct, dominant, and unifying focus that is essential to the promotion of wellbeing, health, and healing. Gadow (1985) was also in agreement, and argued that the value of caring is that it provides a foundation for ethical nursing practice that protects patient dignity. Moreover, Gadow viewed that caring in the context of the nurse-patient relationship created a commitment to meeting the needs of the patient. Watson (1998, 2011) expounded on the concept of care and the nurse-patient relationship with her formulation of the ten 'carative factors'. These factors describe the authentically caring relationship that is meant (ideally) to exist between patient and nurse.

Carative factors are the characteristics of nursing that promote and sustain a therapeutic healing relationship; a relationship that has lasting effects on both the nurse and the patient (Watson, 1998, 2011). For example, carative factor six is dependent upon the nurse-patient relationship to facilitate meeting the patient's needs: "Creatively using presence of self and all ways of knowing/multiple ways of being/doing as part of the caring process; engaging in artistry of caring-healing practices" (Watson, 2011: p. 50). Consequently, the nurse becomes a central agent of caring by providing a unique authentic presence with patients during their times of illness. Further, Watson emphasized being with the patient rather than doing for the patient. It is this manner of providing nursing care and the subsequent experience of connection with the

patient that Watson (1998, 2011) referred to as caring moments. Watson recognized the influence of Carl Rogers on her work, as she asserted that the nature of the caring relationship requires the nurse to have a deep understanding of self. Self-understanding includes awareness of one's own thoughts, feelings, values, and experiences and dedication towards the continual development of one's own potential (Falk- Rafael, 2000). This in turn allows the nurse to be fully present with and available to the patient, not hidden behind professional detachment. So how then does patient centered care compare to the concept of relationship based professionalism?

Comparing patient centered care to relationship based professionalism.

In conversation with and observation of my key informants, I discovered that they understood and described nursing professionalism in terms of the significant relationships they developed while in practice. What they valued about their nursing work, and how they consequently described the way in which they carried out their nursing responsibilities ,was intimately tied to the calibre of relationships created with patients/families, and their nursing/interprofessional colleagues. A strong commitment to developing relationships with patients is a feature shared with the concept of patient centered care. However, patient centered care theories are self-limiting, focused almost exclusively on the benefits and outcomes available to patients when an effective and caring nurse-patient relationship is developed. Moreover, patient centered care theories describe a way that nursing care can be delivered, but are not centrally concerned with how nurses understand or define their nursing practice. Professionalism understood within the context of relationships remains mutually beneficial. However, the focus shifts more predominantly to the outcomes for nurses, who now understand,

describe, and value nursing practice because of the relationships they develop while in practice. Watson's recognition of the importance of self-awareness is another shared aspect. Self-awareness generates authenticity. The majority of my key informants articulated a strong need to feel free to be their authentic selves within the context of the relationships they developed in clinical practice. I will expand upon the idea of authenticity in an upcoming section.

Relationship based professionalism it is not synonymous with the concept of patient centered care. Nursing professionalism (however conceptualized) is a large construct, one that I have often found described as an umbrella term-overarching and encompassing of many different concepts. The description of relationship based professionalism provided by the key informants, was grounded in the development of effective and authentically caring relationships with their patients and colleagues. Arguably then, one of the concepts subsumed within (or blended with) and central to the conceptualization of relationship based professionalism would be patient centered care. In line with the idea of merging one concept within the other, is the newly emerging 'joined-up' concept of patient centered professionalism. Currently, there is a paucity of information on patient centered professionalism in the nursing literature; however, due to the inherently intertwined nature of patient centered care and my research on relationship based professionalism, exploration of this 'joined up' concept is warranted.

Patient Centered Professionalism

Patient-centered professionalism as a 'joined-up concept' recently emerged in the medical literature in 2006 and has yet to be clearly defined, but is about upholding personal, trusting relationships that support individualistic care, where careful attention is paid to patients'

ongoing needs, and where care is delivered accordingly (Askham & Chisholm , 2006; Hutchings et al., 2012; Rapport et al., 2014). In addition medical professionalism is shifting towards preferencing the patient's involvement in and experience of care. The lack of clarity amongst physicians regarding a clear definition of patient centered professionalism may be due to 'patient-centered professionalism' continuing to be perceived and interpreted as two separate concepts ('professionalism' and 'patient-centred care'). Both concepts are discussed in the literature; however, each concept has differing degrees of consensus regarding importance to practice, definition, and included attributes (behaviours and values).

Focusing on the nursing literature, the concept of patient centered professionalism was explored for applicability within the field of community nursing. A study conducted in the United Kingdom by Rapport et. al (2014) found several themes to be central to the concept of patient centered professionalism: 1) the patient 2) nurse as a person 3) nursing ethos (provision of holistic care) 4) knowledge and skill competence 5) working relationships 6) service delivery 7) training and information 8) environment (physical space and culture). The authors did not go into great detail when discussing these eight thematic findings. However, they did indicate that nurses participating in this study regarded the theme of 'the patient' as most important, and the themes of 'training and information' and 'the environment' as lowest. Attributes of the theme '[community] nurse as a person' were numerous and focused on the individual's level of engagement, approachability, and competence. The discussion related to the low ranking themes focused mainly on the barriers to professionalism. Themes ranked with moderate importance were 'knowledge and skills', 'working relationships' and 'service delivery'. 'Knowledge and skills' as a theme encompassed a range of attributes indicative of a professional nurse including:

recognizing other health professionals' skills and knowledge, good interpersonal skills, and having/utilizing the appropriate knowledge at the appropriate time.

Comparing patient centered professionalism to relationship based professionalism.

It is difficult for me to comprehensively compare and contrast relationship based professionalism with patient centered professionalism, as both are emerging concepts in their infancy. However, I do not believe them to be identical concepts, nor are they wholly unique of each other. Both concepts focus on the essential nature of the nurse-patient relationship as integral to defining professionalism, and both agree on the attribute of competence. Additionally, the study conducted by Rapport et. al (2014) also found that environmental barriers exist to demonstrating professionalism in nursing practice. The environmental barriers identified by my key informants will be discussed in a future section of this chapter. Features that I perceive as unique to relationship based professionalism are the focus on authenticity, and developing an understanding of what it means to be a nurse and do the work of nursing through relationships built with patients, families, and colleagues. The central and purposeful emphasis (i.e.: who is of primary import) in the therapeutic relationship, shifts in relationship based professionalism, equally afforded to both the nurse and the patient. Moreover, the emphasis on relationships extends beyond the one created and maintained with patients and families.

Undoubtedly continued research on patient centered care, relationship based professionalism, and patient centered professionalism needs to occur to gain clarity regarding the definition and impacts of each on the other; and how each impacts the discipline of nursing and patient care. After examining all three multifaceted concepts, my understanding has shifted;

patient centered care is one way of delivering care within a nursing practice, whereas patient centered professionalism and relationship based professionalism are ways in which nurses make sense of who they are, why they do what they do, and what they value in their work. Knowing where the concept of relationship based professionalism fits within the existing discourses on patient centered care and patient centered professionalism is important prior to discussing the concept on its own merits. Significant themes emerged from the findings of my ethnographic inquiry that warrant further examination: authenticity to self, authenticity within relationship, boundaries, and environmental barriers.

Authenticity to Self: Who am I?

The privilege of a lifetime is to become who you truly are.
~Carl Gustav Jung~

When asked to describe or discuss nursing professionalism, the key informants spoke about the importance of embodying their authentic selves while in their nursing practice. These becoming nurses disclosed that it was imperative that they feel free to share their unique selves with their patients. They indicated that creating relationships with patients built through transparent and authentic sharing was foundational to what they then thought about their nursing work. The key informants expressed that pride and satisfaction in their practices and in the discipline of nursing stemmed from being able to genuinely connect who they are (as a person) with who their patients are. To accomplish this, a nurse must first know themselves; needing to be aware of one's own perceptions, emotions, values, and beliefs about the world we live in. While listening to the key informants talk about their need to be their authentic selves in practice,

I came to hypothesize that what they were really striving for was to meet their patients in a place of commonality: one human being to another.

There are numerous conceptualizations of the word authenticity. The following description written by McGee (2014) is perfectly phrased, and is the one that resonates most with me and aligns well with the findings of my study:

> With authenticity comes a coherence of experience, understanding and action. What we experience informs our understanding, which then informs our actions. What we say meshes with what we do. Others experience our sincerity, our devotion, our commitment and the truth of our genuine intentions. We are believable. We are trustworthy. We ‘‘say what we mean, mean what we say’’, ‘‘do what we say and say what we do’’ (p.727).

The specific attributes of authenticity include creativity, coherence, self-awareness, integrity, faith, honesty, vulnerability, openness, humility, and conviction (McGee, 2014). To be authentic, a person needs to be open to learning about themselves in new experiences. This is a vulnerable position to be in and requires a certain measure of humility and conviction to stay the course when the ‘new’ becomes uncomfortable. Further, authenticity is about learning to listen to and trust in one’s own feelings and intuitions; while simultaneously acknowledging and analyzing the new understandings gained of oneself, others, and the world. For my key informants learning about themselves, being authentic to self was the necessary first step in understanding who they are as nurses. Moreover, they felt that knowing and being true to self was a prerequisite to forming trusting, caring relationships with patients, families, or colleagues.

Caring and the empathy created from allowing oneself to care about another, cannot be faked. Authenticity is the precursor. Further, for my key informants, they are not mechanical actions but are ways of being; originating internally and flowing outward to potentiate the creation of healing connections. For nurses to be authentically healing requires that we live authentic lives.

The benefits of authenticity to the 'self' have been discussed within many fields including psychology, sociology, philosophy, and Eastern philosophical and spiritual traditions. In the psychology literature, the concept of authenticity is imperative to developing an authentic relationship with one's inner self, as well as with others; this fosters positive psychological functioning (Robinson, Lopez, Ramos, & Nartova-Bochaver, 2012). Living authentically has been found to yield several psychological benefits including: consistency between thoughts, values, and actions promoting stability and personality congruence, fosters self-fulfillment, and enhances perceptions of quality of life (Robinson, Lopez, Ramos, & Nartova-Bochaver, 2012). Conversely, authenticity is diminished when communication patterns in relationships constrain, devalue, or compromise open expression (Neff & Harter, 2002). In addition, Sloan (2007) found that inauthenticity was most predictive of negative outcomes for and among employees who closely and personally identified with their professional roles. This is particularly applicable to nursing, wherein it is near impossible for a nurse to separate personal self from professional self- especially if dedicated towards living authentically.

Being authentic to self is not widely discussed in the current nursing literature. However, discussion regarding authenticity within the context of the nurse-patient relationship is abundant (Peplau, 1952, 1997; Gadow, 1998; Leininger, 1988; & Watson, 1985, 2011). We cannot truly know ourselves, separate from others; part of who we are is created through communication and

relationship with others. This includes our professional selves. My findings suggest that authenticity is created not only from an intimate communion with the self, but through sharing ourselves with others.

Authenticity within Relationships: Can I share who I am with you?

To be nobody-but-yourself-in a world which is doing its best, night and day, to make you somebody else-means to fight the hardest battle which any human being can fight.
~E.E. Cummings, 1958~

What is it that actually defines a professional nursing practice? The concept of the nurse-person relationship has been a focus of discussion within the nursing literature, ever since Hildegard Peplau's book *Interpersonal Relations* was first published in 1952. Since then, nurse theorists, differing in their paradigmatic schools of thought, have written extensively about its imperativeness to nursing practice, research, and education. Could it be that the nurse-person relationship is what defines the purpose of the discipline of nursing? Many nurses, including myself, believe that the nurse-patient relationship is the essence of a nursing practice, what drives it; and therefore, what defines who nurses are and what nurses are supposed to do as members of the discipline.

My key informants agreed that the nurse patient relationship is what most defined their professional practice and how their practice was carried out (seen, heard, and known) in clinical settings: their professionalism. When asked to describe nursing professionalism, the majority of their responses indicated that they most valued their relationships with patients. Moreover, it was through developing authentically caring relationships with patients that they came to understand their role, and what the meaning of nursing work is. Resultantly, they understood the

value and impact their nursing practice could have on the populations they cared for, by actualizing their pride and competence in practice. Similarly, Manninen, Henriksson, Scheja and Silén (2013) concluded that student nurses developed their professional competence through relationships built with their patients. Further, they found that student nurses achieved not only role clarity, but learned how to create meaningful authentic relationships with patients, when enabled to act as nurses. They built, as my key informants did, relationships with patients that aligned with their sense of internal authenticity, which then fostered continued authenticity in their professional nursing work.

The nursing process and 'being a nurse' became tangible and understandable for my key informants through their connections and interactions with patients and colleagues. My findings are in line with McCune (2009), who emphasized that authentic learning experiences influenced the students' professional identity and willingness to engage in further learning and development. The informants articulated that learning through collaborations with other nursing students and health care professionals helped them to understand what nursing is, and how to enact the role of nurse. Further, learning from the nurses they worked alongside in clinical settings, had the most impact on their understanding of nursing professionalism. The majority of the key informants expressed having numerous positive role models of professional nursing practice. When I asked what made these nurses positive professional role models, I expected to hear descriptors like 'organized, competent, and knowledgeable'; but that was not what they told me. Their exceptional relational ability was what made these nurses exemplars of professionalism. Watching these nurses build trust with their patients, families, and colleagues by taking the time to talk with and listen to them, made them proud to be a nurse. It was a

practice they wanted to emulate and be 'known' for: this is where the power and potential of nursing lies. Relationships constitute the basis for learning to be a professional nurse and are fundamental to students' sense of belongingness within the care team (Manninen, Henriksson, Scheja, & Silén, 2013). Mutually trusting and respectful relationships amongst professional nurses creates a sense of belonging that in turn promotes authenticity within a work environment. This type of relationship cannot be formed from a place of inauthenticity, nor could they be sustained in it. According to my key informants, one of the key benefits of forming and working within authentic relationships, are that they provide the context for meaningful learning regarding how to embody the role of professional nurse. However, it is not always easy to form these relationships. Boundaries and barriers do exist.

Boundaries: Real, Illusory, Moving?

"Normally, he liked boundaries. Boundaries were the safety net. Boundaries kept people on the right path. But right now, he felt like rules were made to be broken and consequences were miles and miles away."
~Heather Burch~

Boundaries were a focus of my findings in relation to conceptualizing nursing professionalism. Particularly troubling for my key informants, was what constitutes a boundary, and how the presence of boundaries reconciles with developing an authentic relationship with others. The informants understood boundaries in a very black and white way, as not being able to share personal information with patients, nor being able to be their true selves. They needed to be professional, as if being professional was somehow separate from being their authentic self. Understanding boundaries in this way, caused tension in students who then struggled with building relationships with patients, because they felt they were being 'fake'. The key informants relayed they had acquired their understanding of boundaries from instructors, faculty,

and from bedside nurses. However, in the current nursing literature boundaries are generally addressed and discussed in a different manner.

At the beginning of nursing was Florence Nightingale, and as a tribute to her, Lystra E. Gretter composed the 'Nightingale Pledge' in 1893. This pledge is used at numerous nursing graduation ceremonies as a commitment statement, and is an early address on boundaries:

> I will abstain from whatever is deleterious and mischievous... maintain and elevate the standard of my profession...will hold in confidence matters committed to my keeping...in the practice of my calling...and devote myself to the welfare of those committed to my care (Fetzer, 2012).

From this specific excerpt, I do not interpret boundaries as meaning that a nurse is not allowed to share personal information or be true to who they are, when navigating within a therapeutic relationship. Rather, it is a caution to nurses to avoid taking advantage of patients or the relationships we develop with them. Nursing students need to learn what personal information is therapeutically relevant and appropriate to share with patients. For example, sharing (if asked, or by choice) your street address, age, marital status, with a patient is not going to significantly contribute to assisting them in improving their health and wellbeing. It could however be detrimental to the nurse if a patient chooses to utilize this information with maleficence. Nurses are educated in the importance of therapeutic disclosure with patients, as a tool to support partnering with patients to successfully achieve health care goals (Holder & Schenthal, 2007). Deciding what to share about oneself, why, and when is an advanced nursing skill, and one that my key informants argued is essential to their understanding of nursing professionalism and what

makes nursing valuable, unique, and necessary. However, nurses need to be wary of whose needs are being met, through the sharing of personal information. When nurses attempt to have their own needs met, superseding a patient's needs, then a therapeutic boundary violation has occurred (Peternelj-Taylor & Yonge, 2003). This is a grey zone, because many nurses, including my key informants, report going into nursing because they have a 'need to be needed'. My findings suggest that nurses exhibit professionalism in practice when they artfully negotiate and adjust professional boundaries, based upon the unique context of each relationship and situation. Further, when nurses create and maintain therapeutic boundaries (only engaging in personal sharing to build common ground and trust), a safe space is created, wherein the patient and nurse can participate in healing actions from a position of neutrality (Peternelj-Taylor & Yonge, 2003).

Professional nursing relationships are different from social relationships. In a professional relationship between nurse and patient, one party assumes expert knowledge that is directed towards meeting the needs of the other party. Inherent to this type of relationship is the existence of a power differential (Peternelj-Taylor & Yonge, 2003). Nurses need to be mindful of abusing this power. This can be challenging, as my key informants indicated there is little classroom or clinical discussion on the concept of inherent power differentials, or on the nuances involved in deciding to cross [what appear to be] invisible boundary lines. In the nursing literature, boundary issues discussed range on a severity continuum from giving to or receiving gifts from a patient, to picking up groceries or medical supplies for a patient, to social contacts with former patients or their relatives, to engaging in a sexual relationship with a patient (Holder & Schenthal, 2007). These examples of boundary violations are quite extreme, and not the type of issues that my key informants were struggling with; understanding how to be their authentic

selves, and how to share this person with their patients within the context of a therapeutic and professional relationship. Concern about violating boundaries was identified by my key informants as a barrier to professionalism, but not the only barrier.

Environmental Barriers: Immoveable or Surmountable?

"It makes a difference, doesn't it, whether we fence ourselves in, or whether we are fenced out by the barriers of others?"

~E.M. Forster~

In addition to identifying four significant relationships as descriptive of nursing professionalism, and the particular barriers inherent to relationship building, my key informants were also able to recognize the existence of environmental barriers that inhibited their professionalism in practice. The key informants generally agreed that budgetary constraints, work place culture, instructor relations, and public perceptions of nursing were the greatest barriers that they experienced in maintaining their professionalism.

Resource Constraints

The key informants in my study were fourth year nursing students, and even though they are brand new to the profession of nursing, they were able to identify the tensions and difficulties born of budget restrictions. All of the informants, at one time or another noticed a shortage of medical supplies and/or equipment, needed to complete non-nursing tasks, or practiced on a unit that was under staffed. Resultantly, as their work load increased, so did their frustration. The recognized outcomes of their frustration were decreased time spent with patients, decreased feelings of pride and accomplishment in how nursing work was completed, and increased fatigue

and stress. Frustration in nursing work due to the amount of money allocated to providing service in clinical environments is not a novel phenomenon. Conflict within and amongst nurses is commonplace in hospital environments related to increasing demands placed upon nurses who consistently work understaffed with a decrease in available resources, within the milieu of constant change (Zakari, Al Kahmais, & Hamadi, 2010). Moreover, the addition of non-nursing work such as housekeeping duties, meal delivery, and transporting patients, results in role confusion and a decreased understanding and working at the full scope of a nursing practice. Role conflicts were found to have led to dissatisfaction and frustration, burnout, followed shortly by increasing rates of attrition (Choi, Cheung, & Pang, 2013).

The amount and type of resources provided to support nursing work within clinical settings, directly impacts the degree of nursing professionalism exhibited within these environments. If nurses understand professionalism as grounded in building and maintaining relationships, and are not able to have these relationships due to time and workload constraints, they will not be capable of demonstrating professionalism in practice. Caring is largely understood as a core component of a nurse's professional identity, often the reason identified as directing a person's choice to enter into the nursing profession (Kirpal 2004). Consequently, when this expectation is not supported by the work environment then conflict arises. From the perspective of relationship based professionalism, these issues make the management of money within health care delivery environments a priority. Detailed resource planning, including effective use of existing funds and reallocation of funds to priority concerns, have been effective management strategies (Choi, Cheung, & Pang, 2013). When fiscal management does not occur

to support nurses in providing optimal patient care, negativity, disengagement, and complacency become the culture of the workplace.

Workplace Culture

During the focus group discussion, the key informants described challenging unit cultures and shared the problems they experienced while working within them. According to the key informants, negativity, lack of engagement and support, and gossiping created the difficult workplace cultures. They expressed feeling stressed, intimidated, and isolated while working within these environments, and could not identify resources or activate supports. Conflicts arising from dysfunctional workplace cultures are highly diverse but include miscommunication, distrust, competition for resources or status, lack of engagement, and diminished concern for patient satisfaction or outcomes (Yoder-Wise 2007). Severinsson (2003) argued that high perceptions of unit morale and effective interpersonal relationships amongst nurses mediate the effects of budgetary constraints (often the predominant causative factor to negative workplace culture). The key informants echoed their support of this idea in their description of nursing professionalism; specifically, in their identification of the necessity of building trusting and respectful relationships with their nurse and interprofessional colleagues. Relationship building, (that enables mentorship), no matter how imperative, can be challenging. Mentorship is a technique employed to assist in role socialization. For my key informants, the question became, "What am I being socialized to become: engaged and authentically caring or disconnected and efficiency focused?". A concern that arose in the data was that, at times, the key informants did not feel able to develop best practice approaches to care; resulting from a lack of positive role models and the absence of an attitude of mentorship. They related this issue to the low morale

and negative attitudes within certain clinical settings, which contributed more towards their understanding of what professionalism is not. Another relationship that several key informants struggled to create was the one with their clinical instructors and/or faculty members.

Instructor Relations

One of the most important roles in clinical education is mentorship. In addition, it is fundamental that a clinical educator work to ensure the integration of students into the work environment to prevent feelings of alienation. Time constraints, the indifferent attitudes of clinical instructors, inconsistency, or a lack of visible and engaged support at the point of care delivery are cited as the foremost causes of diminished and/or stress induced learning (Anthony &Yastik, 2011; Pearcey & Elliot, 2004; Sharif & Masoumi, 2005). The majority of the informants expressed a similar view, when asked to discuss the calibre of their relationships with clinical instructors or faculty members. Specifically, they felt the pressure of their instructors' focused attention on evaluation, the parameters of which they did not perceive as being consistently applied. Moreover, the key informants struggled to equate the lack of time spent with their clinical instructors in practice to being accurately and fairly evaluated by them. The power dynamic was evident in this type of relationship, causing a disruption in learning for these student nurses; learning that needed to include not only the tasks and skills of nursing, but what it means to be and do the work of nursing. According to Killam and Heerschap, (2013) trusting and respectful relationships struggle to form in the presence of an unequal power dynamic or authoritarian clinical teaching approach; leading often to feelings of fear, stress, and uncertainty in students. Two of my key informants shared particularly distressing stories that concerned the relationships they had with clinical instructors. The stories shared had a common thread: not

being liked by their instructor, which lead to their perception of being unfairly treated and evaluated within clinical settings. Unfortunately, both informants articulated that they did not receive guidance or support from faculty members towards a resolution of their concerns; despite asking for it. Consequently, their trust in the faculty, and even in the profession of nursing, was severely compromised. Trust, so compromised that one informant seriously deliberated abandoning her nursing studies, and all that had brought her to the profession. Of significance, the degree of professionalism my key informants attributed to, or identified in, both their clinical instructors and faculty members was directly correlated to the quality of their relationships. Being interested in developing a rapport and being present and engaged in the work that was occurring, were key qualities my informants attributed to 'good' clinical instructors. All of which occur within the context of a relationship, not in isolation.

In addition, developing effective relationships with faculty members was identified by my informants as critical to their understanding and conceptualization of nursing professionalism. Multiple studies have provided evidence of the importance of this relationship. Lee (2007) suggested that if this relationship is effective, it encourages students to seek help, which certainly has a positive impact on their learning abilities and academic success. Additionally, a strong and positive student –educator relationship lowers the levels of anxiety and tension for both educator and student (Cook, 2005; Tang et al., 2005), and helps to better manage or alleviate disciplinary challenges (Savage & Favret, 2006). Moreover, students' ability to trust in what is being taught, and motivation to excel in classroom settings are tied to their perception that a caring relationship exists (Preheim et al., 2006). 'My educators are interested in me, and they want me to do well'. This sentiment came through during many

interviews with my key informants when discussing who had helped them come to know what professionalism means. My informants understand professionalism in nursing as demonstrated through the building and valuing of relationships. Then, teaching and modeling within them, what it means to be a nurse and do the work of nursing. Professional identity in nursing is learned through the relationship built between a student and their teacher (Savage &Favret, 2006; Stronge et al., 2004). The findings of my research support this idea; further, contributing to what is known in recognizing that professional identity can be understood as professionalism when activated in a clinical practice. Having a strong sense of professional identity is essential to enacting professionalism in practice, which in turn is essential to influencing how others regard the discipline of nursing.

Public Perceptions of Nursing

I have come to believe that how we feel, and what we think about ourselves is intimately associated to how others feel and think about us; whether in relation to our personal or professional selves. "We cannot develop our authenticity without others, as others serve as the mirror in which we see our reflection" (McGee, 2014, p.729). Consequently, the image of nursing as a discipline is determined by how individual nurses know and see themselves, and how others (outside of nursing) perceive nurses. The professionalization of nursing through education and research, has been one of the most significant and ongoing discussions in the history of nursing. Worldwide, nurses have developed themselves into autonomous professionals' possessive of a vast degree of knowledge and expertise, as evidenced by the creation of nursing protocols, policy, and both theoretical and conceptual frameworks for practice (ten Hoeve, Jansen & Roodbol, 2013). Despite all of the advancements made towards

nursing professionalization, studies on this subject have shown that the public continues to undervalue nurses, or hold a misconstrued notion of what a nurse is and does (Dominiak, 2004; Summers & Summers, 2009). The media plays a significant part in perpetuating the stereotypical nurse personas that have been and continue to be held, to varying degrees including: 'angels of mercy', 'doctor's handmaiden', the 'battle axe', and 'sexy nurse' (Bridges 1990, Hallam 1998, Gordon & Nelson 2005). I do not think any of my nursing colleagues or contemporaries would ever view or describe themselves using these labels. Instead they would agree with the assertion of ten Hoeve, Jansen, and Roodbol (2013) that the professional discipline of nursing has a defined and expansive theoretical knowledge base that is utilized to provide evidenced based caring practices to patients. It is apparent that misalignment exists between what nurses think of nursing (professionalism) and what the public thinks of nursing. The informants in my study articulated that nursing enables them to positively impact the health and wellbeing of their patients and families, through the relationships they create with them. Further, nursing equips them with the knowledge, skills, and resources to do so. This is a very different view from the stereotypical ones still in circulation.

Nurses need to do more work to discuss what it is that we do, and to visibly demonstrate what is valuable about nursing work. It has been argued that having society think 'well of you' boosts the nurses' self-esteem, which then leads to increased job satisfaction, increased morale, decreased burnout, and decreased attrition (Tajfel & Turner, 1986; ten Hoeve, Jansen, & Roodbol, 2013). Nurses who have pride in themselves and value their work, because it is valued and held in esteem by others, are more likely to continue providing the calibre of care they have been recognized and praised for. Consequently, through either passive or active mentorship,

other nurses will be socialized to assimilate an approach of providing high quality, theoretically based nursing care through the relationships built with patients and colleagues. I believe that nursing professionalism can then become contagious. Additionally, public image and the degree of nurses' professionalism are reciprocal, and not mutually exclusive in nature. A nurse's negative self-concept (possibly derived from public opinion) and subsequent negative presentation in practice can then further negatively influence the public's opinion (Tzeng, 2006). A vicious cycle develops. To break the cycle, relationship based professionalism asks that nurses recommit to the consistent building and maintaining of authentic and respectful relationships with their patients, families, and colleagues. These relationships serve to guide and strengthen their understanding of nursing professionalism and enhance their ability to make visible all that nurses do, and all that they contribute to the health and wellness of populations.

Summary of Contributions

"That is what learning is. You suddenly understand something you've understood all your life, but in a new way."

~Doris Lessing~

My research is positioned alongside and aligns (in differing degrees) with previous research and developed theories, such as patient centered care and patient centered professionalism. There are shared characteristics between all three concepts, such as focusing on the best interests of patients and families, and working with them to improve or manage their health and wellbeing. What makes relationship based professionalism unique is that it identifies several essential relationships for a professional nurse to develop, those with patients, families, colleagues, and the public. These relationships are identified by both patients and nurses as

being authentic and caring. Caring is not just a feeling when understood within the context of relationship based professionalism. Caring is a behavior, a choice, and a commitment that nurses make to develop these essential professional relationships, which then enables nurses to understand and describe the value and impact of their work. Moreover, relationship based professionalism is predicated, not only on what a nurse understands is valuable about a nursing practice, but what others see and appreciate as valuable. Further, this conceptualization directly associates the formation of essential relationships within a nursing practice to defining nursing professionalism.

However, relationship based professionalism is not without its barriers. My key informants recognised issues, both internal and external, that impeded authentic relationship development; and therefore the understanding and demonstration of professionalism. Internal issues identified included confusion about what constitutes a therapeutic boundary, and feeling unable to be their authentic selves while in their nursing practices. Barriers such as financial constraints and negative cultures within clinical environments were the main external issues identified by my key informants. Through data analysis, examination, and discussion of emerging themes, it has become evident that cultures within work and academic environments play a significant role in activating nursing professionalism; moving it from an abstract concept to something visible and appreciable in practice.

In the forthcoming chapter I will present how my research findings may positively contribute to creating environments wherein relationship based professionalism could be learned and applied in clinical practice. My findings represent a small sampling of fourth year nursing students, so I will begin the chapter by outlining the limitations of my thesis research. However,

my hope is that relationship based professionalism will resonate with a wider audience, or at least be considered for its applicability. To that end, I will present and discuss my recommendations for its integration within nursing education and nursing practice environments. Additionally, I will outline opportunities for further research related to relationship based professionalism.

Chapter Five:

Chapter Five: Boundaries and Possibilities of Relationship Based Professionalism

My journey to discover what our future colleagues in nursing understand about nursing professionalism, and how they then enact it in their practices, has been personally and professionally rewarding and enlightening. Several of my previously held conceptions have been affirmed. Additionally, I have gained new understandings about nursing professionalism through the fresh eyes, kind hands, and keen minds of my key informants. My focused ethnographic study has both its limits and its potential positive impacts on nursing education, nursing research, and the discipline of nursing.

Limitations

It is in the tradition of ethnography that a researcher chooses through purposive sampling, participants who best exemplify the focus of investigation (Germain, 1993). This selectiveness affords the researcher access to those who are able to contribute a vast and detailed amount of knowledge about the subject under investigation; however, other perspectives are inevitably excluded. Moreover, with purposeful sampling, you characteristically obtain participants who are interested in contributing to the research, because they are invested in both the topic and the potential generation of new knowledge. My research honors the perspective of eight fourth year student nurses, who completed their final clinical practicum within Calgary hospital units or clinics from January to April of 2014. However, the experienced nurse or nurses working in community and/or rural areas may have very different perspectives about what nursing professionalism is, and how to demonstrate it in practice. The eight participants in my study are female and all shared similar economic backgrounds. Several of the key informants were

persons of color; at least one participant was not born in Canada. One of the participants was over the age of thirty while the others were in their early twenties. My findings may have differed if my participant group had been larger or more varied in age, gender, or socioeconomic status. As is typical and expected with a focused ethnography, the number and diversity of participants, and time spent in the field were limited. Therefore, my findings were bound by the amount, context, and duration of data collection. Ethnography is the exploration and description of a particular culture or cultural phenomenon (Hammersley & Atkinson, 1983). In this study the key informants provided rich, vibrant, and illuminating descriptions of their understanding of nursing professionalism. It is the depth and cohesion of these eight participants' shared knowledge that provides validity and credibility to this piece of ethnographic research. Yet it could be argued that the depth of this research is somewhat constrained by its narrowed breadth.

A further limitation may stem from my ability as a novice ethnographic researcher to accurately interpret and write about the experience of what it was like for these fourth year nursing students to come to know nursing professionalism. However, I am hopeful that my writing will do justice to the ideas shared by my key informants. Further, my intention was to stay true to their intended meanings and beliefs about nursing professionalism, while preserving the richness of their lived experiences. It is from my key informants' descriptions of the conceptualization 'relationship based professionalism', that I am able to put forward recommendations for actioning this knowledge in the future.

Implications and Recommendations

The purpose of this study was to capture the experience of what it was like for one group of fourth year student nurses to enter into professional nursing practice. Additionally, my aim was to uncover their description of professionalism; what meaning their professional practice held for them, and what their practice then looked and felt like for themselves and others. Through immersion (interviews and shadow observation) into the culture of student nurses working to understand their professional nursing practice, I was permitted to witness the commitment and enthusiasm these future nurses exhibited in and for their nursing work. I have attempted to elucidate the culture of professionalism among this group of student nurses. The professional culture I describe through the term 'relationship based professionalism' illustrates the vast potential of nursing and what is possible through mindful engagement and passionate commitment. The daily journey of a professional nurse is uncertain, with no two shifts unfolding in the same way. However, a professional nursing practice should aim to safely and consistently provide the highest quality of care to patients and families. High quality care, as determined by patients and families, is largely about the trust and authentic connection between themselves and their health care team (Clarke, 2007; Coulon, Mok, Krause &Anderson, 1996). The intention to develop and maintain authentic relationships with patients, families and others is the foundation of relationship based professionalism. This requires that nurses recognize the importance of relationship building, give consideration to what they value about their practice, and think about what their practice means to them and to others. Based upon my findings regarding relationship based professionalism, I offer the following statements and recommendations for nursing education, practice, and future research.

Nursing Education

Professionalism is learned, and for nurses, that learning needs to begin in their undergraduate degree program. Nurses are expected by employers and licensing agencies to have at minimum, an entry to practice level understanding of professional practice (AHS, 2008; CARNA, 2006; CNA, 2008). My key informants were fourth year students in the Bachelor of Nursing program at the University of Calgary. They shared with me that they had received education related to 'professional nursing' in several seminar classes taken within their four year program. However, they were not familiar with the word 'professionalism'; what they value about being a nurse and doing nursing work, which includes consideration of their impact on others they encounter in their professional practices. A student can attend and successfully complete professional practice courses in nursing without authentically internalizing and committing to professional values and behavior. The word 'professionalism', to the best of their recollection, had not been used as they learned about professional practice issues and topics such as: ethical practice, advocacy, best practice, standards of care, evidenced based practice, patient centered care, legalities, and many others. Professionalism is a nuanced subject matter that develops over time, and can therefore be more challenging to teach, learn, and incorporate into clinical practice. In completing my research, and discovering the concept of relationship based professionalism, I have the following recommendations for nurse educators in relation to teaching nursing professionalism.

While I recognize that professionalism is learned and socialized over time, I argue that the most opportune time to begin formal professionalism education is during nursing education programs. A strong foundation is then built, upon which nurses can continue in their

development of professionalism throughout their careers. A professional nurse continues to be developed through a socialization process that begins with formal, entry-level education to acquire knowledge and skills (Wynd, 2003). Student nurses have an advantage in relation to learning about and valuing professionalism, they have not yet been overly burdened or negatively impacted by the reality that barriers exist to maintaining nursing professionalism: budgetary constraints, deleterious work cultures, horizontal violence, union impact, and burnout to name a few. Professionalism curriculum should not only encourage the teaching and learning of what professionalism is, but how to maintain it within any practice context. Education about professionalism begins after an operational understanding or definition is reached, upon which all curriculum could then developed. This is easier said and written, than done.

It is imperative that professionalism curriculum be clear about what professionalism is, and what it is not. Confusion exists about the word professionalism, and words associated with it. This becomes problematic when attempting to reach consensus about how professionalism for nursing is defined. For example, the words professionalism and professionalization are often used interchangeably in conversation and in the literature; however, they are not the same. Professionalism speaks to how a nurse conducts her practice, the philosophy and theory utilized in support of how nursing work is completed. Professionalization is the process a group moves through when seeking to be officially recognized as a profession (Wynd, 2003). Professionalization is sought because membership in a recognized profession is perceived to be associated with benefits such as increased income, status, and prestige (Parkin, 1995). Required characteristics of a profession or professionalization are: 1) an extensive theoretical knowledge base; 2) legitimate expertise in a specialized field; 3) an altruistic commitment to service "a

calling" or devotion to work with a high degree of idealism; 4) autonomy in work; 5) a code of ethics and conduct overseen by a body of representatives from within the field itself; and 6) a personal identity that stems from the professional's occupation (Parkin, 1995). Relationship based professionalism as a description of how a member of the nursing profession behaves in practice, encompasses many of these characteristics.

Adding to the confusion, the word professional is both a noun and an adjective. A student nurse is not yet a member of the profession of nursing. However, they are expected to conduct themselves professionally during their entire education program, and they become a recognized member of the profession almost immediately upon completion of their education program and certification exam (University of Calgary, 2013). Students need to learn what professionalism is, what practicing professionally looks like, and what practicing professionally feels like. The content of professionalism curriculum across a four year nursing program needs to have clarity, congruence, and continuity; by creating curriculum based on one understanding of professionalism, such as relationship based professionalism, it is possible to accomplish all three.

According to my key informants, the courses they took focused on professional nursing practice encompassed numerous other concepts; topics such as ethics, evidenced based practice, best practice standards, and legal issues. Consequently, professional practice courses run the risk of omitting discussion about professionalism or what it means to be a nurse, and what completing nursing work feels and looks like. When asked if, how, and when professionalism was taught or discussed in the four years of their education, the majority of my key informants visibly struggled to respond; many long silent pauses. If a pause went on too long, I attempted to

rephrase my question, and if that was not successful I shared my working definition of professionalism. It was apparent in their body language and facial expressions that it frustrated them that they had not formed a meaningful connection between the word professionalism and professional clinical practice. Through observations and interviews, I discovered that for my key informants, professionalism was not an all-encompassing or subsuming concept, but rather a more intimate connection between themselves and the people they encountered while immersed in their nursing work. This intimate connection is the impetus for the following suggestions related to professionalism curriculum content and structure.

Professionalism curriculum content.

Nursing professionalism predicated on learning to value building and maintaining differently natured relationships first requires a discussion of 'what's in it for me?' My key informants understood professionalism as the authentic connection of self to others within their nursing work, that results in reciprocal transformation; benefits to both participants with the relationship. Identifying and understanding the potential benefits that nurses attain from, and through their professional relationships, is an important first step towards encouraging ongoing professionalism in practice. I suggest that student nurses be asked to think about how having effective relationships with patients, families, and colleagues, can assist them in completing their work. Would their nursing work be positively impacted (easier, more enjoyable, more effective), and how would they and others then think and feel about nursing work? The important next step for student nurses becomes the necessity of thinking about how their work affects others. Discussion focused on the impact that the manner in which they choose to practice has on others is fundamental to understanding relationship based professionalism. Students should be

encouraged to think about how their body language, tone of voice, and their chosen words and actions are perceived by patients who are likely feeling pain, anxiety, uncertainty, fear, or loss.

"What you share with the world is what it keeps of you (Song lyric "Give A Little Love" by Noah and the Whale, 2011). Poetic words that resonate with me as I reflect back on my twenty years in nursing; what impact have I made on the people I have met in my practice? I think we all enter nursing with the conscious intent to do no harm; however, what harm could we be doing unconsciously? Accordingly, dedicating time for student nurses to think about the manner in which they conduct their work, and what lasting impressions they may be leaving on others is a professional and ethical obligation. Personalizing discussions (connecting personal with professional values) concerning the impact of nursing care may assist in this. I suggest that educators encourage students to consider, perhaps even role play, what it would be like to be in the hospital bed, instead of alongside it. Additionally, encouraging discussion about what they would expect from nurses and nursing care if a person they loved were to require a hospital bed, as there is usually someone's loved one in the bed. Regardless of whether a patient is someone's loved one or not, it remains a professional and ethical imperative to advocate for and to provide safe and quality care to all patients (AHS, 2008; CARNA, 2006; CNA, 2008). It is my hope that discussion topics such as these, that closely align the personal with the professional, will promote increased accountability within student nurses for developing and maintaining professionalism in practice. To develop proficiency in relationship based professionalism, specifically, an educational focus on building and maintaining professional relationships is required.

It is my contention that curriculum built upon the concept of relationship based professionalism will need to include what I understand as the building blocks of relationships:

self-awareness and self-compassion. Recently, as the surgical services representative on the Rockyview General Hospital's patient and family centered care committee, I attended a webinar with speaker Jaeun Macen entitled "Compassion in Balance: Caring for Ourselves while Caring for Others" . Jaeun is a clinical pastor, employed within the spiritual care department of the Foothills Medical Centre in Calgary, Alberta. Her rich background and experience includes a BSc and a PhD in biochemistry, and she is an ordained nun in the Jogye order of Korean Buddhism. Her presentation resonated with me deeply, as much of what she was saying was directly in line with the concept of relationship based professionalism. To care for others well, we have to learn to care for ourselves (Jaeun Macen, personal communication, June 3, 2015). Professional nurses need to extend this idea, and care for their nursing practice as well. Caring about yourself and what you do in the world begins with self-awareness.

Self- awareness.

Self-awareness is having an understanding of what is happening inside ourselves (emotionally, physically, mentally, and spiritually) at any moment in time (Jaeun Macen, personal communication, June 3, 2015; Rawlinson 1990). Caring in nursing is to a degree dependent upon how well nurses know themselves (Burnard, 1992). Further, Burnard suggested that becoming self-aware is a conscious process in which we identify our strengths, and also those areas that can be further developed. It is only when we know ourselves that we become aware of what we will and will not accept from others in our lives; self-awareness enables us to build respectful and reciprocally successful relationships. This then allows for increased authenticity and effectiveness when we engage with others. According to Macen, health care providers need to ask themselves the following questions in an effort to increase their self-

awareness: 1) How do my values affect my perceptions? 2) How does language affect my response to an individual? 3) Are my expectations of the other based in what they are capable of or in my own preferences? 4) How am I feeling right now and what are my needs? These questions ask student nurses to reflect on their own values, needs, and perceptions, just as relationship based professionalism does. Asking these questions of students while they are in clinical courses would encourage deep thought and conversation; and would be especially significant and timely, when linked to situations students have just experienced in their practice. To authentically connect with another person in practice, a student nurse first needs to spend time discovering and acknowledging their own values and perceptions.

In addition, continuing the encouragement of reflective practices is important to the development of self-awareness. Gibbs' (1998) reflective cycle is particularly useful for promoting self-awareness. A student begins by explaining the situation, and then would write about how they felt about what occurred, and finally they would outline the impetus for reflecting on the chosen situation. Understanding why a certain situation triggers a strong internal reaction, often emotional, is what stimulates increased self-awareness. More substantial reflection occurs when we are encouraged to give consideration to how others might see us and what others may think about us. Deep reflection manifests when we begin to examine how we present ourselves, and when we begin to share information about selves; knowledge known previously only to ourselves: our most private secrets and thoughts (Rungapadiachy, 1999).

In addition, clinical instructors would need to facilitate exercises in which students would practice self-awareness through role playing experienced clinical interactions, and then providing each other with feedback about word choice, tone, and body language. Students should then be

encouraged to reflect on and share how the feedback they received, aligns with their values and perceptions. For example, if a student is feeling tired when in practice, they may have the insight that feeling tired makes them more forgetful. However, others who enter into relationship with them likely do not have this insight. So it becomes imperative that we act on our self-awareness and disclose to others how we are feeling and thinking: "I am feeling tired today, and this causes me to be forgetful, so please be patient with me and feel free to offer me reminders". Honest disclosure about state of mind/being, promotes authenticity and trust within relationships because it inhibits erroneous assumption and judgment. Further, having a high degree of self-awareness promotes resiliency, perseverance, and patience (Jaeun Macen, personal communication, June 3, 2015). I believe that nurses, who have a high measure of resiliency, are able to be flexible and patient with themselves and others as they experience a multitude of clinical situations. In addition, resiliency would better equip student nurses to maintain their professionalism, particularly important when working within fluctuating, demanding, and complex clinical scenarios. A resilient nurse would be better able to objectively reflect on practice situations, evaluate them for learning opportunities, and then move their practice forward.

Self-compassion.

Self-compassion is the other component that I think is foundational to developing effective professional relationships. According to Neff (2011), self-compassion entails three core elements: self-kindness, common humanity, and mindfulness. Neff described self-kindness as the ability to be gentle and understanding with ourselves, rather than being overly or harshly critical or judgmental. Common humanity is understood as recognizing that as humans, we share common experiences, while mindfulness is about holding our experiences in balanced awareness

to avoid ignoring or inflating them (Neff, 2011). The connection between self-compassion and relationship based nursing professionalism is that it would likely be difficult to maintain the latter without the former. Nursing work can be arduous, taking its toll mentally, physically, emotionally, and spiritually. If student nurses are not taught and encouraged to care for and be compassionate with themselves, how will they maintain the desire to form caring and authentic relationships with others in their practice? Neff's work on self-compassion includes many questions that can be discussed in partners or within small group situations. My two favorite questions are: 1) What type of language do you use with yourself when you have made a mistake (do you insult yourself, or do you take a more kind and understanding approach)?; and 2) When you notice something about yourself that you don't like, do you tend to feel cut off from others, or do you feel connected with your fellow humans who are also imperfect? These questions stimulate reflection about the interrelationship between personal self and professional self, and the natural connection that exists between self and other, based upon the common experience of being human. Moreover, these questions encourage reflection on how we can support ourselves and others, even in the context of mistakes, or when we are not our best selves. The ability for nurses to be compassionate with those they care for may emanate from their ability to be compassionate with themselves.

A study conducted by Gustin and Wagner (2013), based upon Watson's Theory of Human Caring (2008), discovered that the degree of self-compassion nurses had was correlated to the amount of compassion they were able to give to others. Specific findings included that higher levels of self-compassion appeared to mitigate the power differential that is commonly perceived to exist between caregiver and patient, and produced a greater willingness for nurses to

"give a little extra" in their work (p.180). Heffernan, Quinn- Griffin, McNulty, and Fitzpatrick, (2010) suggested that nurses need to be aware of the significance of self-compassion because without it, nurses may struggle to demonstrate compassion to persons they encounter in their practice: patients, families, and colleagues. Currently, self-compassion is taught in a variety of ways. According to Gilbert and Procter (2006) compassionate mind training (CMT) seeks to alter a person's entire orientation to self and their relationships through techniques such as shifting focus, reframing patterns of thought and behavior, and compassionate imagery. Therapeutic letter writing involving the use of positive visualizations of future events and goal-setting has been used as a method of enhancing self-compassion (Shapira & Mongrain, 2010). In addition, compassionate meditations have been used with success. According to Pace et al (2009) compassion meditation demonstrated positive health benefits such as an increased immune system function (indicated by plasma concentrations of interleukin) and a decreased stress response (indicated by decreased cortisol levels). Therefore, it is my recommendation that curriculum include how to build professional relationships with patients, families, and our colleagues by connecting at the most basic level-shared humanity; which becomes possible when students learn how to be self-aware and self-compassionate.

Professionalism curriculum structure.

To accomplish my recommended changes to professionalism curriculum, the structure of when and how it is taught would also need to change. Having more intimate and connected conversations about professionalism becomes necessary when you are helping student nurses to know professionalism, through learning how to build and maintain relationships in practice. I agree that theory courses related to professional practice topics and issues (offered en masse, and

throughout a four year undergraduate program) have value and should remain in place. However, I suggest that adding a small group component to professionalism education would allow for learning to occur through methods not possible in large group settings; such as role play, storytelling, and lengthier, more in-depth question and answer sessions. Additionally, sharing thoughts and feelings about how it feels to be a student nurse and do nursing work, is a vulnerable position to be in; trust is essential. Trust can be more easily and quickly built within the relationships of a smaller group. In turn, building these relationships becomes a practical exercise for student nurses learning to develop and apply relationship based professionalism into clinical practice. At present, a small group format already exists within the undergraduate program at the University of Calgary: clinical groupings of eight or less students. It is more efficient and practical to look for opportunities to teach professionalism in a different way, within situations or environments that already exist. Within each clinical course, (usually one per semester) time is allotted for pre and post conference. This time, one-two hours, is used by clinical instructors in a variety of ways, and the content is not prescriptively outlined in course syllabi. I propose that explicit curriculum regarding relationship based professionalism could be created and completed within these small group situations. Curriculum would need to focus on how to create and maintain professional relationships through self-awareness and self-compassion. The goal of relationship based professionalism education would be to increase student nurses' resiliency, patience, and perseverance in practice; for it is in practice, that professionalism impacts patients, families, and our colleagues.

Nursing Practice

Understanding and demonstrating professionalism is integral to achieving the primary goals of a nursing practice: a) optimal patient outcomes; b) optimal patient satisfaction; and c) effective collaborative practice within health care delivery teams. Subsequently, professionalism needs to be embedded as a guiding construct for the discipline of nursing, understood as encompassing the 'what' and 'how' of nursing practice. Further, when professionalism is recognized and languaged by nurses as the manner in which they complete their work, it then has the potential of becoming how our colleagues and the public understand nursing work. How other people view nurses and nursing work, impacts the credibility of the entire profession. Therefore, according to Roberts and Vasquez (2004) our credibility as individual nurses and as a collective is predicated upon the degree of professionalism actualized or made visible in practice. Benefits to the discipline of a clearer and deeper appreciation of nursing professionalism include utilization of nurses to their fullest potential, funded opportunities for academic growth, increased financial remuneration, and increased internal and external valuing of nursing work (Roberts & Vasquez, 2004; Tzeng, 2006). Moreover, making the specialized skills and knowledge of nursing visible to all stakeholders will promote the value, and contribution of the discipline to patient care within larger healthcare environments (Benner, Hooper-Kyriakidis, & Stannard, 1999; Hemsley-Brown & Foskett, 1999).

Practice issues arise in nursing related to both technical or skill competence and to professionalism in practice. Alspach (2008) reported that 50 percent of nurse respondents had witnessed colleagues making mistakes, neglecting policy and procedure, practicing below established standards, or behaving in ways incongruent with the ethical and caring philosophies

of nursing. Issues of professional competence must be effectively managed by nurse leaders, and often become time and resource consuming endeavors due to the deficiency in effective management strategies (Keegal, 2013). Moreover, competence assurance and issue management is an ethical requirement of health care organizations as patient care is often the casualty. Subsequently, Cooke (2007) found that nurses who experience issues of professional practice competence are often disliked, distrusted, avoided, and given negative labels by their colleagues. This negatively affects not only the individual nurse but the interdisciplinary team, the organization, patient populations, and the discipline of nursing. Bottom line, professionalism in nursing needs to be monitored and encouraged by individual members of the discipline, health care agencies, and nursing regulatory bodies. Several of my key informants indicated that practice competency is a necessary attribute for maintaining relationship based professionalism, because patients will struggle to trust a nurse who does not possess the technical skills and knowledge base required to provide safe, quality care.

I want to acknowledge that I do not believe that any health care agency has the intention to neglect the continual promotion, encouragement, and support of nursing professionalism. My research reveals that there is an opportunity to better understand, share, and actualize a clearer understanding of nursing professionalism; defining what it means to be a nurse and complete nursing work through the relationships nurses create in practice. This definition has the potential to be internalized and activated by nurses because of its intimate connection to why many persons enter the profession; to make a difference, to help heal, to serve. Discovering what matters most to nurses in practice, is the very thing that will motivate them to care about their practice, specifically what it looks and feels like to others. Intrinsic motivation is the barometer

of professionalism. In conducting my research, I discovered that when you uncover what motivates nurses to be and do their best, you can begin to create a definition of professionalism that is meaningful and purposeful for nurses; and one they understand and are easily able to demonstrate in practice. Professionalism in nursing predicated on strong relationships between nurses and patients, nurses and colleagues, and the discipline of nursing with the public, can serve to mitigate credibility and professional competence issues. It is my contention that when a nurse understands the impact and value of their practice, they will be more diligent in maintaining practice standards, and more cognizant of how they are presenting themselves to others. Additionally, nurses will be more committed to a definition of professionalism that they have helped to create; one that has significant and personally applicable meaning.

Therefore, my first recommendation is that health care agencies consult with nurses when aiming to define professionalism; specifically, expected professional behaviors and values. Alberta Health Services (AHS) has a department titled 'Health Professions Strategy & Practice' that is directed to "support health providers in delivering safe, consistent and quality health services to Albertans and offers resources and services to clinicians and leaders to enhance professional practice, clinical education, workforce planning and service planning" (AHS, 2015). I suggest that definitions coming from nurses themselves (small or large scale) should be considered by departments such as this one, for their more widespread utility within the health care organization. Moreover, persons working in this provincial division could take it upon themselves to solicit information directly from nurses employed within AHS, concerning how they define professionalism in nursing. Relationship based professionalism is the way my key informants viewed and defined the way in which they conduct their practices. Perhaps if

healthcare teams responsible for "enhancing professional practice" considered findings such as mine, a definition of professionalism that resonates realistically with nurses could be generated. It is my belief that when nurses have a tangible role in creating what their practice should mean and look like, they will be better equipped and more willing to maintain professionalism in practice. This then works to mitigate professional practice issues and patient complaints related to decreased satisfaction with the caliber of nursing care received. Patients' value not so much what we say, but how our characters manifest as we conscientiously execute our caring roles (Salmon et al. 2011).

Incorporating what is professionally meaningful to nurses, using their own language and descriptions, would resonate with them more authentically. Relationship based professionalism being one example. Potentially then, authentic expression and expectations of professionalism would better enable nurses to be more consistent in maintaining a professional practice. Further, relationship based professionalism asks nurses to focus on the important connections required to complete their work, in a way that positively benefits not only themselves, but their patients, families, and colleagues. Mindfully focusing on building and maintaining these mutually beneficial relationships in practice, could result in a more pronounced collective understanding of nursing professionalism. Developing therapeutic relationships with patients has been a central theoretical tenant of the discipline of nursing for decades. Reframing professionalism within the context of essential relationships is therefore not a gigantic theoretical leap, and has the potential for easy application within the discipline. I encourage health care agencies to access and review my particular findings regarding relationship based professionalism with their nurses for applicability within their nursing teams. However, I equally support agencies in conducting their

own inquiry into how their nurses understand and define professionalism. Regardless, collaboration remains the key.

After collaboration has yielded an agreed upon conceptualization of nursing professionalism, I would also recommend that health care agencies disseminate it to all nursing staff and appropriate stakeholders. An issue that continues to plague clarity on the subject of nursing professionalism is the lack of discussion or sharing of information relating to it. Subsequently, AHS can then evaluate and promote nursing professionalism through yearly performance review conversations. Continual reengagement with a large construct like nursing professionalism, will invariably promote continued commitment to it, and/or identify the need for re-evaluation. AHS encourages yearly completion of a performance appraisal form designed to support the professional growth of employees. The appraisal process (performance conversation) measures skills and accomplishments and provides an opportunity to identify areas needing performance enhancement (AHS, 2015). Regular connection of an accepted definition of nursing professionalism with the professional expectations of an employer, could contribute to a more consistent and mindful application of professionalism in nursing practice. I suggest that during annual performance conversations (or during coaching sessions geared towards professional practice), managers could bring focused attention to the topic of professionalism in practice by asking questions such as: 1) What is your understanding of nursing professionalism and its significance to your work? 2) How do you know that you demonstrate professionalism in your nursing practice? 3) What is your performance or learning goal this year in relation to your professionalism? 4) What do you value most about your nursing practice? 5) How do you attain

satisfaction in your nursing work? 6) Who is impacted by the way in which you carry out your nursing work?

Posing these questions to nurses will encourage purposeful thinking about how they complete their nursing work, and what impact their work has on others. It has been my contention that there is a correlation between the degree a nurse cares about her practice and the degree of professionalism exhibited. My key informants were in agreement, describing that 'caring' about the relationships a nurse builds in their practice is a foundational feature of relationship based professionalism; relationships with others built and maintained upon trust and the authentic sharing of self. An impossible expectation if a nurse does not care about the manner and caliber of his/her practice. Genuine care and concern for the quality and value of a person's therapeutic work is not a new idea. Authentic caring is tangible, it can be seen and felt, and is imperative to successfully providing a patient centered approach (Jaeun Macen, personal communication, June 3, 2015). In understanding and defining professionalism, the most significant relationship for my key informants was the one they formed with patients. Demonstrating genuine care for another person is integral to the effectiveness of a therapeutic relationship (Halifax, 2012; Neff, 2011). These authors focused specifically on the necessity of caring to the evocation of compassion within therapeutic relationships. However, I believe that the behavior and emotion of caring, and its significance to therapeutic interactions can also be attributed to defining nursing professionalism.

Relationship based professionalism is an understanding of professional practice that is predicated on a nurse's authenticity and mindful commitment to creating engaged relationships with patients, families, and others. Serendipitously, AHS officially launched their Patient First

Strategy on June 8, 2015. The Patient First Strategy is about building a culture of patient-and family centered care (PFCC). This model of care sees patients and families as integral members of the health-care team, and encourages their active participation in all aspects of care, including as partners in planning, implementation and evaluation of existing and future care and services (AHS, 2015).

This strategy and the concept of relationship based professionalism are philosophically and theoretically congruent, as both share features with patient centered care. Therefore, it would be reasonable to include a review of [relationship based] professionalism during yearly performance discussions or performance coaching conversations. This endeavor would also strategically align with the AHS core values of engagement, accountability, and learning and performance (AHS, 2015). In addition, including informal conversations about professionalism into staff meetings and education sessions would assist in assimilating professionalism into the unit culture. I also would encourage unit managers, clinical nurse educators, and staff nurses to regularly survey their unit environments for the presence of barriers to professionalism that were outlined in an earlier chapter. Strategizing amidst the unit team can then occur to overcome or better manage the identified barriers. Professionalism, understanding it, maintaining it, and expecting it, would then have the potential of becoming the norm within health care delivery cultures. For relationship based professionalism to be widely applied and/or universally understood, research beyond a small group of key informants should be considered.

Nursing Research

Several questions arose for me while I was engaged in the iterative cycle of data collection and analysis that illuminated the need for further research on the experience and description of nursing professionalism. Additionally, during my defense of this work, the examiners posed a few more questions. I will present and discuss each question that has surfaced so far, fully aware that this list of questions is not complete or finite; as different questions may arise for readers of this work.

In conducting this study the experiences of eight fourth year nursing students were explored, leaving the experiences of numerous other nursing students untouched. It is my suggestion that a larger scale qualitative study be conducted, focused on ascertaining whether relationship based professionalism is globally understood and experienced by fourth year student nurses. The sampling of students should be diverse, including both genders and all age groups of student nurses. Factors such as gender and age were not a consideration in my study as all eight participants were female and very close in age. Male nursing students may have a different perspective about what constitutes professionalism in practice. Similarly, student nurses that have a previous degree, years in another workforce, or many years of life experience may also have a different view of what nursing professionalism means. Additionally, further study should extend over a longer period of time. My study timeframe was four months in length, which limited the amount of time I was able to spend with each key informant in interview conversation or in observation of their practice. It is my contention that more time spent in the interview process and in shadow observations would lead to richer and more detailed description. More detailed and robust description would assist in generalizing a description of professionalism

beyond the studied group. Lastly, research on professionalism could span the entire undergraduate program; collecting data from a group of participants as they move through year one to year four. It is an expectation of employers and licensing agencies that nurses have an entry to practice level understanding of professional practice (AHS, 2008; CARNA, 2006; CNA, 2008). It is therefore, imperative for nursing faculty to give consideration to how successful their curriculum focused on professionalism is at meeting this expectation.

Further research on relationship based professionalism should be conducted with different levels of experienced nurses working within a variety of clinical environments. The influence of years of practice on the degree of professionalism exhibited needs to be examined. Do years of nursing experience contribute positively to identification with relationship based professionalism? If yes, then what factors both internal (within the nurse) and external (environmental) are responsible for promoting relationship based professionalism. In addition, investigation would need to be conducted should it be discovered that years of nursing experience correlated negatively with understanding and implementing relationship based professionalism. It would then become important to discover the reasons that experienced nurses have for a lessened or lack of association between relationships and professionalism, and/or the barriers to enacting relationship based professionalism in practice. Student nurses in my study spoke passionately about the significance of understanding their nursing work through the relationships they developed in practice. They also identified visualizing the valuing of relationships, in the practice of staff nurses that they worked alongside. Authenticity, engagement, reciprocity, and genuine caring were identified as key attributes of relationship based professionalism. In future, a larger scale research project could examine these key

attributes more closely to obtain increased clarity regarding definition and application in nursing practice.

Through further research, the possibility exists that relationship based professionalism could translate beyond the context of my study, to application within other health care disciplines such as social work, physiotherapy, and occupational therapy. Relationship based professionalism is predicated on the relationships built with patients and between health care colleagues. As such, relationship based professionalism could be applicable to the professional practice of any health care provider who participates in providing patient care. Additional research could focus on investigating whether relationship based professionalism resonates with, and fits into the practice of other health care provider groups.

Patients, and the relationships that nurses build with them, are a central concern of relationship based professionalism. Therefore, conducting research focused on what patients understand about nursing professionalism, and what they need from nurses and their relationships with them, would be instrumental to better understanding the concept of relationship based professionalism and its viability.

Lastly, a question remains for me that I have asked myself since beginning my masters' work on the topic of nursing professionalism: can or should one definition of nursing professionalism be attained and applied universally for the discipline? At this point, my answer is "I am not sure". My idealistic nature would like to answer "yes". Ideally, shouldn't nurses all value and work towards mindfully engaging in and consistently focusing on the manner in which they complete their nursing work; and moreover, what impact they have on the people they

encounter while in practice? The reality is that many factors still need to be investigated to determine if one definition is even a possibility, including the pros and cons of a single definition. Would one shared understanding of professionalism make it easier for nurses to apply in practice, and maintain over time? Would one definition promote increased commitment and compliance to practicing professionally? Continued research is warranted and would determine the answers to these questions, and the course and fate of relationship based professionalism.

Closing Thoughts

The journey I have been on to discover what nurses, about to begin their professional practice, know about nursing professionalism has been both challenging and rewarding. Reflecting back over my time spent as a nurse researcher as I write these final paragraphs is bittersweet. I remember the challenges I experienced. The apprehension I felt when first presenting my proposed study to potential participants, unsure if they would they find value in my research and want to participate? The nervousness I felt about needing to gain eight people's trust so quickly, in order to have the rapport necessary to conduct successful interviews and shadow observations. My worry over whether I would interpret the data accurately to truly represent my key informants' description of professionalism. Being invited into the practices of these student nurses was a privilege. I felt responsible to learn and then accurately and poignantly write about their professional culture. I realize that these challenges arose for me, in part because I am so concerned with the topic of professionalism. Each concern resolved and I am left with a profound sense of satisfaction and appreciation for the experience and for my key informants.

I deeply respect and am thankful to each of my key informants for being brave enough to share their thoughts and invite me into their nursing practices. Their authenticity and willingness to share their knowledge and time with me made my research a pleasure to conduct. I thoroughly enjoyed reconnecting with nursing practiced at the bedside by my student participants, and it was gratifying to discover that I shared many of their views of what it means to be a professional nurse. Additionally, they taught me new things about professionalism. Professionalism for them was possible through all of the relationships they developed in their nursing practice: those with patients, families, colleagues, and the public. The key attributes of all these relationships were identified as being authenticity, caring, competence, and reciprocity. They helped me to better understand the barriers to enacting professionalism in practice, which contributed to my ability to make recommendations regarding professionalism for nursing practice, education, and further research. Most importantly, I have learned that we must never stop thinking and talking about nursing professionalism. This research experience has renewed my conviction that it is fundamentally important to the ethical and competent conduction of a nursing practice. Patients, family members, colleagues, and the public count on nurses to provide safe and high quality care that is sensitive to the vulnerability, uncertainty, pain, and fear experienced during times of illness. Meeting people in these darker places requires a strategy that can be taught, mentored, supported, and maintained over time and circumstance. Relationship based professionalism is one strategy. Keeping a conversation going about it can support nurses to think about nursing professionalism and its significance to practice. It is my hope that dedicated thought will lead to focused application, which will then inevitably lead to significant positive outcomes for all who are nurses, receive their care, or work alongside them.

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Appendix A

Letter of Approval to work with nursing students from the Dean of Nursing

UNIVERSITY OF CALGARY

FACULTY OF NURSING

2500 University Drive NW
Calgary, AB, Canada T2N 1N4
nursing.ucalgary.ca

October 1, 2013

IRISS Ethics Application Review Panel
University of Calgary

Re: IRISS Ethics Application – Faculty of Nursing Graduate Program – Robyn Stewart

Dear Sir or Madam

I am aware that Masters of nursing student, Robyn Stewart's planned thesis study is an ethnographic inquiry into how fourth year nursing students at the University of Calgary describe their shared experience of nursing professionalism. Her proposed recruitment and sampling plan consists of requesting the participation of one group of twelve fourth year students assigned to a faculty mentor for the period of one academic semester. She will obtain informed consent from each student and the faculty mentor including a clear statement that participation is not mandatory and that declining to participate will not have any impact on their scholastic achievement, evaluation, or employment. Ms. Stewart plans to use data collection tools that are minimally invasive and not time or labor intensive for the students; these include one to one interviews, focus group interviews and participant observation. The risk to participants are minimal but are made clear in Ms. Stewart's ethics application; as are her methods for preventing, minimizing, or managing issues that might occur.

Consequently I support her thesis research and am comfortable giving my permission for Robyn Stewart to recruit her participants from the group of fourth year nursing students enrolled at the University of Calgary from January 2014 to January 2015.

Sincerely,

[redacted]

Dianne M. Tapp RN PhD
Dean and Professor
Faculty of Nursing
University of Calgary
[redacted]

Appendix B

Consent form for study participants

TITLE: Nursing Professionalism: The View from the Starting Line

PRINCIPAL INVESTIGATOR: Dr. Gayle Rutherford (phone number)

STUDENT INVESTIGATOR: Robyn Stewart RN. BN. (phone number)

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Professionalism is the image and essence of nursing that then becomes known by nurses, patients, families, colleagues, the media, and the public. How nurses understand their work and how others understand it, is predicated on the fundamental goals of a professional nursing practice: optimal patient outcomes, optimal patient satisfaction, and effective collaborative practice within health care delivery teams.

The student investigator has come to understand how delicate maintaining a high level of nursing professionalism can be when working within highly stressful, emotionally and physically exhausting clinical situations and or work environments. The student investigator has observed student nurses, new and experienced nurses struggle with what it means to be a professional nurse. These professional practice issues often have significant ramifications for the individual nurse, their team or unit environment, and the patients in their care.

As a fourth year nursing student, you are now spending the most concentrated and comprehensive amount of time focused on understanding what it means to be a nurse in your final N599 practicum. Additionally you are about to transition into independent practice, with the expectation that you do know what it means to be a nurse and do the work of nursing. Understanding how you describe your experience of professionalism can be an early step in identifying potential problems and avoiding experiencing them.

Culture can be defined as the values and behaviors essential to and shared by a group of individuals. In nursing, culture finds expression in the learned and shared behaviors, values, language, practices, dress, and rituals of those who belong to the profession. To examine the professionalism of fourth year nursing students through a cultural lens, ethnographic methodology will be used. Ethnography is a qualitative research approach used to describe the values, behaviors, beliefs, rituals, and knowledge shared by a group of people in a given context.

WHAT IS THE PURPOSE OF THE STUDY?

The objective of this research is to describe how persons about to begin their nursing careers experience nursing professionalism; therefore, the student researcher will conduct a focused ethnography to answer the question: How do fourth year nursing students at the University of Calgary describe their culture of professionalism, and how was it learned and shared within the context of classroom and acute hospital unit environments? The student researcher will recruit one seminar group of 12 students working together in the Winter Session (January-April 2014).

WHAT WOULD I HAVE TO DO?

As a participant in this study, you will be working with the student researcher for a period of 3-4 months in the Winter Academic Session-Beginning of January to end of April of 2014.
During this time you will be asked to participate in/consent to:

- one or two audio/visually recorded* 1:1interviews conducted by the student researcher (each taking approximately one hour of your time-will occur outside of course time)
- one or two audio/visually recorded* focus group discussions (group consists of your 12 member seminar group taking, approximately 1 hour of your time-potentially held during course time)
- observation by the student researcher of your seminar group (12 students) during weekly classroom sessions held at the Faculty of Nursing at the University of Calgary that occur within the Winter Semester (January-April, 2014)
- observation by the student researcher of one or two of your 8 hour acute care clinical practicum shifts (occurring on patient care units within Calgary Zone Acute Care Hospitals)

*Interviews and group discussions will be recorded to aid in transcription of data only.
You may be contacted by the student researcher after data collection is completed to confirm or clarify information you provided.

WHAT ARE THE RISKS?

There is the possibility that during one to one interviews, focus group discussions or periods of observation that you or the student researcher may say or do something that makes you feel emotionally vulnerable. The professional practice topics discussed and or the opinions you share about these topics might cause you to feel a little nervous, embarrassed, or worried.
There is the possibility that you may experience some fatigue caused by participation in critical thought provoking discussions (one-one interviews and focus group discussions) or from being observed for a concentrated period of time (8 hours minimum).
You may be concerned about anonymity particularly if giving responses you feel may be met by negative consequences or judgment from the student researcher or faculty members because the research occurs within classroom and clinical practice placements.
The student researcher is a registered nurse and as such is legally and ethically required to report unsafe clinical practice. Therefore if you demonstrate unsafe nursing practice during the time observed in your clinical practicum setting, it will be disclosed to your faculty advisor/mentor.

HOW WILLTHESE RISKS BE MANAGED?

To safeguard your comfort during data collection, the student researcher will ensure that sufficient time is allowed for rapport development and maintenance. Additionally to prevent you from experiencing any negative feelings, information sharing (discuss how you are feeling about the research process, respond to concerns, answer questions) will occur before and during data collection methods (interviews, focus group discussions, and periods of observation).
Additionally the student researcher will ensure that interviews and focus groups take place in a comfortable and private location. The student researcher will make sure that closure (a deliberate and thoughtful ending) occurs at the end of the ethnographic interview-through summary statements, expression of gratitude and plans for future contact and information sharing.
Moreover, if needed, you will have access to support services if difficult emotions surface during the research process.
If you become fatigued during the research process, the student researcher will re-evaluate the objectives and time required to meet them. Consequently a reduction in the number of interviews, focus groups and/or time spent in observation may occur.
If the student researcher witnesses you engage in unsafe or unethical behavior she will speak with you and if necessary (situation dependent) will confer with the Principal Investigator about retaining you as a participant. If you engage in unsafe or unethical behavior within an AHS hospital, that affects either patients or staff therein, the student researcher will disclose the issue to your preceptor and faculty advisor.
The student researcher will maintain strict confidentiality of the data by keeping it anonymous and in a password protected electronic environment. Written field notes will use an anonymous key and be kept in a locked drawer. Additionally because you will be evaluated by your faculty mentor, your decision to participate or not participate will not be disclosed to the Faculty mentor- to prevent your decision from negatively impacting your evaluation.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you.

However as future member of the profession of nursing you are invested in the topic of inquiry-professionalism as the way in which you will conduct your professional nursing practice. Thinking about and talking about nursing professionalism with your peers will enable you to have a better understanding of what professionalism means and how to enact it in your nursing practice. Professional regulating bodies (e.g. CARNA) and employers (e.g. AHS) have expectations for the professional conduct (professionalism) of registered nurses-often described as expected behaviors and values or attitudes. These expectations are shared by all nurses and as a future member of the discipline of nursing you need to know what will be expected of you. Participating in this research will assist you to begin to interpret these professional expectations within the context of your academic and clinical experiences to date.
Another potential benefit for you as a participant is that having and acknowledging a shared experience of what it means to be a nurse, and doing the work of nursing (professionalism) creates a support network that could be instrumental in mentoring professionalism and managing professional practice issues that may arise. (In your academic practice and in your future independent practice)

DO I HAVE TO PARTICIPATE?

Your participation in this study is completely voluntary. There will be no negative consequences for you should you decide not to participate: declining to participate will not affect your academic performance, evaluation or employment in any way. Should you decide to participate, you can withdrawal your consent at any time without recrimination. You will need to speak with the student researcher if you are considering or needing to withdrawal from the study. All data collected from or about you, up until the time you withdraw, will be used. The student researcher will remove you from the study if she observes you engaged in unsafe or unethical practice.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

There is no financial remuneration for participating in this study, nor will you incur any costs.

WILL MY RECORDS BE KEPT PRIVATE?

The persons with access to the data collected during this study include the principal investigator, student investigator, and the University of Calgary Conjoint Health Research Ethics Board. During data collection, only your first name or initials will be used and you will be made aware if audio and/or video recording is used during interviews and/or focus group discussions meant to aid in transcription only.
The student researcher will be doing the transcriptions and will ensure that interview, focus group, and observation data is free of identifiers-any identifiers such as first names or initials will be replaced with a letter and number code (i.e.: P1).
The student researcher will store all electronic data for a period of 5 years on a password protected computer. All written notes (field notes) taken during observation will be coded and kept in a locked drawer for a period of five years. Written data will then be securely shredded.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardy. If you have further questions concerning matters related to this research, please contact:

Dr. Gayle Rutherford (phone number)

Or

Robyn Stewart (phone number)

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at (phone number).

Participant's Name	Signature and Date
Student Researcher's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.
A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix C

Consent form for Faculty Members

TITLE: Nursing Professionalism: The View from the Starting Line

PRINCIPAL INVESTIGATOR: Dr. Gayle Rutherford (phone number)

STUDENT INVESTIGATOR: Robyn Stewart RN. BN. (phone number)

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

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Professionalism is the image and essence of nursing that then becomes known by nurses, patients, families, colleagues, the media, and the public. How nurses understand their work and how others understand it, is predicated on the fundamental goals of a professional nursing practice: optimal patient outcomes, optimal patient satisfaction, and effective collaborative practice within health care delivery teams.

The student investigator has come to understand how delicate maintaining a high level of nursing professionalism can be when working within highly stressful, emotionally and physically exhausting clinical situations and or work environments. The student investigator has observed student nurses, new and experienced nurses struggle with what it means to be a professional nurse. These professional practice issues often have significant ramifications for the individual nurse, their team or unit environment, and the patients in their care.

Fourth year nursing students are now spending the most concentrated and comprehensive amount of time focused on understanding what it means to be a nurse in their final N599 practicum. As a faculty advisor you are working with them to aid in their transition to independent practice; with the expectation that they begin to think about what it means to be a nurse and do the work of nursing. Understanding how fourth year nursing students describe their experience of professionalism can be an early step in identifying potential problems and helping them to avoid experiencing them.

Culture can be defined as the values and behaviors essential to and shared by a group of individuals. In nursing, culture finds expression in the learned and shared behaviors, values, language, practices, dress, and rituals of those who belong to the profession. To examine the professionalism of fourth year nursing students through a cultural lens, ethnographic methodology will be used. Ethnography is a qualitative research approach used to describe the

values, behaviors, beliefs, rituals, and knowledge shared by a group of people in a given context.

WHAT IS THE PURPOSE OF THE STUDY?

The objective of this research is to describe how persons about to begin their nursing careers experience nursing professionalism; therefore, the student researcher will conduct a focused ethnography to answer the question: How do fourth year nursing students at the University of Calgary describe their culture of professionalism, and how was it learned and shared within the context of classroom and acute hospital unit environments? The student researcher will recruit one seminar group of 12 students working together with one faculty advisor in the Winter Session (January-April 2014).

WHAT WOULD I HAVE TO DO?

As a participant in this study, you will be working with the student researcher for a period of 3-4 months in the Winter Academic Session-Beginning of January to end of April of 2014.
During this time you will be asked to participate in/consent to:

- one audio/visually recorded* 1:1interview conducted by the student researcher (taking approximately one hour of your time-will occur outside of course time)
- one or two audio/visually recorded* focus group discussions (group consists of your 12 member seminar group taking, approximately 1 hour of your time-potentially held during course time)
- observation by the student researcher of your seminar group during weekly classroom sessions held at the Faculty of Nursing at the University of Calgary that occur within the Winter Semester (January-April, 2014)
- observation by the student researcher of one or two of each student's acute care clinical practicum shifts (occurring on patient care units within Calgary Zone Acute Care Hospitals)

*Interviews and group discussions will be recorded to aid in transcription of data only.
You may be contacted by the student researcher after data collection is completed to confirm or clarify information you provided.

WHAT ARE THE RISKS?

There is the possibility that during one to one interviews, focus group discussions or periods of observation that you or the student researcher may say or do something that makes you feel emotionally vulnerable. The professional practice topics discussed and or the opinions you share about these topics might cause you to feel a little nervous, embarrassed, or worried.

There is the possibility that you may experience some fatigue caused by participation in critical thought provoking discussions (one-one interviews and focus group discussions) or from being observed for a period of time.
You may be concerned about anonymity particularly if giving responses you feel may be met by negative consequences or judgment from the student researcher or faculty members because the research occurs within classroom and clinical practice placements.

HOW WILLTHESE RISKS BE MANAGED?

To safeguard your comfort during data collection, the student researcher will ensure that sufficient time is allowed for rapport development and maintenance. Additionally to prevent you from experiencing any negative feelings, information sharing (discuss how you are feeling about the research process, respond to concerns, answer questions) will occur before and during data collection methods (interviews, focus group discussions, and periods of observation).
Additionally the student researcher will ensure that interviews and focus groups take place in a comfortable and private location. The student researcher will make sure that closure (a deliberate and thoughtful ending) occurs at the end of the ethnographic interview-through summary statements, expression of gratitude and plans for future contact and information sharing.
Moreover, if needed, you will have access to support services if difficult emotions surface during the research process.
If you become fatigued during the research process, the student researcher will re-evaluate the objectives and time required to meet them. Consequently a reduction in the number of interviews, focus groups and/or time spent in observation may occur.
The student researcher will maintain strict confidentiality of the data by keeping it anonymous and in a password protected electronic environment. Written field notes taken during periods of observation will use an anonymous key and be kept in a locked drawer. Additionally, your decision to participate or not participate will not be disclosed to Faculty of Nursing personnel - to prevent your decision from negatively impacting your employment or performance review.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. However as member of the profession of nursing you are invested in the topic of inquiry-professionalism as the way in which you conduct your professional nursing practice. Thinking about and talking about nursing professionalism with the students you mentor will enable you to have a better understanding of what professionalism means to them and how to help them enact it in their nursing practice. Professional regulating bodies (e.g. CARNA) and employers (e.g. AHS) have expectations for the professional conduct (professionalism) of registered nurses-often described as expected behaviors and values or attitudes. These expectations are shared by all nurses and as teacher of student nurses you need to know what these expectations are in order to teach them and evaluate them in others.

DO I HAVE TO PARTICIPATE?

Your participation in this study is completely voluntary. There will be no negative consequences for you should you decide not to participate: declining to participate will not affect your

evaluation or employment in any way. Should you decide to participate, you can withdrawal your consent at any time without recrimination. You will need to speak with the student researcher if you are considering or needing to withdrawal from the study. All data collected from or about you, up until the time you withdraw, will be used. The student researcher will remove you from the study if she observes you engaged in unsafe or unethical practice.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

There is no financial remuneration for participating in this study, nor will you incur any costs.

WILL MY RECORDS BE KEPT PRIVATE?

The persons with access to the data collected during this study include the principal investigator, student investigator, and the University of Calgary Conjoint Health Research Ethics Board. During data collection, only your first name or initials will be used and you will be made aware if audio and/or video recording is used during interviews and/or focus group discussions meant to aid in transcription only.
The student researcher will be doing the transcriptions and will ensure that interview, focus group, and observation data is free of identifiers-any identifiers such as first names or initials will be replaced with a letter and number code (i.e.: P1).
The student researcher will store all electronic data for a period of 5 years on a password protected computer. All written notes (field notes) taken during observation will be coded and kept in a locked drawer for a period of five years. Written data will then be securely shredded.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardy. If you have further questions concerning matters related to this research, please contact:

Dr. Gayle Rutherford (phone number)
Or
Robyn Stewart (phone number)

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at (phone number).

Participant's Name	Signature and Date
Student Researcher's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix D

Management Permission Form

Date:

IRISS Ethics Application Review Panel

University of Calgary

Re: Masters Research Study-Robyn Stewart

Dear Sir or Madam,

I am aware that Masters of Nursing student Robyn Stewart's planned thesis study is an ethnographic inquiry into how fourth year nursing students at the University of Calgary describe their shared experience of nursing professionalism. Ms. Stewart has informed me that her data collection methods are minimally invasive and will not be time or labor intensive for patients or unit/area staff. I am aware that no data will be collected regarding patients or unit/area staff. She has informed me that she will be obtaining verbal consent from patients and staff prior to observing interactions between these persons and her study participant. Ms. Stewart has indicated that she will not directly observe persons other than her study participant without their verbal consent. I am aware that should Ms. Stewart observe a staff member engaged in unethical, harmful, or unsafe behavior that she is ethically and legally obligated to report it to me.

Consequently I am comfortable giving my permission for Robyn Stewart to be on our unit/in our area to observe one of her study participants, a fourth year nursing student who is being preceptored by one of my staff members.

Sincerely,

[Manager name, date and signature]

Appendix E

Research Study Notice

Dear Unit Management and staff,

My name is Robyn Stewart and I am collecting data for my Masters study on how fourth year nursing students describe their experience and understanding of nursing professionalism. One of the ways I am collecting data is through observing my study participants during one or two shifts they work within their assigned clinical practice environments. One of my study participants is currently completing their 'preceptorship' or final clinical practicum on your unit; and therefore I am here today to observe their practice. I will be writing notes on the observations I make about my study participants practice. I will not be collecting data on or writing notes about the practice of unit staff or including any information about patients. There are no identified risks to you or to the patients on your unit. It is likely that staff members and patients will be present during my observations, so I will introduce myself, study purpose, and obtain a verbal consent to be observed from each staff member and patient. Staff members and patients can decline to be observed without recrimination. I am a registered nurse and as such am obligated to report any unsafe or unethical behaviour I witness: 1) if a unit staff member is involved I will report the event to unit management; 2) if my study participant is involved I will report the event to the student's preceptor and faculty advisor.

If you have any questions or concerns about this research study please contact me: Robyn Stewart, Masters Student, Faculty of Nursing at the University of Calgary. Phone: E-mail:

If you have concerns about the way you were treated during my time on the unit, please contact: Dr. Gayle Rutherford, Assistant Dean of Undergraduate Program, Faculty of Nursing, University of Calgary (phone number)

Appendix F

One to One Interview Questions

1. What is your understanding of nursing professionalism?
2. How did you come to understand nursing professionalism in this way?
3. Who influenced your understanding of nursing professionalism?
4. How and when has nursing professionalism been discussed within your nursing education?
5. Can you describe how you demonstrate professionalism in your clinical practice?
6. How do you know what is expected of you as a becoming professional nurse?
7. Can you identify your resources for understanding nursing professionalism?
8. Describe what guides your nursing practice within clinical settings?
9. Describe how your relationships with fellow students have influenced your understanding of nursing professionalism?
10. Describe how your relationships with faculty members have influenced your understanding of nursing professionalism?
11. Describe how your interactions with RNs have shaped your developing professional nursing practice?
12. How have the relationships you develop with patients and families impacted your understanding of nursing professionalism?
13. How have you been asked to reflect on your understanding of professionalism in academic or clinical environments?
14. Can you describe the importance of nursing professionalism?
15. Tell me about the barriers to understanding and demonstrating nursing professionalism?

Appendix G

Focus Group Questions

Engagement questions:

1. What is or are your favorite thing(s) about being a nurse?

2. What qualities do you admire most in your nursing colleagues?

Exploration Questions:

1. What comes to mind when you think about the work of nursing?

2. What opinions do others (patients, family, coworkers, public) have about nursing work?

3. How do you feel when you hear the opinions others have about nursing work?

4. What impact does the work environment have on nursing professionalism?

5. How can you maintain your standard of professionalism over time and in differing work environments?

6. How does the way in which you conduct your nursing practice impact the work environment?

7. What do you want others to think about your nursing work?

Exit question:

1. Is there anything else you would like to say about nursing professionalism?