2017

The lived experience of the Western Australian graduate registered nurse who is male

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Chapter 2. Literature Review

According to Streubert and Carpenter (1999) "to obtain a pure description of the phenomenon of interest being investigated, only a cursory literature review is undertaken to verify the need for the study and provide a background to the study" (p. 61). Therefore, a preliminary literature review was undertaken to gain an insight into the selected topic, thereby to inform the significance of the study. The in-depth literature review occurred at a later stage concurrently with the data analysis and the data collection. At this later stage the investigation focused on whether the current study findings fitted with what was already known, if they differed to other studies, and what contribution this study's findings added to the known literature.

2.1 What is known

The study's conceptual framework in relation to GRNMs focused on personality career traits of those who chose nursing and the graduate's transition to the professional practice environment. Moreover, in relation to a minority group, men in nursing, within nursing centred on the co-cultural communication that they employed.

2.1.1 Holland's theory

Holland's seminal works (1973, 1985 and 1997) put forward that individuals actively pursued and selected environments similar to their personality types. Further, Holland (1985) argued that "people search for environments that will let them exercise their skills and abilities, express their attitudes and values, and take on agreeable problems and roles" (p. 4). His theory categorised personality types and work environments into six dimensions; Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (RIASEC); in most cases the personality types included a combination of these dimensions (Ohler & Levinson, 2012). Holland's personality types (Figure 1), a prominent configuration in vocational interests, gave a visual account of the personality classifications used. These classifications collated to the three-letter code linkage between personality and environment with the shorter

the distance between the personality types and environments the greater their similarity (Nauta, 2012).

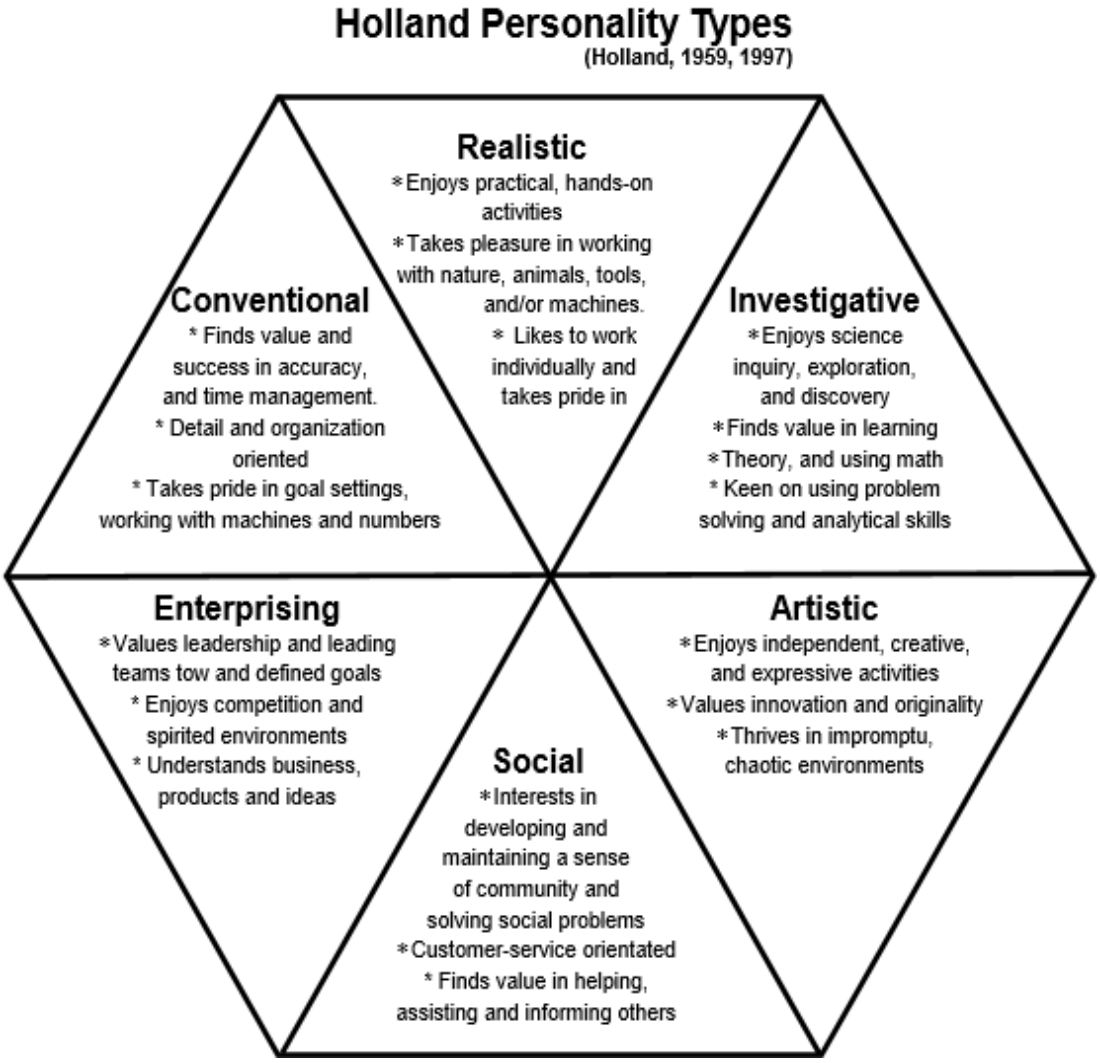

Figure 1 Holland's Personality Types
Source: Holland (1985)

In Holland's (1997) typology, the first letter indicated the job that had most in common, the second the next most in common with the third most common after the first and second with the vocational type (Saksvik & Hetland, 2011). For instance, according to Gottfredson and Holland (1996) nurses have the social occupation code of SIA. Thus indicated that nurses had dominant social beliefs with lesser investigative and artistic traits respectively that tempered influences on their behaviour and preferences. Refer to Figure 2: Classification of SIA for details on the specific characteristics for each of the classifications.

Social (S): Likes to do things to help people, such as teaching, nursing, giving first aid, or providing information; generally avoids using machines, tools, or animals to achieve a goal; is good at teaching, counseling, nursing, or giving information; values helping people and solving social problems; and sees self as helpful, friendly, and trustworthy.

Investigative (I): Likes to study and solve math or science problems; generally avoids leading, selling, or persuading people; is good at understanding and solving science and math problems; values science; and sees self as precise, scientific, and intellectual.

Artistic (A): Likes to do creative activities, such as art, drama, crafts, dance, music, or creative writing; generally avoids highly ordered or repetitive activities; has good artistic abilities in creative writing, drama, crafts, music, or art; values the creative arts and likes drama, music, art, or the works of creative writers; and sees self as expressive, original, and independent.

Figure 2 Classification of SIA
Source: Ohler and Levinson (2012, p. 147)

Holland's theory has stood the test of time for stability in occupational interests in relation to personality traits comparisons after been extensively scrutinised and validated (Miller, 2002). According to Zanskas and Strohmer (2011, p. 18), "Holland's theory suggests people will seek and remain in environments that allow them to use the skills and abilities that are consistent with their attitudes and values, and will adopt roles that are compatible with these characteristics". Further that "individuals with an SAI Holland code prefer helping others, being creative, are curious, and enjoy solving problems . . . that individuals with an SAI work personality will be most satisfied in a SAI or similar work environment" (p. 14).

However, there were limited literature on using personality traits as a guide for selecting potential nursing students (Baldacchino & Galea, 2012). Although Diann and Robert Eley's (2011) Australian study of 23 nurses, 12 registered nurses and 11 nursing students, used semi-structured interviews and a validated personality inventory measuring temperament and character traits to investigate personality traits and reasons for entering nursing. They concluded that "a caring nature is a principle quality of the nursing personality" (p. 1546); and thus predominantly altruistic with the opportunity to care for others. Whilst Wilkes and colleagues (2015) reported on qualitative survey data of early nursing students from a larger search project to investigate why they chose nursing indicated that 'helping' and 'making a difference' were the two most cited words by the respondents. Further, concluded from the respondents text that "caring is more closely aligned to helping rather than other

attributes of caring seen in the literature such as compassion or sharing" (p.263). Empathy has been noted as a personality trait of males in nursing, Penprase and colleagues (Penprase, Oakley, Ternes, & Driscoll, 2015) from their descriptive correlative USA study of 390 nursing students and 1,482 non-nurse college students reported that male student nurses had higher empathy than the non-nurse males. They further purported that the male nursing students, with their high systematic traits, required exposure to complex areas such as emergency and critical care, to challenge their problem-solving and analytic acumen for satisfaction in their professional practice as they become RNs.

2.1.2 Duchscher's transition stages model

Under the Transition Stages Model (Boychuk Duchscher 2007) Figure 3, the theory of transition was a "journey of becoming where new nursing graduates progressed through the stages of doing, being and knowing . . . encompassed ordered processes that included anticipation, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring, and engaging" (Duchscher, 2008, p. 441). Further, this process involved a "complex but relatively predictable array of emotional, intellectual, physical, sociocultural, and developmental issues" (p. 442).

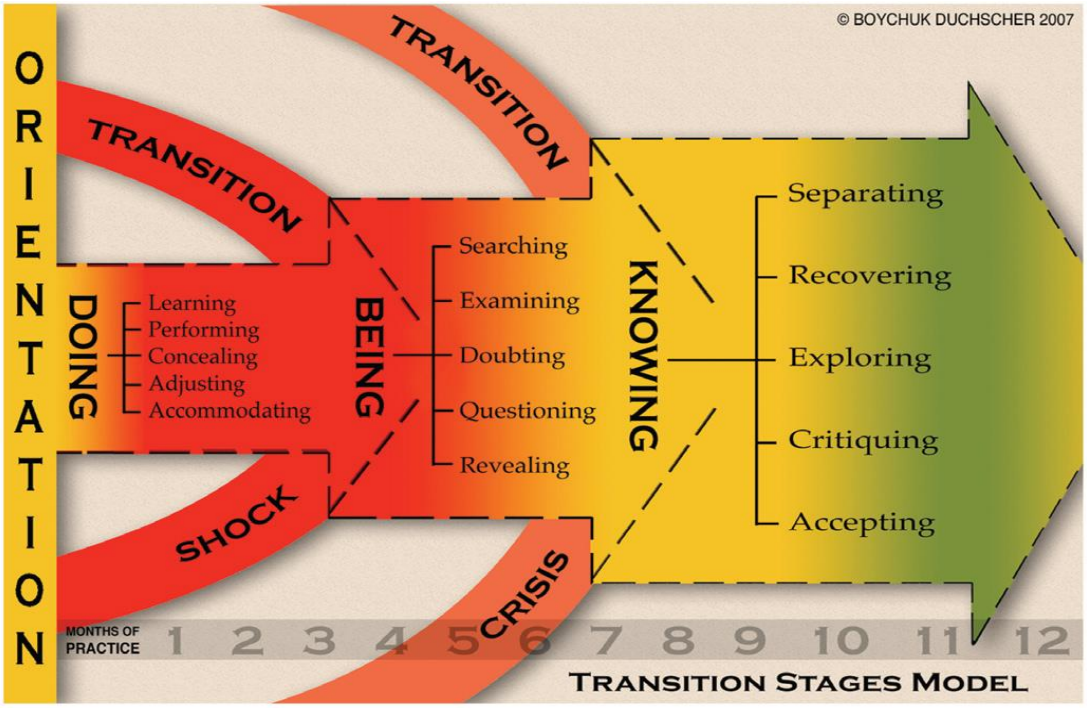

Figure 3 Transition Stages Model (Boychuk Duchscher 2007)
Source: Duchscher (2008, p. 443). Used with permission from Judy Duchscher.

The 'doing' stage was the initial three to four months of professional practice where GRNs were '*doing'* professional nursing. These graduates mainly focused on themselves and their performance during this stage; however their adjustment to the professional nursing role in a new professional practice work environment presented challenges for these new nurses during this time (Duchscher, 2008). The learning, performing, concealing, adjusting and accommodating characteristics of these nurses during the 'doing' stage and their desperate desire to fit in to the workplace culture, often left them feeling overwhelmed, fearful, insecure, and lacking confidence in their skill levels and their ability to perform (Duchscher, 2008).

The 'being' stage in the following four to five months, the GRNs gained better insight of what being a nurse entailed, often longing for feedback, reassurance, and validation about how they were doing (Duchscher, 2008). They were more comfortable with their roles and responsibilities of a RN, and sought space to practice independently with clinical practice support from a distance on a needs basis preferred. They were emotionally and mentally better equipped and ready towards the end of the 'being' stage, at six to eight months, and sought out challenges of new and unfamiliar practice situations. Awareness of the inconsistencies between their perceived ideals about nursing and the realities of professional practice occurred, as they started to look towards the future considering their long term career goals during the later months of the 'being stage' (Duchscher, 2008).

The 'knowing' stage in the last three to four months of the GRNs twelve month journey represented the most stable period of their transition where they had greater awareness of the nursing profession, and their place within it; however, they become more aware of issues of hierarchal inequalities inherent in nursing (Duchscher, 2008). Concerned about their learner role coming to an end with the safety and support that comes with being a GRN no longer be in place in the near future surfaced during the 'knowing' stage (2008).

The transition stages model underpinned the study's interview schedules and contacts in relation to known stages that the new GRN experiences in 'becoming' a professional RN. Therefore, the contact face-to-face interviews were conducted at the commencement of the participants' employment as newly GRNMs, at six month and then twelve month post commencement of GRN employment. Reflective diary

entries, over five days at four months and eight months stages of their first year, were also undertaken by the participants

2.1.3 Orbe's co-cultural communication model

The co-cultural communication model was well suited for exploring the GRNMs' experiences within the context of how males navigate the processes of becoming professional RNs. As previously purported in Chapter one this model was deemed relevant to a minority group, the GRNM study participants, communication behaviour within a dominant group, the female dominant nursing profession. Orbe (1998) stated "the essence of the model revolves around the explication of how four factors influence the process by which co-cultural group members adopt various communication orientations during their interactions in the organizational settings" (p. 240). The four factors being, "the perceived costs and rewards, field of experience, abilities and situational context" (p. 269). This model focused on what Orbe coined 'the outsider within perspective', and was used "as a basis in understanding the complex relationships between culture, power and communication within organizations" (p. 274). Further, it concerned the "communication process of persons traditionally marginalised in dominant societal structures" (p. 240). In this context, the outsider within referred to the men in nursing communicating in the female-dominant nursing profession.

Moreover, Orbe (1998) mentioned preferred outcome where reflection by the outsider within occurred as to what communication behaviour would result in the desired outcome the person sought through accommodation. Other communication behaviours, referred to as communication orientations, employed in preferred outcomes were those of assimilation and separation. Assimilation perspective was one where the marginalised person conformed to the communication structures of the dominant group to minimise differences. In the preferred outcome of separation, Orbe (1998) purposed that the marginalised person formed of a common bond with the dominant group by having separate group identities outside and within the dominant group, thus remained 'the outsider within'. Orbe (1998) contested the effectiveness in co-communication was finding the balance between non-assertive and aggressive communication orientation.

2.2 Men in nursing

Men in nursing from a historical aspect and the nursing recruitment and retention of males and new GRNs were included in this introduction to provide the background to this study. Followed by the literature that both informed the study initially and occurred as a result to the emergent themes that evolved.

Historically, as early as the fourth and fifth century during the monastic movement, men provided nursing care for religious orders members; men continued this role later on in other military nursing orders (Evans, 2004a, p. 322). In the eighteenth century males and females in nursing had similar roles in charity hospitals with men caring for same gender patients up until the mid-to-late 1800s (Mackintosh, 1997; O'Lynn, 2004). In the Australian colonial hospitals a mix of both male and females provided nursing care up until this time (Harding, 2012). However, the Industrial Revolution provided better wages and opportunities for men, triggering the decline of men in nursing. This decline was further accelerated with the reforms established by Florence Nightingale in the 1860s, consolidating a female-dominated nursing profession (Harding, 2012; Mackintosh, 1997). Nursing continued to be a female-dominated profession (Solbraekke et al., 2013). As a result this dominance has stunted recruitment of men into nursing.

2.2.1 Recruitment and retention

Health workforce management emphasised the importance in the retention of both new GRNs and the recruitment of males (AIHW, 2012). This to minimise the future nursing shortage in addition to improve standards of care with the retention of nursing staff (Bally, 2007). Insufficient entry into nursing to meet current and future health care demands; with large numbers of nurses leaving to seek other careers (Kelly & Ahern, 2009); ageing workforce retirements pending (HWA, 2013); the negative effects of horizontal violence on the retention of new nurses (Weaver, 2013); and with gender bias impeding recruitment of men into the profession (Bartfay, Bartfay, Clow, & Wu, 2010; O'Lynn, 2004) has caused concern. A study by Rajacich et al (2013) found that men were more likely to enter nursing as a second career. It has been acknowledged that men have thought hard and long about a nursing career before they entered due to their awareness of the challenges and

stereotyping that occurs when men enter a female-dominant profession (Simpson, 2011). The stereotyping of men who are nurses as effeminate had the tendency to restrict male recruitment into the profession (McKinlay, Cowan, McVittie, & Ion, 2010). From an alternative stance, "men remain an untapped reservoir of potential nurses and need to be targeted through recruitment strategies" (Roth & Coleman, 2008, p. 149).

Further, Xu (2008) saw "increasing number of men in nursing as an overwhelming positive development because it will not only meet clients' needs better but also promote nursing as a profession" (p. 73). In relation to meeting the clients' needs, in particular with intimate care provision, the preference from the clients was for a nurse of their own gender (Chur-Hansen, 2002). The depiction of nursing as a diverse career accommodating multitudes of functionalities and specialties endorsed to increase the percentages of men who select nursing as a career choice.

2.2.2 Career choice

It has been acknowledged that some men remain unconcerned about the gender-stereotyping in their career choice (Williams, 2015). Moreover, men in their teens with a higher female friend percentage and with highly educated parents were more likely drawn to a career in a female-dominate occupation (Hardie, 2015). From the career choice aspect, the nursing profession collaboration with high school career guidance counsellors to promote accurate information on neutral-gender nursing to interested students was supported (Meadus & Twomey, 2011). According to Gottfredson and Lapan (1997), the rationale for this collaboration was that adolescents confine their vocational interests consistent with social expectations linkage to gender-based career options. Turner, Conkel, Starkey and Landgraf's (2010) study investigated gender differences among vocational skills, motivational approaches, and with same-gender and cross-gender interests of adolescents in relation to Holland's RIASEC code. They recommended "educational policy makers address issues that promote gender-equitable pursuits of various types of careers" (p. 166). Further, they concluded that less rigid gender-role expectations and gender-impartial career counselling for young people could augment "a lifetime of personally valued and genuinely satisfying career success" (p. 165). Diversity in nursing for men as a career has increased with technology now more prominent in

nursing practice and a desired work element for men (Rambur, Palumbo, McIntosh, Cohen, & Naud, 2011).

To explore why some males chose nursing as a career, Harding (2009) interviewed 18 New Zealand NMs and revealed that they came into the nursing profession "in search for meaning, personal fulfilment or a way of providing service to humanity" (p. 13). Other studies have postulated reasons such as job security and employment opportunities (Meadus & Twomey, 2007; Zamanzadeh et al., 2013) and career advancement (Ierardi, Fitzgerald, & Holland, 2010; MacWilliams, Schmidt, & Bleich, 2013). Flexibility in crossing between the various nursing specialities have recently been revealed as another reason for the uptake of men into nursing (Christensen & Knight, 2014). Further, Christensen and Knight's (2014) study of five New Zealand male nursing students conjectured that the opportunity to travel was another drawcard for men to choose nursing. Although, some men admitted that nursing was an alternate way into medicine (Ellis, Meeker, & Hyde, 2006).

Of the Australian men in nursing one-third work in the mental health clinical areas followed by critical care and emergency units then rehabilitation and disability services (AIHW, 2012). The reasons for the higher percentage of NMs in these settings was not fully understood, although it "may be perceived that these settings as more acceptable or masculine" (HWA, 2013, p. 15). Nursing care in relation to intimate touch has also been speculated as the reason for men entering these aforementioned specialities (Stott, 2007). Intimate touch has been defined as the "inspection of, and possible physical contact with, those parts of the body whose exposure can cause embarrassment to either the patient or the nurse" (Harding, North, & Perkins, 2008, p. 88). This embarrassment for males occurred when nursing care involved patient genitalia or associated to sexual health (Inoue, Chapman, & Wynaden, 2006). Thus perpetuated the belief that nursing was 'not a job for a man' (Harding et al., 2008; Inoue et al., 2006), that added to gender minority and gender discrimination.

Gender discrimination remains within nursing (Kouta & Kaite, 2011), with gender appropriateness of specific nursing specialities such as midwifery and paediatrics for RNs who are female has also been purported (Muldoon & Reilly, 2003). Nonetheless, gendered division of labour within nursing still visible with men being

more prominent in mental health nursing (Evans, 2004b), and high technical nursing specialities (Rambur et al., 2011). The migration towards the more accepted male nursing areas offered men strategies to distance themselves from the femininity of their chosen profession and thus maintained their masculinity (Wingfield, 2009).

Men in entry level health employment often choose nursing to achieve technical expertise, decision making, and career development that nursing can provide (Ierardi et al., 2010; Snyder, 2011). In contrast, the men who entered nursing as a second career sought more satisfying employment (Harding, 2009; Zamanzadeh et al., 2013), and wanted direct patient care roles in speciality practice with a desire for advanced practice (Moore & Dienemann, 2014; Rajacich et al., 2013). A large American study with 498 respondents, revealed that the majority of men who entered nursing come from this second career group (Hodes, 2005). According to Tracey and Nicoholl (2007, p. 678) "men undertake most of their major career changes early in their careers with job changes becoming less as they get older". Although for men who considered nursing to seek meaning work, were often older and had life skills, which were found to be advantageous in their initial socialisation into the profession (McLaughlin, Moutray, & Moore, 2009; Moore & Dienemann, 2014). .

In Malloy et al. (2015) study 'finding meaning in the work of nursing, where 11 focus groups were conducted in five countries (based on religious and cultural variance), revealed relationship, compassionate caring, identity and mentoring cultures themes from 57 statements. Further, the respondents viewed nursing as a commitment to compassionate caring. This was due to their exposure to significant others such as having mothers as nurses, with nursing giving the respondents an identity and meaning to their lives; hence the reason for their entry to nursing. Despite this, it has been alleged by both the nursing profession and society that gender norms may inhibit caring expression in NMs (MacWilliams et al., 2013).

Recent research (Kluczyńska, 2017) on why men in nursing may inhibit caring expression could provide insight into this matter. Kluczyńska's (2017) qualitative research study using a grounded theory approach interviewed 17 NMs. It was reported that these nurses saw the provision of care and helping others as part of nursing. Thus, instead putting forward altruism as their reason for entering nursing, they tended to promote practical reasons for their decision. It was purported by

doing this, it "may help them deal with the fears associated with choosing a feminized profession*"* (p. 1366). Similarly, a qualitative interpretative study (O'Connor, 2015) that investigated the gendered experiences of men choosing to be nurses in Ireland interviewed 18 RNMs. This study revealed that these RNMs often played down the emergent motivation of caring and nurturing, and used other factors such as career progression instead when clarifying why they entered nursing.

2.3 On entry to nursing

Timing of the entry for males into nursing has been reported as crucial (McLaughlin et al., 2009). Some participants in an Irish study by McLaughlin et al. (2009) alleged that age, being older, and having acquired life skills equipped them for nursing. Regardless of age, the initial overwhelmed feeling with episodes of vulnerability and marginalisation, being the outsider within the female-dominant nursing profession, has been reported by men as they entered nursing (Christensen & Knight, 2014). For some men this 'outsider within' status was the driver for their gravitation towards male collegial groups (Christensen & Knight, 2014; Stott, 2007). Hence, suggestions have been purported on the need to promote male networks in nursing (Moore & Dienemann, 2014), and the presence of male role models in nursing education (Stott, 2007).

Female focused nursing curriculum was reported by the male student nurses in Christensen and Knight's (2014) study as an issue. The NMs role in care provision was often negated due to the female gender orientation of the curriculum (Duffin, 2006; Ierardi et al., 2010). Nursing reference books, course text referring to her/she as reference to the nurse provided female media image has added to this negation (O'Brien, Mooney, & Glacken, 2008), and consequently reinforced the minority status of men in nursing (Bell-Scriber, 2008).

2.3.1 Image of nursing

There has been an urgency to present a realistic nursing image that included both genders in order for workforce sustainability (O'Brien et al., 2008); although for some, their health professional family members did provide a true account of nursing (McLaughlin et al., 2009). Although, men in nursing tend to be more accepted today

(Koch, Everett, Phillips, & Davidson, 2014; O'Lynn, 2013), gender stereotypes still occurred (Kouta & Kaite, 2011) with nursing still regarded as a 'woman's job' (Colby, 2012; Snyder, 2011).

Simpson's Australian study (2011) of nurses, 16 males and eight females, reported "because of the identity threats posed by their entry into a feminized occupation, men are likely to have thought carefully about their chosen career and the implications of working with women" (p. 395). Another study noted that most men in nursing avoid being viewed as feminine (Zamanzadeh et al., 2013). Contrary to this, recent research elucidated that RNMs had a dislike for the title 'male nurse' (Herakova, 2012; Rajacich et al., 2013). Rajacich and colleagues (2013) who focused on the experiences of men in the nursing professional revealed that the 16 male participants disliked commonly being called a male nurse and preferred 'nurse' as their title. In contrast, a women being called a female nurse not perceived as common with a female nurse usually called 'nurse'.

In gender stereotyping constructed by society of nurses as females (McKinlay et al 2010), RNMs have been mistaken for physicians (Ierardi et al., 2010), and patients surprised that men undertook nursing as a career has been reported (Wingfield, 2009). In addition, NMs have been "questioned about their masculinity with assumptions based on patriarchal beliefs around the construction of nursing as a role suitable for women only" (Meadus & Twomey, 2011, p. 270). Thus enhanced the myth that if you are a RNM then you were assumed to be homosexual (Harding, 2007; Stanley, 2012). It has been inferred the need to highlight the masculine side of nursing to reduce femininity aspects and associated negative impressions attached to the image of RNMs (Allison, Beggan, & Clements, 2004; O'Brien et al., 2008). Moreover, to highlight RNMs "as average men with wives . . . have an interest in football . . . accepted by their fellow health care colleagues and who receive professional recognition for their accomplishments" (Allison et al., 2004, p. 173).

Media portrayal of nurses' further fostered skewed images of RNMs often stereotyping them negatively as undesirables, blatantly effeminate or overtly masculine, homicidal, lazy and incompetent (Bartfay et al., 2010; Stanley, 2012). In addition, Stanley (2012) revealed, in his study of 13 films portraying NMs images, that "films featuring male nurses lack important representation of the hegemonic

view of masculinity" (p. 2535). Hence men who enter nursing faced a unique challenge, to find the balance between being seen as effeminate and that of being overtly masculine (Simpson, 2011; Stott, 2007).

Men in nursing have been perceived by peers as 'muscle' because of their physical strength (Brown, 2009; Hart, 2005; Meadus & Twomey, 2011). In Clark and Springer's (2011) study of the male student nurses, several of these men revealed a sense of discrimination when staff used them purely for their physical strength in lifting and moving patients as well as in the care of potential violent patients. Men in nursing often called to care for violent patients (Loughrey, 2008), or more difficult and aggressive (Keogh & O'Lynn, 2007). Hence, the gender-bias stereotyping of men as muscle coupled with the gender minority reflected in the male nurse title has enhanced gender-based role strain (Herakova, 2012; Rajacich et al., 2013).

2.3.2 Gender-based role strain

Oermann and Heinrich (2005) described gender-based work role strain as "the relationship between one's sex and actions related to role enactment, which may lead to role conflict in the context of societal expectations for gender-based behaviours" (p. 227). Further, they suggested that to minimise the role-strain men in nursing may migrate more toward male congruent clinical specialities. Moreover, gender-based role strain and issues around intimate touch nursing care identified as a reason why they tend to seek out mental health specialisation or the low intimate touch, technical and rapid assessment areas of emergency and intensive care (Harding et al., 2008; MacWilliams et al., 2013). Men in nursing reported being uncomfortable about fulfilling role obligations (MacWilliams et al., 2013), and felt vulnerable when providing female intimate nursing care (Harding et al., 2008). Vulnerability and feeling isolated in clinical practice at times in the female-dominant workplace not uncommon for men who entered nursing (Wilson, 2005). This vulnerability increased where they cared for culturally diverse female patients when this care was seen by the patients' and family members as inappropriate (Rochlen, Good, & Carver, 2009). Increased isolation of men in nursing when being treated differently during clinical placements has also been reported (Keogh & O'Lynn, 2007; Wingfield, 2009).

Feeling isolated in clinical practice and patient allocation restrictions with practice limitation noted by men in nursing in the more feminine specific nursing specialities added to the gender-based role strain. However, in general men in nursing in their earlier stages welcomed the role modelling of and valued their interactions with experienced RNMs both in the clinical and academic settings (O'Lynn & Tranbarger, 2007; Stott, 2007), and especially in their GRN transition.

2.4 Graduate registered nurse transition

The transition from student status and academic settings brought the fear of the unknown, a common theme that resonated from GRNs as they navigated through the complex professional practice environment (Jewell, 2013; Wolff, Regan, Pesut, & Black, 2010); with job stress thought to be the main cause of NMs turnover being twice that of NFs (Duffin, 2006). Some studies have shown that first year GRNs with limited clinical experience who worried about their reduced ability to progress in nursing (Dawson, Stasa, Roche, Homer, & Duffield, 2014) or who felt that they did not 'fit in' (Beecroft, Dorey, & Wenten, 2008) often turned to other careers.

2.4.1 Professional socialisation

The concept of 'fitting in' in relation to the professional practice environment deemed a crucial part of socialisation as new nurses sought a sense of belonging needed in the formation of their professional identity (Zarshenas et al., 2014). Professional socialisation extremely applicable to the minority groups, such as GRNs and especially these NMs, in order for them to feel accepted in their chosen profession (Herakova, 2012). The move to a RN role encompassed a process of learning and adjustment to the new workplace (Jones et al., 2014). This learning of appropriate workplace behaviour deemed by GRNs was "more difficult than bridging the gap between theory and practice" (Goodare, 2015, p. 38). It was inclusive of "increasing accountability for patient care, coping with fears of making mistakes or interacting with other health professionals" (Newton & McKenna, 2007, p. 1232), that influenced the unpreparedness felt for their new role.

2.4.1.1 Unprepared for the professional practice environment

Plethora of studies have reported that new GRNs were unprepared for what lay ahead of them in their professional practice environment. Unpreparedness for these novice nurses included but not exclusive to: competing or limited learning opportunities and inadequate workplace inductions/orientations (Parker, Giles, Lantry, & McMillan, 2014; Phillips et al., 2014); excessive patient allocations and inappropriate high acuity patient assignment (Johnstone, Kanitsaki, & Currie, 2008; Newton & McKenna, 2007; Phillips et al., 2014); prioritising for unplanned events with lack of critical thinking time (Clark & Springer, 2012) whilst multitasking other care provisions and non-nursing duties (Mooney, 2007; Walker & Costa, 2017); lack of management and organisational skills (Fink, Krugman, Casey, & Goode, 2008; O'Shea & Kelly, 2007); inadequate staff skill mix and increased accountabilities and responsibilities (Duchscher, 2009, 2012; Kelly & Ahern, 2009; Odland et al., 2014); working within non-supportive professional practice environments and negative workplace cultures (Clark & Springer, 2012; Laschinger, Grau, Finegan, & Wilk, 2010; Parker et al., 2014); challenging inter-professional communication (Pfaff, Baxter, Jack, & Ploeg, 2014); unprofessional behaviour of other staff (Kelly & Ahern, 2009); difficult working relationships (Suresh, Matthews, & Coyne, 2013); and expectations of them to be work ready (Kelly & Ahern, 2009; Parker et al., 2014; Wolff et al., 2010). A recent Australian study (Walker & Costa, 2017) identified the five main categories that impact health graduates' transition and integration into the workplace as "dealing with change, dealing with conflict, workload, taking responsibility and factors that influence performance" (p. 1). The aforementioned being reflected in new GRNs perceiving that they were 'flung in at the deep end' with the 'sink or swim' mentality within the nursing workforce (Horsburgh & Ross, 2013) as they endeavoured to perform as a RN.

In relation to performance, 37 United States new GRNs in Clark and Springer's (2012) descriptive qualitative study expressed the need for dedicated professional development in such areas as communication, teamwork and management of stress. Further, within their first 19 weeks reported they required sufficient time to think through their nursing care provision. A recent scoping review of studies on critical thinking in nursing over the last decade plus deemed critical thinking as essential in nursing practice, that it "encourages professional activity based on evidence and

advances those aspects of the profession related to competence" (Zuriguel-Pérez et al., 2015, p. 827). An earlier qualitative study (Duchscher, 2003) explored how five new GRNs perceived critical thinking over their first six months in RN practice. This study revealed these nurses relied on others initially "to be told what to do, as well as when and how to do it" (p. 18). This reliance on others, the experienced nurses, as their principal knowledge source was thought due to the new GRNs' limited experience, unfamiliar routines and time constraints when confronted with issues that require safe clinical decisions (Voldbjerg, Grønkjær, Wiechula, & Sørensen, 2017). Toward the third month with familiarity of task-orientated procedures and learnt routines "initial signs of the capacity to make more responsibility for judgements" were displayed (Duchscher, 2003, p. 18). Clinical judgments conjoined with problem-solving, decision-making and critical thinking becoming more confined as GRNs' neared the sixth month transition in their professional practice (p. 21). According to Tanner (2006, p. 205) clinical judgement was complex requiring a flexible and nuanced ability to recognise relevant aspects of an undefined situation, in order to interpret and respond to appropriately. The depth of the GRNs perceived role and responsibility in recognising the undefined situation could lead to environmental reality shock.

Kramer, Brewer and Maguire (2011, p. 377) quantitative study of 468 GRNs on 191 clinical units over 17 participating hospitals revealed that there were significant differences in the degree of what they called 'environmental reality shock' experienced by new GRNs that appeared to coincide with their transition stages. Further, this shock being at its highest towards the fourth month in the precepted dependent stage when graduates were expected to take on more responsibility with insufficient time for critical thinking. It was thought that new GRNs being unprepared as they enter professional practice contributed to the level of environmental reality/transition shock they experienced (Duchscher, 2008, 2009, 2012; Kramer et al., 2011).

2.4.2 Transition shock

Transition shock model (Boychuk Duchscher, 2007) Figure 4 provided an insight to the complex issues that are inherent as the GRNs move from student status to the

often unknown role of the RN during the first stage of role transition (Duchscher, 2009).

Figure 4 Transition Shock Model (Boychuk Duchscher 2007)
Source: Duchscher (2009)

Fear linked with transition shock has been recognised by the nursing profession as a major issue for new GRNs transiting into the professional practice environment (Duchscher, 2009). Transition shock noted as "the fear of making a mistake and feeling unsafe that can be crippling to a new graduate's confidence and self-image" (Harwood, 2011, p. 8). Fear of making a mistake with adverse effects on patients and having doubts about their readiness as they enter the professional practice environment was common amongst new GRNs (Clark & Springer, 2012). The fear of making a mistake, a global phenomenon, requiring realistic understanding of the new GRN's skill sets by the new GRNs themselves (Clark & Springer, 2012) and by staff, with the provision of learning opportunities and positive workplace supports recommended (Jones et al., 2014).

Although a United States study reported new GRNs were fearful, they had confidence in their own abilities with the exception of supervising and delegation (Dyess & Sherman, 2009). This lack of confidence with supervising and delegations proved consistent with Duchscher's (2009) finding, where "considerable stress was involved in supervising, delegating and providing direction to other licensed and non-licensed personnel, many of whom were senior to the GRNs in both practice experience and age" (p. 1108). Delegation to non-licensed personal who are additional to and support nursing staff in the workplace, such as nursing assistants, have been found to cause major consternation among new GRNs, especially when these assistants are confrontational and not willing to answer new GRNs' questions (Chandler, 2012).

In a systematic review of literature on oppressed group behaviour (Roberts, Demarco, & Griffin, 2009), the use of silence and lack of unity were some of the negative behaviours displayed by this group, which could be applicable to the reported negative behaviour of the non-licensed personal. Further, Roberts and colleagues conceded that this type of behaviour has been shown to have an impact on nurses and their workplace.

2.4.2.1 Workplace culture

Workplace culture has an important part to play in how staff within the professional practice environment behave and the variance in transition success that new GRNs' experience (Duchscher & Myrick, 2008; Regan et al., 2017; Walker, Earl, Costa, & Cuddihy, 2013). The support requirements of new GRNs differed as they transition through the stages from being to doing and then knowing to reach competency and confidence in their RN role (Duchscher, 2008). These differing new GRNs needs accommodated in an inclusive workplace culture that welcomed and valued new GRNs, and encouraged supportive and trusting relationships with experienced staff, thought to enhance these graduates professional development and augment a smoother graduate transition (Moore & Cagle, 2012; Regan et al., 2017; Thompson et al., 2011). A supportive and inclusive culture that enhanced the team approach and embraced the GRNs enthusiasm reduced the need for these graduates to prove themselves (Benner, Sutphen, Leonard, & Day, 2010). Akin to existent literature (Duchscher, 2008; Johnstone et al., 2008), a recent Australian study (Walker et al.,

2013) that compared the perceptions of GRNs and nurse unit managers in relation to their transition during their first year revealed that regular constructive feedback provided in a supportive team enabled GRNs to feel valued and empowered.

2.4.2.1.1 Authentic leader

Recent quantitative correlational descriptive studies have highlighted the importance that empowerment has on GRNs' progression. Numminen et al. (2015) found the strongest relationship in their study was between GRNs' competence and empowerment, with suggestions of higher the competence higher the empowerment. Laschinger's (2012) study revealed structural empowerment and authentic leadership were significantly linked to job satisfaction and turnover intent.

In relation to authentic leadership, Laschinger et al. (2015) stated that their "study results provide further empirical support that authentic leaders may influence new GRNs' work experiences by providing them with a supportive, healthy work environment that helps build professional confidence in their nursing abilities and skills" (p. 1087). Further Fallujah, Laschinger and Read (2016) revealed that authentic leaders had a significant positive effect on new GRNs' personal and organisational identities that increased the new GRNs' self confidence in managing workplace challenges. Moreover, authentic leadership was found to underpin positive and effective leadership styles, be anchored in altruism, and embedded in what is the right thing that enhanced healthy workforce environments (Murphy, 2012).

In contrast, an oppressive and restrictive environment was found disempowering (Boychuk Duchscher, 2001). Disempowerment and emotional exhaustion revealed to impact on job satisfaction of GRNs in their first year of practice (Laschinger, 2012). A workplace culture that tolerated conflict and lacked nurse colleague and nurse manager support found to have a negative influence on new GRNs work satisfaction and team performance; thus inhibited their transition (Chernomas, Care, McKenzie, Guse, & Currie, 2010), and reduced patient safety (Benner, 2015). Moreover, this negative workplace culture generated incivility (Roberts et al., 2009). The majority of GRNs perceived some degree of incivility in the workplace (Smith, Andrusyszyn, & Laschinger, 2010). Dealing with incivility gave credence that

reality/transition shock can be heightened in the presence of unprofessional behaviour such as horizontal violence (Walker et al., 2013).

2.4.3 Unprofessional behaviour

Horizontal violence, synonymous with lateral violence, deemed as the bullying and incivility of nurse to nurse behaviour; noted as insidious, wide spread and long standing in nursing culture and often underreported (Hutchinson, Vickers, Wilkes, & Jackson, 2010; Myers et al., 2016; Roberts, 2015). New nurses and students acknowledged as the most vulnerable to this violence (Rittenmeyer, Huffman, Hopp, & Block, 2013, p. 468). For example, GRNs report being ignored, even verbal refusals, when calling for assistance (Dyess & Sherman, 2009) making them feel emotionally exhausted and undervalued (Laschinger, 2012). Further, Kelly and Ahern's (2009) study of Australian GRNs revealed that silence in particular "was used as a form of communication to demonstrate resistance to the presence of the GRNs in the workplace" (p. 916).

Recent literature reviews highlighted the significance of unprofessional behaviours on job dissatisfaction, nurse retention (Rittenmeyer et al., 2013) and patient safety (Roberts, 2015). Roberts (2015) claimed that:

> Key elements of bullying include a persistent attack by managers or co-workers that cause intimidation, isolation, damage to professional identity, and obstruction of work. Lateral violence also includes demeaning behaviors and actions that inhibit work, but also include passive-aggressive communication and inter-group rivalry related to powerless groups (p. 39) . . . literature suggested that it is a learned behavior in individuals related to workplace power dynamics (p. 40).

Comparative to Roberts (2015) findings, the types of behaviours that constitute bullying was revealed in the first stage of a three-stage sequential mixed methods Australian study (Hutchinson et al., 2010), where a topology of bullying behavior emerged in the qualitative first stage from 26 nurses who experienced bullying. Three types of bullying behaviours published as:

1. *Personal attack,* where isolation, intimidation and degradation were used to attack the identity and self-concept of nurses,
2. *Erosion of professional competence and reputation*, where damage to professional identity and limiting career opportunities occurred, and

3. *Attack through work roles and tasks*, where obstructing work or making work difficult, including denial of due process and economic sanctions, were used by bullies against targets (p. 2321).

More frequent bullying has been reported on medical-surgical or high-acuity areas (Vessey, DeMarco, Gaffney, & Budin, 2009) with more senior staff members revealed as the offenders (Johnson & Rea, 2009; Vessey et al., 2009). Medical-surgical areas predominately where most new GRNs commence their graduate year.

2.4.3.1 Bullying in the workplace

Figure 5 provides a visual summary related to bullying in the nursing workforce. Illustrated that bullying in the workplace has four elements of the negative behaviours of the perpetrator, the negative affect of bullying on the victim, the power imbalance between the perpetrator and the victim, and duration and persistent negative behaviours of the perpetrator:

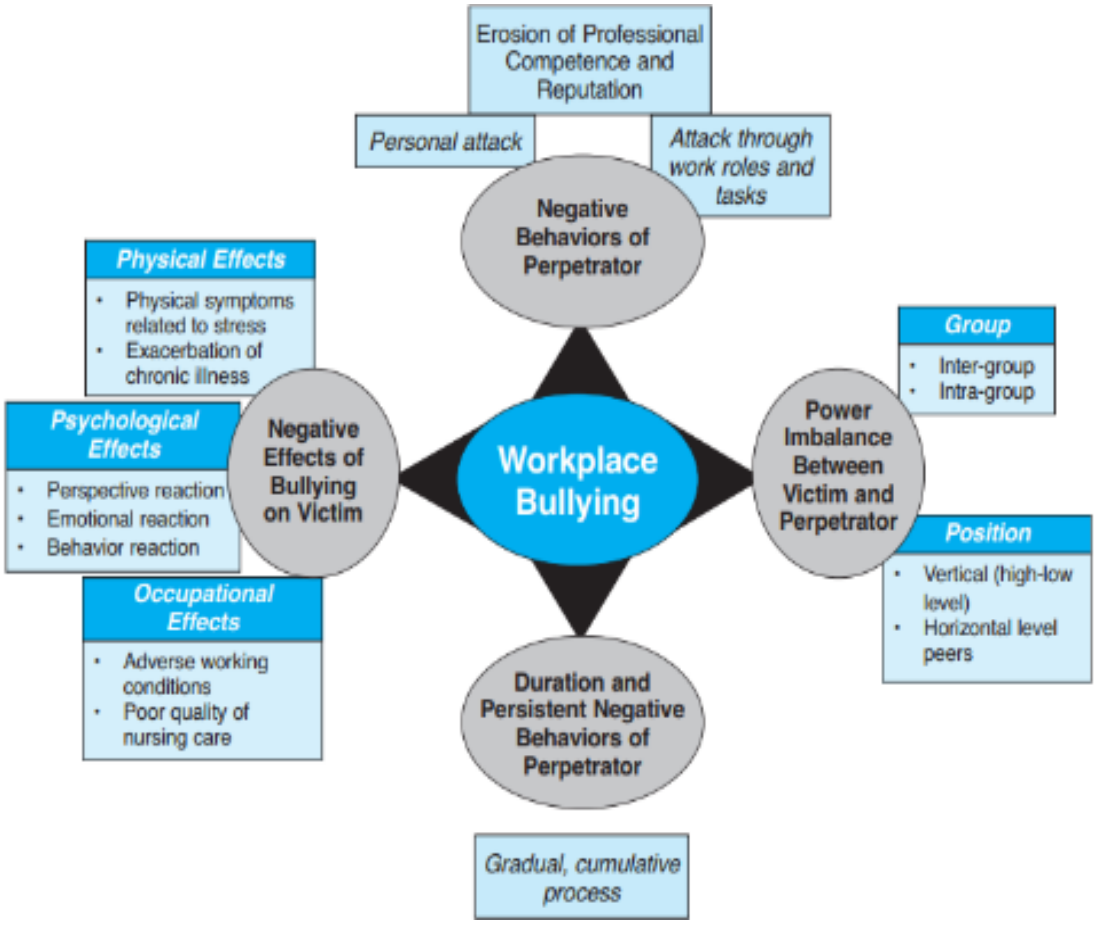

Figure 5 Conceptual Framework of Bullying in the Nursing Workplace
Source: Lee, Bernstein, Lee and Nokes (2014). Used with permission of the publisher, Jannetti Publications, Inc.

A plethora of research of bullying in nursing generally included the impact on new GRNs. Although there is dearth literature in relation to GRNMs specifically in this area. What is known is that the silence discourtesy of nurse to nurse communication in workplace, marginalisation, and lateral violence cause major dissatisfaction in NMs (O'Lynn & Tranbarger, 2007).

2.5 Summation

I initially used search engines accessed via the university's library summon search to investigate whether investing time in this thesis could lead to new knowledge. The keywords centred on men in nursing, graduate, transition shock, and nursing workforce. I was mindful that this initial search was cursory so I rejected the urge to explore in more depth as this thesis is more about the men I interview and their experiences and not what has been published.

The literature review reinforced the majority of my assumptions and observational experiences, especially the challenges new graduate registered nurses face as they enter the professional-practice environment. Although Holland's theory and Duchscher's transition stages model were not new knowledge I gained more insight into these. However, Orbe's co-cultural communication model was a new area for consideration. As I delved into the thesis method and analysis where the themes evolved, I undertook a more continuous extensive literature search that also included books and recent publications. I furthermore used the internet search engines Google and Google Scholar. The keywords for this search extended to nursing leadership, male academic support, significant others, socialisation and co-cultural communication.

With this gained knowledge, now as I interact with undergraduate NMs I have a new found appreciation and an increased awareness of their communication styles they employ; hence I have altered the way I communicate with these undergraduates. Moreover, like many of my female nursing colleagues, I would often wonder why my male colleagues seemed not phased or dismissive of some situations encountered. I now see their behaviour differently so I encourage and provide more opportunities for undergraduate NMs to have their say on why they act in certain ways so as to enlighten their female undergraduate colleagues on co-cultural communication.

My knowledge on why men choose nursing as a career has expanded and provided the rationale for asking GRNMs why they went down this career pathway. Professional socialisation was an area that opened up more questions than answers on why this issue has not been addressed within the nursing profession with the information that is currently available. The graduates' transitional shock was well documented; however, strategies to combat this shock were limited within the literature. For men in nursing the gender-role strain, their professional practice socialisation and the image of nurses came to the forefront as issues for them. Hence, through this study I have taken up the recommendation from Rochlen, Good and Carver (2009) "to investigate the meaning and impact of these gender-related barriers, using the NMs own words, qualitative examination is supported".