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

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THE LIVED EXPERIENCE OF THE WESTERN

AUSTRALIAN GRADUATE REGISTERED NURSE

WHO IS MALE

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Declaration of Authorship

This thesis is the candidate's own work and contains no material which has been accepted for the award of any degree or diploma in any other institution.

To the best of the candidate's knowledge, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Dianne Juliff

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Abstract

Nursing professionals are ageing and alternate career opportunities for females threatens nursing workforce sustainability. Largely untapped human resource and underrepresented within nursing in Australia are men. Therefore, the attraction and retention of men into nursing is imperative for the profession to support a sustainable workforce.

A qualitative longitudinal phenomenological study, explored the lived experience of nine newly graduated registered nurses who are male during their first year in their professional-practice environment. The methodological approach that guided this study was Interpretive Phenomenological Analysis (IPA). The IPA enhanced the exploration of the lived experiences of these participants by investigating the meaning of such experiences and how these are made sense of. Moreover, the analysis focused on understanding how these nurses who are male perceived their lived experiences by the researcher; positioned within the study interpreting their perceptions in an attempt to find meaning behind their lived experiences.

Purposeful sampling, using a snowball technique, ensured expertise was obtained through the voiced experiences of the nine participants who are male and newly graduated. Data collection used both individual face-to-face interview phases and participant reflective diaries in line with important mile stones acknowledged during graduate nurse transition.

Phase one findings were the emergent theme motivators for entering nursing. Elicited responses identified the influence and support of significant others and career choice triggers such as observing nurses in action. Phase two findings indicated the importance of nurse leadership and collegial support. Nurse to nurse communication and workplace marginalisation proved challenging during this transition phase. Phase three produced professional practice reality in their quest to become a valued team member and their professional self. Overall, their journey began with their desire to help others, then being faced with the reality of needing others help to develop their own skills as a professional helper. And finally, self-actualisation of being a registered nurse.

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List of Abbreviations

AIHW	Australian Institute of Health and Welfare
DCP	Department of Child Protection
ED	Emergency Department
GRN	Graduate Registered Nurse
GRNs	Graduate Registered Nurses
GRNF	Graduate Registered Nurse who is Female
GRNFs	Graduate Registered Nurses who are Female
GRNM	Graduate Registered Nurse who is Male
GRNMs	Graduate Registered Nurses who are Male
HWA	Health Workforce Australia
IPA	Interpretative Phenomenological Analysis
NF	Nurse who is Female
NFs	Nurses who are Female
NM	Nurse who is Male
NMs	Nurses who are Male
PCA	Patient Care Assistant
RIASEC	Realistic, Investigative, Artistic, Social, Enterprising, and Conventional
RN	Registered Nurse
RNF	Registered Nurse who is Female
RNFs	Registered Nurses who are Female
RNM	Registered Nurse who is Male
RNMs	Registered Nurses who are Male

Glossary of Terms

Registered nurse (RN)	Refers to a person with appropriate educational preparation and competence to practise, who is registered under the National Law administered by the Australian Health Practitioner Regulation Agency to practise as a RN in Australia (HWA, 2012a).
Graduate registered nurses (GRNs)	Refers to registered nurses who are male (RNMs) and registered nurses who are female (RNFs) with eligibility for registration with the Nurses and Midwifery Board of Australia in Division One and who in their first year of professional-practice who have never been registered as a registered nurse in Australia or overseas, or never practiced as a registered nurse in Australia or overseas.
Graduate registered nurses who are male (GRNMs)	Utilised in this research to differentiate from 'graduate registered NFs' (GRNFs). This differentiation acknowledged previous studies that have challenged the use of the title 'male nurse' inferring that this title adds to the existing gender-bias and stereotyping outside and within the nursing profession (Herakova, 2012; HWA, 2012a; Rajacich, Kane, Williston, & Cameron, 2013).

List of Publications

Articles

Juliff, D., Russell, K., & Bulsara, C. (2017). The essence of helping: significant others and nurses in action draw men into nursing. *Contemporary Nurse, 53*(2): 156-166.

Juliff, D. (2017). Graduate nurses face frustration in gaining registered nurse experience. *News, Opinion, Top Stories, Workforce August 9*.

Juliff, D., Russell, K., & Bulsara, C. (2016). Male or nurse what comes first? Challenges men face on their journey to nurse registration. *Australian Journal of Advanced Nursing, 34*(2): 45-52.

Juliff, D., Russell, K., & Bulsara, C. (2015). The value of male faculty from the perspective of newly graduated male registered nurses. *Australian Nursing and Midwifery Journal, 23*(5): 25.

Presentations

Juliff, D. (July 2017). *Nursing leadership influence on male graduate nurses retention experiences explored in the professional practice environment*, Sigma Theta Tau International, Honor Society of Nursing: 28th International Nursing Research Congress, Dublin Ireland.

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Chapter 1.   Why This Journey

I am one of the many ageing nurse professionals who are ending their clinical work-life. As I reflect on my journey I marvel on where my nursing career has taken me and moulded the person I am today. I marvel on how the profession has morphed, its advancement and its manoeuvre into the ever-challenging complex health arena. But, and there is always a but, I have trepidations on the current nursing climate and I wonder could I have done more to shape the profession? Have I used my nursing mantra of caring effectively? What have I contributed to the nursing leadership attributes required for the development of a nurse professional who is nurturing yet has a political voice? These are the questions that recur in my subconscious formed by what I perceive to know, have experienced and observed in my professional life. My greatest apprehension now is how the profession is going to sustain a professional nursing workforce that contributes to both today and tomorrows shifting health consumer needs and the ever-increasing complexity in nursing care. With the above in mind, I have embarked on this journey of discovery, commencing with the nursing workforce challenges and issues around retention of nurses, especially the novices who are our future nurse leaders, which eventually formed the basis of this study.

1.1   Background

The nursing workforce currently faces challenging times and will continue to do so into the foreseeable future. The World Health Organisation (WHO) acknowledges that there is an ever-increasing global nursing shortage due to inadequate human resources, difficulties with workforce retention and increased migration (WHO, 2013). According to Health Workforce Australia (HWA), although most states in Australia are currently experiencing a short-term oversupply of nursing and midwifery graduates, a looming nursing workforce challenge with a shortage of 85,000 nurses is projected by 2025 (2014a). This current oversupply is thought to be due to the increased enrolment of nursing students in recent years; and registered nurses (RNs) older than fifty years continuing to work longer, although most of these older nurses will be retired or nearing retirement by 2030 (Auerbach, Buerhaus, &

Staiger, 2015). It is widely acknowledged that the recruitment and retention of qualified nurses is critical to the delivery of optimal healthcare (HWA, 2014b). Hence key strategies recommended by the Health Workforce Australia to address the predicted shortfall include the retention of new graduate registered nurses (GRNs) (HWA, 2012a), and the potential recruitment of males into nursing (HWA, 2013). Moreover, these GRNs must be supported and have successful transitional experiences, job satisfaction and retention rates improve (Phillips, Kenny, Esterman, & Smith, 2014).

The GRN attrition is an issue given that the loss of these nurses are not sustainable with the rapidly ageing Australian nursing workforce impacting on the continuing nursing shortage (Cowin & Hengstberger-Sims, 2006; Scott, Engelke, & Swanson, 2008). Currently, the three largest general registration groups by age for Australian employed nurses are in the 50-54 (12.6%), 45-49 (11.7%) and 55-59 (12.6%) group (Nursing and Midwifery Board of Australia, 2017, p. 8). An independent Australian national survey on nurses and midwives conducted in 2016 revealed that "32% of those surveyed indicated they have considered leaving the nursing /midwifery profession and 25% reported they were either likely or very likely to leave the profession" (Tham & Gill, 2016, p. 5). Moreover, "the early exit of nurses from the workforce gives rise to a loss of investment from training, a loss in productivity given the future years the nurse would otherwise have provided into the nursing workforce, and the significant cost of staff turnover" (HWA, 2014a, p. 20). Hence, the retention of younger nurses and GRNs in particular is recognised as paramount in addressing future nursing workforce shortages (Drury, Francis, & Chapman, 2009), especially in the current climate where there is lower GRN employment and low early career RN retention (HWA, 2014a, p. 8).

The exact attrition rates have been difficult to quantify due to the lack of systematically collected data. It has been suggested that internationally up to 60% of new GRNs will leave their first year nursing position (Odland, Sneltvedt, & Sörlie, 2014). In Australia, it is estimated that the attrition rate for nurses generally is around 12% (HWA, 2012b, p. 55). A study by McLaughlin et al (2010) noted that more males than females indicated they intend leaving the nursing profession in the future (McLaughlin, Muldoon, & Moutray, 2010); with an average of 39.97% male attrition rate compared to female attrition rate of 32.29% (HWA, 2014a, p. 42);

hence this is a concern when around 90% of GRNs are female (p. 18). Further, it has been postulated that the attrition rates specifically for men who enter nursing is high (Stott, 2007), that poses a professional concern when men in nursing currently make up only 8.7% of the nursing workforce in Western Australia (Nursing and Midwifery Board of Australia, 2017). Although men are seen as a potential nursing workforce for the professional practice environment (HWA, 2012a; Roth & Coleman, 2008), the attrition rate demonstrates that addressing the issues for men in nursing is crucial to sustaining the future workforce.

There remains a strong link in the literature between new graduate nurse attrition and the challenges posed for these new professionals in Australia and internationally (Park & Jones, 2010). The first year in the professional practice environment for GRNs can be a stressful experience (Jewell, 2013); with these nurses experiencing role performance stress and reality/transition shock causing strain on their initial socialisation period (Duchscher, 2008; Jones, Benbow, & Gidman, 2014). Excessive workloads and poor work conditions cause extreme levels of stress and burnout (Holland, Allen, & Cooper, 2012; Kramer, Brewer, & Maguire, 2011). The new GRNs leaving the profession within the first six months post-graduation (AIHW, 2012) reveal that the third month and sixth month to be the most stressful period for these graduates (Chang & Daly, 2012; Duchscher, 2008; Newton & McKenna, 2007).

1.2   Current study

The area of this study focused on the nursing profession, in particular the Australian nursing workforce. The topic of interest was the recruitment and retention of GRNs within Western Australia. I, as the researcher, have a keen interest in both GRNs and nurses who are male (NMs) retention, and in particular the issues of graduates leaving the professional and the lower numbers of men in nursing. Therefore, this study centred on the experiences of the GRNM.

1.2.1   Purpose

The purpose of this research study was to investigate the lived experience of a select number of Western Australian GRNMs. Moreover, how they came to their decision

to enter nursing, their journey to registration and through their first year as RNs. It was anticipated that by developing an understanding of their lived experience, including what fostered their interest in becoming a nurse and how they socialise into the profession, dialogs on schemes that may assist with future recruitment and sustainability of men entering the nursing workforce may occur.

1.2.2 Research questions

To explore the lived experience of these nurses, with a focus on understanding their perceptions and viewpoints, the following research questions were formulated:

- How do the GRNMs choose nursing as their career, in particular what motivated them to decide to enter the nursing profession?
- How do GRNMs perceive their professional practice experiences within their first twelve months employed as a GRNMs, and were their expectations met?
- At the end of their graduate year, how do the GRNMs place themselves in terms of a future career pathway?

As the researcher, I endeavoured to elicit the meaning and the essence of the participant nurses' lived experience as GRNMs in the Western Australian nursing workforce. Thus, I documented a phenomenon of increasing interest connected to the predicted nursing workforce shortages. In so doing, I hoped to describe what initially interested these GRNMs to enter the nursing profession; to gain an understanding of their experience in relation to their values and beliefs of their new role and responsibilities; and their expectations of their fit within the professional practice environment as they transitioned.

1.2.3 Researcher perceptions

My perceptions of men in nursing has been established over a four decade nursing career in acute clinical and community health settings, staff development and nursing executive roles where I worked with, managed and mentored registered nurses who are male (RNMs). These perceptions are that men in nursing:

- Have certain personality traits that foster their desire to enter and remain in the profession.

- Face a similar transition as their female colleagues into the professional practice environment; however, they bear added unique challenges related to their gender.
- Modify their communication style in order to gain acceptance, in other words, 'fit in' to the female-dominant professional practice environment.

1.2.4   Conceptual framework

There was no absolute requirement for a conceptual framework in an interpretative phenomenological study (Smith, Flowers, & Larkin, 2009). However in the interpretative end stage of the analysis "comparing the fit" between the study findings and existing literature in order to make sense of the analysis can be done with caution (Smith et al., 2009, p. 48); to "further develop theories, models and explanations that help us understand human experiences better" (Fade, 2004, p. 647).

In light of my perceptions and prior knowledge extracted from the cursory search undertaken and the theories that had become explicit and connected with this knowledge; a conceptual framework was considered appropriate to support the iterative process of this study (Punch, 2006). Insomuch as the known literature on why certain men may be attracted to nursing, their gender minority and GRNMs socialisation during professional practice transition acquainted well with John Holland's (1997) theory of vocational interests where personality traits can indicate career suitability; Judy Duchscher's (2007) transition stages model that outlines the significant milestones the graduate nurses transition through into practice; and Mark Orbe's (1998) co-cultural communication model 'outsider within perspective' relevant to a minority group communication behaviour within a dominant group. Hence, these aforementioned models and theory were used as a conceptual guide for this study, the details of such are presented in the literature review.

1.2.5   Significance

The recruitment of men into the nursing profession remained low (HWA, 2012a). By investigating how GRNMs view their transition into the workplace, the workforce managers responsible for graduate programs and university faculties may be able to modify their curriculums to support and encourage more men into nursing.

Understanding why men choose nursing as a career and their experiences of completing a nursing education program, inclusive of their graduate year, was deemed important to strategise ways to increase this workforce and diversity within the nursing profession (Keogh & O'Lynn, 2007; Meadus & Twomey, 2011; Solbraekke, Solvoll, & Heggen, 2013).

Further, to understand the co-cultural communication style between women and men as male communication style has been reported as restricting male participation within the nursing profession (Herakova, 2012). For example, the literature indicated that RNMs tend to alter the way they speak and what they say to a female colleague as opposed to a male colleague for fear of being misunderstood and/or being seen as not caring (Herakova, 2012). Understanding and accepting differing communication styles of both men and women within nursing may enhance socialisation into the professional practice environment and increase satisfaction of the RNMs career choice. Of note, even with their minority status, RNMs who were satisfied with their career choices readily recommended nursing to other men (Twomey & Meadus, 2008). Despite their minority status, this status could be advantageous as it has been reported that being male promoted rather than hindered their career progression within nursing (Simpson, 2014). According to Ryan Mallo "from a professional standpoint, it is easier to stand out among the masses when the majority of your peers are females" (Gardenier, Mallo, & Moss, 2016, p. 302). Hence increasing men's awareness of the nursing profession benefits including their minority advantage may be a strategy that will increase the number of men in nursing (McMurry, 2011).

Moreover, both male and female GRNs represent the future leaders of the Australian nursing workforce and the consequences of new graduates leaving the profession will only exacerbate the projected nursing shortages. Understanding how these new GRNMs see their world through their experiences as they enter the profession can assist workforce decision makers to enhance the new GRNMs' socialisation into the workforce.

Improved stability of the graduate cohort, decreased attrition and the associated reduced need to recruit and train new staff will provide cost savings in healthcare and the associated costs of replacing staff. The literature reported that the high attrition

rates of nursing staff had considerable impact both on patient outcomes and health service budgets (Roche, Duffield, Aisbett, Diers, & Stasa, 2012). This included direct and indirect costs such as compromised patient care, reduced staff morale (Ulrich et al., 2010), and problems with sustainability of the nursing workforce (Huntington, Gilmour, Neville, Kellett, & Turner, 2012).

1.3   Summary

This chapter provided the introduction as to why I embarked on this research journey and covered the development of the concepts and premise for the study. It outlined the background of the phenomena, namely the lived experience of GRNMs. The purpose of this study was to investigate the lived experiences of GRNMs during their journey from the decision to enter nursing through their completion of their first year as a GRN. The rationale for the study was to provide an insight into their actual lived experiences, as they become competent registered nurses (RNs). My perception being that men in nursing have a particular personality trait that underpins their decision to enter this female-dominant profession; even when they are aware of the unique barriers they will face in addition to those challenges that all undergraduates and graduates tackle as they enter their nursing career. The research questions and conceptual framework that guided this study were highlighted to add an informative bearing on the study in light of the phenomena of interest.

This thesis proceeded as follows. Chapter two examines the known literature inclusive of cursory and continual searches undertaken. After which an overview of the conceptual framework in relation to the experiences of GRNMs is provided. This chapter ends, as do the subsequent chapters with my reflexivity account. In chapter three, the research approach and research method for the qualitative study is outlined. Chapter four provides a profile of each participating GRNM. Chapters five, six, and seven the analysis of the data is presented, and the description of each phase of this longitudinal study of the participants' experiences, being paraphrased and supported by quotations of their own words. Chapter eight affords the overall discovery of the IPA that permeated throughout each of the phases under investigation and the underlining essence of why men choose nursing and remain in this profession. Chapter nine presents the discussion on the study's findings in comparison with existent literature and the study's conceptual framework inclusive of the relevant

theories. Chapter ten suggests implications for the nursing profession and offers recommendations for the recruitment of men into nursing and the retention of GRNMs in order to support a sustainable nursing workforce.

The summaries in the following chapters are in italics and titled summations, to alert the reader that these were the researcher's contemplations which are intended to give an insight into why the study progressed the way it did. It also formed part of the reflexivity process within this thesis.

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).

Holland Personality Types
(Holland, 1959, 1997)

Realistic
* Enjoys practical, hands-on activities
* Takes pleasure in working with nature, animals, tools, and/or machines.
* Likes to work individually and takes pride in

Conventional
* Finds value and success in accuracy, and time management.
* Detail and organization oriented
* Takes pride in goal settings, working with machines and numbers

Investigative
* Enjoys science inquiry, exploration, and discovery
* Finds value in learning
* Theory, and using math
* Keen on using problem solving and analytical skills

Enterprising
* Values leadership and leading teams tow and defined goals
* Enjoys competition and spirited environments
* Understands business, products and ideas

Social
* Interests in developing and maintaining a sense of community and solving social problems
* Customer-service orientated
* Finds value in helping, assisting and informing others

Artistic
* Enjoys independent, creative, and expressive activities
* Values innovation and originality
* Thrives in impromptu, chaotic environments

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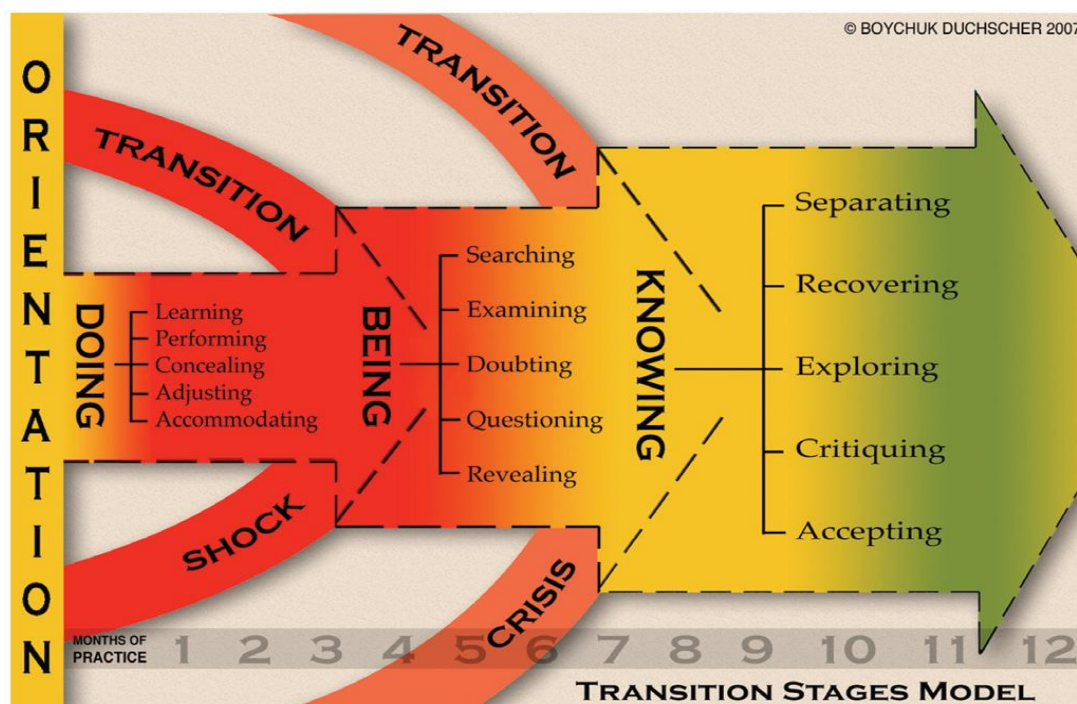
Figure 3   Transition Stages Model (Boychuk Duchscher 2007)
Source: Duchscher (2008, p. 443). Used with permission from Judy Duchscher.

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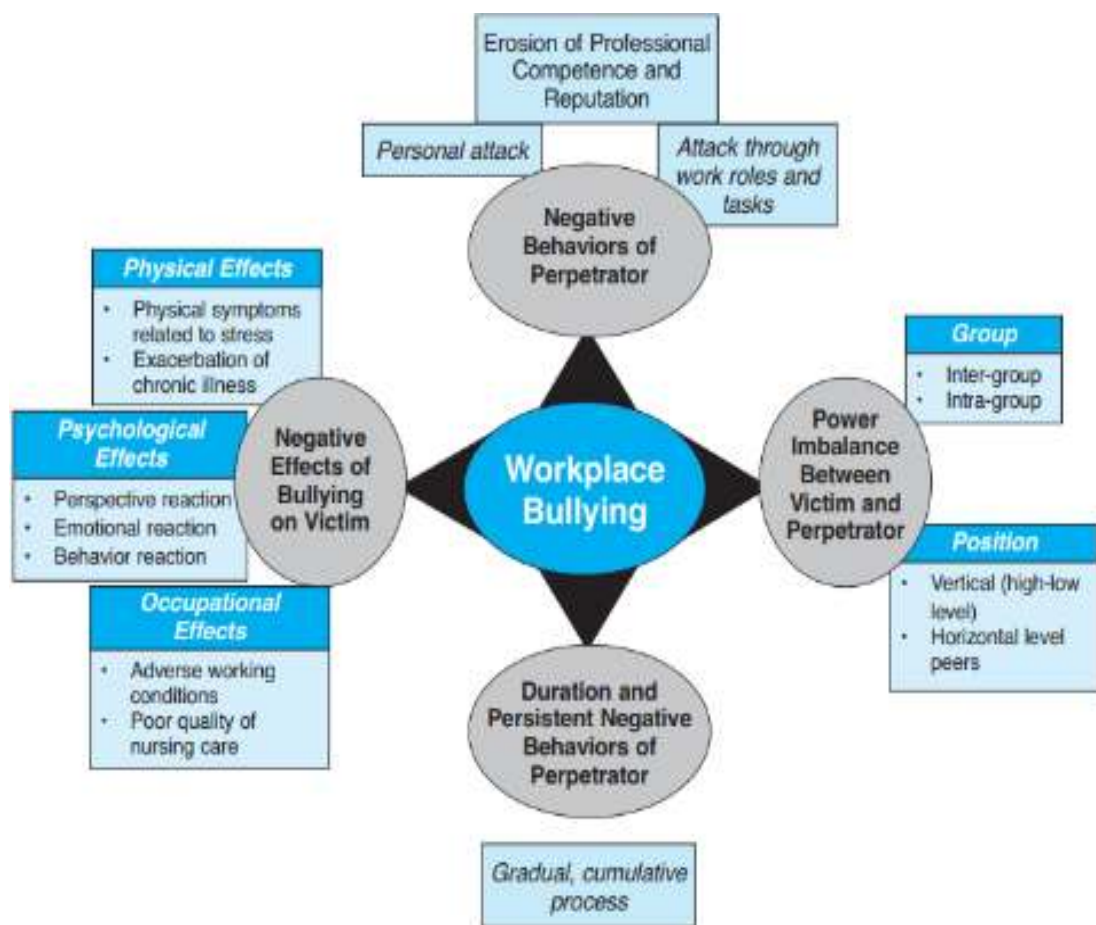
Figure 5   Conceptual Framework of Bullying in the Nursing Workplace
Source: Lee, Bernstein, Lee and Nokes (2014). Used with permission of the publisher, Jannetti Publications, Inc.

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".

Chapter 3. Methodology

As previously stated, the aim of this study was to explore the Western Australian GRNMs lived experience. Moreover, the study sought to investigate and make sense of how these GRNMs perceived their own experiences. This was done by providing detailed interpretations of the understandings derived from the constructive dialogues between the GRNMs and myself as the researcher to extract the participants' experiential meanings. At the same time acknowledgment was given to the importance of capturing the individual GRNM's uniqueness that each of them bring to the phenomena under investigation; namely, his lived experience.

The mode of inquiry for this study used the language of human science. Human science language being an extension of social science with the Heideggerian stance of 'being in the world' through human encounter (Rolfe, 2015). As this study was to investigate a deeper understanding of the GRNMs lived experience, their human encounter, and their motivation for entering nursing; the focus on 'being in the world' was deemed apt for this project. Moreover, in discovering the main themes associated with the GRNMs human encounters through their lived experience, the ability of these themes in relation their translation into the professional practice of nursing, now with the mantra of the holistic nursing approach; gave authority for the use of qualitative phenomenological research from a hermeneutic field with a focus on the particular. In this case, the particular was the individual GRNM.

The sections within this chapter follows Figure 6: Methodology flow chart. This chart was developed as a guide to the flow of information provided to aid in the comprehension of why the specific research strategy and design was used; the specific methods employed in the study; the way rigour and quality of the study; ethical considerations are addressed; and the limitations of this study.
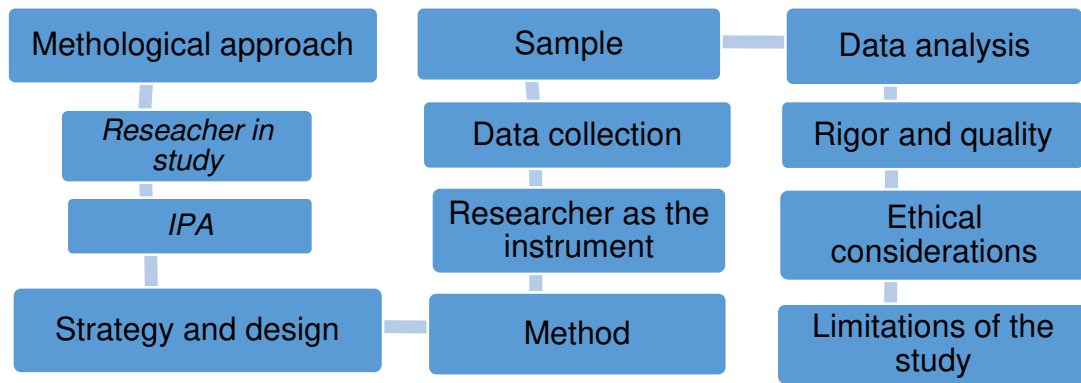
Figure 6   **Methodology flow chart**

3.1   Methodological approach

The methodological approach was grounded in the social science research field and with social science being the science of people and their individual or collective behaviours (Bhattacherjee, 2012), lent itself to qualitative research. Qualitative research encased the "assumptions and uses interpretative / theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem'' (Creswell, 2013, p. 44). Moreover, phenomenology focused on human understanding of what they experience and originated from the work of the philosopher, Edmund Husserl (1936) where he expounded the importance of the 'lived experience' with the belief in core meaning of entities through understanding intuition (Fade, 2004). Husserl centred on arriving at an understanding and meaning of human experience and consciousness, thus facilitated the essence of the phenomena in the process of investigation of the experience (Dowling, 2007). Capturing this essence and remaining outside the experience, in other words "looking beyond preconceptions became known by various interchangeable terms: phenomenological reduction, epoche or bracketing" (Tufford & Newman, 2012, p. 82).

Qualitative interpretative phenomenology was used for this study. Interpretative phenomenology was based on the theoretical underpinnings of Heidegger, a student of Edmund Husserl, where he sees "human existence as interpretative" (Moran, 2000, p. 235). Heidegger proposed that "all knowledge emanates from people who are already in the world and seeking to understand other people who are already in the world" (Corney, 2008, p. 165). Contrary to Husserl's remaining outside the experience, Heidegger adopted ontology, 'the science of being', with the premise of

being in the world rather than knowing the world (Reiners, 2012), where interpretation and meaning are embedded in everyday activities (Cerbone, 2006). Heidegger insisted that bracketing out preconceptions was not possible in an interpretative process (Tufford & Newman, 2012).

3.1.1   Researcher's position in the study

Heidegger's interpretive phenomenology promoted the researcher as an integral part of the field being studied as a 'common being' with the participants, therefore the researcher cannot negate her prior understanding in the subject under study (Reiners, 2012). As previously mentioned, Heidegger believed that the putting aside of the researcher's own experience by bracketing is not fully achievable (Finlay, 2008). Further, "the researcher's involvement including preconceptions, beliefs and aims prior to the analysis stage of the research proceedings is generally acknowledged" (Brocki & Wearden, 2006, p. 91). However, "a focus on researcher's characteristics may not necessarily benefit reader's interpretations of an analysis and might perhaps even represent a misleading diversion" (p. 92). Moreover, Sorsa and colleagues (2015) cautioned the researcher that their background should not influence the participants' understanding of the phenomenon under investigation. The researcher's curiosity, often the instigator for investigating the phenomenon, led LeVasseur (2003) to suggest that curiosity about the phenomenon may be seen as a form of bracketing.

The use of bracketing remained a contentious issue, therefore, to aid the researcher in noting details such as the nature and origin of emergent interpretations a reflexive journal was recommended (Biggerstaff & Thompson, 2008). Reflexive journaling enabled acknowledgment of assumptions and reflexive assessment on interpretations during the researcher's making sense of the participants' experiences that was congruent with interpretative phenomenological analysis (IPA) (Smith et al., 2009).

3.1.2   Interpretative phenomenological analysis

The Heideggerian stance supported the use of the IPA due to its research approach where it aimed to qualitatively explore individuals' perceptions and experiences through the interpretive stance of the researcher (Finlay, 2008). IPA provided both a theoretically informed framework on how to conduct the research and a technique for

analysing data (Smith et al., 2009). It focused on the individual's ability to express their thoughts and experiences through self-reflection in order to interpret their experiences that is understandable to them (Silverman, 2011). Thus it was envisaged that this interpretive approach would lend itself to eliciting the understanding of the Western Australian GRNMs lived experiences with the aim to illuminate the essence and make sense of their being there in this world.

3.2   Strategy and design

The strategy used was a longitudinal qualitative research approach to enable qualitative explorations about the GRNMs lived experiences as these occurred at designated time points during their transitional year. Moreover, to elicit the causes and consequences that focused on their narratives and their journey in order to capture significant moments involved in their transition (Calman, Brunton, & Molassiotis, 2013). It is acknowledged that

> the analysis is complex and multidimensional . . . tackled both cross-sectionally at each time point to allow analysis between individuals at the same time as well as longitudinally capturing each individual's narrative . . . the addition of a theoretical framework can help to guide researchers during analysis to move beyond description (p. 2).

IPA was selected as the research design to understand how these GRNMs' make sense of their lived experience as they journeyed into and through their first year in the female dominant nursing profession. Phenomenological from the aspect of pursuing an insider viewpoint of the individual's lived experience; interpretative by considering the researcher and the individual's perspectives in making sense of his lived experience; and idiographic as IPA focuses on the particular, in this instance, the individual GRNM.

From the IPA's interpretative facet, the 'making sense of' the lived experience was through the participant's and the researcher's interpretative analyses taking into account the context (social, cultural and theoretical) in the process of the analysis (Pietkiewicz & Smith, 2012). This interpretative activity was termed the 'double hermeneutic', in other words, the researcher is trying to make sense of the GRNM, who is making sense of himself (Smith et al., 2009, p. 35).

The idiographic facet of IPA fostered the detailed analysis of each GRNM's data before moving onto the next, in order to give importance 'prioritise' each individual data set before undertaking convergence and divergence across the data sets (Larkin, Eatough, & Osborn, 2011). This analysis, as an iterative and inductive cycle, moved from the individual's experience to the shared experiences, and from the descriptive to the interpretative whilst staying true to the individual's personal meaning-making in particular contexts (Smith et al., 2009, p. 79).

In this study, the idiographic aspect was maintained by the use of research questions using the verb 'explore' inference on how do the GRNM choose nursing as a career, how do they perceive their professional practice experiences and how do they place themselves in terms of a future career pathway; and by focusing on the 'understandings' and 'experiences' of the individual participant's perception of his personal experience (Giorgi, 2012). Although, not all the questions are known prior to the commencement of the data collection (Liamputtong & Ezzy, 2005). This was in keeping with the IPA where maintenance of flexibility and avoidance of preconceived directional questions with the tendency to influence the analysis was promoted (Brocki & Wearden, 2006). These questions are also inductive as they are broadly presented to encourage unanticipated themes to materialise.

3.3 Method

Western Australian GRNMs who were about to commence employment in the metropolitan area were invited to participate in this qualitative longitudinal study. Having contact, in this case via the telephone, with the potential participants prior to the interviews was central in the recruitment process in setting the cornerstone for rapport and relationship building between the researcher and the participants (Wagstaff & Williams, 2014). Meeting the participants more than once further augmented the relationship building and enhanced the richness of data that evolved. Moreover, multiple meetings provided the opportunity for further exploration, investigation and clarification of matters that surfaced in previous contacts. Furthermore, the study's in-depth three-phase longitudinal approach enabled the investigation of the participant's lived experiences at specified times post-graduation that has been identified previously by researchers, such as Judy Duchscher (2008), at significant points within the GRNs graduate year. These significant points identified

by Duchscher (2008) were the 'doing stage' from commencement of the graduate year up to the fourth month where the impact of transition shock is common; the 'being stage' from five months up to the eighth month with the emergence of transition crisis; and then the 'knowing stage' from around the eight month up to the completion of the first graduate year. This focus of what is happening at a particular time for an individual participant has congruency with Heidegger's 'Being-there' or 'Dasein' (Smith et al., 2009).

The semi-structured design allowed the same open-ended questions and flexible probes to be used in each interview to elicit the individual's narratives about his experiences of the phenomenon under investigation (Trautrims, Grant, Cunliffe, & Wong, 2012). Interview transcription straight after participant contact elicited the real time thoughts, feelings, ideas and concepts of both the researcher and the participant relevant at the specific phase.

Data analysis occurred simultaneously and iteratively with the data collection process (Silverman, 2011). Moreover, it was linguistically focused on what the participants said "in order to learn about how they are making sense of their experience" (Smith, 2011, p. 10). Based on data interpretation and in order to investigate fully the GRNM lived experience, the IPA method outlined by Smith, Flowers and Larkin (2009) was followed. The method commenced with multiple reading and making notes before transforming notes into emergent themes, followed by seeking relationships and clustering themes, and then producing a narrative account of the study from the analysis (Pietkiewicz & Smith, 2012). Moreover, following the IPA analytical "procedures for moving from single case to more general statements, but still allow one to retrieve particular claims for any of the individuals involved" (Smith et al., 2009, p 32).

3.4   Sample

In keeping with IPA methodology, a purposeful sampling technique was used due to the unique status of being RNMs about to commence their graduate year where their lived experience has relevance and personal significance to this study. Those selected "experienced the phenomenon in question so that the researcher, in the end, can forge a common understanding" (Creswell, 2013, p. 38). Recruitment was via

the snowballing technique where existing participants recruited future participants amongst their peers. This technique using referrals from the other participants is commonly used in IPA, particularly amongst vulnerable groups and where sensitive issues are to be researched (Smith et al., 2009).

The study was introduced at an undergraduate nursing final semester lecture where five male students who were about to embark on their RN graduate year indicated their interest in the study after being invited to participate by sharing a detailed first person account of their experiences. At this initial contact these five men knew of others who may be interested and agreed to pass on the study information (Appendix A: Information sheet) and contact details to them, thus resulting in nine GRNM study participants in total. The sample number was not rigidly pre-set nor the process of saturation applied as the number of participants was less important than the richness of the data (Liamputtong & Ezzy, 2005; Smith et al., 2009). The interpretative approach tendency is for a small participant number to produce a large amount of detailed information (O'Donoghue, 2007). Moreover, IPA is an idiographic method and focuses more on the "intensive qualitative analysis of detailed personal accounts" (Smith, 2011, p. 10), "concerned with examining divergence and convergence in smaller samples" (Brocki & Wearden, 2006, p. 94). A small sample size of up to eight participants is deemed acceptable (Smith et al., 2009), with caution noted that using a sample over eight to obtain adequate participants extract variations or density of themes can become a quality issue (Smith, 2011, p. 17). The acceptable number of eight participants was reached at the first recruitment contact as a consequence the participants came from the same university. The participants coming from the same university into study was not considered problematic due to the idiographic nature of IPA. Each participant had his own unique story of why he wanted to become a RN and each participant's journey as a GRNM was undertaken in different health settings. This study initially recruited nine to allow for attrition of potential participants, a known risk with the application of a longitudinal design where continued engagement of the study participant is necessary (Cotter, Burke, Stouthamer-Loeber, & Loeber, 2005).

3.5   Data collection

For the purpose of both confidentiality and for data collection, the participants'
identities were protected using numerical identifiers for the transcription and analysis
of the interviews and their diaries. For example the first interviewed participant was
identified as P1, then added numerical codes of P1 for Phase one, P2 for Phase two
and P3 for Phase three. For example P1 P2 represents participant one Phase two. In
the findings and discussions to maintain anonymity of the participants and to add a
human element when using their quotes, the numerical identifiers are replaced with
pseudonyms, such as Wes for P1, Connor for P2 and so on.

The preferred IPA method of semi-structured in-depth face-to-face interviews using
guiding research questions (Smith et al., 2009) and participants' diaries at specified
contact phases were the primary means of data collection. In-depth interviews,
informal and conversational, were used to draw on an interpretative focus with the
meanings being continually constructed and reconstructed in the interactions
(Liamputtong & Ezzy, 2005). The iterative practice began in the early stages of data
collection with the repeated returns back to the data to check for meanings and
continued throughout this collection process.

The use of guiding research questions allowed for multiplicity of findings to emerge
(Creswell, 2014). A interview schedule of guiding questions aided the flexible flow
of the discussions at the interviews and guided the participants' narratives (Harris &
Brown, 2010), from a general stance to a more specified experiential basis that
included thoughts and feelings (Smith et al., 2009, p. 68). Moreover, enabled
engaging flexible dialogue between the researcher and participant to accommodate
unanticipated notions to materialise during the interviews (Shinebourne & Smith,
2011). Refer to Appendix B: Contact schedule and interview guiding questions.

Each participant attended multiple individual face-to-face interviews at a participant
preferred place of his choosing over the twelve month period following his
commencement as a newly GRNM. This interview multiplicity enabled the
participant to reflect on his journey over time that afforded additional insights on his
lived experiences and enabled validation of emerging themes at subsequent
interviews. In addition, using more than one method of data collection more than

once with each participant, three interviews combined with two diary entries, provided comparison with this study's aforementioned conceptual framework and existent literature. Thus enabled completeness of data through enhancement in findings by the use of the multiple methods that also minimalised potential systematic bias that can occur in a single method approach (Antin, Constantine, & Hunt, 2014).

The semi-structured format enabled questions to be modified in accordance to the participant responses in order to probe areas of interest or importance. Moreover, the probing questions provided the opportunity for the participants in their own words to "tell their stories, to speak freely and reflectively" (Smith et al., 2009, p. 56).

The participant diaries were utilised to enhance dialogue between the participants and the researcher by providing the opportunity for the participants' to write their GRN journey immediately after each worked shift to capture their nursing activity and thoughts relevant to them at that time. Refer to Appendix C: Electronic reflective diary instructions given to each participant at his first face-face interview as a guideline. The participants diarised on the two occasions over five consecutive days, at the sixteen weeks (fourth month) and thirty-two weeks (eighth month) stage of their graduate year in between the face-to-face contacts, to further uncover unprompted and unexpected thoughts and experiences to surface. This unprompted and unanticipated data, according to Smith and colleagues (2009) "are often the most valuable aspects of interviewing" (p. 58). The diary writing of five days, on shift as a GRNM, was deemed sufficient to gather the relevant data required (Punch, 2006). The rationale for the diarising timeframe was that it reflected the GRN's transition from 'doing' to the commencement of the 'being' stage (fourth month) and the 'being' to the commencement of the 'knowing' stage (eighth month) in accordance to the transition stages model of Duchscher (2007). It was during these transition points, that the GRNs questioned self's professional identity and had crisis in their confidence as they entered the 'being' stage, and then sought out of challenges and their long term career planning surfaced around the middle of the knowing stage (Duchscher, 2008).

A follow up contact with each participant via his preferred method either via an email or a telephone call occurred at the sixteen-month conclusion of the study.

Figure 7 provides a visual presentation of the aforementioned data collection methods aligned with the relevant the phase in which they were conducted.
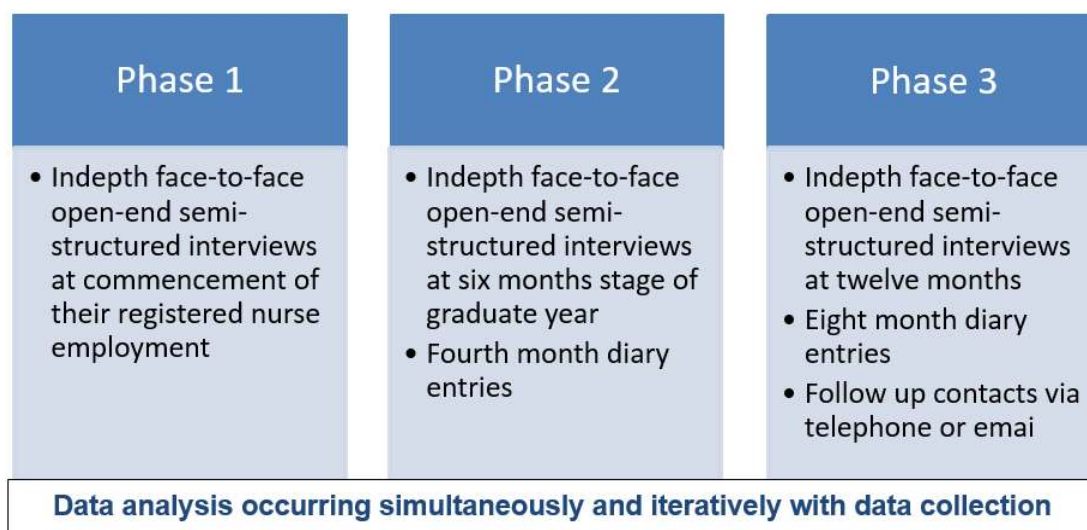
Figure 7   Qualitative data collection and analysis plan

All interviews were digitally recorded with permission from the participants, and then listened to closely numerous times whilst transcribing verbatim to ensure transcription accuracy, plus noting the tones, speed and pauses in the participants' voices and any significant points that surfaced. The notes included questions on the participants' viewpoints, their thoughts and beliefs that needed further exploration and clarification at their next contact. QSR NVivo 11 was used in this study to assist with data management. The notes and the researcher's journal entries were kept with the interviews within the QSR NVivo 11.

3.6   Researcher as the research instrument

According to Creswell (2013), "the researcher as the key instrument collects the data through examining documents, observing behaviour, and interviewing participants using open-ended questions . . . and does not tend to use or rely on questions or instruments developed by other researchers" (p. 45). As the research instrument tasked to elicit rich detailed personal accounts of the participant's lived experience, the researcher was entrusted with systematic data collecting, skilful interview techniques, and undertook rigorous data analysis by being fully immersed in the data (Pietkiewicz & Smith, 2012). Thus transforming the analysed data into emergent themes and related sub themes whilst retaining the participant's voice to enable the reader to assess the relevance of resultant interpretations (p. 368).

For cognisance of positionality within this study, the researcher's journal focused on reflexivity where self-monitoring of preconceptions, personal values and beliefs were acknowledged for transparency and to minimalise their potential influence on the research (Rodham, Fox, & Doran, 2015). In addition, the journal captured the interpretation of the data collected to support the documentation of new questions, notation of known literature related to a specific area of data, and the reflect on the "conceptualization relationship of the codes and processes used" (Liamputtong & Ezzy, 2005, p. 274). Moreover, "the researcher's reflective engagement in dialogue with participant's narratives and meanings" was paramount (Shinebourne & Smith, 2011, p. 57). Paramount in this sense due to IPA's double hermeneutic stance where "the researcher is trying to make sense of the participant trying to make sense of what is happening" (Smith et al., 2009, p. 3). The researcher's journal was located in the memo section of the QSR NVivo 11. According to Vicary, Young and Hicks (2016) "using a journal inside the software package and alongside the stages of the IPA . . . quality and validity becomes dynamic, not static constructs" (p. 1).

3.7　Data analysis

There was no finite process for conducting the data analysis for IPA (Smith et al., 2009). Although IPA's idiographic stance required transcripts to be analysed in detail case-by-case before cross-analysis occurred. The focus being on "the balance of convergence and divergence within the sample" to ensure common themes and the 'particular' individual themes were represented (Smith, 2011, p. 10).

Throughout the data collection phases, the importance of the participant to take the lead during the conversation was emphasised (Biggerstaff & Thompson, 2008). In addition, the development of questions from the data obtained straight after each interview to form new or further probing questions for the next contact with the individual participant was essential. These questions evolved from the notation of thoughts, feelings, main areas of concerns and any ambiguities or contradictory ideas of both the participant and the researcher. This information was documented in memos and the researcher's journal associated with the relevant transcript and were inclusive of any interpretative challenges.

For this study, the analysis process was sectioned into the individual level followed by the group level approach used recently by Callary, Rathwell and Young (2015) with alignment to Smith et al. (2009) steps in the IPA data analysis process. Visual interpretation of this process for each longitudinal phase with participants (p) data is presented in Figure 8 with the three phases portrayed in Figure 9.
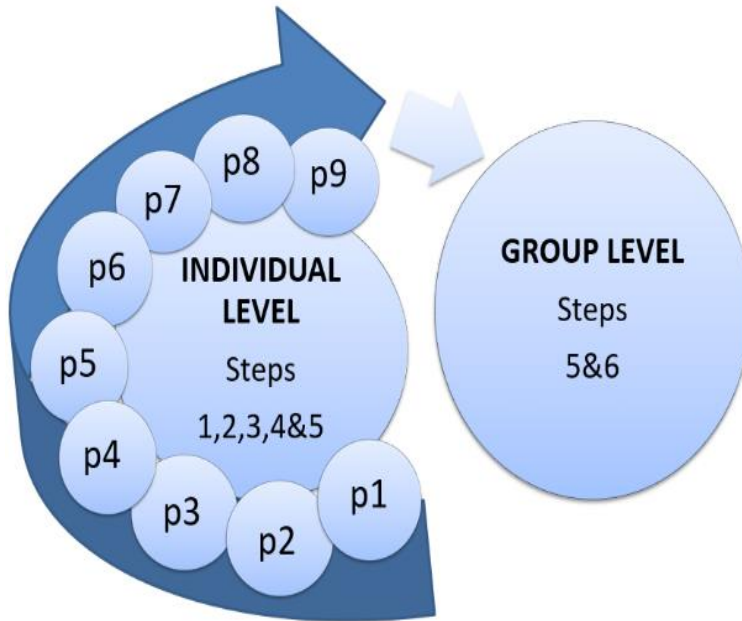
Figure 8   Data analysis process for each phase
p = participants
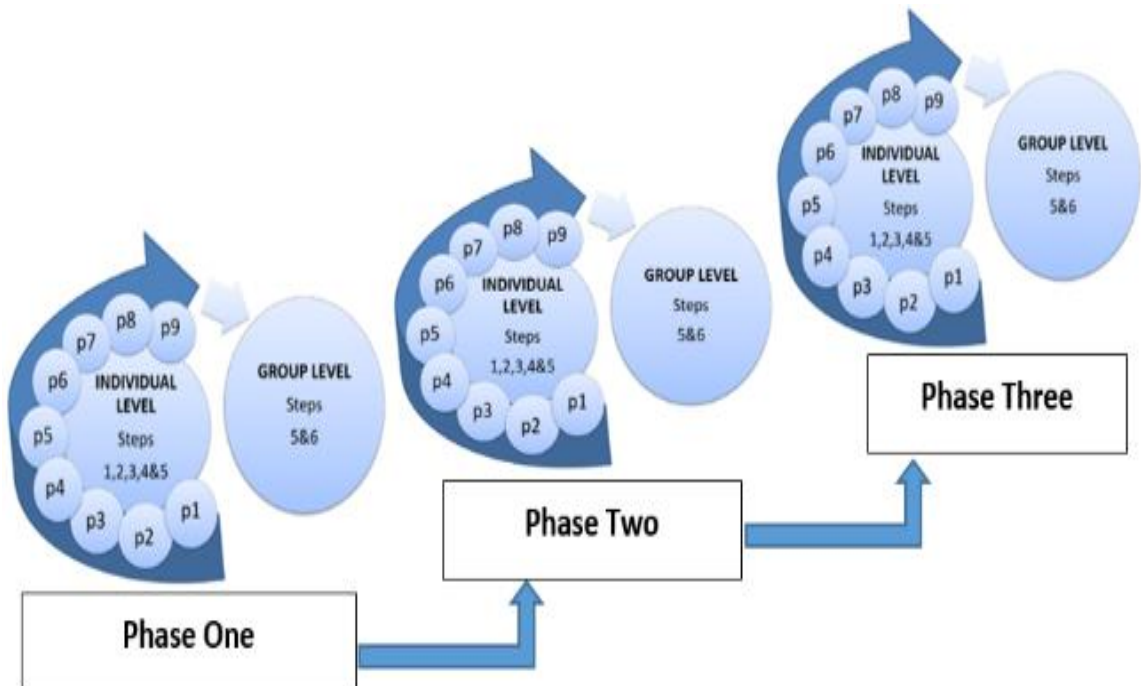
Figure 9   Three phases in the analysis process
p = participants

3.7.1   The way data was processed

The data was collected at the face-to-face interviews in Phase one on commencement of their graduate year, in Phase two at six months into their graduate year and in Phase three on completion of their graduate year; along with the data obtained in participants' diaries at the fourth month and eighth month stages of their graduate year. The follow up contact, via email, four months post completion of their graduate year was undertaken to obtain the final member check feedback on the study as a whole, and to enquire where the GRNMs were at in regards to their career progression.

A step-by-step approach was used to order to obtain an in-depth understanding with the participant's account and enhance interpretation of the data (Smith et al., 2009). Data analysis process Figure 10, utilised Callary, Rathwell and Young's (2015) sequence approach headings and aligned these with Smith et al.'s (2009, pp. 82-107) six steps in the IPA data analysis.
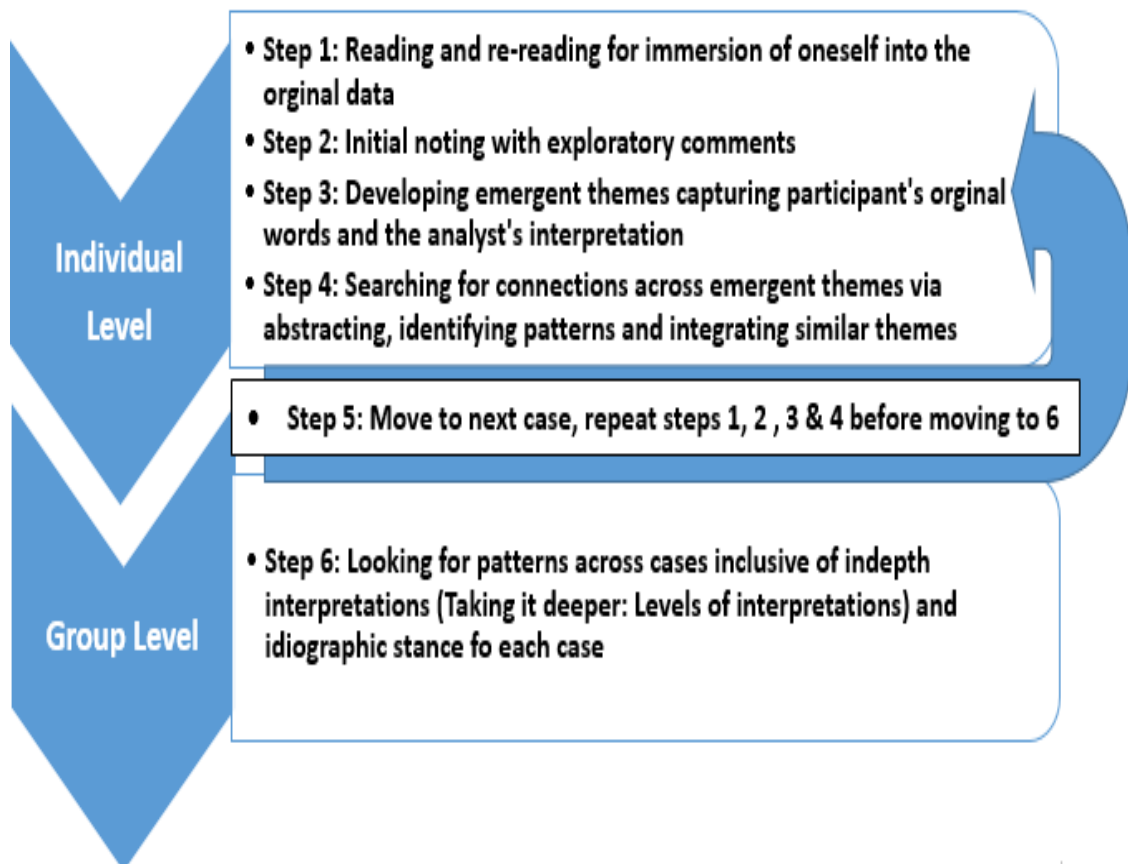
Figure 10   Data analysis

3.7.1.1   Individual level

The multiple steps within this level were required in order to meet the idiographic nature of the research design. This utilised a 'ground up' approach whereby notes were made from the individual participant's data (case) before the generation of themes for this case. Comments related to the researcher's personal reflexivity were also captured in the researcher's journal throughout the data analysis. The analysis moved from "the descriptive to the interpretative by capturing initial thoughts, generating tentative themes, and the refining these themes . . . proceeds from exploratory comments to emergent themes to super-ordinate themes for each participant" (VanScoy & Evenstad, 2015, p. 345). Following the personal transcription of the digitally recorded interviews that commenced the process of in-depth familiarity of the data, the following steps were undertaken:

Step 1: This consisted of reading the first participant's transcript (text) as a whole to get a general sense of the participant's account that enabled reflecting on the overall meaning of his 'lived experience'. Then reading and re-reading the text several times more closely thereafter, even re-listening to the digital recording to become fully immersed in the data.

Step 2: Data immersion was undertaken that aided in the detailed investigation of the participant's text by interrogation of the data line-by-line to develop initial notes with exploratory comments (exploratory notes) that were participant-orientated. Participant-orientated insomuch as these initial notes were encased descriptively, the participant's account; linguistically, how the participant verbally and expressively communicated meaning within his account; and conceptual with the linkage to existent literature and theoretical views.

Step 3: The emergent themes were identified and labelled through working primarily from the exploratory notes developed in the previous step, and by being interpretatively focused on "discrete chunks of transcript . . . mapping the interrelationships, connections and patterns between the exploratory notes" (Smith et al., 2009, p. 91). Using a cyclical process, each theme was related back and linked to quotes in text; thus followed the IPA's idiographic nature by developing each stage of the analysis for each theme before moving to the next. Throughout this process, care was taken to ensure that the linkage between the interpretations derived and the

participant's voice was maintained by being mindful to stay close to the data when developing of emerging themes from the actual data; thus to enhance the focus on the unique characteristics of each individual participant (Smith et al., 2009).

Step 4: Investigation of the separate emergent themes was undertaken to obtain the conceptual connections to enable the clustering of related themes into super-ordinate themes. The activity necessitated the "grouping and regrouping the emergent themes for an individual participant to identify and organize connections between the themes" (VanScoy & Evenstad, 2015, p. 346). This required a more comprehensive examination of the text for greater in-depth meaning and interpretation from the participant's aspect with consideration of theoretical knowledge in order to provide a conceptual and descriptive labelling to the clustered themes. This was done by working continuously, moving back and forth, between the themes for abstraction. This abstraction, according to Smith and colleagues (2009) "is a basic form of identifying patterns between emergent themes and developing a sense of what can be called a 'super-ordinate' theme" (p. 96).

A table of super-ordinate themes for the participant was developed that included each super-ordinate theme with its relevant sub-ordinate themes, and key narrative text (quotes) that provided evidence for each theme (Pringle, Drummond, McLafferty, & Hendry, 2011; VanScoy & Evenstad, 2015). Narrative text was included as "IPA promotes what the participants are actually saying with direct quotes being used widely to substantiate findings" (Pringle et al., 2011, p. 21). Moreover, the ideographic element of IPA ensured the table of super-ordinate themes notated the shared and divergent aspects of the GRMNs making sense of their experiences. In-depth discussions with the researcher's two supervisors followed after the supervisors had completely read, coded and inductive themed the first transcript in each phase independently. The comparing and contrasting the results produced an agreement on the themes. Again, following Callary and colleagues (2015) lead:

> The researcher and supervisors read the remaining transcripts . . . immersed themselves in the data, but only one (the researcher) performed a line-by-line analysis of the data to code for inductive [emergent] themes for lived experiences. Co-researchers (the supervisors) reviewed the themes and supporting codes and provided feedback, often raising ideas for alternate themes . . . resolved any disagreements by a consensus decision (p. 69).

These discussions also provided the evaluation of the analysis process undertaken. Further, these discussions with the resultant frequent contacts provided an avenue for brainstorming and refining the researcher's interpretation of the participants' interpreting their lived experiences and the meaning derived from these.

In relation to data management, the QSR NVivo 11 computer qualitative software program was used as it enhanced the coding process of the data obtained from the participants' diaries and the interviews conducted. Education and training in the use of QSR NVivo 11 was undertaken prior to commencing the data analysis. To maintain the IPA process the NVivo annotation function provided an the initial coding in the left hand column thus developing nodes (codes) for detailed coding in the right hand column; with journaling undertaken through the memo function allowing linkages to a source and designated nodes (Bazeley & Jackson, 2013). The emergent themes were colour coded that enabled clustering of these themes into super-ordinate themes.

Step 5: This step occurred once a full analysis of the previous case was completed. Steps 1, 2, 3 and 4 in the data analysis process were repeated for subsequent cases until all cases had been completely analysed before moving onto step 6, the group level analysis.

3.7.1.2   Group level

The researcher undertook this group level analysis and then further discussions with the supervisors occurred. Discussions focused on gaining "the agreement on the names and operational definitions of the themes and how sub-themes fit under the higher-order themes" (Callary et al., 2015, p. 69).

Step 6: Master themes for the group involved formulation of a master table from the syntheses, and then integration of the individual participant's super-ordinate themes in their summary tables. This activity was undertaken with "careful examination of similarities and differences across cases to produce detailed accounts of patterns of meaning and reflections on shared experiences" (Shinebourne & Smith, 2011, p. 49). Again this process was iterative with the requirement to repeatedly return to the data and review each participant's summary table with the relevant text to check meanings during the formation of the master list (Shinebourne & Smith, 2011). Thus

the process was a constant comparison within and across cases for patterns and connections that made sense of the data, resultant super-ordinate themes that highlighted higher order qualities, inclusive of the uniqueness for each participant and the overall common group themes, being established. In relation to the overall common group themes, recurrent themes were highlighted. The criteria set for the recurrent themes was guided by Smith and colleagues (2009) in that "to be classified as recurrent it must be present in at least a third, or a half, or, most stringently, in all the participant interviews (p. 107). NVivo's Node Summary Report provided the prevalence and density of themes evidenced by each theme notated with the number of quotes used and the number of quoted participants.

Of note, Smith et al (2009) had noted that "as there is not a clear-cut distinction between analysis and writing up . . . as one begins to write, some themes loom large, others fade so this changes the report" (p.110). Therefore in reality, the data analysis continued throughout the detailed, interpretative, and reflexive written account undertaken for each phase of this longitudinal study. Thus some of the themes were adjusted and reallocated to another or new super-ordinate theme.

3.8   Rigour and quality of the study

To meet rigour of this qualitative study Lincoln and Guba's (1985) trustworthiness criteria of credibility, dependability, transferability and confirmability (Baillie, 2015) with the accepted rigor techniques (Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013; Polit & Beck, 2010; Ryan-Nicholls & Will, 2009) were applied. Refer to Appendix D: Trustworthiness criteria linkage to examples of the techniques used. The study's quality was assessed by using Yardley's (2000) principles of sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance (Smith et al., 2009).

At the completion of each phase of the study a summary of the individual interview was emailed to the relevant participant for member checking. This member checking formed the assessment for credibility and validity of the interpretations that focused on verification of the accurate account of the participants' experiences and as such enhanced the trustworthiness of the study (Creswell, 2013). This member checking of the written interview summary post the face-to-face interviews acknowledged the

participants as the experts in this phenomenon under investigation (Karnieli-Miller, Strier, & Pessach, 2009). All participants were offered the opportunity to read their own full interview transcripts. This opportunity was not taken up by any of the participants' as the emailed summary of their interview was deemed sufficient. Feedback via email was encouraged as it has been noted that written summaries provided at the interviews limited exchange of ideas (Kornbluh, 2015). Hence, to increase this feedback the summaries were emailed out two weeks prior to the forthcoming face-to-face interviews. This enabled both parties the opportunity to discuss areas of interest, clarification of themes elicited or to add information before commencing the digital recording of the next interview at this contact. No changes were requested as a result of the verbal feedback received. Peer review by the researcher's two supervisors provided the external check of the themes and the research process (Leedy & Ormrod, 2013). Authenticity and confirmability were established by ensuring that the reporting of interpretations and emerging themes included participants' quotes to enable the reader to gain the essence of the participants' experiences (Cope, 2014). Analytic decisions to enable assessment of the authenticity, credibility and validity of the interpretations was maintained via an audit trail (Leedy & Ormrod, 2013). Contents of audit included interview transcripts, summary reports of the three phases, data analysis and research process included in this thesis and a reflexivity journal (Ryan-Nicholls & Will, 2009). A reflexivity journal enabled the researcher to notate thoughts and feelings to highlight perceptions and subjectivity to avoid biases and factors that had the potential to affect the research process (Polit & Beck, 2008). These thoughts, etc., augmented modifications to the researcher's interviewing techniques and kept a check on the research process to ensure it was the lived experiences of the participants that were at the forefront of this study. The participants' face-to-face interviews and their diaries also provided reflexivity where they engaged in reflection of their graduate journey at specific times (Enosh & Ben-Ari, 2015). Theses reflexivity techniques supported trustworthiness in the credibility of the data, dependability of the study, and conformability of findings (Houghton et al., 2013).

In accordance with Smith, Flowers and Larkin (2009, pp. 180-181) sensitivity to context for this study occurred via the purposeful sample of participants who were deemed experts in the phenomena under investigation; the researcher's full emersion

in the data to elicit in depth interpretations of their lived experience; quoting the participants in order for the reader to concur with the interpretations put forward; and the inclusion of substantive and theoretical literature. Commitment and rigor was ensured by the researcher's personal commitment to portraying the participants' actual experiences captured through high quality in-depth interviewing and meticulousness systematic data analysis to enable interpretive (idiographic) assignation (p. 181). Transparency and coherence was established through the provision of a clear description of all stages of the research process that remained cognisant with the IPA interpretative emphasis (p. 182). The impact and importance aspect of this study was highlighted and with all being considered was thought to be of interest to the reader (p. 183).

3.9   Ethical considerations

This study was conducted in accordance with the National Health and Medical Research Council's (NHMRC, 2015) Australian code for the responsible conduct of research. Ethical approval was obtained from the University of Notre Dame Australia, Human Research Ethics Committee (Appendix E: Ethics approval). Ethical considerations for the study were outlined in the informed consent form (Appendix F) and the information sheet (Appendix A) that included the voluntary participation, study process, withdrawal from the study and data storage information. Throughout the research process re-establishment of the consent and reiteration that the participants were free to withdraw from the study at any time occurred verbally prior to each interview in case unforeseen changes happen (Streubert & Carpenter, 1999).

With the small sample size and in-depth descriptors involved in obtaining the meaning of the participants' lived experiences, maintaining confidentiality and anonymity was the key focus due to the nature of this qualitative research. The study information, as previously stated, the participants' names and all data were de-identified by using pseudonyms and numerical identifiers. The only place that contained participants' correct names was on the participants contact details and schedule list that only the researcher had access to via a password protected computer file. The digital recordings were de-identified with the use of the numerical identifiers and pseudonyms that the supervisors had access to in order to

fulfil the credibility of findings component in qualitative research rigor. This access to the digital recordings became vital when collectively, the researcher and the supervisors, explored the analytical trustworthiness and engaged in the process of reaching consensus on themes. All participants were aware of this situation, explained as being part of the research methods, and gave permission in this instance. The use of these pseudonyms and numerical identifiers enabled confidentiality of all data and ensured that it could not be traced back to its original source. Further, the use of pseudonyms heightened the human element of the individual's experiences for the reader and enabled a trail for each participant as they transverse their graduate year. Any identifying information such as identifying names within quotes or employment institutions were not included in any published materials. However, due to the idiographic nature of the study with the importance placed on giving voice to the individual and portraying the uniqueness that each participant brings to the study, some quotes used may be recognised by the relevant participant. All participants were in agreement in using such quotes as they felt it was doubtful that others would know the original source; however, it was not seen as an issue if it did occur. Member checking throughout the research process, although used more for accuracy of participants account, assisted in this area by giving the opportunity for discussions with the relevant participant on any likelihood of specific information been identified.

All hard copy study information was secured in a locked cabinet within the School of Nursing and Midwifery at the University of Notre Dame, Australia (Fremantle campus). The data was transcribed from digitally recorded interviews and stored electronically, and password protected on a designated computer hard drive. Once the digitally recorded data was transcribed, this data was deleted. The electronic data was also stored in a password protected digital file maintained in a secure location. The study data files will be destroyed in accordance with the National Health and Medical Research Council's 2007 (Updated May 2015) Australian code for the responsible conduct of research guidelines in five years.

3.10   Limitations of the study

Due to idiographic nature of the IPA, there was no claim that the findings be generalised to the wider population of NMs beyond the participants of this study. As

previously stated, the small sample size was appropriate for the IPA process (Brocki & Wearden, 2006), with 'authenticity' of experience rather than the sample size being the focus in qualitative research (Silverman, 2011, p. 48). Participants who agreed to participate after receiving information about this study came from the same university may be seen as a limitation. However, volunteering indicated participant willingness to share their lived experiences; thus potentially provided rich data that fulfilled the aim of this study in gaining an insight into the participating Western Australian GRNMs lived experiences as they transitioned into the professional practice environment.

A noted limitation was the selection of participants who are employed in the Western Australian metropolitan health area only. The decision to exclude GRNMs employed in the rural and remote areas of Western Australia was based on the manageability and affordability; in relation to the time and distance of 2,529,875 square kilometres of Western Australia and cost constraints of the research project involved with multiple face-to-face contacts. Face-to-face contact was seen as the optimum interview medium when conducting IPA to enhance rapport, facilitate empathy and promote conversational flow in order to obtain rich data (Smith et al., 2009). Although, as the researcher I was aware that the gender difference between myself as a female interviewer and male participants in the face-to-face interviews may have negated the participants' readiness to explore sensitive issues. In order to address this, the use of two different data collection methods, participant dairies and interviews with multiple contacts with each participant, was employed to enhance the engagement and researcher participant relationship. It was also pointed out to the participants that as GRNMs they were the experiential experts of their lived experience being explored; and as the males in female-dominated profession their voice was deemed valuable to gain insight on the sensitive issues that challenge them.

3.11   Summation

My desire was to undertake qualitative research and to be accepted that I would become part of the research process. However, I was unsure of this whole concept when focusing on the hermeneutic aspect of the lived experience. Knowing the importance of the hermeneutic cycle in order to fully understand the context of the

participants' conversations; then interpreting the meaning that required attentive listening; and remaining objective when acknowledging that inter-subjectivity is inherent, I questioned my ability to do so. Would I be able to give voice to the individual participant? Would I be able to represent the meaning behind his experience? With further reading and searching to my relief and delight I discovered IPA. IPA allowed exploration of self-reflection, both mine as the researcher and the individual participant. Thus it was deemed the best fit for investigating the participant's understanding and his meaning-making. Furthermore, IPA's framework has straightforward guidelines with a flexible and inductive approach that lent itself to the research questions in this study.

With the methodological approach established and the understanding of my position within the study I was mindful of the skills required to undertake the IPA. These skills involved the engagement of double hermeneutic and reflexivity in order for me to use my interpretations to make sense of the data collected. I was aware that my bias, beliefs and own experiences in relation to working with men in nursing may impact on this research. Hence, I employed continual reflection, journaling and self-monitoring that became very important throughout all aspects of this longitudinal study. Bracketing, moreover the use of it, was an area that required attention and after numerous readings, searches and discussions I adopted the four strategies proposed by Zenobia and colleagues (2013). Refer to Appendix D: Trustworthiness criteria linkage to examples of the techniques I used.

Curiosity about the newly GRNM and why this career path, his journey into nursing and transition through his first year post graduation was at the forefront of all activities undertaken. Specially, when I was establishing the methodological approach and processes required to gain the data sought. The responsibility and ethical stance of being a qualitative researcher and interviewer was reinforced through the preparation units undertaken as a higher degree student. Although interviewing, exploring and investigation enquiry had been major components of previous positions held, I held a quiet enthusiasm about my part in this study.

On the initial contact with the prospective participants, I checked that the prospective participants had read the study information sheet and answered any questions that the prospective participants had. I was surprised with the level of

interest the study drew, the prospective participants willingness to tell their story and the ease of the recruitment process that eventuated.

From here on in I, as the researcher, proceeded with carefulness, providing information focused more on my stance as the 'common being' with the participants. This stance was important in order to set the scene for the reader and to build rapport and trust with the participants.

Chapter 4.   The Participants

"What am I if I am not a participant? In order to be, I must participate"

Antoine de Saint-Exupery

The purpose of this research study was to investigate the lived experience of the nine purposefully selected Western Australian GRNMs, from their decision to enter nursing, their journey to registration and through their first year as a RN. A large volume of data was derived from each participant; therefore each participant's lived experiences of their graduate journey was documented as an individual longitudinal case study to ensure that the uniqueness of each journey was captured. The first order inductive analysis for each case preceded the second order across cases analysis to enable participants' common themes to emerge (Smith et al., 2009). A brief introduction on each of the participants from their entry into nursing and an overview of each of their journeys was provided before the findings of the longitudinal phases were revealed.

A GRNM participant profile, using pseudonyms to protect the participants' identities, was provided to enable individual participant's nuances and their related journey to be described. Moreover, this provided the reader with the opportunity to gain an understanding behind the individual participant's perception of his own journey, which was the core to the study's chosen methodology, interpretative phenomenological analysis. Refer to Table 1: GRNM participant profile, for details on their status that included first career or second career, age on entry to nursing studies, previous employment, and whether they undertook a graduate registered nurse (GRN) program. The definition of career used for this study was "the evolving sequence of a person's work experience over time" (Arthur, Hall, & Lawrence, 1989, p. 8).

Table 1   GRNM participant profile

Participant (Number & pseudonym)	On entry to nursing		Previous employment status	Graduate program
	Age	Career		Yes/No
P1 Wes	20	2nd	Enrolled nurse	yes
P2 Connor	26	2nd	Patient care assistant	yes
P3 Jacob	27	2nd	Hospitality, Social justice	yes
P4 Oliver	23	2nd	Community support worker / Computer programmer	no
P5 Ben	23	2nd	Youth worker	yes
P6 Dean	29	2nd	Patient care assistant	yes
P7 Ryan	30	2nd	Financial analyst, Army reservist	yes
P8 James	28	2nd	Defence force	yes
P9 Wade	21	1st	Secondary school student, Part-time tennis coach	yes

Table 1 displayed the diversity within the GRNMs' backgrounds before they entered nursing. The majority of the participants had previous careers; some within the health sector such as a patient care assistant (PCA), an enrolled nurse (EN), and a community support and youth worker. While others had worked within the financial setting and the defence force; with the exception of one participant who had come straight from finishing secondary school, although he worked part-time as a tennis coach out of school hours. Their experiences outside health varied and were inclusive of but not exclusive to hospitality, marketing, retail and sales, computing and technical advisory, seafood processing and sports coaching.

Furthermore, three of the GRNM participants had already obtained previous higher degrees. These degrees included environmental science, international relations and politics, and agriculture. Another participant was part way through his music degree.

4.1   Individual participant multiple contacts

The qualitative longitudinal research approach of an IPA study permitted the gathering of dynamic richness of data from the same participant thereby enabled the changes that influenced the participant's lived experience over time to be noted (Snelgrove & Liossi, 2013). These contacts, the face-to-face interviews and diary

entries, also provided the opportunity to probe and clarify the data from the previous contacts. Further, when unanticipated interesting issues emerged at one of the GRNM's contact, the following multiple contacts provided the opportunity to discuss the issues with the other participants. These multiple contacts with each of the GRNM's also allowed the member checking and feedback, being essential for the internal reliability to support the study's credibility (Creswell, 2013).

Caution in the use of multiple contacts with the same participant was warranted due to the possibility of ongoing emotional engagement that may potentially change the researcher-participant relationship (Snelgrove, 2014). This matter was at the forefront when conducting the interviews, and in providing the summation for each of the participants that follows where direct quotes were used to support the interpretation stance.

Participant #1: WES

Wes grew up in a mining town with ample mining job opportunities, however he proclaimed "I have always been interested in a health career for as long as I can remember, there is really nothing else I really want to do". Wes commenced the EN diploma whilst in his last year of secondary schooling knowing that this diploma would enable his transition into the RN degree. He worked as an EN full-time for eight months then went part-time for the duration of his undergraduate studies. Wes opted for a collaborative 18-month GRN program that included six months in mental health, although he was keen to remain in the acute general hospital setting. The journey to RN graduation for Wes was mostly positive. He did however at times feel that being a male in nursing had some setbacks.

Wes was excited about commencing his graduate year and felt that his EN experience would be advantageous especially with medication administration and wound management. Wes's expectation as he commenced his RN journey was to be able to fully function autonomously in a RN position by the end of his first six months. Ultimately, Wes wanted to gain RN skills first in the general wards before heading into the emergency department (ED) with his dream to eventually find permanent work in ED or work for the Royal Flying Doctor Service.

As Wes' journey unfolded he found his first three months overwhelming, especially the first three weeks. The hardest part was learning his RN role, staff members'

names and hospital policies. Wes spent the majority of this time focusing on his performance in areas related to time management and prioritising his allocated patient care as the care provision constantly required adjustments. Although he had been an EN, shift work continued to be a challenge for him, especially the late to early shifts; however he admitted this shift combination promotes patient continuity. At times he agreed to work double shifts due to staff shortages on the condition he continued to care for the same patients from his previous shift. Although he expressed that going the extra mile for patients can be joyous nonetheless, it could at times be disappointing when the patients do not acknowledge it.

Wes' preference was afternoon shift on the weekend as there was more time to enhance his therapeutic relationship with his patients. He found he could also get through his nursing tasks more efficiently thus enabling him to help other nursing staff, which in turn helped him build rapport with them. Wes also opted to relieve in other wards to gain experiences in the various fields of nursing, which he found rewarding.

From a career point of view, Wes's expectations of consolidating his knowledge and skills in his for first six months as an RN were exceeded. He felt more confident working in the modified team environment with patient allocation, and in negotiating work assistance when needed. However, Wes had real issues concerning his professional identity and being taken advantage of due to his gender throughout his journey. He stated:

> I really dislike being called a male nurse or even the grad as I am a RN in my own right and so should be recognised as a RN. . . Another thing that irritates me is when I keep getting asked to lift other nurses' heavy patients. . . I have my own workload to get through plus most of the other nurses are a lot bigger than me and have more muscles than I do.

Wes' rotation into mental health, even though a different field of nursing, was less stressful for Wes due to his RN experience he had gained in his first rotation, and his previous health employment as an EN. He does not regret choosing a collaborative graduate program believing the mental health experience would be beneficial for whatever nursing field he enters.

The final third rotation found Wes in the medical assessment unit where he was able to experience the urgency and critical thinking nursing care required of an emergency nurse with the benefit of being in a more controlled environment. Wes admitted it has taken him the full twelve months to be able to articulate what his RN role is and how he fits within this profession. Throughout his journey Wes did not lose sight of why he started nursing, caring for people and helping them live the best life they can and being empathic with the issues they face. He still looks forward to going to work. The future for him is to do some traveling through his nursing career and eventually work in the Royal Flying Doctor Service or a similar service.

Participant #2: CONNOR

Connor was undecided on a career path after finishing his schooling so took a PCA job. Here he gained an insight into the various health sector careers, which eventuated in him entering nursing. His journey through the undergraduate RN degree was as he put it "as good as all students would have had", and coming from a hospital environment he was comfortable on his clinical practicums, stating "I sort of knew where to be when things happened and what I was looking for". However, he did highlight a negative experience during this time of a comment from an RN "make the student do it . . . oh the student can do it", where he recalls thinking, "I'm here to learn, I'm happy to do it but I'm not missing out on something more clinically I may not see again".

Connor's expectations as a new GRN was that he was going to be on a steep learning curve and he was excited about this prospect, as well as holding a firm belief that emergency nursing was for him. He stated, "I think that I'm very logical that's why I'm keen to do emergency as I'm good at prioritising". Connor recapped that he brought five years full-time experience of working in the hospital where he had the knowledge of a hospital's general layout and the roles within the health system. He acknowledged the importance from the whole team aspect with each person having a specific role. Moreover, he stated "the hospitals can function without some people sometimes but to make it really effective you need everybody working as a team". Further, Connor finds hospitals exciting, commenting "a place of disease it's not, it's where people get better, get a new start on life, its special, there's no place like it".

Connor found being a GRN a positive experience, with supportive colleagues and reassuring senior nurses when he made judgment errors in the early days of his graduate year, although he felt that the formal support was lacking. As time went on Connor felt more confident most of the time but realised he was still new in the scheme of things. The second half of his graduate year Connor was happy to orientate agency staff and take on a lead role with ENs and students. Further, he felt more able to escalate concerns with confidence and initiate early interventions in the best interest of his patient. By the end of his first year Connor felt competent and confident of this own decision-making, contributing to workload adjustments and promoting patient care improvement strategies. Connor concluded:

> I love nursing, my last twelve months has been great, I've loved every minute of it . . . when I'm at work I'm in my element and nursing is the best fit for me even more so now that I am have a permanent RN position in emergency.

Participant #3: JACOB

Jacob with his interest in how global community members' care for each other had a degree in international politics and relations prior to commencing nursing. Initially he had thought about becoming a paramedic, however, nursing to him was a better avenue to connect with more people in need and assist them with their mental health. He stated "only had generalised idea of nursing so thought I would pick it up along the way . . . loved the undergraduate mental health practice, really did think that's what scored it for me". Hence his decision to undertake a mental health GRN program.

In his journey Jacob was not expecting to be so identifiable as a NM although he acknowledged that domination of certain professions by gender still exist today. Jacob did not have any pre-established expectations as a new GRN. From his previous experience Jacob noted that when he had tried to imagine things it never turned out that way, furthermore he expressed that he does not particularly stress out about the unknown.

The experience that he brought into nursing was the expansive interactions he has with diverse people through his community social activism where people have various ways of looking at things and different ways expressing them. Therefore,

Jacob would look for the common ground to figure out how to take on their ideas and his own in a way that is not seen as antagonistic, which he believed is a skill suited to nursing. Shift work and dealing with people as Jacob puts it "perhaps not at their full functioning level" was also not uncommon to him due to his hospitality experience.

At the beginning as a new RN Jacob would have just asked the nurse on shift coordinating what to do? However from midway through his GRN program Jacob would put forward the action he believed to be the best fit to seek confirmation on this being the way to go. Jacob believed this change was due to his ability to reflect and critically look at what's going on based on the experience he gained in the first six months of his GRN program.

Jacob's journey through his graduate year was generally positive although excessive workloads and administrative duties caused him frustration at times when patients' needs were not being met and his energy levels were depleted. He also found that communication pathways could be ad hoc with a lack of detail provided when changes occur. He had his challenges with other staff members with their lack of insight into the benefits of the education and in-service provided, however he took these in his stride. As Jacob progressed as a RN he developed more awareness of other people's roles with the health team and the recognised the importance of being able to connect to them.

At the end of his graduate year Jacob has found working full-time and being able to have work life balance a struggle due to his community and social justice commitments. He is planning to continue with his nursing career in mental health, be it on a part-time basis, as he takes up more community-based responsibilities when he stands as a local parliamentary candidate for his government electorate. Jacob has no regrets about choosing nursing as a career when considering his age, the time considerations and his interests, and still believes that nursing is the best fit for him. Jacob concluded:

> I didn't really set many expectations when starting as a new RN,
> however, I did not realise that there would be so much admin work
> that lessens the time with the patients . . . being with the patients and
> building a rapport can help the patients to reshape the behaviours
> causing issues this is what I'm here . . . help them get the best out of
> their lives.

Participant #4: OLIVER

Oliver had a Certificate 111 in Aged Care and was employed as a community support worker prior to becoming a RN. Expectations as Oliver started his journey, as an RN was to gain proficiency in his new role. Oliver believed that there were a lot of job opportunities in aged care, an area of interest for him. He did not initially apply for a GRN program, as he could not find a program that was specific to aged care. However as time went on the reality of both RN jobs and places within GRN programs being very limited in the current Australian nursing workforce occurred to him after numerous applications for nursing positions proved unsuccessful for him. Oliver's graduate year journey was unique to the other GRNMs in this study, as they had successfully obtained graduate programs, although James was delayed in the commencement of his GRN program by six months. Oliver's detailed account of his personal journey to his GRN program attainment has been published in Nursing Review, an Australian newspaper dedicated to reporting important issues to nurses, refer to Appendix G.

After his relentless persistence, Oliver successfully obtained a mental health GRN program eleven months after graduating as a RN. He stated, "I am excited and happy about this opportunity but a bit disappointed it will nearly be a full year before I gain entry into this program". He went on to voice his disappointment at the lack of opportunities for GRNs who are unable to obtain entry into GRN programs or find RN positions, a career for which they have been trained. He further reiterated that there is a very unrealistic view of what new GRNs should be able to do as they enter their new career environment.

At the final interview Oliver reported that the exposure to the GRN program was rewarding and a really good experience. It has provided the interaction with patients while looking after their mental health, and hoped to combine mental health with aged care nursing in the future. Oliver felt more confident in himself but reinforced that this confidence was not about being in the GRN program that it was more about having full time nursing job with a regular income and continuous experience rather than his previous inconsistent work and ad hoc nursing exposure. Although on reflection he did admit, "the grad program has been really good, I don't know how I would have done without it . . . to be honest I would have left and gone into another

job, not nursing". However, he no longer has thoughts about leaving nursing due to an opportunity for permanency in the aged care mental health setting.

Participant #5: BEN

Ben was a year out of secondary school not knowing what to do so volunteered for a one year stint at a Christian charity camp for school aged children. From his exposure to the Department of Child Protection (DCP) children from disadvantaged families at the camp Ben developed a keen interest in mental health; hence his decision to enter nursing and why he applied for a mental health GRN program.

The experience as a student nurse overall for Ben was good, with everybody being supportive and there had never been a huge problem, although he was surprised that the NMs to NFs ratio was so vast in the general nursing setting. Moreover, he commented at times he has been mistaken for the doctor and even asked about his gender preference where his reply was that he was a nurse and happily married.

Ben brought experience of teamwork and his interactions with the disadvantaged children from his exposure to and working with DCP children at the camp to his nursing role. Furthermore, this experience included his development in personal boundaries and privacy settings when dealing with children, and being responsible for their care within his scope.

He found the transition from youth work to general nursing different to mental health nursing. Ben stated, "I really like nursing, I like the team work aspect with a team responsibility base and I'm more comfortable in taking on responsibility through a team environment with the support of others when I need it". Over the first six months into his RN career Ben did have some self-perceived challenging episodes due to being a male in the female dominant nursing profession. Although he continued to reiterate that he remained committed to nursing and when reflecting on his twelve months graduate year at the last interview Ben stated:

> There was a period about not being sure about nursing as a good fit
> during the early stages with the stress of it all, but I think I made the
> right decision I think it has been a good thing for me, I don't know
> about general nursing but mental health especially have been good . . .
> when I think about changing I'm not thinking about changing careers
> I'm thinking about changing paths within mental health nursing.

Post Ben's GRN program he obtained a three-month contract extension and then was successful in obtaining a permanent RN position in mental health. On the subject of his career pathway Ben commented that he will remain in mental health as he does not believe that general nursing would suit him, although initially he had thought about nursing in the intensive care unit and emergency department had he not got into mental health.

Participant #6: DEAN

Dean worked as a patient care assistant and held a Certificate 111 in Aged Care. After which he commenced a Bachelor of Music, however with job security limited in music and working in the health industry at the time, he transferred his music degree over to nursing. This was due to the opportunities a nursing career could provide. He commented "at the end of the day I'm happy with the decision as nursing can provide a lot of variety and you can travel with it, even do postgraduate studies as well".

According to Dean, his journey had been good although at times he felt a bit on the periphery in the female dominant work environment. However, he admits that having been in this environment long enough for this dominance it not to be a real issue for him. Dean brought his experience in dealing with people, particularly the elderly from working in aged care. He felt capable in dealing with a wide range of people and able to tailor approaches to the uniqueness' of each patient. He revealed that to him "hospitals predominantly have people aged over 65 so it wasn't difficult to make the transition in terms of caring with patients as opposed to aged residents". However, he acknowledged "there is a wider variety of medical and more acute patients and its more interesting working as a nurse in this environment". Moreover Dean remarked:

> Being nurse as opposed to a patient care assistant provided more enjoyment in terms of being able to interact with allied health and doctors and feel a lot more integral to the team as opposed to the limited scope as a carer.

Prior to commencing nursing Dean had thought about working with the more 'mentally challenging' patients with psychological histories but had not ruled out working in emergency. Initially, Dean just wanted a job but as he progressed

through his graduate year his thoughts changed. According to Dean, "this change was the interacting with people on a daily basis and seeing a tangible difference, what people present with to when they're discharged became more of the focus".

Dean, although having worked in the aged care health setting previously, initially found his transition into the new RN role challenging at times in getting to know the environment, the people, and the routines. Dean entered his new RN role with reasonable confidence in his nursing abilities from his nursing home experience, and caring for confused residents with dementia. He became more comfortable in knowing what was expected of a RN with the confidence of being able do the shift properly and safely a third of the way into his graduate year. Midway through his first year, Dean's confidence in working with both higher acuity patients and increased number of patients allocated to him, using a team-nursing format, and delegating tasks amongst each other according to scope of practice was consolidated. Towards the end of his first year, Dean became more focused on where to with his career and felt he had to prepare for the future. So Dean applied for and was successful in obtaining a second year GRN program in country health that included rural and remote nursing experience. He was thrilled about being able to travel and at the same time gain more RN experiences, moreover hoping that this second GRN with WA Country Health will help define the postgraduate degree he will eventually undertake.

Of note, Dean revealed that being involved in this study was interesting in so much as it promoted self-reflection as he rarely gave himself time to really think about what was happening. From this he realised that a lot of nursing skills are very transferrable in life. For example, caring included challenging self to be better in self and those he comes into contact with. Self-reflection is something that Dean admits that he will continue to do as part of his nursing improvement.

Participant #7: RYAN

Ryan's previous career was in finance and corporate business before he started a nursing career. Initially he had thought about becoming a paramedic but after further investigation Ryan came to the conclusion that nursing seemed the 'natural fit'. Although he alluded to nursing being 'a woman's job', this did not deter him from

entering the profession. Ryan wishes to undertake a PhD at a later stage of his nursing career. In the meantime, he sees nursing providing him with the challenges and experiential learning that he enjoys.

Ryan's biggest challenge throughout his journey to RN registration was not relating to younger females so he found himself gravitating more towards the more mature aged males with common backgrounds to him. He acknowledged his natural progression was towards nurses of similar gender and life experiences but denied it was about safety and security, it is more that he enjoyed their company. Other challenges initially were nursing patients at the end stage of life as he had never been exposed to the dying patient before; being mistaken for a medical student or doctor; and being an older male student where he felt there were different expectations from health staff, which was incongruent to the learning objectives for the same level student. He recognised the challenges he faced as being part of his journey from feeling incompetent initially while he transitioned from student status to fully competent and confident general RN by the end of his GRN program. Ryan felt that nursing has been a good career transition for him.

Ryan believed that his previous experience in the army reserve was conducive to nursing as both are factual with requirements to attention to detail, discipline of self and the need for a sense of urgency for ultimate outcomes. Furthermore, during his undergraduate nursing degree he became a carer in aged care so his experience of shift work and being a carer brought realistic expectations in regards to his role in basic nursing provision and also in the prioritising of patient care. His attentive listening skills have been established through his communication with dementia residents from different backgrounds that he believed aided his ability to develop rapport and build therapeutic nurse patient relationships. Ryan also believed that being older brings learnt differences that helped with interpersonal skills and interactions with people in general. Moreover, Ryan's previous carer's experience had increased his carer empowerment knowledge in relation to the advocacy role and responsibility for patient safety. This empowerment was about the authorisation that the designated job brings. He admitted he was still working on this empowerment element in his new RN role, however as a GRN he felt that he was heading in the right direction. He remained mindful of patient safety as he progressed with learning

new skills during his graduate year. He also felt comfortable asking for help when needed.

Ryan reflected on episodes of doubting and questioning his own performance in the early stages of his GRN journey with time management remaining a never-ending challenge. He felt overwhelmed and out of his depth initially, however with supportive staff members Ryan became more confident in his performance as a RN and he began to feel part of the nursing team. There were times when dealing with challenging patients, being short-staffed and doing shift work with depleted energy he started to doubt whether this was the career for him. He found himself in a specialist area in the second half of his GRN program that opened up a technical role in a controlled cardiac catheter laboratory 'Cath lab' where he learnt new skills and gained new knowledge not taught at university.

Although overall Ryan's preference is for ward nursing from the team aspect and the autonomy, but with his dislike of shift work and feeling fatigued. Ryan commented:

> I feel I fit in more in the Cath lab due to the downtime where I have
> time to get to know the staff, and unlike the ward on my previous
> rotation in the Cath lab I am more able to discuss cases and have more
> informal education I find it exciting being in the lab seeing some of
> the more acute cases and being able to reflect on self and health
> preventable events.

Ryan is now doing further studies part-time, a diploma of science, hoping that it will lead onto a higher degree in research in the future. So the Cath lab hours works well for him while he is studying but he acknowledged that ward nursing is better for developing nursing skills. Ryan has no regrets about becoming a nurse and sees the value in having males in nursing. He also believes that increased public awareness of the roles, responsibilities and diversity within nursing would promote nursing to more men.

Participant #8: JAMES

James entered nursing after being the in defence force. He started the GRN program in orthopaedics and spinal where he learnt a lot and gained really good nursing experience. James found the staff really approachable and he believed this area was the best place to start his RN journey.

On reflection, James first started with a lack of confidence. He found getting to know the environment as well as working in a team a real challenge that took at least three to four months to overcome. The challenge was more about time management and being able handle the workload then still be able to help colleagues and thus be part of the team. He sees the value of a staff gender mix in the team that enhance staff safety when dealing with inappropriate patient behaviour and it also allows patient carer gender preferences to be accommodated.

James found with each rotation that it took nearly three months to become comfortable within the professional practice environment especially as he transitioned from a ward to a specialist area. He commented "in ED [emergency department] there was a lot of staff coming and going so it's not the same kind of culture as a smaller ward . . . ED was fast paced". James admitted that half way into his GRN program he definitely enjoyed ED more than the general ward and he revealed that "it is real challenging type of nursing however it can be really rewarding and the helping in that environment is a great learning experience". Six months into his graduate year James was still enjoying nursing with no regrets, although he has found that the nursing culture to be totally different from the defence force.

However, at the final interview twelve months post commencement as a GRN, James was having negative experiences in ED. He had been put into situations that he believed was beyond that of a GRN and perceived within a culture of blame and minimal to no support nor nursing leadership had him questioning his nursing career pathway. James still enjoys the actual job helping people and stated, "I want a role where I can be respected and be allowed to do the best I can do". Currently he is critiquing where best to use his skills for caring and helping people, in knowing and accepting that the tertiary hospital environment is not for him at this point of time. He concluded with "once I find that area in nursing I will be fine and I will be in there for the long haul".

Participant #9: WADE

Wade was not sure what he wanted to do on completion of secondary school. It was suggested that nursing was a starting point to find his feet, to get a good job in a field

that he will have no problems finding work. Wade's interests are travelling and languages so he thought nursing would possibly be a good career for him, although he admitted he was not that passionate about nursing initially. Wade did a year of the nursing degree then deferred to travel and to rethink what he was doing, however he decided to come back and finish the other two years of his degree. Wade found it frustrating coming back into the nursing initially but admitted that from second year onwards was definitely more enjoyable than the first year. He had positive support and encouragement throughout his career. The majority of Wade's nursing journey has been good. Although, Wade revealed it was difficult at times being a male nursing student in relation to making good friendships because of nursing being a female-dominant degree. On the positive side he had a lot of encouragement from the ward nurses and really enjoyed working with other male students.

Wade had considered what he might want to do in a few years. He thought about getting into nursing management or staff development, as he believed males are encouraged to do so. He also noted that some doctors began as nurses and then moved on to medicine and thought that could be another option for him. He noticed when he was on practicum that the doctors who were nurses had a difference in their bedside manner and spent a lot of time with their patients.

Wade's previous experience was dealing with large groups of people with age variety and mix as he coached tennis outside school hours. He believed he knows how to talk and engage people and that he is able to take on different challenges as he has learnt how to engage and work around each person's barriers or obstacles concluding that he has a lot of patience too.

Wade was both excited and nervous about starting as a GRNM. He revealed, "I'm nervous as it's a new part of my life, it's the real deal, it's a full time job however at the same time I'm looking forward to it all". He considered time management to be his biggest challenge. Although Wade prefers speciality areas where he has the responsibility of one or two patients, such as intensive care or theatre recovery, he was not bothered about having a multiple patient load in challenging situations. He had experienced a busy surgical ward in his final student practicum where staff deliberately stepped back and let him handle challenging situations, then feedback that he performed well giving him a real sense what it would be like as a RN.

Wade's fourth month diary entries and his second interview midway through his GRN journey indicated that Wade had grown in confidence and was really fitting into the professional practice environment. He provided examples of challenges that he faced and how he managed his workload with proficiency and in a professional RN manner. He acknowledged that socialisation in a female dominated work environment had caused some frustration especially when he was advocating for his patients in regards to their caregiver preference.

Wade's time management and his confidence in his own ability improved towards the second half of his GRN year. He commented "there is no such thing as the perfect shift you just have to be accept things as they are and do the best you can". He was accepted as a valued team member and really enjoyed working in the team environment. Communication with other health professionals such as doctors took more time to get used to, "it just took time and just sort of me getting into the ward and my role and my confidence in challenging why things were being done or not done with my patients". Demanding and difficult patient personalities and their expectation of nursing care was a constant challenge, however one that Wade felt he handled well.

Wade revealed that he finally got comfortable in his RN role around the sixth month mark and then he was put into the second rotation and thrown into something new again, which he found was quite difficult. Moreover he commented, "it was another really sharp learning curve but I settled in much quicker than I did the first six months". Wade's second rotation was in a more technical area of theatre recovery that he preferred, although Wade stated:

> It was a big change, having to talk directly to the consultants and the anaesthetist rather than going up through the interns and then the residents . . . and although it is in a more controlled area it is a critical environment that I really enjoy.

Wade admitted that when he started nursing, even on his first GRN rotation, he still was not really sure that nursing was for him or if in fact it was what he wanted to do. However, at six months in the post anaesthetic care unit, he genuinely enjoyed nursing in this area and felt that it suited him. He concluded, "I learnt how diverse nursing is and now feel more comfortable and happy about what I'm doing, can see myself travelling and nursing as my job and I know that I would quiet happily build

on my nursing". No further contact after numerous attempts with Wade occurred. He had alluded at the last contact, the six months face-to-face interview, that his desire to travel was making him unsettled and so he was looking for opportunities to travel and use his RN qualifications at the same time, even if it meant not finishing his GRN program.

4.2   Summation

In keeping with the IPA process of focusing on the particular (specifically in this study being the individual GRNM's lived experience), a case file was developed for each of the GRNM's inclusive of transcribed interviews, diary entries and summation of data collected at the specified times along the GRN year. I selected a single interview transcript to critique one at a time ensuring it was read in its entirety, often having to re-read several times before moving on to interpreting how the GRNM experienced nursing, being mindful to relay his story from his perspective. At times this process was challenging as my assumptions and the urge to relate certain facets with other transcripts came to the forefront. Therefore I did a report of the overall experience, and added as much detail as I could before I made a list of themes related to the individual GRNM's experience. In relation to the experiences, the use of narratives within this chapter ensured that the individualism of GRNM participants is not lost when considering the commonalities within this cohort.

In the multiple contacts with each participant I remained vigilant to any emotional engagement that may potentially change our researcher-participant relationship. There were occasions when a GRNM would ask my opinion on certain nursing issues where I would remind him that this study was about him and his experiences and it was his voice I wanted to capture that would then bring the discussion back on track. There were no instances where I ever felt uncomfortable within the researcher-participant relationship, or that the participant was unsafe in his practice nor in person as I have extensively experience during my career working with newly graduated and novice nurses and in research projects where I know my limitations, professional boundaries and my responsibilities. I relied heavily on the use of reflexivity after each contact and would seek discussion and guidance from my supervisors should any concerns arise.

*However, as I progressed through my contacts with the participants, I gave each of the GRNM's a generalised title as they each portrayed their own unique characteristics, which at times assisted me with understanding where they were coming from in what they were or were not saying. I found Connor to be the **'logistics'** person who wanted to be challenged and to coordinate the distribution of resources such as how and where to place staff and patients for the best usage possible. Wes as the **'giver'** wanting to meet the needs of and help others where he seeks identity as he looks for acceptance, to fit in and be seen for his identity as an RN. Jacob came across as the **'humanitarian'** from all aspects of his life including his previous degree in human relations, his current social justice work in the community and his attraction to mental health. Ben as the **'nurturer'** trying to bring out the best in others with his previous youth work and now in mental health also wanting to assist persons to be the best they can. Oliver was the **'persistent'** one who never gave up in order to reach his goal of gaining full time employment at an RN as he kept knocking on doors until he finally got into a GRN program. Dean was the **'opportunist'** who was going to experience whatever came his way, to go with the flow and he was open to anything that would advance his career. James portrayed himself as the **'protector'** wanting to protect his country in his past career and now wanting to protect those whom he is responsible for from adverse health effects. Wade as the **'adventurer'** who wanted to travel and use nursing as an avenue to assist his adventures until he finally works out what he really wants to do. Ryan was the **'deep thinker'** of the GRNMs who is the knowledge seeker interested in how science can improve health so he is analytical, objective and observant and is highly intelligent wanting higher knowledge.*

The GRNM participant profile and the synopsis for each of the GRNM was supplied in this chapter in order to provide a general snapshot of the individual GRNM. This snapshot maybe used in association with the experiences provided in the following results and discussions as the reader steps through this thesis to provide the complete picture for each GRNM. .

Chapter 5.   Commencement of the Graduate Year

The longitudinal interpretative phenomenological first phase explored why the men in this study chose to enter nursing. Moreover, the study investigated their motivation for their decision to follow this career path and report on how their journey has been so far up to the attainment of their RN qualification. This was the first of three scheduled face-to-face interviews for each of the participating GRNM at the location selected by the participant at a time and date convenient to him. Refer to Figure 11.
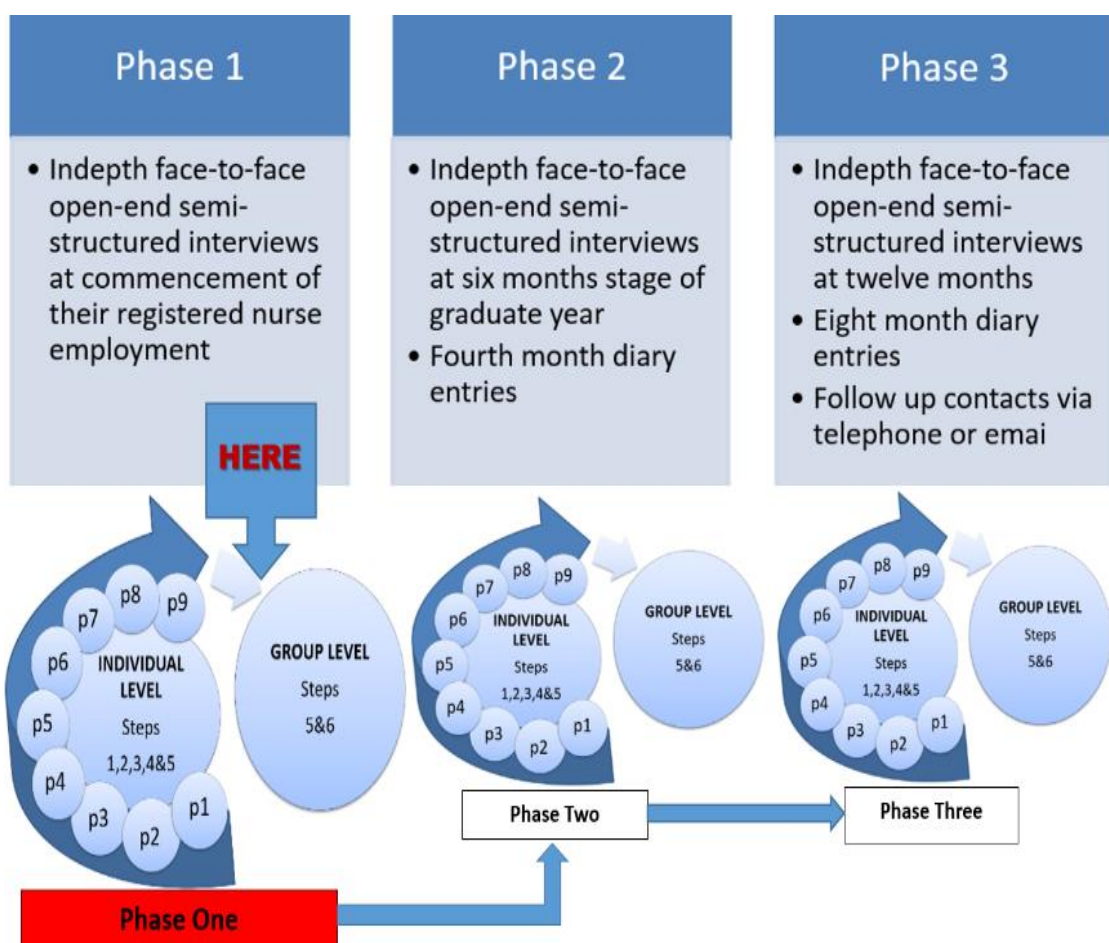
Figure 11   Flow chart Phase one

At this contact importance was placed on building a cohesive participant-researcher relationship with the emphasis on the participant as the expert of his lived experience. This initial participant contact also provided the avenue for the researcher to introduce self, outline where she is located within the study, and to clarify the research process. Further, it enabled each participant to be fully informed

of the study's requirements such as the interview schedules, diarising, and gaining consent especially highlighting his ability to withdraw at any time during the study. The research question for this particular phase was how do the GRNMs choose nursing as their career, in particular what motivates them to decide to enter the nursing profession? Being mindful that the IPA stance was for flexibility within the semi-structured interviews with open-ended questions used only as a guide and to avoid preconceived directional questions. The focus of the interviews was for the GRNMs to verbalise their experiences in detail with reiteration that this study was about their own journey. The flexible flow of the dialogue allowed for unanticipated information from the participants with probing enhancing the opportunity for the GRNMs to freely tell their own stories in their own way.

At the end of this chapter, in keeping with the idiographic style of IPA research, the summation in italics was inclusive of my reflexivity. The following findings through the use of individual narratives enabled a rich account of each GRNM's experience that then with cross case analysis assisted the common themes to evolve.

5.1 Phase one findings

The semi-structured interviews, which on average lasted about thirty-five minutes, were conducted at the GRNMs' place and time of choice. The iterative stages in the analysis process derived from the research guiding questions (Appendix B) asked at the first face-to-face interviews created the following themes.

The emergent superordinate themes were defined as 'motivators for entering nursing' and 'becoming a registered nurse (RN)' that evolved from the subordinates. Direct GRNMs quotes provided the labelling of the themes with similar retorts such as "becoming a registered nurse is the way to help people in terms of living their everyday lives" (Oliver) and "guess the motivation for entering nursing is seeing and knowing people who work in health" (Wade). Table 2 outlined the subordinate themes that eventuated from the initial categories.

Table 2   Phase 1 Master Theme: Desire to help

Superordinate and subordinate themes, categories, narrative exemplars and the overall meaning behind the GRNMs lived experiences

Superordinate	Subordinate	Categories	Narrative exemplars
Motivation to enter nursing	Significant others	• Influence	Mum's side they are all nurses so it seemed the way to go for me (Wes) My family are all health counsellors (Chris) Parents are both doctors, always helping others, mum was a nurse (Wade)
		• Support	My fiancé is a nurse so is a great support for me (Jacob) She [mother] big motivator saying 'you can do it', helped me financially (Wes) Good to have them [other RNMs] to bounce things off (Ben)
	Career choice triggers	• Nurses 'in action'	As a patient in emergency had a male nurse look after me (Chris) Visiting relatives in hospital you get to see what nurses do (Oliver)
		• Impressionable events	Working alongside trauma nurses and wanting to more (James) Assisting at accident and wanting to do more for the injured (Ryan)
Becoming a registered nurse (RN)	Professional practice entry	• Expectations	Expect initially it will daunting until I find my feet (Ben) It's going to be a huge learning curve, it's all new (Jacob)
		• Emotional stance	I'm really excited but also really nervous at the same time (Connor) You feel like you haven't done anything and know nothing (Oliver)
		• Initial experiences	It was a reality shock, realised how much I didn't know (Wes) Full on, very hectic and just really intimidating (Ryan)
	Gender nuances	• Gender stereotyping	Society has a skewed view of how males fit into the nurse role (Ben) There's sly remarks on the sexual orientation of men in nursing (Wes)
		• Marginalisation	Have been mistaken for the doctor as times (Dean) Lonely at times, you feel like you are an outsider within nursing (James)
Desire to Help			overall meaning

5.1.1   Motivation to enter nursing

The superordinate theme of 'motivation to enter nursing' was derived from the GRNMs narratives with common retorts that informed the subordinate themes:

> Bounced between different jobs…customer service jobs and sales,
> nothing in health or science related, just want to help others (Oliver);
> Just was not satisfied with what I was doing (Jacob);
> Wanted to do something where I can make a different (James);
> Saw nurses caring for patients and thought nursing seemed like the
> something I could do (Connor);
> Watched my parents all my life, helping people and I knew that's
> what I wanted to do (Wade).

The two subordinate themes emerged as significant others with the categories of influence and support, and career choice triggers with the categories of nurses in actions and impressionable events brought nursing to the forefront for the GRNMs. The ordinance of the findings for these superordinate themes and the associated narratives were reported in the published research article Appendix H: The essence of helping: significant others and nurses in action draw men into nursing.

5.1.1.1   Significant others

The research article, Appendix H, emphasised significant others as the GRNMs family inclusive of immediate and extended family members. In the case for five of the GRNMs in this study the influence of significant others and support they provided was positive. Wes, Wade, Ben and Jacob had direct family links to health professionals such as nurses, doctors, allied health and psychologists, with Oliver having close family friends that are nurses. Wes stated "all my overseas aunties are nurses", Wade added "my father is a doctor and so is mum although she was a nurse before that", and Jacob contributed "my family are health counselling professionals".

5.1.1.2   Male faculty influence

An unanticipated finding that emerged during these first face-to-face interviews with the GRNMs was the influence of their nurse lecturers who are male (male faculty) had on them as they journeyed towards RN registration. The GRNMs narratives were reported in a published article, Appendix I: The value of male faculty from the

perspective of newly GRNMs. Additional GRNMs comments and extension of their published narratives provided as exemplars:

> I don't get embarrassed about things I ask as much when I have a
> male educator (Wes);
> I tend to ask more questions as the male lectures know how us blokes
> [nurses who are male] think . . . they understand what we are asking
> (Dean);
> They [the male lectures] don't misunderstand where us boys [male
> students] are coming from (Jacob);
> I don't feel so alone I suppose I mean isolated and the feeling of
> uncertainty isn't there when the other guys [male student nurses and
> male faculty] are present (Ryan).

The GRNMs all agreed that having RNMs as faculty members provided them with role models to learn how to deliver empathetic nursing care was their foundation in forming their identities as men in nursing. The retort that resonated from the GRNMs was similar to the comment from James "it's good to hear how they [male faculty] see things as opposed to the female lecturers".

5.1.2   Career choice triggers

Whereas career choice triggers highlighted the impact of and the exposure to impressionable events and included nurses in action, all of which were given by the GRNMs as the reasons for entering nursing. Trigger for choosing nursing as a career for Ryan occurred whilst he provided assistance at a vehicle accident where he felt he wanted to do more for the accident victim. He commented:

> I bounced over to see if I could help not quite knowing what I could
> really do . . . I remember thinking as I approached am I going to have
> to do CPR on the poor woman or do I go into the doctor's surgery
> nearby and get help . . . it turned out she was fine but it left me feeling
> I wanted to do and probably could have done more so I started
> thinking about becoming an ambulance driver and during the research
> I came across nursing which seemed to be the better choice for me.

For James, it was while he was on active defence force deployment after a request by American coalition combat support hospital to the Australian Defence Force base next door for assistance with incoming casualties. With his combat first aider experience and whilst looking after these casualties he observed the American

combat nurses in action that ignited the idea of nursing as an alternative way to help people. He recalled:

> After the combat first aider course over two weeks we [the combat first aiders] are able to cannulate, give morphine, start IVs and do a lot more advanced things than civilian first aiders . . . that's what started my interest and then they [the American combat nurses] were really good . . . working hand in hand with the doctors and making lots of decisions . . . I realised just how much responsibility they had and I thought then of becoming an RN.

The other GRNMs from entry level health-related jobs had similar comments on observing nurses in action. Dean as a PCA stated "I saw what nurses did and thought I could do that". Connor as an orderly provided an example of one particular incident that had a significant impact on him:

> I was an orderly and there was a patient about the same age as me . . . I remember taking him to theatre and he was freaking out and I couldn't do much for him as an orderly . . . then the nurses came in settled him down and reassured him I then thought you know I'd be good at that I really enjoy helping people.

Nurses in action also emerged from GRNMs who had been treated by nurses that fostered their interest in nursing as career. Jacob was treated by a male registered nurse in the ED when he had cut his hand on broken glass at his hospitality job and Oliver was hospitalised briefly as a child, both acknowledged observing nurses during their treatments that ignited their thoughts on becoming a RN.

5.1.3   Becoming a registered nurse

The superordinate theme of 'becoming a registered nurse' emerged from similar GRNMs narratives that also informed the subordinate themes:

> Becoming an RN is my ultimate dream (Wes);
> I want to become the best RN I can be (Connor);
> Becoming an RN seemed like the natural progression for me (Dean);
> Toyed with the idea of nursing for a long while as I am fully aware of the male stereotyping that happens (Jacob).

For this superordinate theme of becoming a RN, professional practice entry and gender nuances were the two subordinate themes that informed it. When the GRNMs were asked, "how has the journey as a male nurse been so far?" Both positive and negative experiences emerged with more positive experiences

outweighing the negatives. On the positive side all the GRNMs in this study had enjoyed studying nursing and learning the technical aspect of their skills acquisition with comments that mirrored Connor's comment of "loved the whole experience of nursing so far, loved the clinical practice and the whole identity of being a nurse". One negative retort came from Dean "it was quite frustrating for me at times, I knew a lot of the stuff having come from a health job so throughout the degree I was feeling that I should be qualified rather than as a student". Dean acknowledged that he had been an aged care PCA for nearly five years and some of what was being taught he already knew, which added to his frustration on his entry to professional practice.

5.1.3.1   Professional practice entry

Under the professional practice entry subordinate theme, the majority of the GRNMs, seven of the nine participants, were nearing the end of or commencing the second week of their GRN programs; hence narratives of the seven GRMNs on their initial experiences were elicited at their first fact-to-face interviews. For the other two GRNMs, Wade was to commence his GRN program the day after his first interview and Oliver had not managed to gain RN employment as yet, although he had an interview for an RN position two weeks post his interview. All the GRNMs spoke extensively of their expectations and how they are feeling as they embarked on their new careers.

5.1.3.1.1   Expectations

The GRNMs' expectations ranged from supportive team and welcoming environment, learning opportunities and huge learning curves to a tough year with challenges, and really not knowing what to expect as they entered the professional practice environment. Jacob revealed his expectation was for a supportive team environment with help at hand when needed and where learning is continuous. Dean commented "I anticipate that there would be additional educational in-services and self-directed learning packages to do for the GRN program and staff development RNs to guide me in my skills attainment". Wade expected that nurses will be very welcoming as he verbalised "I found the nurses during my application process and

interview to be quite welcoming and warm which I am looking forward to". Although Wade followed this comment up with:

> I'm really not sure what to expect . . . I try not to think too specifically about what sort of patients I will have, I keep telling myself that each shift will be different but will probably have the same patients for subsequent days which will be good.

Ben strongly voiced with certainty that his new role of a RN was going to be challenging. Ben commented:

> It's going to be a rough time finding my feet as I learn the skills in mental health such as de-escalation and directed conversations with someone having paranoid delusions . . . but by the end of the grad year I'll be as good as any other nurse I'll just be experienced completely and ready as I don't think I felt completely ready when I left uni [university].

Ryan's expectation mirrored Oliver's of gaining proficiency in the new RN role and acknowledged it would be thought-provoking and hectic. Oliver stated:

> It will be pretty full on in those first few days, massive learning curve, jumping out from uni you feel like you haven't done anything and it's like jumping into the deep end . . . getting comfortable and proficient at doing the tasks, observing how things are done and knowing why their done that way and by asking questions . . . gets you to be able to critically think in terms of best practice and that's exciting but can be challenging and very emotional.

5.1.3.1.2 Emotional stance

The emotional stance captured feelings of excitement and fear with fear reported as apprehension and nervousness. Majority of the GRMNs had the combination of both fear and excitement at the same time similar to Connor's comment. Connor revealed this combination with:

> I'm going to learn a lot, plus time management and joining the full-time work force is going to be a big shift . . . so apprehensive but also really excited as well, the learning curve is going to be amazing . . . can't wait to start.

This real sense of excitement about becoming an RN seeped through the other GRNMs. Excitement shown through such comments as:

> I am really excited to actually be able to get going, be confident now that I've finished training and especially now that I am graduated as an official RN(Wade);
> I'm so excited and happy to finally be starting as a RN (Wes);
> It is a new phase it's a beginning and it's exciting, all these new opportunities all these new places to go . . . it's great having that theory and actually seeing it and doing it in practice (Ben).

There was also a sense apprehension and nervousness amongst the GRNMs as they commenced their graduate year. Wade focused on how he is going to fit in his new environment, revealed "I'm really apprehensive as a GRNM working with ward nurses who been there for a while . . . how will they respond to having new grads . . . how will they be with me". Wade commented further:

> Being a RN is a new thing, no longer having the security of being a student . . . I'm uncomfortable with the unknown and know I will need to watch this procedure or ask how do I do that, etc., . . . so nervous about putting theory in practice . . . I want to impress but I know that errors and mistakes will happen, I'm so nervous about consequences of that but I tell myself that I will take every step I can to prevent those happening.

Overall, the GRNMs hoped to gain basic nursing skills with time management and prioritisation of patient care as their main focus. They wanted to understand processes and the administration role of the RN. The GRNMs all mentioned that they wanted to consolidate their nursing theory into safe nursing practice in their allocated nursing areas where they will get their initial experience.

5.1.3.1.3 Initial experience

Ryan found his initial experience as a new RN was exactly as he had expected, Ryan stated, "some pretty hard core days but most of the time you get through it . . . it was intimidating initially even though I was prepared as well as I could be". Other GRNMs comments included:

> I certainly was nervous in those first few days as I found getting back into full time work bit of a shock and soon I became acutely aware of my limited knowledge" (Dean);
> I knew a fraction of what was to know but I feel comfortable with that . . . mental health is quite specific in itself so from the beginning I didn't bet involved in nursing at all from the medical perspective per

se, it was the psychology and the interactions that people have part
that was all new to me (Jacob).

The initial experience Ben shared was unique from the other participating GRNMs where he turned up for duty in the mental health assessment unit in his second week but was transferred to mother and baby ward for three days. Ben verbalised:

> You have no idea . . . I counted every hour for those three days . . . I
> have never really dealt with any kind of babies and stepping on that
> ward as a fully qualified nurse I had to ask one of the other nurses
> how to pick up a baby . . . certainly found out what gender
> stereotyping is all about working in there.

5.1.3.2   Gender nuances

The subordinate theme of gender nuances captured the issue of the GRNMs experiences relating to gender stereotyping and marginalisation. This gender stereotyping added to the GRNMs feeling like outsiders within the nursing profession.

5.1.3.2.1   Gender stereotyping

This included patient gender preference of care provider particularly with intimate nursing care, and their image of nurses. Ben's narrative continued with:

> I've been told no other male had stepped onto the mother and baby
> ward except the builders and one of the doctors . . . I had a pretty cold
> reception from all the nurses and the mothers themselves so . . . I
> actually felt a kind of hostility towards me for being a guy and this
> was actually hanging over me while I was there . . . couldn't get out of
> there quick enough and not something I ever want to experience
> again.

Ben suggested that the specific gender preference of care by patients' themselves is more prevalent in general nursing although he had experienced it in mental health in the mother and baby unit. Occasionally, he admitted he does hear "how it's good to have guys in nursing", while it is a positive comment, it also raised the point that there is that difference. Ben felt it is almost like saying, "it is good you're standing up and being different from the norm".

This inference of being different from the norm was directed to the image of nurses being female and sexual orientation of NMs. Wes, Connor, Jacob and Dean

similarly added "there is a bit of stereotyping, every now and then where I've been mistaken for a doctor". Ben revealed "being asked by someone if I am gay that I quickly refuted by mentioning my wife". Ben reinforced that he is not gay by voicing that he is married stating "she 'my wife' is very supportive of my nursing career". Wade found some patients were quite surprised at a young guy starting off in nursing and he tended to get a lot of references made about the males in nursing. Further, Wade admitted these references annoyed him, even small things like at his graduation the speech made by a female graduating nurse referred to how nurses in the old days used to be called 'sisters'. Wade stated "the guys get deterred quiet easily by knowing and hearing things like that". Wade added that he would like to see the referring back to the old days especially the references to 'sister' and 'sisterhood' faded out and commented:

> This sister thing it's not current anymore there is a lot more guys getting into it [nursing] although guys still need to be encouraged more to do nursing but we [nurses who are male] still get marginalised which is really off putting.

5.1.3.2.1.1 *A sense of marginalisation*

A sense of marginalisation within the gender nuances subordinate theme was further evident from the GRNMs narratives in Appendix J: Male or nurse what comes first? Challenges men on their journey to nurse registration. This article highlighted not only the issues of gender stereotyping but marginalisation that the participants experienced as they journeyed to RN registration. Most of the GRNMs in this study reported being mistaken for a medical student and even a doctor. The GRNMs also verbalised that none of them wanted to be seen as unique or different. Further, the GRNMs supported the title of 'nurse' but dislike being called 'sister' or 'male nurse'. Comments such as "I am not a male nurse, I am a nurse" (Connor) and "we [NMs and NFs] are all nurses and we all have to do the same job" (Wade), resonated amongst the other GRNM participants. When outside of work most of the GRNMs avoided volunteering their actual nurse title to mitigate judgment on their career choice or their sexual orientation with retorts such as "I'm a public servant" (Wes) or "I work in health" (Dean).

Marginalisation consisted of two main areas, the feeling of being the outsider within and when providing intimate nursing care. The issue of intimate care, although not seen as a major challenge by the GRNMs in this study, came into their conversations

from role misconceptions. All the GRNMs generally found that women patients prefer female staff more than male staff to provide their intimate nursing care. Jacob echoed similar comments of the other GRNMs with "it's a person's right to choose who provides their care . . . we as nurses are here to help make people feel comfortable in an uncomfortable situations". Wes added "so why acerbate patients being uncomfortable because you have your own ego if there is female staff who can accommodate the patients' wishes". Although Ben, James and Dean mentioned that it can work both ways as there had been times for them that male patients only wanted intimate care from NMs. The GRNMs consensus was that nursing is about caring for the patients in the best possible way and if that meant readjustment to the staff allocation during a shift then they were in agreement that if at all possible the patients' preferences should be accommodated.

When probed further on what caring meant Ben, James and Dean clarified that 'caring' for them was about "helping to meet the needs of the patients", which consolidated the helper within aspect with the comments that followed. Comparable comments of:

> Nurses are a figure of authority in providing comfort and security when a person is at their most venerable . . . caring is about patient safety and holistic nursing inclusive of patient involvement . . . being able to help them the best life they can (Ryan);
> Caring is about focusing on the immediate and future health of the patient by working with and helping the patient initially through the patient's symptoms and the reduction strategies needed whilst maintaining the patient's dignity, and then through empowering the patient towards self-determination for their own health including who provides the care for them (Oliver).

Both Ryan and Jacob reinforced that their draw to nursing was more about the holistic caring, helping the mental and physical wellbeing of the people they interact with. Thus added to the notion that the essence behind their decisions to enter nursing as the helper within.

5.2   Desire to help

After defining the exploratory comments from the GRNMs that informed the subordinate themes of significant others and career choice a probing question "what is it about nursing that actually drew you to nursing?" elicited the two aspects of

helping, external influences and the internal factor of altruism, both underpinned in the desire to help. The essence of helping, essential in the desire to help, was the meaning derived from double hermeneutics where the researcher makes sense of the GRNM who is making sense of himself. The two aspects, the external influences on and the altruism within the GRNMs were evident from the GRNMs.

The interpretation of the meaning from the GRNMs' narratives on their individual experiences with the emergent themes represented in Figure 12: Drawn to nursing the essence of helping. This essence of helping further refined to highlight the essence of helping concept outlined in Figure 13: Essence of helping.
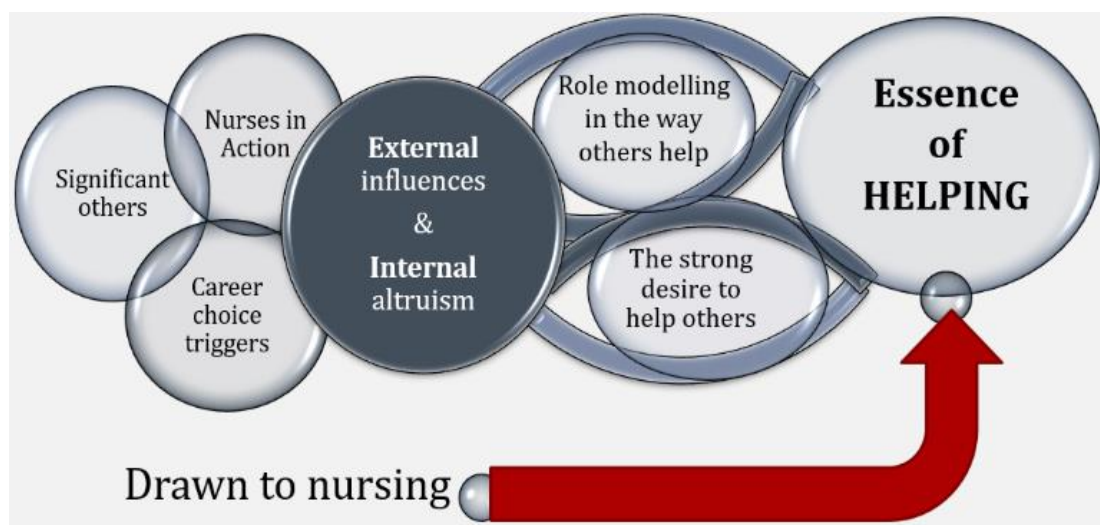
Figure 12   Drawn to nursing the essence of helping
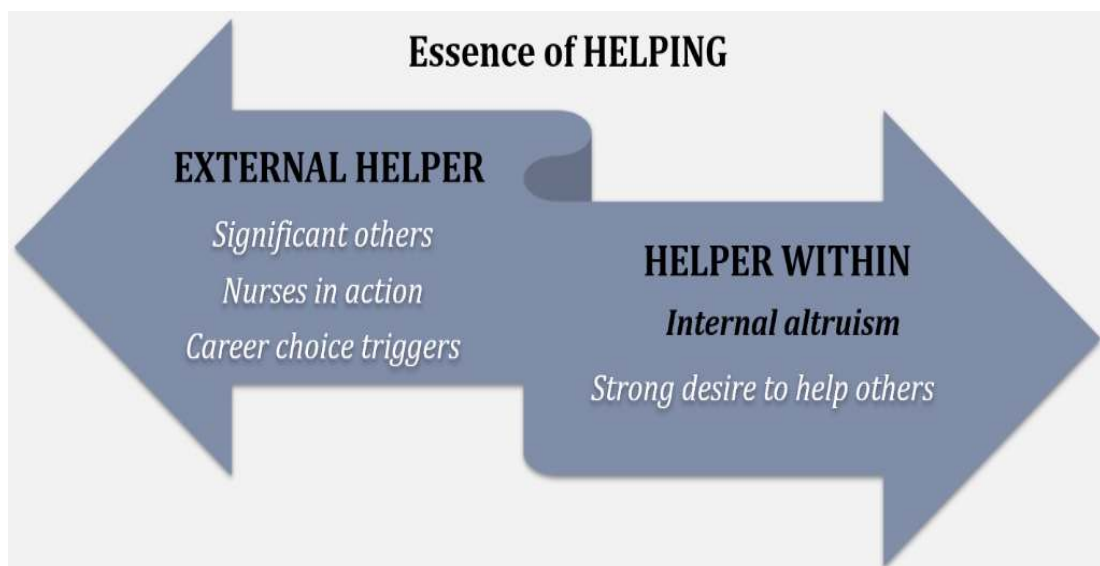
Figure 13   Essence of helping
Source: Juliff, Russell and Bulsara (2017)

The GRNMs were informed at their following contact as part of the member check process that the essence of helping was deemed the meaning behind the motivator for their interest in nursing and as their drive to enter a nursing career. All participating GRNMs agreed with this overall finding that lead them to their desire to become a RN.

5.3   Summation

As I commenced the data collection for the first phase of the study I reflected on my chosen methodology, IPA, and felt confident that it was the best fit for this investigation on the lived experience of men in nursing. Moreover, the IPA process kept me focused on my interpretation of the meaning the participants gave to their experiences behind why they chose nursing as a career and what their journey was like as they entered this female-dominant profession. I was mindful that my engagement with the participants was to gather data in order to provide insight into their experiences (Silverman, 2011) and that "the quality of the information obtained during an interview is largely dependent on the interviewer" (Patton, 2002, p. 341). In this case, I as the interviewer and having many years' experience in conducting interviews and mentoring the transition of novice nurses into the professional practice environment I was comfortable with the face-to-face interviews undertaken and my probing techniques used for clarification of their thoughts. To gain in-depth data and encourage elaboration on narratives during the interviews I used probing questions used such as how did that make you feel? What does that mean for you? Tell me more about that?

I employed active listening skills and probed spontaneously when needed. Smith and colleagues (2009) mention "the role of the interviewer as an active listener" noting that "through listening as an active co-participant . . . will often follow the concerns of the participant" (p. 64), as I did, to seek out important information. I noted both the verbal and non-verbal gestures for contextual insight. Further I used open-ended questions to encourage each participant to tell his own story whilst providing appropriate periods of silence to encourage completeness of his responses from his perspective.

Of note with the first interview conducted for Phase one, although Wes had chosen the location and time for the interview that was convenient for him, he appeared apprehensive once recording commenced, even with time being spent prior to recording with icebreakers and general conversation to enhance his comfort in this process. When I turned the digital recorder off, Wes relaxed into explaining his experiences, which was the rich data that needed to be captured. I soon learnt from this experience that when the participant recommenced with his story at the conclusion of recording, it was often to clarify something he had previously said or something he wanted to add. When this occurred with the following interviews I would ask permission to restart the digital recorder with consent to do so provided every time.

The challenges, both emotional and physical, of transiting into the professional practice environment that newly GRNs face is something that I have been exposed to in recent years due to my experience in facilitating GRN programs within health settings. I have been privileged to hear the graduates' stories and observe the environments in which they have entered and from the formal knowledge revealed in literature. Hence I believe as the researcher with the above background I am a valuable tool to critique possible topics of importance for this study and for analysing the data collected. My appreciation of their challenges and the complexity of transitioning enabled me to bring perspective to the participants' experiences that enhanced the elucidation of the nuances and subtleties of aspects of their professional practice world.

During the analysis stage I consistently revisited transcripts, readjusted the themes and subthemes to give ordnance to the process. I examined each GRNM's transcript in detail to ensure I captured its individuality, within transcript, as part of idiographic inquiry before moving on to reveal commonality, across transcripts, using extracts from within and across the GRNMs transcripts. This activity resulted in a table of super-ordinate themes for each transcript with associated sub-themes, which I repeated for each GRNM before attending to the across transcription theming. Although this part of the process was arduous and very time consuming I found my interpretation of the GRNMs making sense of their experiences rewarding and resulted in further literature searches. The extant literature emanated additional themes that resonated with the participants' experiences, again both as a

collective and on an individual GRNM basis that I will cover in the discussion section of this thesis. The data analysis supported my perceptions that men who enter nursing align with the Holland's personality trait of SAI in how they described their experiences and the reasoning behind their career choice of nursing.

An unanticipated element that emerged was their high level of enthusiasm, positivity shown for the career they had chosen and their anticipatory socialisation that elucidated from each of the participants. Although I was fearful that their anticipatory socialisation would not match their actual socialisation due to my previous experiences with newly graduated RNs. Another area was the distain for the title of male nurse that resonated with two of the GRNMs. These two areas I felt needed further attention in the next phase of the study. Therefore I found myself extending my literature search to anticipatory socialisation in relation to graduates' transition into the workforce and the title of 'male nurse' and 'sister'.

I remained mindful that IPA provides me the avenue for interpreting meaning from the GRNMs experiences. However, there is a need to ensure my assumptions and implications are clear and explicit when interpreting the data, which had me continually referring back to my field notes, their transcripts and my reflective journal, not only during the analysis stage but through this whole process to complete chapter five the commencement of the graduate year.

I am looking forward to reading the GRNMs fourth month diary entries. The information in the diaries and the hearing about their experiences in their first six month as GRNs I expect will bring forth more experiences both anticipated and unanticipated.

Chapter 6.   Six Months into the Graduate Year

This chapter centred on the findings of the data collected at six months contact, the halfway point of the GRNMs' journey through their graduate RN year, and was Phase two of this longitudinal study. This was the second of three scheduled face-to-face interviews for each of the participating GRNM again at the location selected by the participant at a time and date convenient to him. Refer to Figure 14.
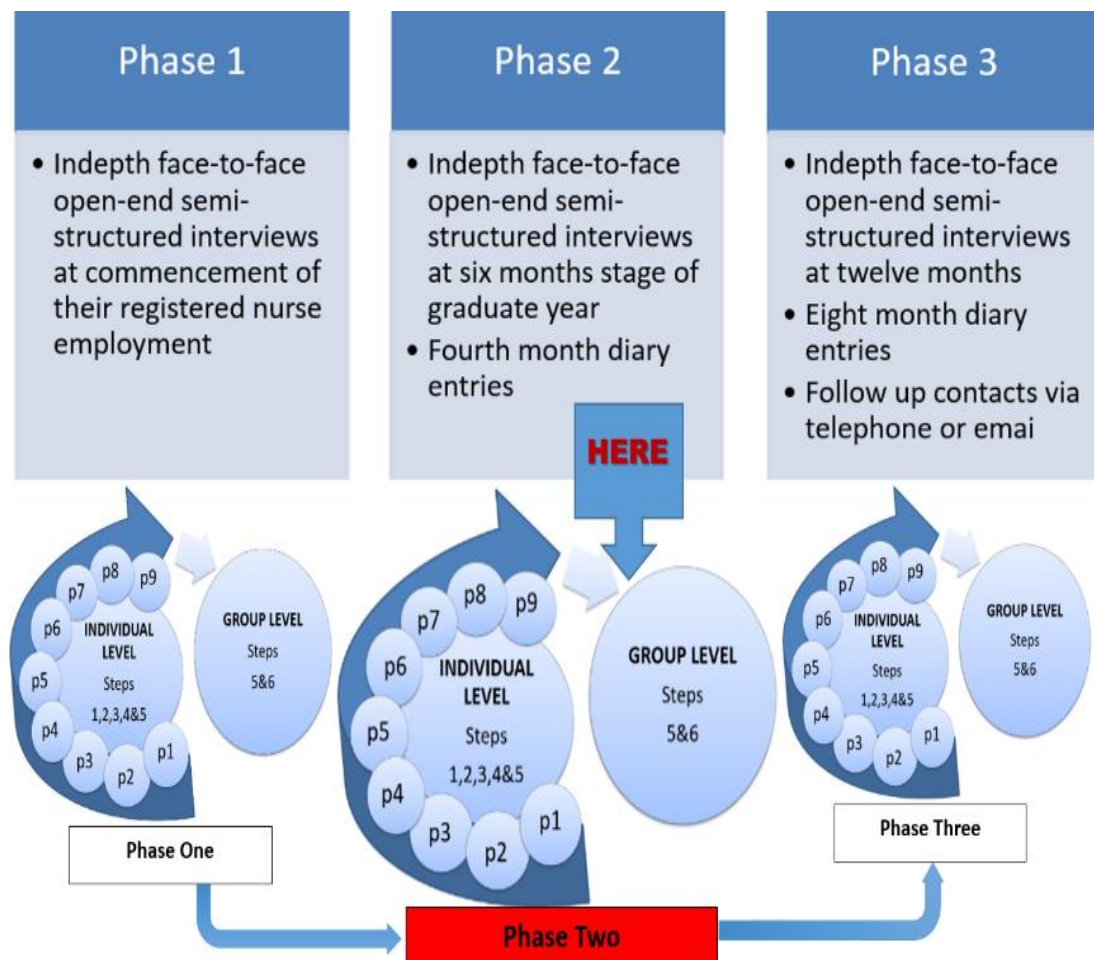
Figure 14   Flow chart Phase two

At Phase two any clarification of data received in Phase one and the GRNMs' four month diary entries were used at the second face-to-face interviews to explore further any written content that required clarification that was of interest and relevant to their journey. Two weeks prior to the second interview each GRNM received an email summation of his journey so far that included information from his first interview

and contained in his fourth month diary entries undertaken over a five-day period. Exemplar of the email sent to the GRNMs with the response received from Ryan refer to Appendix L: GRNM email and response. This journey summation provided the participating GRNM the opportunity to reflect on and clarify the information that he had provided and any unprompted information he wanted to include. Moreover, this summation provided an audit and member check for verification of the content and context accuracy of his lived experience so far. The final draft of the journal articles for publication derived from the data of the first interviews were also emailed with the journey summation for member checking and verification by the participants prior to the publications submissions, with no participant addendums received.

6.1   Phase two findings

The semi-structured interviews, which on average lasted one hour, were conducted at the GRNMs' place and time of choice. The five consecutive days of diarising by the GRNMs at their fourth month mark resulted in two plus pages of single spaced typed information from each of them. It involved nine individual GRNM interview transcripts and nine participant diaries.

6.1.1   Diary entries

These entries enabled probing questions such as "you mentioned in your diary about 'X' why was this important to you? How did this make you feel?" for the second phase interviews. The probing questions focused on clarification and expansion of the identified categories from their diaries, this included their lack of practice readiness, being overwhelmed with allocated workloads and a fear of making mistakes. The demographic descriptions are presented followed by the information that reflected on their practice skills and ability.

6.1.1.1   Demographic descriptions

The first sentence of every entry was descriptive in relation to the shift demographics that set the background for the information presented further on in the GRNMs diary entries. An exemplar of a first sentence entry describing patient allocation inclusive of patient care workload from Wes was:

Today on the ward I had a patient load of four and the acuity of my patients was about 12 with a 4, a 3 and two 2s, can usually determine how busy of a shift I can have by the acuity number with acuity scale ranges from 1 to 4 on my ward 1 being an independent self-caring patient with nil invasive devices requiring minimal nursing care with a 4 usually a post op or someone who requires full nursing care.

Descriptions of both patients care workload and staff mix comments included:

I began work today in the short stay unit of ED [emergency department] on an afternoon shift, a small area of fifteen beds where three nurses each have five patient beds allocated and there is one nursing lead, we have one junior RMO [resident medical officer] to oversee the department (Connor).

Whilst Dean wrote:

Today I looked after four patients, all female in a four-bedded room, they all required schedule eight analgesia at 0800 and was fortunate to have another nurse who as a float on workers comp was an extra pair of hands for me.

6.1.1.2   Questionable skills and ability

The information later in their diary entries was more reflective on their questionable skills and ability in their new roles, in particular patient deterioration, time management and their perception of fit. The GRNMs main focus was on making errors due to their perceived lack of knowledge with similar comments reflective of Connor and Dean's:

Made an error . . . I really felt out of my depth, just lacked the knowledge . . . by not knowing really made me question whether I can do this job and what else have I missed (Connor);
Felt real bad today as I didn't do something that I should have but didn't know I had to (Dean).

6.1.1.2.1   Patient deterioration

Missing early signs of patient deterioration and not being confident in their advocacy role emerged for Jacob and Ryan. Comments being:

Learn from handover that patient I nursed on the afternoon shift had collapsed overnight and had been transferred to emergency . . . this experience made me think I should have done more to advocate for my patient" (Jacob);

> One of my patients returned from a scan in bad shape, I started to
> question my ability as it felt weak saying he was fine when I had him,
> there was nothing to indicate to me that he was deteriorating (Ryan).

6.1.1.2.2 Time management

Time management likewise featured in the GRNMs diaries. Dean's comment mirrored how the GRNMs felt when they achieved their shift workload "I really came home feeling good about the shift that we got it all done when at the start of the shift it may have seemed like a daunting prospect". In contrast the GRNMs used words such as 'unnerving', 'disheartened' and 'overwhelmed' about the end of their shifts when faced with excessive workloads and their workloads were unfinished.

6.1.1.2.3 Perceptions of their fit

The majority of the GRNMs further reflected on whether they fitted in to the professional practice environment and how patients perceive them. Wes's written expression was the common retort amongst the GRNMs:

> I don't fit into the regular nursing demographic although I stand out
> like a sore thumb I usually can get through my shift without getting
> into any drama . . . it made me upset to think that all my hard work in
> caring for a sick patient went unnoticed until the patient in the bay
> next door recognised my effort than it all became irrelevant I clearly
> don't do nursing for praise I do it because I genuinely like to help
> people . . . but it [nursing] can be overwhelming at times.

A sense of being overwhelmed and confusion permeated throughout the diary entries for all the GRNMs. This confusion, sometimes even conflict, between what the GRNMs believed was their RN role within the professional practice environment and what the reality was for them leading to the GRNMs' self-doubting of their fit within the nursing profession.

6.2 Themes

The GRNMs' fourth month diary entries provided information that supported the elicited categories formed from their second phase face-to-face interviews and assisted in the creation of the second phase themes. Table 3 provided the overview of the two superordinate themes, professional practice reality and becoming a valued team member, and was inclusive of categories that informed the subordinate themes.

Table 3   Phase 2 Master theme: Helping others

Superordinate and subordinate themes, categories, narrative exemplars and the overall meaning behind the GRNMs lived experiences

Superordinate	Subordinate	Categories	Narrative exemplars
Professional practice reality	Practice ready	Unprepared • Shift work • Non-nursing duties • Dealing with patients and families • Others expectations	I didn't realise how exhausted I would be with continuous shift work (Ben) Didn't expect I would be doing so much administration work (Jacob) They don't understand what nurses do and have unrealistic expectations of us often not realising we have other patients to look after as well (Wes) Expected to work at the same level of the experienced nursing staff (James)
		Overwhelmed • Allocated workload • Time management • Performance self-doubt	Find it hard to get all the work done with the patient numbers I have (Wes) Snowed under with time management issues and worry at times whether I can deal with the job (Dean) Real doubts about doing everything well without making mistakes (Ryan)
	Job dissatisfaction	Gaining RN experience • Limited nursing leadership • Lack of collegial support	There is very limited professional guidance and leadership out there, usually no or every limited support to help you grow as an RN (Connor) With excessive workloads and being understaffed it's really difficult for other nurses to provide the collegial support I need, just get thrown into the deep end most the time (James)
		Incivility	The eye rolling and side glancing when I speak gets to me at times (Wes) I try to steer clear of all the bitchiness between the female staff (Dean)

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Superordinate	Subordinate	Categories	Narrative exemplars
Becoming a valued team member	Socialisation	Outsider within • Professional relationships • Communication style • Patient care preference	Until we have equal ratios of men to women in the nursing, male nurses are going to be on the outer within the profession (Ryan) I have learned to be adaptable to fit in and find a place in nursing (Wade) Always watching what I say and how I say it with female nurses (Dean) Comfortable with patients voicing their preferred care provider gender and accommodate where possible as we are here to help the patients (Wes)
		Support • Debriefing and feedback • Collegial recognition • Leader role modeling	Complex care debriefings with others supports my learning (Wade) If time permits most nurses are happy providing constructive feedback (Ben) Being congratulated on great team work at the end of a busy shift (Dean) Work with some great clinical nurses who inspire me to be the best I can (Connor)
	Registered nurse (RN) role consolidation	Consolidation / self-confidence • Knowing role and responsibilities • Helper skills	At the half way mark I feel more confident in my RN role as I now have a better idea of what I am doing and what I am responsible (Jacob) Have graduate nurses ask me questions and I'm so glad I can help (Wes)
		Teamwork	Actually take my fair share of the work now and really feel part of the team (Ben)

Helping others ⟶ overall meaning

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6.2.1 Professional practice reality

'Practice ready' and 'job dissatisfaction' were the subordinate themes that informed the 'professional practice reality' superordinate theme. The GRNMs professional practice reality comments provided an insight of when this reality occurred and if they were prepared for this. Reality hit them with likewise comments of:

> Reality hits in that first three months where you realise what it [nursing] is actually about, not what you might have thought it's about . . . Coming from working as a 'carer' in a nursing home, it's just chalk and cheese in terms of staff and the way things happen, it's totally different (Dean);
> A key time where you sort of think I might not be able to do it [nursing], this I found really unsettling (Wade).

Ryan, Ben and Jacob had similar comments to Connor:

> From a student to a graduate nurse is a very hectic start, it's massive and just so different . . . first couple of weeks are full on, although it's [nursing] is exactly as I thought it would be with some pretty hard core days but most of the time you get through it . . . not sure if you would ever really be ready for it.

6.2.1.1 Practice ready

Practice ready was the main focus as they entered the professional practice environment. This readiness evolved from the GRNMs annotations on being unprepared and overwhelmed.

6.2.1.1.1 Being unprepared

Unprepared ranged from the issues of shift work, directly dealing with patients and their families, large amounts of non-nursing duties and other staff members' unrealistic expectations of the graduate nurse. The majority of the GRNMs voiced being unprepared for shift work, physically and emotionally.

All the GRNMs, in particular mentioned the difficulty they had with the late early shift combination with similar commentaries of "shift work is a bit of a shock to the system . . . don't like the late and early shift combination as I find that it is really difficult on the body" (Wes). Wes, Wade, James, Connor and Dean noted this difficulty was being not able to sleep right away after the late shift before heading

back to the early shift. Wade further added "you can't really go straight to sleep as you need to unwind, so you would run on less sleep than you would normally like . . . plus working weekends also meant sacrificing my personal hobbies". Unprepared in these instances related to their difficulty in obtaining adequate sleep between shifts especially the late and early shift combination, feeling stressed and tired, and reduced access to weekend outside of work hobbies.

The GRNMs also expressed the unpreparedness of the large amount of non-nursing duties such as administration that they faced as a RN. Similar comments to Wes and Wade's emerged such as "there is a lot of admin tasks with lots of admissions and discharges with heaps of paperwork needing to be done". Jacob stated "the biggest thing is getting my head around all the administrative tasks that need doing, what form needs to be done by when". Jacob further voiced "a growing frustration I'm feeling in that my interactions with patients are generally limited by other administrative tasks on the ward like doing notes, making calls and routine checks". Moreover, Dean found he was not prepared for dealing with patients and their families' expectations of his role and what they expected from the hospital. Dean remarked:

> A lot of patients just have different ideas about what services they should receive in hospital . . . a big issue I found is a lot of people have the idea my time is devoted in a sense to them alone, that they are the only patient I have to care for.

James, Oliver and Dean further indicated of being unprepared for the unrealistic expectations that other staff appeared to have of the GNs. They mirrored Ryan's comment, "there are quite high expectations of a grad [graduate RN] which are unrealistic . . . you're expected to do the same level of work as that of someone who has had five years' experience can do".

6.2.1.1.2   Being overwhelmed

Being overwhelmed brought up the issues around the GRNMs time management, allocated workloads, orientation to the RN role and their new environment, and performance self-doubt. Time management and allocated workloads dominated this category. Oliver volunteered "found it difficult to get all the tasks done in time because of my lack of experience". Wade contributed "time management is a huge

stress", and Wes with "still struggle with time management . . . it can be so overwhelming at times". Overwhelming was also present in Ben's statement "we, the grads only have limited amount of experience and then we are thrown the challenge of having a very violent and very manipulative 'mentally challenged' patient it becomes a bit overwhelming". Ryan added "it took til around the fourth month before I felt I could handle four patients without freaking out or needing to ask for help". Moreover, Dean augmented the common voice of the GRNMs with "its prioritising what needs to be done, when it needs to be done, getting it done and doing a handover on time".

Prioritising patient care with time constraints surfaced in Ryan's comment "don't have enough time to do a lot of things so tend to drop off the ones which are less relevant to patient safety and their [patients] comfort". Whereas, frustration featured in Jacob's retorted "workload priority that's been really frustrating but part of that is also me managing my time better and being aware that you can also do things in instalments". Other GRNMs added:

> It is a sink or swim environment, you just get chucked into the deep end . . . a task is set and it couldn't be met in the time they want . . . and it gets all too much unfortunately but that's how it is (Dean); Limited orientation is like being thrown to the wolfs with the huge amount of e-learning packages and airway training that needed to be done with no time to really get your head around it all (Connor).

Orientation to the RN role and their new environment was an added factor that all the GRNMs reported impacted on their time management, with such comments as "getting used to a new job environment and assimilating to a new ward and getting to know the routines is massive" (Wade); and "there is still probably things we [the new graduate RNs] don't know because we haven't been told" (Jacob). Wes remarked:

> The hardest part was not so much the nursing skills to learn. It was learning what everybody did and the hospital policies . . . knowing what the hospital staff want you to do, like the admissions and discharges, was really hard for me to begin with . . . doubting whether I would ever get a handle on it.

Performance self-doubt was expressed by the majority of the GRNMs in relation to time management with commentaries that reflected Ryan's, "being overwhelmed with self-doubt of your performance because you don't like to handover things you haven't done or haven't completed, makes you feel bad . . . just wanting to do

everything well and not make mistakes". Not making mistakes in their performance was a major concern for all the GRNMs, where they emphasised that making mistakes led to their job frustration and dissatisfaction.

6.2.1.2 Job dissatisfaction

Job dissatisfaction related to their perceived lack of support within the professional practice environment. This lack of support, in particular, the lack of collegial support in the presence of limited nursing leadership and incivility, the GRNMs perceived inhibited their gaining of RN experience needed for their development.

6.2.1.2.1 Gaining registered nurse experience

On further probing, it was reported that unclear directions and inadequate education opportunities when trying to gain their RN experience had the greatest impact on the GRNMs. A common response amongst the GRNMs were comments similar to Connor's:

> As a graduate I feel as though I am constantly knowing the basics of what I am doing very well, but then have massive gaps in knowledge which I don't know I have until an error occurs . . . I feel as though if there was basic teaching and more education or mentorship with preceptors and nurse leaders giving me clearer directions I would have more learning and I would avoid learning through errors and recognise these before an incident.

Ben contributed further to this to lack of access to professional knowledge and support with "I've never really gone to my clinical educators because they're so busy and so hard to access". Moreover, Jacob concurred with Connor and Ben about the feeling of isolation due to lack of support with the following:

> Being shell shocked in the first three months mainly due to formal support not being there . . . thought there would be more teaching and mentoring and coaching support than there was . . . initially had clinical coaches who went through orientation checklists but due to high workloads they were often used elsewhere . . . at times left feeling isolated due to lack of support.

James and Ryan perceived that the lack of support was most likely the result of low morale amongst the nursing colleagues and being understaffed. Although they both

stressed that the real issue was the lack of nursing leadership that hindered them in gaining RN experiences.

6.2.1.2.2 Limited nursing leadership

Limited nursing leadership, as voiced by the GRNMs, ranged from no visible nursing support, minimal to no collegial caring behaviour within the workplace, difficulty in accessing graduate programs and dearth RN jobs for graduating RNs. The accessing a graduate program issue for James was having to wait six months to commence his GN program and for Oliver was having difficulty in actually gaining a RN job. They both reiterated that these factors had an impact on them gaining timely RN experience further added to their lack of self-confidence. James revealed as the months went on after graduating he became more nervous about commencing as a new GRN and was not sure how it would go for him. He recapped on his lack of confidence, "with the responsibility of having a patient load on my own was definitely a big factor coupled with the medications ensuring not to make an error, etc." This lack of confidence intensified as he neared his entry into the GN program with doubts about his ability to perform as a RN and not meeting the team's expectations of him in his new role. James stated, "I feared not holding up in my end when it came to being in a team environment".

Initially Oliver did not apply for a GN program, as he could not find one that was specific to aged care, the area he believed was his best fit. The next few months proved very challenging as Oliver continued to get rejection after rejection on his nursing job applications. His frustration was highlighted when he commented "they kept saying I needed more experience, this coming from both the acute and aged care jobs I applied for, but how can I get the experience if I can't get jobs in the first place?" Finally four months into his first year post RN graduation, Oliver started working in a small private aged care facility as the casual RN. On his first day, he felt overwhelmed and overloaded with the duties he was tasked with. As the shift progressed, he found himself getting faster and becoming more confident. Oliver stated:

> I just needed to find my way around the ward and get my head around
> what I was expected to do . . . it's not only because of my limited
> experience it's mainly due to the lack of support . . . no one there to

> ask how things work, etc., and really hard when I was the only RN on
> duty, it's so stressful.

The following shifts that were a few days apart and proved to be no better with two residents requiring hospitalisation taking up substantial amount of Oliver's time. As a consequence some uncompleted duties were handed over to the staff on the following shift. As a result of uncompleted work and with no consideration to Oliver's overall workload and his novice status, he was not given any further shifts. Oliver stated, "I was not alone in this situation as other graduates had faced the same fate". He further commented on his disappointment in terms of leadership and the lack of support he received with:

> I felt really let down by the nursing profession and really
> disappointed, feeling very disillusioned, there's no visible leadership
> in nursing from what I have experienced so far . . . I am rethinking my
> career and if I should look for something else outside of nursing
> where there is support as you learn.

6.2.1.2.3   Lack of collegial support

A sense of a lack of support reverberated throughout the GRNMs narratives during the interviews. Connor's comment provided a summary of their collective views:

> Definitely being thrown into the deep end with very minimum and at
> times no support . . . from a graduate perspective, you become very
> good at asking questions and we definitely ask because otherwise we
> wouldn't be told…the only times that there is sort of learning,
> building knowledge, is either as it's all happening organically or
> we're making mistakes and then we're learning big lessons from those
> . . . I don't know that I don't know until something happens.

Added to GRNMs job dissatisfaction was the overall work stress that occurred within their professional-practice environment. This work stress was heightened when allocated complex patient care with no or minimal collegial support provided. The majority of the GRNMs had experienced such situations. Exemplars included:

> I had never felt so alone and unsupported when I walked into my
> allocated room where I was confronted with two patients who
> required care beyond my level, so I did the best I could with what
> knowledge I had as I had no one to ask for advice or check with…I
> felt like running away but I knew I couldn't as I needed to care for
> them [the allocated patients] as I was told there was no one else as
> half the staff were off sick and there was no agency nurses available. .

> I went home that night thinking I can't keep doing this then went to work the next ready to quit but this day proved to be better (Wade);
> I had the shift from hell, the department was overflowing with really sick patients and staff were being pulled all over the place, I started with four allocated patients that grew to nine I felt so out of my depth with the sheer volume of patients I had no one to seek advice from . . . on the one occasion I sought clarification I was dismissed abruptly and told just work it out yourself (James);
> Confronted with a really busy shift and got a lot more patients then I usually had on shift I was left on my own and when I escalated my concerns repeatedly about one of my patient's deterioration I was ignored and not supported by the clinical nurse . . . I was so stressed by the time the next shift arrived when finally my concerns were taken seriously (Wes).

6.2.1.2.4   Incivility

This work stress often presents as incivility with most of the GRNMs having observed incivility within the workplace. They emphasised that incivility was usually between the 'girls' [NFs]. Ryan, Jacob, and Wade, concurred with Dean's comment, "female nurses tend to leave us blokes alone as they know we don't take their stuff on . . . blokes just have it out with each other, tend to be upfront and then get on with it [nursing]". Although Wes mentioned that at times he has had the eye rolling and side glancing between less qualified female staff when he delegated. He added, "I find the eye rolling behaviour so disrespectful as I am a registered nurse in my own right and it is my role to delegate patient care when I am the lead within the team". Connor suggested it can be seen as bullying however for him and other GRMNs (Dean, Jacob, Wes, Ben and Wade) actually preferred to call this behaviour incivility. They named this incivility as rudeness, shouting at and berating others, unjust workloads, inappropriate patient allocations, unfavourable rostering, and even individual staff member exclusion coming from within the various levels of nursing personnel. James reiterated a similar comment congruent amongst the GRNMs with:

> Nursing has the reputation of eating our young . . . had to learn that it wasn't a personal thing . . . realised that they [the older nurses] always talk to people like that but it's not good for team work or the patients really . . . that's a big thing [incivility] I have had to adapt to . . . Although lateral violence is an issue in nursing, men don't sweat the small stuff and when people behaviour unprofessionally it tends to stop in the presence of a guy, as most guys don't make a big deal

about it and don't want to know about it . . . just want to be part of a supportive team, a valued member.

6.2.2 Becoming a valued team member

The subordinate themes that informed the 'becoming a valued team member' superordinate theme were 'socialisation' and 'RN role consolidation'. The thread of time management became apparent as the connector for both the subordinate themes as time management was deemed by all the GRNMs as essential in their RN roles to accomplish their teamwork status. Other GRNMs had likewise comments to James, "I've been there nearly three months now and it has taken me until now to become comfortable in what I'm doing and to feel like I'm part of the team". Wade added "at the end of three months maybe the fourth I had mastered my time management where I could handle my side of things and then still help someone else that's when you really become part of the team".

6.2.2.1 Socialisation

When asked how they saw socialisation, the GRNMs expressed it as their 'fit', in other words, their acceptance into the professional practice environment. They found the help from others such as recent former graduates enhanced their 'fit' within the professional practice environment. Most the participating GRMNs concurred with Ryan's statement "it was former grads themselves that ensure I am included in the team as they know what it's like when you first start". Their socialisation further involved their acceptance of the outsider within status and the need for communication style adjustments being a male within a female-dominant workforce. Support, in the form of debriefing and constructive feedback and collegial recognition and leader role modelling, was also deemed importance in their socialisation process.

6.2.2.1.1 Outsider within

Outsider within. On further discussion about their 'fit' the GRNMs iterated it was their learning to accept that they are and will remain the outsider within the nursing profession. Although the outsider within the nursing profession was touched on under gender stereotyping. As the GRNMs progressed into their graduate year, this

'outsider within' became more about building their professional relationships within the professional practice environment and establishing their communication style with their peers and other health professionals. Majority of the GRNMs commented likewise to Jacob's "I will always be the outsider in nursing as it is full on female dominant and that's fine as it is what it is". James added:

> Nursing is much different to my last career because my last career was male dominated where my colleagues were roughly about the same age . . . it can feel a bit lonely at times but that's how it is in nursing . . . just have to learn to adapt and try to fit in the best you can.

Being adaptable to fit the professional practice environment and form work relationships was a collective response amongst the GRNMs. Representative of GRNMs comments being Connor's with, "I had to be adaptable to fit in . . . to be one of the 'girls' [NFs] which I'm ok with as it's the nature of being a male in a female dominant job".

Both Ryan and Dean further added that it had taken a good few months but now they had more awareness of other people's roles and the importance of being aware of that when interacting with other health professionals. The GRNMs uncertainty initially when interacting with doctors and senior staff was a common thread within their interviews. Wade's comment being reflective of the GRNMs, "to interrupt a group of doctors when needing a patient reviewed urgently was a big thing in the beginning, the first few months anyway, but now much happier to just jump in and ask".

6.2.2.1.2 Communication style adjustments

Communication style adjustments, more so when communicating with female colleagues, resonated with the majority of the GRMNs. According to the GRNMs these adjustments pertained to the way they spoke as males and their mannerisms, and the behavioural and social modifications they felt they needed to make when working in a female dominated profession. Similar comments from Jacob, Wes and Ben of "being a male within nursing you just have to watch your Ps and Qs [mind your language and manner] around female colleagues" surfaced. Whereas, Wade's

focus was more on his confidence in using an appropriate communication approach when he conversed with female colleagues. Wade commented:

> It took some time to get my confidence up to be able to contribute to conversation being the only male in the group as I didn't want to be seen as too needy or too sure of myself or be taken the wrong way.

In contrast being more relaxed when working with other NMs was a recurring element common amongst the GRNMs. Comments included:

> More relaxed now as there is more male nurses on the ward (Dean); Able to have some good banter and a few jokes amongst us blokes especially when really busy, just makes the shift more bearable (Ben); Being one of a few guys [nurses who are male] and when we end up on the same side of the ward it can be a fun day as you tend to ask each other more questions and get to know each other so when you get to work together it's great (James).

Being misunderstood by those these GRNMs came into contact with in their professional practice environment was also something they spoke about. Wes summed this up with "being a bloke it's really hard forming work relationships just knowing how to act, not be misunderstood by patients and colleagues because of something I said or way I said it . . . I'm always double checking myself".

On probing the GRMNs further on their professional relationships with patients, the GRNMs discussed respecting patient care preference and the building of therapeutic nurse patient relationships when the nurse is a male. GRMNs responses in relation to patients' preference for a NF included:

> When I have felt uncomfortable or the patient has given signs of being uncomfortable about me providing nursing care I have asked to be reallocated which has never been an issue . . . it's about me being an advocate for what the patient wants and about my integrity (Wade); Once or twice the patients have said that they prefer a female to do the stuff down there and I've said that's fine . . . it doesn't bother me at all, it's about making the patients comfortable (Wes).

Ryan, Ben and Jacob had identical comments with "sometimes patients say they prefer a female nurse . . . happy to accommodate". The GRNMs also provided commentaries where the preference for a NM as the nursing care provider. Their common retort was reflected in Dean's comment, "some patients react better to a male personality or have sensitive issues where a nurse who is male is better

equipped to deal with". Wes, Ben and Jacob recalled that there have been times when they have been reallocated to look after a male patient because he, the male patient, refused to be cared for by a female. James provided additional information that patient reallocation to a NM maybe due to "a cultural issue or the patient's inappropriate behaviour towards nurses who are female", and concluded with "so it can work both ways in regards to whom, male or female nurse, provides the patient care".

All the GRNMs expressed their willingness to accommodate patients' care preferences where possible as they saw themselves as patient advocates there to assist patient access the care providers that they were more comfortable with. Further, they felt this was paramount in positive therapeutic nurse patient relationships and found that this stance was supported most of the time within their professional practice environments.

6.2.2.1.3   Support

Support from within the professional practice environment in the form of debriefing and constructive feedback, leader role modelling and collegial acceptance were the elements the GRNMs found enhanced their socialisation. Remarks included:

> When staff are really supportive and really focused on catching issues before they become major problems, just building you up, it's a good environment and you learn heaps" (Ryan);
> I have very supportive seniors on staff who just kept checking and giving me reminders when needed, all of which had a huge impact on how I progress (Connor).

6.2.2.1.3.1   Debriefing and constructive feedback

The importance of debriefing and constructive feedback as part of staff support was evident with GRNMs remarks of:

> On this new ward I now realize how supportive the staff on my last ward were, and how valuable the debriefing was and how much they helped me find in terms of my RN role development" (Wade);
> When you are not there by yourself and the other nurse, usually a CN [clinical nurse] who is quite knowledgeable, you can get one on one time for feedback, really helps with settling into the RN role (James).

Connor, Ben and Wes admitted that the vast majority of nurses were constructive in their feedback. They also found most staff members were ready to help knowing the RN role complexity and that collegial support was needed for the GRN socialisation.

However, debriefing and feedback was often inhibited due to time constraints from excessive workloads and inadequate staff mix. Jacob summed the time constraint issue up with "I'm very mindful when I seek out feedback to pick my time to do so when time permits as the other clinical staff have their workloads to contend with as well". He further added "so it [the feedback] tends to be informal and opportunistic, maybe on the way to a meal break or heading off duty". Connor commented:

> it's really good when I get positive feedback from nurse leader who I admire on how well I am doing, it gives me a real buzz. . . it may only be a quick comment like 'you did really well today' but it's really reassuring.

6.2.2.1.3.2   *Collegial recognition and nurse leader role modelling*

Collegial recognition and nurse leader role modelling were posited by all the GRNMs as paramount to positive socialisation. Supported by similar comments to Connor and Wade:

> Had a great lead who knew exactly how to support staff by readjusting workloads, reallocating patients and picking up slack when needed . . . admire this trait and hope to emulate it as a senior RN (Connor);
> At the end of the shift, all staff congratulated each other on a getting through a busy shift and thanked each other for their support, it was so good to be part of this shift . . . each person felt valued, accepted by their colleagues as being essential to the shift (Wade).

Connor, Wes and Wade further concurred that supportive nurse leaders such as nurse managers and clinical nurses who are visible, approachable and inclusive of others in care provision decisions are role models that they would emulate in their own practice. Moreover, Jacob and Ben indicated that the nurse leaders' willingness to provide coaching and debriefing when needed had a significant impact on their RN role consolidation, development and progression.

6.2.2.2 **Registered nurse role consolidation**

The subordinate theme of 'RN role consolidation' centred on the GRNMs consolidation and increased self-confidence in their new role and responsibilities as RNs, and furthermore, the refinement of their helper skills. All of which, the GRNMs perceived as needed for them to become valued team members.

6.2.2.2.1 Consolidation and self-confidence

Consolidation and increase in self-confidence GRNMs common narratives included:

> At six months you feel like you belong, you can handle your own, others [nurses] ask you questions and you've got the answer . . . suppose its confidence in your ability (Ryan);
> Now at six month I am more comfortable and more confident in my RN skills (Wade);
> More confident with my time management and communication now" (Wes).

Further, GRNMs retorted:

> All seemed to come together, like it's a natural process over the months of being exposed to and gaining experience in being an RN . . . I'm feeling very confident and happy as an RN (Ben);
> At the end of the forth month mark had worked out my time management where I could handle my side of things and help others making everyone's life easier than you know you really are part of the team (James).

6.2.2.2.2 Teamwork

Acknowledgements on their positive contributions when working within a team produced GRNM comments on their consolidation of and increased self-confidence in their RN role. Further, concurring that knowing their role and responsibilities was required before they were seen as valued team members. Comments reflecting this included:

> Now more confident where I'm able to reflect and critically look at what's going from the experience I've had so far, and not just passing the buck to somebody else is all about being a team member (Jacob);
> The fact that I get given challenging cases in terms of patients' needs and behaviours, and I'm given students to mentor in some ways is an indication that I'm valued within the team and trusted to help others (Connor).

6.3   Summation

The data collection for the second phase really tested my role as the researcher in this IPA study. I found myself repeatedly referring back to the GRNMs transcripts to ensure I was capturing their narrative not what I thought they were reporting from information I had read in literature and what I had experienced previously with other male graduates. I replied heavily on what I had diarised after each interview in my field notes and reflective journal aiding my reflexivity as I progressed through this second phase. Their data took me a lot longer to digest and report on than I had expected due to the dense data I was receiving and trying to interrupt the meaning from the GRNMs experiences plus double checking myself that I was performing as I should in the IPA field.

From the interview process I found the GRNMs really engaged and wanting to tell me their stories, both the funny and serious sides, of their journeys so far. I felt that there was no guarding or selectivity of what they were narrating, they were actually telling me their perceptions of what they experienced. I felt privileged that they trusted me enough to open up about their inner emotional matters, how they felt whether negative or positive on scenarios they provided. The use of diarising at fourth month into their journeys proved to be of benefit from both my search aspect and for the GRNMs. For me the valuable information and insight these diaries provided informed the clarifying and probing questions I used for their second interviews. These questions gave me the opportunity to delve deeper into their commentaries to gain a better understanding of where they are coming from and thus to find the meaning behind their perceptions of their journeys. The GRNMs also verbalised that they find this task of diarising a good reflective tool, with the majority of them stating that they will continue to use diarising in their RN professional practice.

From the data aspect I was surprised about an unanticipated element that emerged of their high level of enthusiasm positivity shown for the career they had chosen, despite three of them around the fourth month mark having thoughts that nursing was not for them. I was also fearful that their anticipatory socialisation would not match their actual socialisation due to my previous experiences with newly graduated RNs. This proved to be the case, however, the majority of the GRNMs

were not deterred by this and remained enthusiastic, and appeared to taking the challenges they faced in their stride.

I was not surprised by the superordinate theme of professional practice reality as the categories that underpinned this theme is well documented in literature and I have also observed this reality. However, their emphasis on the lack of nursing leadership under the job dissatisfaction subordinate theme surprised me with their strong views in this area, although not unexpected as recent literature is supporting what they verbalise. This prompted me to submit a successful application for a poster presentation entitled 'Nursing leadership influence on male graduate nurses retention experiences explored in the professional practice environment' as a part of a session entitled 'Nursing Leadership' for Sigma Theta Tau International's 28th International Nursing Research Congress in Dublin, Ireland July 2017. Refer to Appendix L: Dublin nursing leadership presentation.

As I started to undertake the second phase of this longitudinal study I became overwhelmed in the whole research process where I needed to stand back from it and reset my thoughts. I had not anticipated the lengthy process the IPA would be for this second phase as the first phase, the interview of nine participants, was straightforward in coding, analysing and interpreting the data. Although I am aware of what Jonathon Smith and colleagues (2009), in their comprehensive guide to IPA, suggest a small sample size of up to ten participants and reducing in number when multiple interviews for each participant is applied to enable successful analysis as the analysis needs time, reflection and dialogue. Furthermore they propose it takes around seven hours of transcription for every hour of interview with anything from one week to several weeks to analyse each transcript with an added one week for across cases analysis and a further two weeks to write up a first draft of analysis (Smith et al., 2009). Taking this into consideration I now realise I have greatly under-estimated my time allocation required for this study in completing the analysis for Phase two as this phase has proven to be more complex due to the dense data collected, inclusive of multifaceted elements presented by the participants as they experience their new and often unknown aspects of their chosen career. The added coding and analysing of their individual diary entries has also proven to be time consuming, however is a valuable triangulation of data that is adding to the data and supporting their verbal responses. My endeavour to investigate and moreover to

interpret both the physical and emotional aspects for each of the participants from their perceived meaning of their own experiences, having to be mindful of both the commonality and individuality of the participants within this study, has required many hours of deliberation and reworking areas to ensure I reflected the participants' authentic journey.

As I embarked on the final phase I was curious to know how the last six months of their graduate RN year had panned out for them. I was also feeling more prepared for the volume of data I expected to receive from the GRNMs due to my experience in the second phase and I believed I had a more concrete grasp on my role within this study.

Chapter 7. End of the Graduate Year

This contact with the participating GRNMs was at the twelve months mark, end point, of their journey through their graduate RN year. It was also Phase three of this longitudinal study. This was the last of three scheduled face-to-face interviews for each of the participating GRNM once again at the location selected by the participant at a time and date convenient to him. Refer to Figure 15.
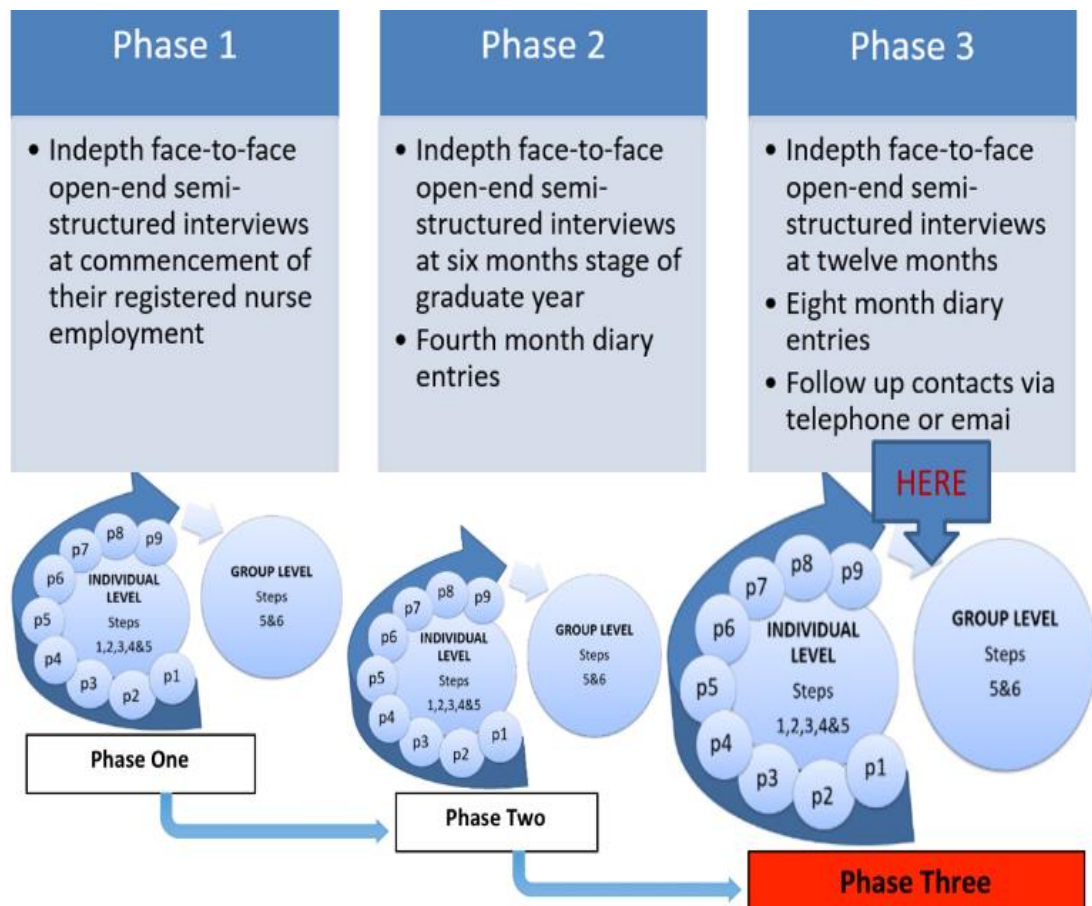
Figure 15   Flow chart Phase three

Two weeks prior to this third interview each GRNM received an email summation of his journey so far that included information from his second interview and that contained in his eighth month diary entries undertaken over a five-day period. This acted as another member check of his lived experience as part of the audit process, and aided in clarification of content and for verification of information provided. This third phase involved eight individual face-to-face interviews that on an average

was eighty minutes in duration and eight diary entries. Wade, participant number 2, was not able to be contacted after numerous attempts; hence Wade's data was not collected during this time.

7.1   Phase three findings

Triangulation of the findings continued with the data obtained from both the GRNMs diary entries and the individual GRNM face-to-face interviews. The data from the GRNMs' eighth month diary entries was used as probing questions at the face-to-face interview again to clarify and explore any captured unprompted and unexpected thoughts and experiences that surfaced during this part of their journey.

7.1.1   Diary entries

Contrary to the fourth month entries, the first sentence for most of entries had little to no demographic introductions, only stated what rotation they were on and time in the area. For example "working in the ED for the second rotation of my graduate program" (James) and "currently have been in mental health for about two and a bit months now" (Wes). The diary entries focused more on how and when their shifts started, patient care and others behaviours, and self-reflection on their progression.

7.1.1.1   How and when their shifts start

The GRNMs commenced with statements relating to how the area was as they started work with "quiet shift, a good opportunity to spend quality one on one time with the patients" (Jacob); "busy day today, structural heart day where we have two left atrial appendage occlusions under GA [general anaesthetics]; or where they are allocated with similar comments of:

> On arrival to the ward today I was allocated to 5B, one of the acute
> medical units where patients are transferred either as direct
> admissions or from ED" (Connor);
> Today I have moved wards to work I am working on a locked chronic
> ward that has patients with brain injuries and require long-term care
> (Wes).

7.1.1.2   **Patient care concerns and others behaviours**

The GRNMs then went straight into providing information more reflective of nursing care concerns and behaviours of other staff or how they are handling patient management. Jacob's documented reflection was typical of the kind of difficult patient care issues the GRNMs faced. Jacob provided:

> Asking for support from CN [clinical nurse] to hoist transfer a patient and assist in a pad change when the CN suggested leaving the patient in their bed for the rest of the day as it was 'too hard' to transfer the patient back to the recliner chair as the patient wished, as this occurred at 2pm I thought this was inappropriate, and requested help from another grad nurse to assist . . . we [Jacob and graduate nurse] jokingly but also seriously made a 'pledge' to not become slack in providing patient care as we continue our careers.

Dean wrote about power play from a senior nurse:

> Came on to a really hectic place, I was completely run off my feet so really glad to sit down at the nurse's station while paging the doctor about an issue to do with my patient. Unfortunately, the Clinical Nurse Manager walked out at that exact moment so it looked like 'I'm doing nothing', I tried to explain and eventually she allowed me to talk but not before saying *but be careful what you say next you're the grad and I'm the senior nurse* in a very hierarchical-know-your-place kinda tone.

Dean's and Ryan's diary entries prompted the need to probe the GRNMs about how they saw themselves in relation to incivility, either observed between others or directed towards them. Ryan wrote:

> With an arrogant and bullying consultant . . . realised early in the piece, that he [the consultant] does not direct any of his attitude at me, suspect it is a male thing as most males will not bully other men until they get the full measure of them . . . even though I lack the courage to say anything to him, I do feel annoyed at the nursing profession in general that over the years it has allowed itself as a group to be treated in such a way . . . communication is something I will reflect on as I progress as males can be perceived as direct and blunt.

7.1.1.3   **Self-reflection on progression**

Throughout the entries there was also evidence of self-reflection on their progression in areas such as time management, communication, skills and confidence levels in their RN role. Exemplars included:

Feel like I am improving on my communication skills both with staff and the patients/family to ensure I am presenting current realities as clearly as possible to both groups" (Jacob);

Felt confident in my ability to speak to different departments and communicate with confidence the history around the patient as well as best possible future outcomes" (Dean);

I feel as though I have a solid grip on patient flow and try to expedite my transfers and discharges in keeping up with the hospital flow, my time management and flow skills are good and I am confident in taking more senior roles which are generally reserved for nurses of more experience (Connor).

Further probing questions used at the GRNMs final face-to-face contact were derived from the diary entries. These questions focused on communication styles and again incivility within their workplace as they were the common threads in the GRNMs diary entries.

The GRNMs' eighth month diary entries provided the information that supported the elicited categories formed from their third phase face-to-face interviews and assisted in the formation of the third phase themes. Table 4 provided the overview of these themes with the superordinate theme of 'professional self' and the subordinate themes, 'RN mastery' and 'better RN fit', inclusive of categories that inform these subordinate themes.

Table 4   Phase 3   Master theme: Professional helper

Superordinate and subordinate themes, categories, narrative exemplars and the overall meaning behind the GRNMs lived experiences

Superordinate	Subordinate	Categories	Narrative exemplars
Professional self	Registered nurse (RN) mastery	Competent RN • Role and responsibility clarity • Trusted and valued • Continuing education	It's taken nearly the full year to gain clarity around my RN role (Dean) Eight months in, still getting my head around RN responsibilities (James) Being offered a permanent job makes me feel trusted and valued (Ben) Nursing is complex so continual education for me will be lifelong (Connor)
		Workplace culture • Nurse leaders and peers • Self-care • Incivility	Approachable senior nurses and helpful colleagues make it a great job (Wes) Learnt quickly to look after myself first before I can help others fully (Jacob) There's an undercurrent of you don't belong here so exclusion occurs (Ben)
		Co-communication • Language and manner	Continually having to watch what you say when working with RNFs (Jacob) Adjust my style when engaging with others especially females (Dean)
	Better RN fit	Professional development • Career planning • Self-leadership	Career direction changes due to the experiences you have as a GRNM (James) Learnt early that you chose your leadership type from observing others (Ben)
		Job satisfaction • Job flexibility Wanting to help others	Nursing provides various types of jobs and flexibility so finding the right type is about keeping the door open for opportunities that come along (Dean) I want to help others in the best way I can, make that difference (Connor)
Professional Helper	⟶		**overall meaning**

7.1.2   Professional self

On commencement of the third interview it became evident that at this point of time for the GRNMs their emphasis was more about their futures within nursing as they finish their graduate RN year and complete the employment contracts they had in place. The superordinate theme of 'professional self' was deemed reflective of this stage in their graduate nurse journey as it nears the end of their first year graduate status where they focused on 'RN mastery' with consideration to the 'best RN fit' for their career progression.

In regards to their career progression, a sense of frustration and urgency permeated throughout the GRNMs discourse due to the recent permanent employment embargo placed on nursing positions for a six month period across the West Australian health sector. Hence at the face-to-face interviews their main focus was on their professional self although four months earlier their RN mastery, in particular their competency as an RN and workplace culture, was the key paradigm of the GRNMs' diary entries.

7.1.2.1   Registered nurse mastery

This RN mastery theme evolved from the commentaries in the GRNMs eighth month diary entries. For example Connor diarised about his increased awareness in what he can do and what he saw as important in his RN role with:

> Have become more familiar with nursing duties and roles and have learnt limitations and how not one person can do everything. It is important to work in a dynamic team who are able to work together to deliver best patient outcomes and more confident to trouble shoot, liaise with the consultants and to speak to different departments to communicate issues that arise to ensure the best possible patient outcomes.

Further probing at the interviews to clarify their RN mastery resulted in their perception of being a competent RN. Moreover, this RN mastery attainment provided them with a sense of belonging through being seen as trusted and valued. This RN mastery also included dialogue on their continual education needs, and focused on the impact of workplace culture inclusive of nurse leaders and peers, self-care, incivility and co-cultural communication.

7.1.2.1.1   Competent registered nurse

For the GRNMs being a competent RN occurred when they had RN role and responsibility clarity and were trusted and valued. They revealed that having the opportunity for continual education and support from their nursing leaders and peers enhanced their RN mastery attainment. The GRNMs expressed that they felt more comfortable within the professional practice environment as evidence of this mastery. Exemplars included:

> I'm more comfortable in myself as I now feel I have the confidence of an RN rather than a confident grad RN (Ben);
> More comfortable asking questions now than I did six months ago as I now know my role and what is expected of me (Jacob);
> Enjoyed coming back into the emergency department from acute medical I have those acute skills now and my clinical skills are so broad I'd be happy to work most anywhere as I feel competent as an RN (Connor).

Connor continued, "competency is more than just knowing things but it was the knowing how to talk to people and liaise with colleagues, which I wasn't doing to start with". His rationale, which was a common retort amongst the GRNMs, "you are timid and shy initially trying to get your head around nursing rather than being in the environment and now I have both, the knowledge of nursing and the environment, I feel way more comfortable and relaxed". Jacob added:

> The first six months was about a grounding foundation and now I have found my feet entirely, particularly in this last four to six months I am much more aware of the overall process of working in the wards, therefore I don't have that niggling doubts that I've forgotten to do something and whether I need to do something else that takes me away from me being within the moment . . . I'm more confident in myself as a competent RN.

7.1.2.1.1.1   Trusted and valued

This RN mastery confidence was further articulated by the other GRNMs with similar commentaries relating to their critical thinking and feeling trusted and valued by others. Dean declared, "I feel I am more like a critical thinking nurse now in terms of when something comes up I consider why the doctors made this decision, why this medication rather than just taking things as they just are". Dean, Wes and Connor perceived the confirmation of being a valued RN occurred when others ask

for their opinions and trusted that their responses were correct. For Connor "when you are one of the first they want to give a permanent position to then you know you are valued". Other GRNMs added:

> Being given challenging cases in terms of patients' needs and behaviours, and given students to mentor in some ways is an indication and acknowledgement that I'm trusted and a valued team member (Jacob);
> I know my role and what is expected of me now I'm trusted . . . now more than capable of handling the workload and situations that arise and I do enjoy the RN work of a knowledgeable helper and patient advocate, however I don't like being put into positions that are unsafe so feel the need for ongoing education to keep up with things (James).

7.1.2.1.1.2   Continual education

Continual education was an area that the majority of the GRNMs talked about needing to enable them to maintain RN competencies. Jacob contributed "even though I continue to work in adult mental health, my main task for the next few months is to request extra training days for myself to continue my learning as a clinical nurse". Others commented:

> My first six months was about a grounding foundation in clinical practice . . . now I have found my RN feet entirely I do feel that it [learning] is going to be an ongoing process (Jacob);
> Ongoing learning besides competencies for me it is about leadership . . . how to communicate, support and help others especially those new to the team and students to provide the best care we can (Connor).

The GRNMs also supported the RN learning gained by ward rotations, although most believed it is beneficial to have at least six months on the first rotation due to the initial steep learning curve encountered, and being physically exhausted and emotionally drained in those first few months. Connor reflected "there were six of us graduates down in emergency, three of us rotated and three didn't . . . I learnt so much more rotating like different styles of nursing and a whole new set of skills". Although, the majority of the GRNMs revealed that on commencement of a second rotation they had a short-lived regression reflective of their first few days as a newly GRN. This included the accompanying feelings of uncertainty, being outside their comfort zone and having to learn new nursing skills applicable to the new

professional practice environment. This regression was summed up in the following comments:

> Does feel like you are starting from scratch in a way but at the same time you have done six months in the first rotation giving you a greater level of confidence than when you first started" (Dean); Actually did go backwards initially, it was almost a process of trying to get my feet back to the ground again . . . similar aspects of trying to acquaint myself with this new area with different challenges and different culture and everything else that goes with that . . . also learning the staff names and learning how to work with different staff members and getting to know the workplace culture which was a lot quicker second time round (Ben).

7.1.2.1.2 Workplace culture

Workplace culture impacted greatly on whether the participating GRNMs had positive or negative experiences as they journeyed through their graduate year. The GRNMs experiences of how others communicate and behave towards them influenced their own behaviours, which necessitated the need to look at self-care and coping mechanisms to enable them to continue in their chosen career. The GRNMs highlighted the fact that the major influences were the nurse leaders and peers they encountered.

7.1.2.1.2.1 *Nurse leaders and peers*

Moreover the GRNMs discussed the importance of nurse leaders and proactive peers in their adjustment to workforce culture as they consolidated their theory into practice now and in the future as they advance in their careers. The GRNMs talked further about supportive staff members enabling them to settle more quickly into their new professional practice environments. Similar GRNMs comments to Dean's reflection on finding a good team and good place to work surfaced. Dean reflected on the inconsistency in the workplaces and the value of a good manager "when it's a good team it's a good place to work and the manager is much better and rostering is much better . . . but some are not so good . . . you accept that". Ryan continued with "it [good workplace] is about the people who you are with, the staff will keep you in it, if you are struggling at times they will be the ones who will pick you up and help you cope", a sentiment that Wes, Connor, Ben and Jacob concurred with.

7.1.2.1.2.2   Self-care

Self-care for the GRNMs was entrenched in their coping mechanism that enabled them to continue as RNs. Wes talked about self-care in relation to coping with long hours, shift work and the resultant fatigue. He reiterated likewise comments of the other GRNMs with:

> Looking after myself went out the window in those first few months . . . I was all out of whack, overwhelmed and stressed, not eating nor sleeping properly, trying to continue my pre nursing social life but wanting to be helpful so never saying no to taking extra shifts when the ward was so short staffed . . . it all came to a head about five to six months into the grad year . . . I finally realised I needed be self-caring if I am to survive this job, so I learnt to say no when extra shifts were offered if I felt fatigued. Also aimed to sleep more, eat better and alter my lifestyle . . . I now work through issues as they occur, reflect and debrief as needed that has led to me being more confident in myself.

The GRNMs talked further about becoming resilient as a self-care mechanism otherwise they 'would not survive nursing'. Wes provided a comment that summed up the GRNMs feeling on being resilient with the words "yep definitely grown into my nursing skin now . . . better able to deal with complex situations, workplace conflicts and incivilities and there's a lot of it".

7.1.2.1.2.3   Incivility

Incivility mentioned by the GRNMs in the second phase interviews, was again spoken about in this third phase. This time the incivility related more to their observation of the incivility within the work culture and the lack of support and motivation within the organisation to change the situation. Dean stated "it is about the big picture stuff throughout the organisation, respect and staff supports". James added to this reveal:

> One of my colleagues got assaulted in the acute medical ward and he decided to do the thing what we have been encouraged to do, get the police in and charge the person the assault . . . however, this was not the case as the process doesn't support the people trying to stop violence in the workplace.

Whilst other GRNMs contributed with:

> The lack of respect because you are young or new makes you feel like that because you are a grad nurse you can't bring anything to the table, you are not worth knowing or helping (Wes);
>
> Feel as though there should be more support for graduates in that regard and if there is somebody who is new and if they're interested in moving up and interested in and passionate about learning the organisation should rally behind them because that's what's going to make them better nurses (Connor).

The majority of the GRNMs also acknowledged their increased awareness of the incivility from less qualified team members towards GNs and non-permanent new staff and suggested this behaviour seems to be overlooked by senior staff. Wes commented "yeh the eye rolling and side glancing at each other continues but I will now challenge this behaviour by asking is there a problem here?" Dean and Connor both concurred that they also use the strategy of asking is there a problem when they get an unacceptable response to their delegation. James added the abruptness and incivility towards each other was inherent within all levels within his workplace. Although emergency nursing was James career interest initially he now investigates other nursing specialties that may suit him better where he can receive collegial support and have some comradeship. James reiterated "I am over the lack of support, no leadership and the indifference between the ED nursing staff". In contrast, James, Oliver and Jacob noted from their experiences that there was less incivility and better support for each other in mental health. James putting this down to "being a more male dominant nursing field where there is no having to watch what you say and how you say it".

7.1.2.1.2.4   *Co-cultural communication*

In regard to the co- cultural communication aspect, Wes supported Jacob's comment:

> Communication style does change when you are in a male nursing area, like mental health . . . I think it is to do with being more laid back and more accepted as one of them . . . even with the ladies [registered NFs in mental health] . . . mental health nursing is not like general nursing where with the ladies you had to hold back and be a bit careful . . . watch your Ps and Qs".

The watching of the Ps and Qs [attention to language and manner] was something that had been mentioned in Phase two findings as a male within nursing. As Wes was the first GRNM to be interviewed in Phase three the opportunity was there to

further probe the watching of their Ps and Qs with the other participating GRNMs. Their responses were similar in that they concurred with having continually to be careful in their use of language and their manner when they communicated within a female dominant nurse setting. Although, Connor remarked "I am more comfortable when communicating now with more confidence because I use my professional voice". Further clarification on his 'professional voice' revealed the co-cultural communication style adjustment Connor has made with a professional practice repertoire he now uses. This adjustment was also mentioned by other GRNMs:

> You learn what to say and how to say it (Dean);
> You pick your time to say what you want to say and only when it needs to be said . . . I try to avoid awkward conversations and ignore colleague Facebook requests so I won't be misunderstood" (Wes);
> This is what professional development is about, learning how to communicate effectively, in other words, in a way that is accepted by the profession and the teams you work with (Jacob).

7.1.2.2   Better registered nurse fit

The GRNMs reflected on their journey, how they felt as they began their new RN role, where they are now, and what their next career step is for them. A common retort was the "looking for a better fit' where they mentioned professional development inclusive of career planning and self-leadership, then job satisfaction and job flexibility, and wanting to help.

7.1.2.2.1   Professional development

Professional development was a category inclusive of career planning and authentic leader that informed the subordinate theme 'better RN fit'. Job satisfaction was the other category inclusive of seeking job flexibility and wanting to help others that informed 'better RN fit' subordinate theme. Connor provided an exemplar that was resonant of GRNMs feelings as they near completion of their twelve month graduate year with "overall, still wanting to do nursing . . . the thing next for me is perhaps where to next as looking more forward rather than looking at the now". Connor expanded this with:

> At the very beginning it was looking at the now, how to deal with now, then in the middle of the grad year it was more looking at how I'm doing now and let's see where I'm going, and now heading towards the eighth month mark I'm very much looking into after my

grad finishes . . . where am I going? What am I wanting to do and
then making those goals.

Connor and the other GRNMs had congruent positive and enthusiastic responses of
enjoying the now and looking forward to the future pretty much, and the new
challenge of how to deal more with being new again. Dean, James and Wes
furthermore believed it is the best to experience different types of nursing to get a big
picture with professional development ongoing to enable finding their best fit.

7.1.2.2.1.1   Career planning

Career planning, involved their critiquing where they were at and where they wanted
to be. Oliver reflected "I would have gone straight into mental health as opposed to
general after what I have experienced so far". Ben added "if I couldn't do mental
health I think I would have to left health care". Connor reaffirmed his initial career
choice "I have always wanted ED and it has proven to the best fit for me and they
[senior nursing staff] are already talking about my role progression". Dean revealed:

> Have just found out that I have been successful in a second year
> graduate program with country nursing positions . . . once I
> commence that will be like starting all over again as I will know
> nothing and it will be great because that's how you learn and what
> keeps it interesting.

Wes outlined his career thoughts and rationale with:

> Lately I have been looking at doing my mid [midwifery nursing] as I
> would actually like to work for the RFDS [Royal Flying Doctor
> Service] and as far as I'm aware you have to be a midwife for RFDS
> positions . . . one of the family's I grew up with their dad was an RN
> and a midwife and he worked for the RFDS . . . to me he was a
> personable and a trusted leader.

7.1.2.2.1.2   Self-leadership

For the GRNMs self-leadership involved observing the authentic leader traits within
colleagues and other health professionals. This observation influence on the GRNMs
in their career decisions emerged in relation to the GRNMs identifying with their
leaders' qualities and becoming a self-leader. Connor, Wes and Dean provided
similar instances where specific clinical nurse managers and senior colleagues
inspired them by the way they carried out nursing based traits in a professional

manner. These traits included providing guidance and feedback and assigning duties fairly within the given skill mix available. The GRNMs comments included:

> I recognised these leader traits as ones I want to emulate (Connor);
> I learnt so much by having decent senior staff providing constructive feedback in a way that motivates rather than demotivates, it helped me heaps so I hope to do the same for others (Wes);
> It's the attitudes and professional behaviour I take on-board from supportive colleagues who provide guidance and are ready to help with complex and difficult situations when needed . . . traits of a true helper (Dean).

Ryan affirmed that working closely with other health professional leaders as they go about their business expanded his clinical and leader skill base, and provided him with alternative ways to help others. Ryan commented:

> I have been exposed to other ways of helping as it all comes down to patient safety and quality of life . . . it's about keeping these guys [cardiac patients] going . . . like in the Cath Lab doing quality improvements with the medical staff and being encouraged to do the science degree from professionals who are committed and dynamic in their field . . . I get a lot of job satisfaction working amongst this team.

7.1.2.2.1.3   Job satisfaction

The GRNMs talked about job satisfaction in terms of diverse nursing roles, career opportunities and working part-time. James expressed the sentiment of satisfying work reflected in likewise comments from other GRNMs. This sentiment being:

> Just want to find something I enjoy every day that makes me want to go to work then that way I will do it the best way I know how and I would get a lot more out of it . . . I will find it, it is just a matter of trying to find it.

Wes and Connor added comments similar to Ben's statement:
> Nursing can be challenging at times but it is also so extremely satisfying at the same time . . . there is so many nursing career pathways and lots of flexibility opened to me now that I'm finishing the grad program . . . it is daunting deciding what to do next.

7.1.2.2.1.4   Job flexibility

Job flexibility came up when the GRNMs discussed job satisfaction. Job flexibility was a common retort amongst the GRNMs with comparable comments to Ryan's,

"that's the other good thing about nursing if ward and shift work doesn't suit there are other venues for nurses". Jacob and Ryan contributed with alike statements, "the job flexibility especially working part-time allows a life outside nursing to follow other passions". For Jacob this passion was and still is his social justice and community commitments, and for Ryan his ability to undertake research and a science degree. Dean added:

> I have accepted that I will stay in nursing as opposed to when I was
> thinking about doing med [medicine] . . . nursing is suiting me and
> giving me job satisfaction knowing that there is a lot of career
> leverage in getting more experience and being more qualified for
> better positions and at the same time I'm still helping others.

In contrast, James highlighted his frustration and disillusionment with his original nurse pathway choice of working in emergency department (ED). His experiences in this area has been far from satisfying, "I am thinking about getting out of the main stream hospital setting all together . . . it is as far from being safe as you can get really and I am not comfortable with that". Probing James on his comment he further revealed:

> It's not safe for patients . . . staff ratio is not adequate, staff are pushed
> to the limit and put into unsafe practice situations as well unsafe
> personal situations, the wards seem to be no better . . . when you do
> have an issue there is no support from management or senior staff, it's
> a full on blame culture . . . I want a role where I can be respected and
> be allowed to do the best I can do . . . I've been looking at the
> possibility of going to mental health.

When asked why he is considering mental health as an alternative, James replied:

> Well they have a better take on staff safety and not afraid to speak up
> when patient situations are unsafe . . . I'm also missing comradeship
> that is lacking in general nursing . . . I really enjoy working with other
> guys [RNMs] and that's another reason for looking at mental health.

7.1.2.2.1.5 *Mental health appeal*

This appeal to work in mental health for these GRNMs became evident throughout their Phase three interviews. On first contact with the participating GRNMs, the only GRNM that wanted to do mental health nursing purely was Ben. Jacob also started in mental health although he was keeping his options open, he did eventually reveal "I can see myself at some point as a psych liaison in ED". As the GRNMs

progressed through their graduate year and experienced mental health nursing, the majority of the GRNMs were in or now seeking mental health positions. Oliver affirmed this:

> I couldn't get a general nurse grad position and ended up in mental health grad program instead . . . not a nursing field I had ever considered but I have found it really great experience and have realised I can combine my love of aged care with the physical ageing process and include their mental health . . . I guess this is true holistic nursing . . . really enjoy it both working in mental health and working with other guys . . . I would have gone straight into mental health as opposed to general from what I know now.

Jacob contributed "I'm still really enjoying mental health . . . I've had really lovely interactions with folks . . . on the geriatric ward with the folks there and with their families there's lots I can help them with". He added "it was my wanting to help others that drew me into nursing in the first place".

7.1.2.2.2   Wanting to help

This' wanting to help' was another common retort throughout the GRNMs Phase three interviews. Exemplar of comments included:

> I still enjoy the actual job helping people . . . I got into this [nursing] because I enjoy the helping people and I wanted to do that every day as a job (James); I found it funny reading over it my journey . . . how excited for nursing I was and still am, it's still there I'm still loving it, helping where I can (Connor); If you want some excitement and adventure in life where you are able to help people to reach their full potential then nursing is the way to go (Ryan).

Ben summed up with "I think I have reached a point now that I know enough and I'm comfortable with my knowledge to really be able to help others in the best possible way . . . it's really about the art of helping".

7.2   Summation

The data collection for the third phase again required me to repeatedly refer back to the GRNMs transcripts to ensure I captured what they were narrating, and to my reflexivity journal for notations that needed consideration. The dense data this time was more concise with less categories identified as the GRNMs focused on their

professional self in relation to attainment of their RN mastery and where best they fit within the nursing profession.

From the interview process once more I found the GRNMs really engaged and eager to tell me their stories. Moreover, they wanted to share what they thought their career pathway could look like and how they would like nursing to be. How they would like nursing to be brought an undercurrent of concern about negative nurse behaviour that many of them conveyed with their general conversation in the interviews. Although when probed on the substance of the concerns most of the GRNMs shrouded it off as 'just something that happens in nursing'. However, most admitted that they would not imitate the negative behaviour and incivility they observed and in some cases had experienced in their professional practice environment. The majority of the GRNMs defined their leadership style as one of a helper. Development of their nurse professionalism and self-leadership monopolised their conversations and the information they provided in this last phase of their journey.

*Enthusiasm for nursing was still evident although their initial choice of nursing specialties for most of them had changed with most GRNMs waiting to see what job vacancies were available. I then gave thought to each of the GRNM's generalised title I had initially given each of them in Phase one. Connor remained the **'logistics'** person who thrives on challenges within his practice professional environment and eagerly steps up to lead nursing teams, to mentor students and new RNs, and coordinates shifts when asked. Wes, the **'giver'**, wanting to be recognised as a helper and be accepted in his own right as an RN remained committed to nursing as his career of choice still having the long term goal for working for the Royal Flying Doctor Service. Jacob as the **'humanitarian'** continued to combine his outside social justice activities and working as a RN in mental health. Ben, the **'nurturer'**, has successfully obtained permanent work as a mental health RN where he finds fulfilment in assisting patients to be the best they can. Oliver, the **'persistent'** one, is now considering when he completes the mental health GRN program of combining this nursing specialty with his original desire to nurse in aged care by seeking employment in elderly mental health services. Dean, the **'opportunist'**, has taken on a second year graduate rural and remote nursing program offered to him to see where this experience will take him in his nursing career. James remained true to*

*his **'protector'** title as he continues to seek a nursing position that will provide him with the opportunity to use his nursing skills and knowledge to protect those whom he is responsible for from adverse health effects, which his current ED position is not providing. Wade, the **'adventurer'** with his strong desire to travel, was not available for Phase three of this study and remains overseas. Ryan, the **'deep thinker'** who seeks knowledge on how science can improve health is now undertaking a postgraduate science degree whilst working as a RN in the Cath lab.*

In reporting the findings, particularly in Phase two and Phase three, I was mindful of the large amount of verbatim quotations I used. I was aware of the over use of quotes disengaging the reader; however, I also needed to meet the rigor requirements of IPA for each finding of having "illustrations from at least three participants" (Smith, 2011, p. 24). Hence I carefully selected the quotes I thought provided evidence for the emergent themes that were complementary to the information already published from this study noted in the related appendices.

I found value in publishing early as the related peer reviewers and editors with their constructive feedback I received provided the motivation for me to continue on this journey. The feedback also provided alternate viewpoints on my arguments, and provoked further thoughts on data issues and the direction I was taking. Most of all these publications enabled refinement in my academic writing, in particular with the arguments and readability of the papers and presentations I produced.

In the next step of my doctoral journey, Chapter nine, is focused on the essence of the GRNMs journey. Moreover, the meanings that lay beneath their experiences that they have shared.

Chapter 8.   Essence of the Journey

"I may not have gone where I intended to go, but I think I have ended up where I intended to be"

Douglas Adams

In Chapter eight from the findings of this study, as the researcher and in following the IPA methodological approach, I endeavoured to make sense of the individual GRNM trying to make sense of his journey, in other words to find the essence of this journey. This journey started from what motivated the study's GRNM to enter nursing and his lived experiences along this journey through to the end of his first year as a GRNM. I strived for a successful interpretation, for IPA this "is one which is principally based on a reading within the terms of the text which the participant has produced" (Smith et al., 2009, p. 37). It is to this end I used my interpretations behind the overall findings in each phase (chapters five, six and seven) to gain sense of the meanings behind the perceived experience of the individual GRNM and of the GRNMs collectively. Thus, forming the master themes being the essence of helping from Phase one, helping others from Phase two and with Phase three ending in the professional helper.

8.1   Essence of helping

After defining the exploratory comments in Phase one from the GRNMs informed subordinate themes of significant others and career choice, a probing question "what is it about nursing that actually drew you to nursing?" elicited the two aspects of helping, external influences and the internal factor of altruism. These two aspects, the external influences on and the altruism within the GRNMs were evident from the GRNMs narratives. Appendix H: The essence of helping: significant others and nurses in action draw men into nursing informed the visual representation of the two aspects of helping in Figure 10: Drawn into nursing.
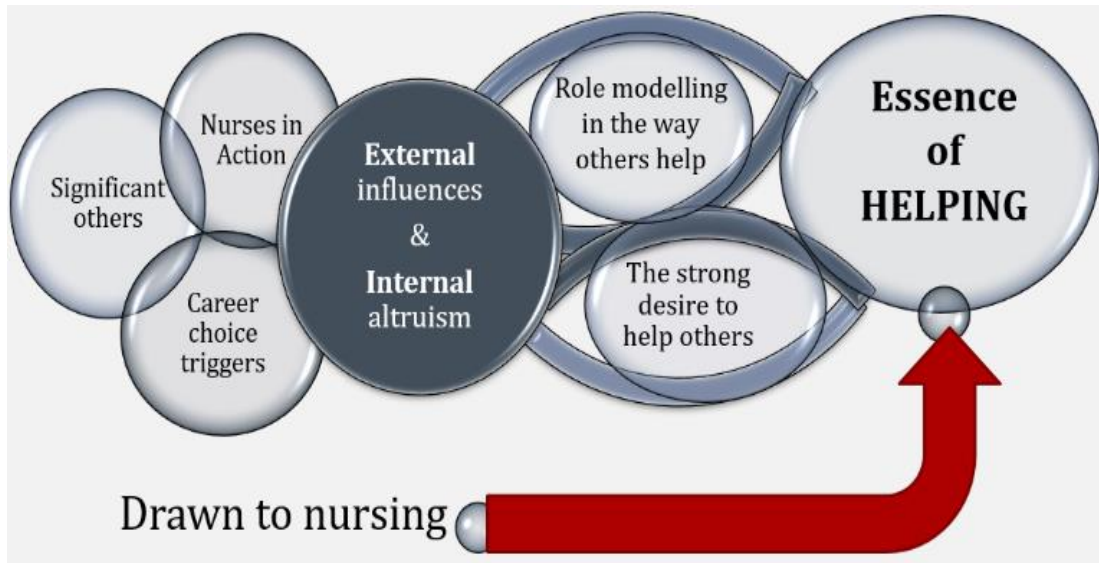
Figure 10: Drawn to nursing. Duplicated from Chapter five.

The interpretation of the meaning from the GRNMs' narratives on their individual experiences with the emergent themes, represented in Figure 10, was revealed as the essence of helping. This 'essence of helping' was further refined to highlight the essence of helping concept as outlined in Figure 11.
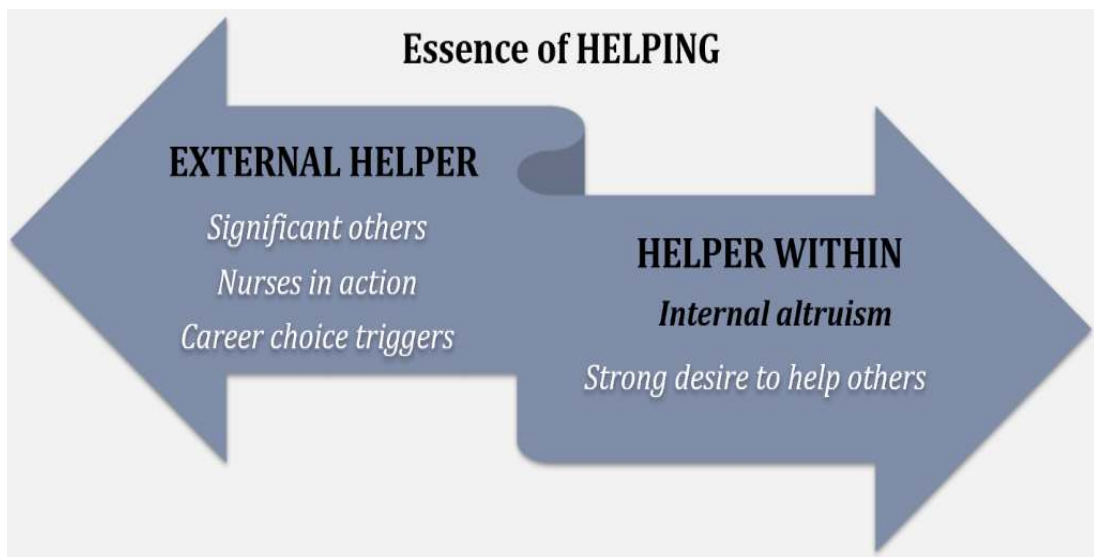
Figure 11: Essence of Helping. Duplicated from Chapter five.

The GRNMs were informed at their following contact as part of the member check process that the essence of helping was deemed the meaning behind the motivator for their interest in nursing and as their drive to enter a nursing career. All participating

GRNMs agreed with this overall finding that lead them to become a RN, being their desire to help others.

8.1.1 Helping others

From Phase two, 'valued within the team' was the common reverberation throughout the GRNMs interviews when putting nursing theory into practice in the professional practice environment in order to help others. According to the GRNMs the helping of others included the patients they care for, undergraduate students, and graduate RNs and others such as agency nurses and novice doctors within their professional practice environment. Exemplars included:

> I now help with orientating agency staff, new doctors and taking the lead role in teaching students so really feeling like a valued team member" (Connor);
> Urge to storm out and give nursing a boot when looking after an agitated guy for most of the shift to him being grateful at the end, one of those challenging patients . . . that's being the patient's advocacy, being his helper, being part of the nursing team (Ryan).

The majority of GRNMs noted that when they were tasked or able to help others of their own volition, that they had a greater sense of being a valuable member of the team. Wes summed this up with "I think I have reached a point now that I know enough and I'm comfortable with my knowledge to really be able to help others in the best possible way . . . it's the art of helping through me being the professional helper".

8.1.2 Professional helper

From Phase three, 'increasing self-leadership and the leading of others' was the common reverberation throughout the GRNMs interviews when nursing theory into practice as a RN was becoming more defined in the professional practice environment that enhanced their helping of others, through the art of helping. According to the GRNMs the helping of others included the patients they care for, undergraduate students, and graduate RNs and others such as agency nurses and novice doctors within their professional practice environment. Exemplars included:

> Nursing allows me to professionally help my patients in the best possible way when they are at their most vulnerable (Dean);

> Have new grads [graduate RNs] and new residents ask me questions
> and I'm so glad I can help them professionally (Wes);
> Being able to help new doctors find their feet within our busy
> department and seeing them develop their confidence in caring for
> patients is one way I see myself as the professional helper (Connor).

The GRNMs in this study believed nursing to be a 'helping' profession and used the word helping to describe the act of caring where they care for those who are not able to care for themselves. When exploring why they used the word 'helping' rather than a 'caring' profession most of the GRNMs felt that caring was a feminist word. So in taking into account of the common terminology that each of GRNM's used when making sense of his lived experience that evolved over his professional journey, helping appeared to be the essence behind the motivation to become a RN. The table 5: Essence of helping summary signposted how this concept of helping was reached.

Table 5   Essence of helping summary

<table>
<tr><th colspan="3">ESSENCE of HELPING</th></tr>
<tr><th>On entry to nursing</th><th>0-8 months</th><th>8 month onwards</th></tr>
<tr>
<td>Seeking meaningful work to help make a difference as the motivator to enter nursing through exposure to:

• Significant others
• Nurses in action
• Altruism within

"Where I am able to help people more"

Desire to Help</td>
<td>Putting theory into practice by being exposed to the skills of the helper:

• Others within the professional practice environment through their leadership
• Gaining experience in nursing practice to develop the helper skills to
Help Others</td>
<td>Self-leadership refined by enhanced professional practice independence in own right through clarity in:
• Registered nurse roles and responsibilities
• Art of helping
• Leadership of others

Above being encased in the qualities of a

Professional Helper</td>
</tr>
</table>

This was also illustrated in the Figure 16: Professional helper. Figure 16 provided more detail as to who was the external helper at what time along their GRNM journey in relation to the development of the GRNMs professional helper skills and knowledge acumen.

Figure 16   Professional helper

8.1.2.1   Art of helping

The art of helping, although previously not outlined in the literature review, the implications of helping did not fully originate until assembling of the professional helper structure in Figure 14, and as such necessitated attention to gain the extent of this art. Nursing was highlighted as the art of helping in the 1960s and was described as the process to meet the needs of the individual when there is a need for help (Wiedenbach, 1963). Simply, nursing help was deemed multifaceted in regards to the skills, techniques, procedures and devices a nurse utilised to assess a patient's experienced need for help, provide the help needed and validate the usefulness of the help given (Wiedenbach, 1970). However, there is dearth literature around nursing as the art of helping in recent times and this could be due to the advancement of nursing insomuch that this art for nursing, although still existent, has been intertwined in all aspects of nursing practice and thus would be complex and difficult to define.

Madsen (2014) acknowledged the art of helping as complex and termed it collaborative helping. Further claimed that the practice framework of collaborative helping was derived from multiple approaches such as appreciative inquiry,

motivational interviewing, and approaches that focus on narrative therapy, solution-focused therapy, and family-centred care. Thus indicated that the multitude of skills and knowledge required for nurses as professional helpers was due to intricacy in the art of helping in practice.

8.2　Summation

On reflection of Douglas Adam's quote that introduced this chapter I cannot but feel that it is apt for both myself as a novice IPA researcher and the GRNMs participants. I do not think that at the beginning of this journey that professional helper would be the overall essence of this journey for either of us.

Empathic caring and strong desire to help remained with them throughout their journey, even at times of self-doubt. It was this desire to help that kept them within the nursing profession, this desire coming from within them and those around them who recognised when they were unsettled and needed assistance. It became apparent that the GRNMs valued the forthcoming help from their male faculty and also those RNs who had recently completed their own GRN year. Then when the tables turned and they became the ones who were helping others within the profession such as student nurses, new and agency nurses, they revealed that they felt they had arrived at being a fully functional and valued RN. I must confess I too wanted to provide professional advice and give guidance as I listened to their stories. However, this would have changed my role as the researcher within this study to one of a collegial professional helper. It was during this time reflexivity was important for me and journaling my thoughts was invaluable as I worked through this situation.

As the GRNMs progressed through their GRN year it became evident that they were compassionate and caring, although this took two face-to-face contacts for the majority of them to let their guard down for me to see that; hence the value of doing a longitudinal study. They all seemed to thrive once they reached their helping others stage where they found their own self-leadership styles and had mastered the art of helping. They had found confidence in their RN role and being comfortable in their professional practice environment. Although one of the GRNM, James struggled with the lack of comradeship, lack of collegial and organisational support

throughout his second half of his GRN program even when confident in his RN capabilities. This situation left him unsure of his career pathway at the end of his graduate year, although he stressed he was still interested in nursing, he just needed to find his niche. This became evident with his final member check feedback where he replied:

> Thanks for the email. It looks like a good summary in regards to my experiences in the grad program. I definitely had some experiences which changed my perception on how safe working conditions are and recognised a lack of fair support and protection (email communication, 11th October, 2017).

What I came to realise was how sensitive these GRNMs were to way they are portrayed and how the nursing profession and others including the patients and families they care for accepted them. Although men in general are seen as less nurturing and at times less caring, in contrast I found the GRNMs in this study to be sensitive to others needs and very compassionate. These current GRNMs are the type of nurses I would be privileged to have care for me in my hour of need.

Chapter 9.   Bringing It All Together

"It's the journey, not the destination, but that doesn't

make sense until you get there"

J.R. Rim

Chapter nine brought the major themes together from the three phases in this longitudinal study. Due to plentiful data supported by the abundance of quotes used for plausibility and transferability of this study, the discussion was kept to the key themes from the time GRNMs made the decision to enter nursing and then through their journey to the end of their RN transition year. However, to ensure sufficient dissemination of the GRNMs' lived experiences enabled their voice to be heard, and to maintain an idiographic focus through the inclusion of the particular, the individual GRNM's perceived experiential meaning, publications from this study have occurred prior to completion of this thesis.

Contrary to Kwan's (2013) Hong Kong study where novice researchers begrudged the time spent on publishing; although time consuming, it was time well spent for this project. The early publications enabled robustness in the research process and in-depth reflection on research authorship. Further, assisted with the communication and distribution of relevant findings pertinent to the specific periods in the GRNMs journey that had the potential to be overshadowed in the overall summation of this research project. Moreover, concurred with Wisker (2013) in that publishing ensured that "the knowledge we construct is articulated and communicated effectively to others" (p. 354). Hence, some of the viewpoints from this study's earlier publications were used in the discussion. These publications included:

- Juliff, D., Russell, K., & Bulsara, C. (2017). The essence of helping: Significant others and nurses in action draw men into nursing. *Contemporary Nurse,* 53(2): 156-66. (Appendix H)

- Juliff, D., Russell, K., & Bulsara, C. (2016). Male or nurse what comes first? Challenges men face on their journey to nurse registration. *Australian Journal of Advanced Nursing, 34(2):* 45-52. (Appendix I)
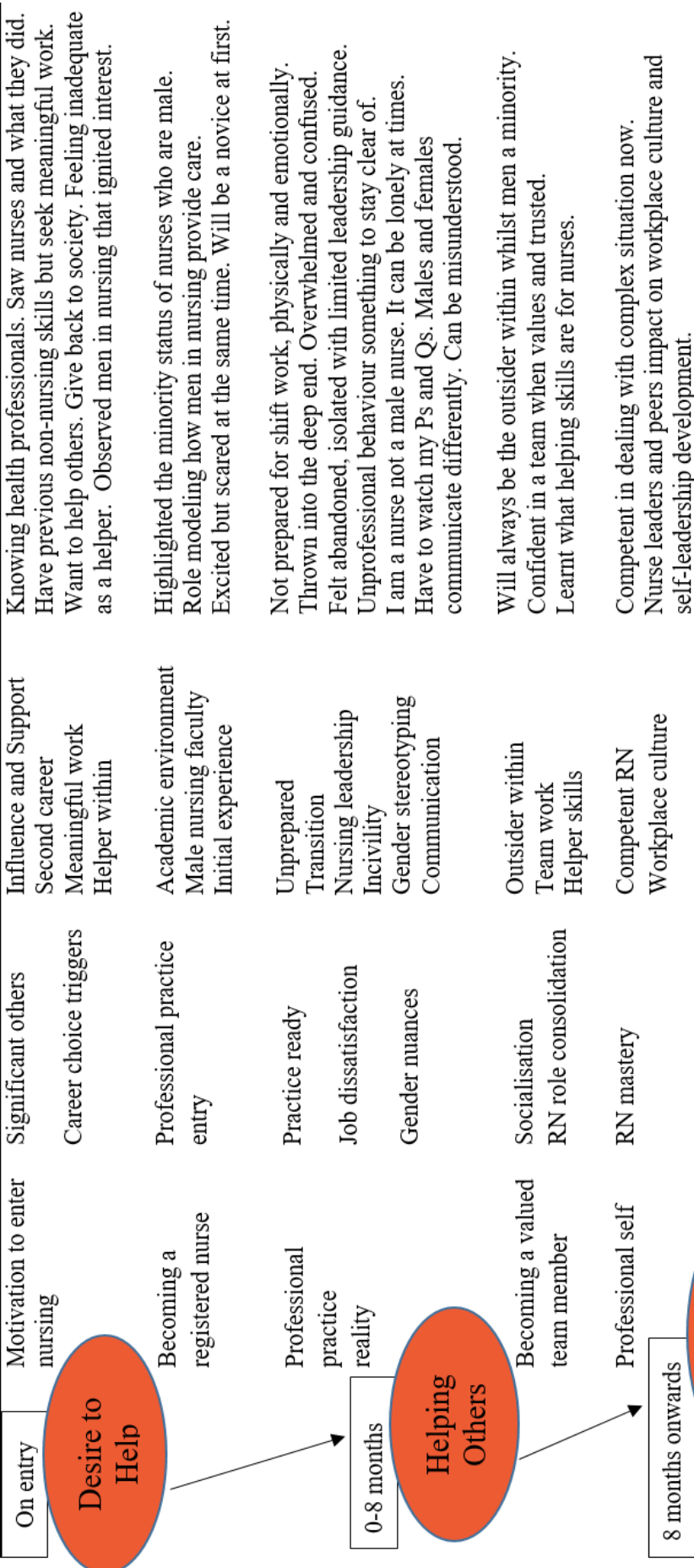
- Juliff, D., Russell, K., & Bulsara, C. (2015). The value of male faculty from the perspective of newly graduated male registered nurses. *Australian Nursing and Midwifery Journal, 23*(5): 25. (Appendix J)

- Graduate nurses face frustration in gaining registered nurse experience by Dianne Juliff in *News, Opinion, Top Stories, Workforce August 9*, 2017. (Appendix G)

- Nursing leadership influence on male graduate nurses retention experiences explored in the professional practice environment. (Appendix L)

Although IPA is not theoretically driven, this study had relevance to existing theories used as part of the study's conceptual framework. Therefore the discussion included reference to relevant literature and how the results expand on the conceptual framework in relation to the phenomena under investigation, the lived experience of the Western Australian GRNM. Much of the relevant literature has been previously revealed in Chapter two, though there was recent literature that surfaced when in-depth literature search occurred concurrently with the data analysis and the data collection as part of the research process.

The discussion that followed centred on my endeavour, as the researcher within this study, to elicit the meaning and the essence of the GRNMs' responses as they attempted to make sense of their own perceived experiences during their journey. With the focus on understanding the GRNMs' perceptions and viewpoints, the discussion was contained within the limited guiding research questions used in this study. These questions were:

- How do the GRNMs choose nursing as their career, in particular what motivated them to decide to enter the nursing profession?

- How do GRNMs perceive their professional practice experiences within their first twelve months employed as a GRN, and were their expectations met?

- At the end of their graduate year, how do the GRNMs place themselves in terms of a future career pathway?
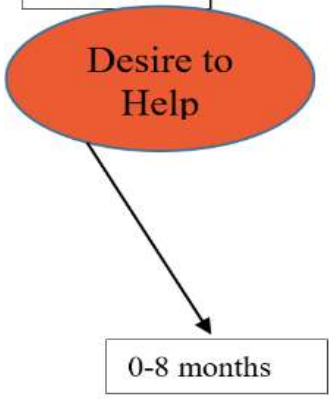
In consideration of the above study questions, the key themes (Table 6: Summary of key themes) aligned with the essence of helping overall meaning as it evolved over the GRNMs journey; thus formed the structure for the discussion.

Essence of Helping	Superordinate	Subordinate	Areas for discussion	Consensus exemplars
On entry / **Desire to Help**	Motivation to enter nursing	Significant others Career choice triggers	Influence and Support Second career Meaningful work Helper within	Knowing health professionals. Saw nurses and what they did. Have previous non-nursing skills but seek meaningful work. Want to help others. Give back to society. Feeling inadequate as a helper. Observed men in nursing that ignited interest.
	Becoming a registered nurse	Professional practice entry	Academic environment Male nursing faculty Initial experience	Highlighted the minority status of nurses who are male. Role modeling how men in nursing provide care. Excited but scared at the same time. Will be a novice at first.
0-8 months / **Helping Others**	Professional practice reality	Practice ready Job dissatisfaction Gender nuances	Unprepared Transition Nursing leadership Incivility Gender stereotyping Communication	Not prepared for shift work, physically and emotionally. Thrown into the deep end. Overwhelmed and confused. Felt abandoned, isolated with limited leadership guidance. Unprofessional behaviour something to stay clear of. I am a nurse not a male nurse. It can be lonely at times. Have to watch my Ps and Qs. Males and females communicate differently. Can be misunderstood.
	Becoming a valued team member	Socialisation RN role consolidation	Outsider within Team work Helper skills	Will always be the outsider within whilst men a minority. Confident in a team when values and trusted. Learnt what helping skills are for nurses.
8 months onwards / **Professional Helper**	Professional self	RN mastery	Competent RN Workplace culture	Competent in dealing with complex situation now. Nurse leaders and peers impact on workplace culture and self-leadership development.
		Better RN fit	Self-leadership Job satisfaction	Want to be allowed to do the best I can do so looking for a better fit where I can get job satisfaction through helping others.

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9.1 Desire to help

The question of how do the GRNMs choose nursing as their career, in particular what motivated them to decide to enter the nursing profession was investigated from the time the GRNMs made the decision to enter nursing up until they gained their RN registration. The overall finding was the essence of helping derived from external motivators and the GRNMs altruism, described as the helper within. This essence of helping, 'the desire to help', was the driver for the GRNMs continuation of their journey as they entered the professional practice development world as an undergraduate nurse and their experiences as a GRNM. This desire to help others has been reported in previous studies (Price, McGillis Hall, Angus, & Peter, 2013; Wu, Low, Tan, Lopez, & Liaw, 2015) as an intrinsic factor for the motivation to enter nursing. Table 7 was extracted from Table 6 to outline the key themes and areas for the desire to help discussion.

Table 7   Desire to help discussion

Essence of Helping	Superordinate	Subordinate	Areas for discussion
On entry	Motivation to enter nursing	Significant others	Influence and Support Second career
Desire to Help		Career choice triggers	Meaningful work Helper within
	Becoming a registered nurse	Professional practice entry	Academic environment Male nursing faculty Initial experience
	Professional practice reality	Practice ready	Unprepared Transition
0-8 months		Job dissatisfaction	Nursing leadership Incivility
		Gender nuances	Gender stereotyping Communication

9.1.1   Motivation to enter nursing

Motivation to enter nursing presented an insight from the GRNMs lived experiences and existent literature during their decision period before their entry into the nursing profession. The discussion centred on the identified motivators and included altruism from the helper within aspect and the GRNMs desire to help. Specifically, significant others influence and support as motivators, the second career men why they join nursing, and career choice triggers including seeking meaningful work, empathetic caring and the helper within.

9.1.1.1   Significant others influence and support

The current study GRNMs motivation to enter the nursing profession and commence their journey to RN registration was synonymous with copious literature where significant others, in particular close friends and family members in health related professions (Rajacich et al., 2013; Traynor & Buus, 2016) such as nurses (Harding, 2009) and academic parents (Hardie, 2015), provided positive influence on the GRNMs decision (Chou & Lee, 2007; McLaughlin et al., 2009). Furthermore, the majority of the GRNMs were in agreement that most encouragement and support came from the influential females from within their families and females in their close social circles (Stott, 2007).

The GRNMs primary response for this motivation, like others before them (Hodes, 2005; Ierardi et al., 2010; Jirwe & Rudman, 2012; Whittock & Leonard, 2003), was their wanting to help others; moreover, 'the desire to care' (Mooney, Glacken, & O'Brien, 2008). This wanting to help was further accentuated after being exposed to positive role models who help/care for others, whether this be a family member working in health or a health professional in action such as a nurse (Mooney et al., 2008). Although, in McLaughlin's (2009) study that drew on Holland's (1958) model of vocational choice, 68 undergraduate Northern Ireland nursing students participants who were mainly females, revealed in their essays the perceptions from their families for "suitability and value of nursing as a career were mixed" (p. 406). This was not the case for the current GRNMs where they reported positive support and encouragement from all family members and close friends.

The majority of the nine GRNMs, like some of the 19 male RN New Jersey participants in Snyder's (2011) study, voiced that caring had a broader emphasis for them; it was not just about nurturing and bedside caring, the GRNMs felt caring was more about 'helping as a whole', 'to give back to society' and 'being able to help people'. They further concurred with the belief that "although male and female nurses perform clinical tasks in the same manner, men do bring special skills to the job" (p32). For example, these skills include being less emotional in crisis situations such as trauma. In contrast to Snyder's male participants who focused on physical strength, camaraderie and unionist interests, the current GRNMs voiced technical

attributes such computer applications, administration and project management, and critical intelligence in complex situations as the skills they bring to nursing.

9.1.1.1.1 Second career

This element of bringing other skills into nursing was due to the fact that most of the current GRNMs had undertaken nursing as a second career and brought with them life and work-related skills . This being not uncommon as recent studies (Moore & Dienemann, 2014; Rajacich et al., 2013) have reported that men were more likely to enter nursing as a second career. Moreover, the second career GRNMs aligned with previous studies where they voiced that their previous non-nursing experience would be advantageous to their nursing careers (Raines, 2010). Further, being older was beneficial due to the acquired life skills that equipped them for their complex roles as nurses (McLaughlin et al., 2009). The second career GRNMs, included two of the three GRNMs from entry level health-related work, also concurred with the aforementioned studies that nursing was not a career that they had entertained as they commenced their early working life. In addition, the GRNMs purported that being a gender minority in this female dominant nursing profession at an earlier age would be too challenging for those males without life skills.

Furthermore, the GRNMs reported not being fulfilled in their previous occupations, thus in seeking satisfying work turned their attention to nursing. This was not dissimilar to Raines (2010) findings where 66 stories from second career participants revealed 'seeking satisfying work' as a major theme, which on observing nurses in action providing care demonstrated the satisfaction they were seeking. This seeking satisfying work was also evident in the GRNMs who had come from entry level health-related work with the added reveal, similar again to Raines participants, where nursing provided them the opportunity to develop nursing skills and technical skills and use critical thinking. Although, contrary to Raines study where participants made no mention of self or family hospitalisation as influencing factors in their career decision, the current GRNMs revealed that these factors had indeed ignited their interest in nursing and for some was the trigger for their decision to enter nursing.

9.1.1.2 Career choice triggers

As reported in an earlier publication of this study (Appendix H), for the majority of the GRNMs what specifically enhanced their interest in a career in nursing, comparable to existent literature, was encounters with RNs (McLaughlin et al., 2009; O'Lynn & Tranbarger, 2007; Wilson, 2005), in particular those RNMs (Christensen & Knight, 2014; McLaughlin et al., 2009; Rajacich et al., 2013). As with two male participants in Rajacich and colleagues (2013) Canadian qualitative study of 16 men on how they entered nursing, the current GRNMs had specific encounters with RNMs in action that ignited their interest in a nursing career. These encounters included being patients themselves or having relatives being cared for by RNMs, and witnessing first-hand these RNMs helping behaviours. Although, for one GRNM it was an impressible event where the feeling of inadequacy as a helper at a motor vehicle accident that instigated his desire to do nursing. For the two eldest GRNMs (aged 28 years & 32 years on entry to nursing) the intrinsic factor was their desire to give back to society; this was consistent with Raines (2010) study where this desire to give back was strongest in the older person entering nursing.

Additional augmentation of the GRNMs motivations to undertake nursing varied. Some GRNMs voiced that nursing provided more career opportunities in the same way as Traynor and Buus (2016) study of 49 United Kingdom nursing students where some of them saw a nursing career as "more advantageous compared to other career opportunities" (p. 189). More explicitly, nursing was seen as a career that provided job security (LaRocco, 2007; Rambur et al., 2011), career advancement (Ierardi et al., 2010; MacWilliams et al., 2013), and career diversity (Jirwe & Rudman, 2012). The opportunity to travel (McLaughlin et al., 2009; Mooney et al., 2008) and be a team member (McLaughlin et al., 2010) revealed by the two younger GRNMs as additional factors that enticed them into nursing. For the GRNMs with previous entry level health-related backgrounds it was their desire for career advancement and technical nursing skills attainment that saw them enter nursing as a career (Ierardi et al., 2010; Snyder, 2011).

9.1.1.2.1 Meaningful work

With the second career GRNMs being in the majority in this study's cohort, seeking meaningful work was further explored as it became a recurring theme throughout

their interviews. As with the many respondents in Malloy et al. (2015) study, the current GRNMs viewed nursing as a commitment to compassionate caring 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. Further, alike with Malloy et al. respondents, the GRNMs found that the core to meaningful work was relationship development such as others within the workplace or patient connectedness, both of which the current GRNMs were seeking.

Although the current GRNMs were not forthcoming in using the word caring, they tended to use the word helping in its place. This gave credence to recent studies where it has been supposed that gender norms may inhibit caring expression in NMs (MacWilliams et al., 2013); where males view the provision of care as part of nursing so will promote practical reasons for their decision to enter nursing (Kluczyńska, 2017); or play down the emergent motivation of caring and nurturing using other factors instead (O'Connor, 2015). Thus, may have assisted them in handling their fears in choosing a feminized profession (Kluczyńska, 2017).

9.1.1.2.1.1 *Empathic caring*

The current GRNMs voiced the 'desire to help' with multiple other reasons as to why they chose nursing and in doing so may have hoped to lessen the focus on empathetic caring. Although, empathy has been described "as a predominantly cognitive attribute that involves an understanding of patients' experiences combined with a capacity to communicate this understanding and an intention to provide help to the patient" (Fields et al., 2011, p287-8).

Contrary to the opinions that NMs were not empathetic (Grady, Stewardson, & Hall, 2008) and lacked the ability to provide caring as well as females (Cudé & Winfrey, 2007), Penprase and colleagues (2015) study revealed when comparing a large sample of nursing (390, 54 being male) to non-nursing (1,482) students, "that men who are attracted to nursing do so because of their high empathizing traits" (p. 6). Further commented that "men can bring strong empathetic traits of compassion and caring attitudes to the nursing field" (p. 7). Thus added weight that nurses who are men themselves believed whilst keeping their male dominant characteristics they had empathic caring traits of a nurse (Loughrey, 2008), that were linked to their

particular biography and personality (Traynor & Buus, 2016). Derntl and colleagues (2010) from functional MRI studies found gender differences within the components of empathy. Further noted that females tend to use more emotion-related regions of the brain and males utilise more cognitive-related regions, even though both females and males rely on divergent processing strategies when solving emotional tasks. Thus underpinned the belief that the current GRNMs motivation for entering nursing was their personality traits within; moreover, their altruism expressed as the helper within.

9.1.1.2.2   Helper within

The GRNMs' helper within traits aligned with Holland's (1997) typology of personality theory. As mentioned in Chapter two, nurses revealed strong traits in **S**ocial followed by **A**rtistic and **I**nvestigative types respectively. Figure 17 modified Holland's Typology of Personality Theory diagram by the use of words in red to indicate the SAI traits the GRNMs portrayed.
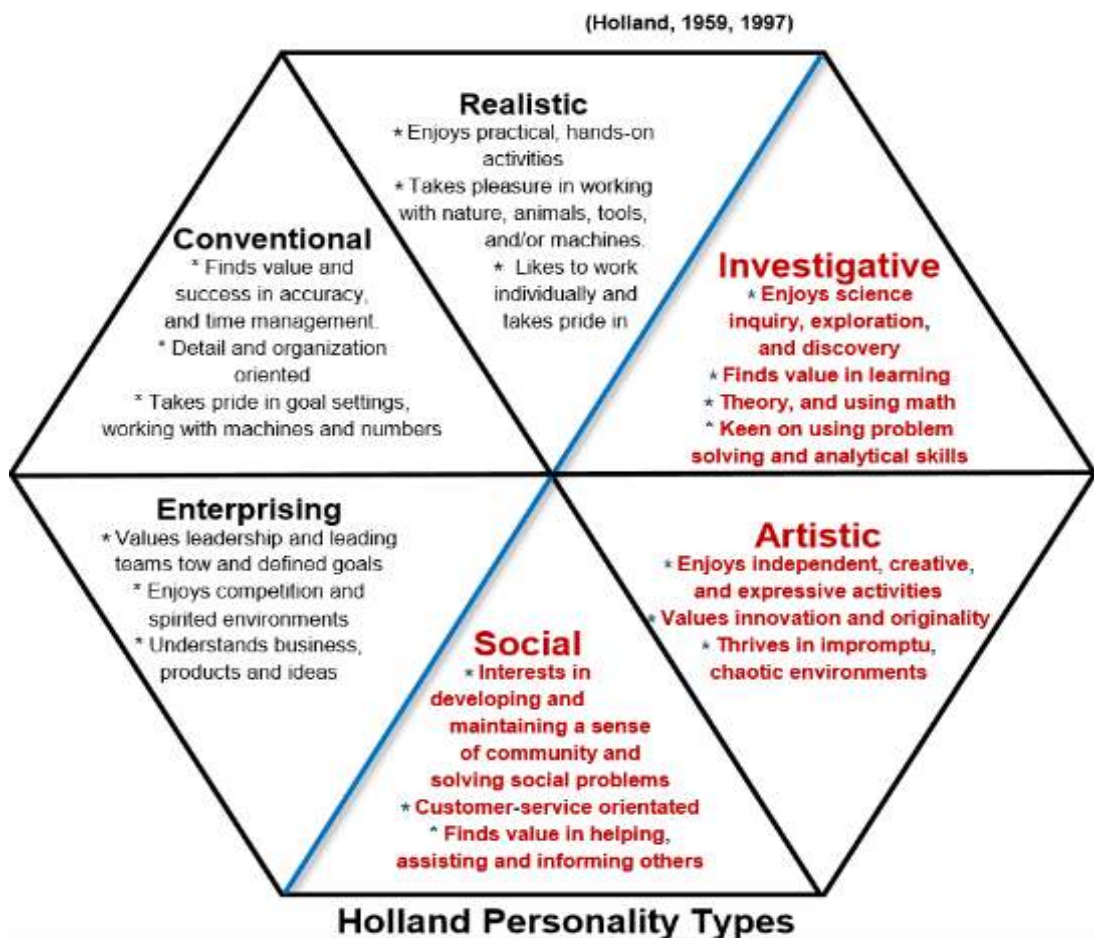
Figure 17   GRNMs alignment with Holland's Personality Types

In the narratives of all the GRNMs they professed a strong urge to help others that highlighted the meaning behind their desire to enter nursing as a career focused on the essence of helping. They also alluded to being caring, patient-centred, responsible and friendly through their narratives, all of which according to Holland (1997), places their major personality type, in relation to occupation interests, in the social field of his typology of personality theory. Artistic type came through with the GRNMs being emotional and expressive, and sensitive and supportive of equality for all. From the investigative type there was evidence of the GRNMs desire to learn and value learning, having inquiring minds, being analytical and curious, wanting to use critical thinking in their nursing practice and being intellectual. Overall, these findings indicated that the current GRNMs have the SAI personality traits. The ability to help community, noted in both Wilkes et al. (2015) and Eley, Eley and Rogers-Clark (2010) studies, also featured in the narratives of the current GRNMs where they voiced wanting to have the opportunity to help for others.

The current GRNMs desire to help was reflected in what they perceived as their preferred nursing specialties that often aligned with the skills and knowledge they brought with them into nursing. Following RN graduation, as reported in an earlier publication of the Phase two findings of this study (Appendix H) and in concurrence with existent literature (Penprase et al., 2015; Rambur et al., 2011; Stott, 2007), the majority of the GRNMs revealed that they were empathic in nature. Further with their preferences toward the technical specialties areas was in their belief that areas such as critical care, operating theatres and emergency departments suited them the most. The GRNMs, similar to Penprase et al. (2015) participants, revealed the need for exposure to complex areas such as emergency and critical care, to enhance their professional practice satisfaction. Only one GRNM had specifically voiced his interest in mental health nursing initially; however as the GRNMs neared the completion of their graduate year more GRNMs had become interested in mental health as a nursing career option.

This study's findings contributed to the long held impression that males are attracted to nursing for the same reason females are, the desire to help others. What this study brought to existent literature was that promoting nursing as a caring profession did not ignite their interest for the majority of them as caring can be seen as effeminate and as such the GRNMs explicitly focused more on the helping aspect of nursing

instead. These GRNMs believed that the desire to help is fundamental in nursing and in becoming a RN.

9.1.2   Becoming a registered nurse

Becoming a RNM for the GRNMs was contentious with specific issues that they needed to digest as they journeyed along their career path. This path began with their professional practice entry within the academic environment that gave credence to the importance of male faculty, and highlighted their initial experiences in relation to their anticipatory socialisation versus their actual socialisation. Furthermore, gave an insight into gender nuances that the GRNMs encountered on their professional practice entry.

9.1.2.1   Professional practice entry

The current GRNMs, as with existent literature (McKinlay et al., 2010; Simpson, 2011), had thought hard and long before they commenced their nursing degree knowing that the stereotypical nurse is viewed as a female. Regardless of whether the GRNMs were straight from school or from health-related work or second career men, they all had ponded extensively about nursing as a career due to their awareness of the implications in entering this female-dominant profession and the ramifications this might bring into the academic setting. Further, consistent with literature, the majority of the GRNMs were concerned initially with the media portrayal and public perception stereotyping men who are nurses as effeminate (McKinlay et al., 2010). However, they overcame these concerns with encouragement from their families, close friends or NMs they knew (Mooney et al., 2008) to continue with their journey into the nursing academic environment.

Contrary to studies that suggest targeting high school males for entry into nursing (LaRocco, 2007; Rajacich et al., 2013), the majority of the GRNMs concurred with McLaughlin and colleagues (2009) that timing of entry to nursing is crucial. Further, until nursing becomes more gender balanced these GRNMs believe that being older and having acquired life skills equipped them for nursing. Although, most of the GRNMs had come from other employment, they all had the initial overwhelmed feeling with episodes of vulnerability and marginalisation, similar to that of being the outsider within the female-dominant profession reported by other men as they

entered nursing (Christensen & Knight, 2014). For some men this outsider within is the driver for their gravitation towards male collegial groups (Christensen & Knight, 2014; Stott, 2007), as was the case for the majority of the current GRNMs in this study. Further, the current GRNMs support the suggestions that have been purported on the need to promote male networks in nursing (Moore & Dienemann, 2014), and they stressed that both formal and informal networks are warranted especially in their undergraduate years as they grapple with their minority status.

9.1.2.1.1 Academic environment

Some of the GRNM participants felt that text book references to nurses highlighted their minority status by using 'she/her' and images of nurses being female (Bell-Scriber, 2008; Sherrod, Rasch, & Brad, 2005). Further to this, the reality of being outnumbered by females came for one GRNM on his first day walking into the lecture room of over 100 nursing students. He was overwhelmed with the lack of men present. The other GRNMs likewise admitted being overawed by the sheer numbers of females, with the majority of them seeking out other males present.

The current GRNMs at times perceived they were treated differently than the female students by the nursing faculty. Nevertheless, unlike previous studies that reported the lack of support and negativity received from the faculty staff (Keogh & O'Lynn, 2007; Stott, 2007), the GRNMs empathised that for them this was more about the female faculty being excessively supportive and all inclusive. These female faculty unintentionally were at times 'over the top' with their enthusiasm that they perceived drew too much attention to the GRNMs gender difference. The exclusion from the clinical setting previously reported (Christensen & Knight, 2014; Inoue et al., 2006; Kouta & Kaite, 2011) was not verbalised by the current GRNMs either. Moreover, the GRNMs commented that overall they had positive experiences in the clinical setting and enjoyed their time in the academic environment; thus supported similar findings with the students in Ierardi et al. (2010) study regarding their educational experiences. Ierardi and colleagues qualitative American study of seven male students in nursing that explored their educational experiences, like the majority of the current GRNMs, revealed that they were caring individuals who were committed to nursing having left previous careers with a desire to help for others; and they were both complimentary and positive about their nursing education. The GRNMs further

conceded that they had learnt a lot from the presence of male role models in nursing (Stott, 2007), especially the male faculty within nursing academia.

9.1.2.1.2   Male nursing faculty

The current GRNMs due to frequent contact with male faculty in their undergraduate nursing years reiterated that the feeling of uncertainty and a sense of isolation as reported by men in nursing schools (Cudé & Winfrey, 2007) when there were a lack of role models (O'Lynn, 2004) was not an issue for them. In contrast, the GRNMs revealed that they experienced a sense of belonging; moreover supported the inference that this belonging enhanced their learning both in clinical practice (Levett-Jones & Lathlean, 2008) and in the academic setting from the male faculty role modelling how men in nursing deliver nursing care. Although as expected, and consistent with literature, the GRNMs viewed that too few male role models in nursing as problematic (Stanley, 2012) as they conceded that NMs and NFs care differently (Evans, 2002; Fisher, 2009). An Australian study (Fisher, 2009) examined 21 RNMs life stories in relation to the labour processes of NMs performing bodywork with bodywork defined as "the direct work on others' bodies, and involves interactions of bodies and the control of emotions" (p. 2338). The narratives provided by the current GRNMs mirrored those in Fisher's (2009) study and were synonymous with the following (pp. 2675-2676) :

> The conflict for study participants between being a male and having a masculine identity and the culturally constructed nurse as feminine creates a state of confusion in their identity. The need for these men to take precautions and perform (masculinity and nursing practice) in various safe ways to avoid being labelled a deviant.

The performing in a masculine way during the nursing practice, likewise, the delivery of nursing care was highlighted in the value of male faculty reported in an earlier publication of the Phase one findings of this study (refer to Appendix J). Congruent with literature (Etheridge, 2007), the GRNMs saw the male faculty as role models. It was the positive attitudes and professional behaviour of the male faculty (Baldwin, Mills, Birks, & Budden, 2014), and their role modelling how NMs deliver nursing care (Grady et al., 2008), that negated a lot of the confusion and concerns that the GRNMs had about their nursing care delivery. In particular, the concern that most of the GRNMs focused on was whether nursing was for them that intermittently

surfaced at stressful times as they journeyed to RN registration. Further, this role modelling by the male faculty, as reported elsewhere (Morrissette & Doty-Sweetnam, 2010), was undertaken in a safe environment devoid of embarrassment that augmented the GRNMs learning in nursing care delivery; and established the attitudes and behaviours that the GRNMs voiced they would carry forward into in the clinical setting (Horsfall, Cleary, & Hunt, 2012; Sparacino, 2016). Moreover, the GRNMs reinforced Watson's (1996) theory of transpersonal caring, in particular between the faculty and students (Bevis & Watson, 1989) that mimicked the professional-client relationship (Watson, 1988). For these GRNMs the professional values they were taking into the professional practice environment were those of being person-centred, kind and caring, and a commitment to learning, all of which gained from the exposure to male faculty and inspiring clinical nurse role models, both male and female, whom they came into contact with. These same values of person-centred, kindness and caring, and commitment to learning were reported recently by Lyneham and Levett-Jones (2016) as the professional values expressed by 14 Australian graduating nursing students. Further, both Lyneham and Levett-Jones' participants and the current GRNMs, revealed these aforementioned values gained from the clinical behaviours of the RNs they worked with were the ones that they wanted to emulate as they become RNs.

9.1.2.1.3 Initial experience

On their entry to professional practice as a RN, all except for one of the GRNMs had been successful in obtaining GRN programs that necessitated them working in general surgical and medical wards as part of the program rotations before they could pursue their preferred nursing areas. The majority of the GRNMs, especially the older second career participants, agreed that their anticipatory socialisation did not match their actual socialisation, however they were not deterred by this. Although they all admitted to mixed emotions from being excited and scared at the same time on their initial entry into their new RN career. This initial entry point has been acknowledged where graduates will have their anticipatory socialisation challenged as they confront the realities of their workplace (Cowin & Johnson, 2015), which was certainly the case for the GRNMs in this study.

The current GRNMs had expected acceptance of their novice status with adjusted workloads in accordance with their limited skills and minimal RN experience, but still thought they would have a say in decision-making as a qualified RN, and thus be eased into their professional RN role. This was not so for the current GRNMs, and as evident in existent literature, they voiced concerns with their actual induction being ad hoc and experiencing inadequate orientations to the professional practice environment (Parker et al., 2014); where they had limited collegial support and unrealistic patient allocations (Johnstone et al., 2008; Phillips et al., 2014); all added to their emotions of despair, being overwhelmed and self-doubt (Duchscher, 2009). Further, the GRNMs concurred with the UK National Health Service inquiry submitted by Robert Francis QC (2013), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry,* where it was reported (Section 23.48, p. 1513):

> Most of those entering the nursing profession do so because of a wish to undertake work helping and caring for others . . . the stark differences between nursing as they imagined it to be and the reality will challenge their ability to maintain their motivation.

The GRNMs agreed with existent literature that as student nurses they had been sheltered from the full extent of the RN role, and thus were not fully prepared for this new role (Jewell, 2013; Kelly & Ahern, 2009). However, the GRNMs thought this was the natural process, and again muted their belief that this situation would be accommodated by the health services they were entering which was not the actual reality.

9.1.2.2   Professional practice reality

The guiding question for the Phase two interviews focused on how do GRNMs perceive their professional practice experiences within their first twelve months employed as a GRN and were their expectations met? In the early stage at the commencement of their RN journey the GRNMs displayed what Kramer (1974) called the honeymoon phase with their excitement and idealistic views of their new role, even those GRNMs with previous health-related experience, before they were confronted with the actual professional practice reality. The GRNMs sought both individual support and a supportive professional practice environment as they believed this was critical for them to function safely in their new GRN role but found this was not forth coming. They purported this was needed at least for the first few

months, just to have someone there to ask questions, provide guidance and to bounce things off to enhance practice readiness for them.

9.1.2.3 **Practice ready**

Practice ready for the current GRNMs was the acknowledgement of their novice status with their knowledge obtained from nursing theory and skills gained in their clinical practicums needing to be transferred to their RN professional practice. Further, they recognised the steep learning curve they were embarking on, although nervous at the same time they were enthusiastic to get on with putting theory into practice. As reality hit this practice readiness became contentious with the GRNMs reveals being in agreement with Johnstone and colleagues (2008) Australian study findings. These findings revealed that the lack of support perceived to be due to staff shortages and a large number of part-time staff impacting on the consistency of preceptors, workload issues and poor staff mix impeding on the level of support they sought. Further Johnstone et al. (2008) suggested that

> Support is critical to the process of graduate nurse transition, and that integration into "the system" is best provided during the first 4 weeks of a graduate nurse transition program . . . that "informal teachers" and the graduate nurses themselves are often the best sources of support (p. 46).

The current GRNMs revealed, similar to existent literature (Johnstone et al., 2008), that they valued the support provided by the nursing staff who had recently finished their own RN graduate year. There was a sense that these staff could relate to the feelings and challenges that the current GRNMs were experiencing. Further, they gave the GRNMs encouragement that it would get better as the year goes on and assisted the GRNMs in their socialisation. Although this support was limited at times due to increased workloads and complex patient care demands. Even so, the GRNMs still felt unprepared within those first few weeks as a GRN.

9.1.2.3.1 Unprepared

The GRNMs admitted that in the first few weeks after their initial induction into the professional practice environment they felt stressed, anxious and often confused; thus moving into Kramer's (1974) second phase of reality shock from the honeymoon first phase. Consistent with previous studies, they voiced being daunted from not

having the safety net of a protected university environment and being supernumerary in clinical practice to the responsibilities of their unfamiliar RN role (Cowin & Johnson, 2015; Duchscher, 2009); whilst the health care providers expect graduates to be practice ready (El Haddad, Moxham, & Broadbent, 2016) to "hit the ground running" (Phillips et al., 2014, p. 106). The majority of the GRNMs perceived, similar to existent literature, that it was expected of them to be able to perform as a fully functioning RN from the beginning, and when this did not happen, a sense of guilt prevailed (Etheridge, 2007; Newton & McKenna, 2007). As a consequence, the GRNMs revealed, like others before them, of feeling responsible but inadequate 'like a fish out of water' and 'been thrown into the deep end', being in a 'sink or swim' environment adding to their self-doubts in their ability to provide safe patient care (Duchscher, 2009; Kelly & McAllister, 2013; Odland et al., 2014). Similarly, Kelly and Ahern (2009) revealed half of the 13 GRNs in their Australian phenomenological study as being unprepared for the accountability and responsibility they were taking on and feeling unsupported in their early stage of transition.

9.1.2.3.2 Transition

Ultimately, the GRNMs felt overwhelmed with the allocated workload and what was expected of them in this early stage of their GRN journey. Further, the GRNMs themselves conceded this was a reality shock for them, all of which aligned with the ten years plus of seminal research by Duchscher around the transition experience of newly graduate nurses that lead to her internationally acknowledged work on role transition and role shock (Duchscher, 2008). The experiences the GRNMs had in their initial first few months, even the GRNMs with previous health-related experience was mirrored in the Transition Concept Model (Boychuk Duchscher 2007) depicted by Figure 18.

RELATIONSHIPS

Physical
- Relentless and terminal physical, emotional, intellectual exhaustion
- Energy consumed to conceal feelings and transition responses
- Physical demands of acute-care
- Unaccustomed to full shift presence (12 hours with minimal time off unit) or FT shift rotation (36-48 hour work week)
- Emotional extremes
- Maladjustments to shift-work
- Sleeplessness – active dreaming
- Poor nutrition and lack of exercise
- Change in social habits and routines

Emotional
- Labile nature of emotions
- Emotions variable in origin
- Intense and overwhelming period
- Extreme sensitivities
- Seeking validation and reassurance
- Look for familiar protective nurturing
- Require positive reinforcement
- Fears of failure or incompetence
- Fears of disappointing family, friends, and colleagues
- Loss of control
- Lack of support

LOSS

DISORIENTATION → **TRANSITION SHOCK** ← CONFUSION

Intellectual
- Reality shock – theory/practice incongruencies and practice improprieties
- Lack of knowledge on transition
- Lack of awareness regarding graduate roles and responsibilities
- Limited practice aspect/pattern recognition
- Limited tacit/practical knowledge
- Practice inconsistency/unpredictability
- Limited DM and CJ capacity
- Organizational naiveté
- Professional role-relations immaturity
- Limited performance feedback

Socio-Developmental
- Changing social structures
- Role uncertainty & unfamiliarity
- Inadequate & insufficient guidance/assistance
- Professional culture naiveté
- Intra-interdisciplinary relations
- Intergenerational dynamics
- Leadership & delegation skills lacking
- Oppressively hierarchical work structure
- Evolving self - separation from dependent role
- Loss of known supports
- Insufficient exposure to role models

DOUBT

ROLES

RESPONSIBILITIES

KNOWLEDGE

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Figure 18   Transition Concept Model
Source: Duchscher (2009, p. 1107)

The current GRNMs recalled the impact of shift work, especially the late to early shift combinations, as physically draining with periods of extreme intellectual exhaustion often impairing their psychological health with sleeping problems, inadequate eating and ad hoc daily routines featuring during this time. Poor sleep quality, reduced sleep efficiency and daily dysfunction associated with shift-work nurses has been acknowledged (Zhang, Sun, Li, & Tao, 2016). The poor sleep quality reported by the majority of the GRNMs they believed contributed to their lack of control emotionally, when normally they perceived themselves as level headed and positive. Further, they became fearful of not succeeding in the role they had trained for and appearing incompetent in front of other nurses. Whilst the other GRNMs played down their emotional stance and were matter of fact that all this upheaval in their professional lives they were experiencing would pass as they transitioned through their GRN year. Although these GRNMs did admit to seeking

validation on their performances during this time and needing reassurance that they were on the right track, especially in the areas of time management and nursing priorities. All of which has been reported in existent literature as revealed in Arrowsmith and colleagues (2016) mixed methods systematic of peer reviewed primary empirical research between 1990 to the end of 2014 that included Duchscher's studies (2001, 2008, 2009). The conclusion in Duchscher's (2009, p. 1111) study provided a summation that mirrored the initial stages of the current GRNMs graduate journey, the passage of note being:

> The initial 3–4 months of professional role transition for the newly graduated nurse as a process of adjustment that is developmental, intellectual, sociocultural and physical and which is both motivated and mediated by changing roles, responsibilities, relationships and levels of knowledge in the personal and professional lives of the new professionals.

As a conceptual framework used in this study, the Transition Stages Model (Boychuk Duchscher, 2007) proved to be an accurate reflection on the transition pathway of doing, being, and knowing for all of the GRNMs. The stages of 'doing', 'being', and 'knowing' are visually represented in Figure 3 and were previously outlined in Chapter two of this thesis:

Figure 3: Transition Stages Model
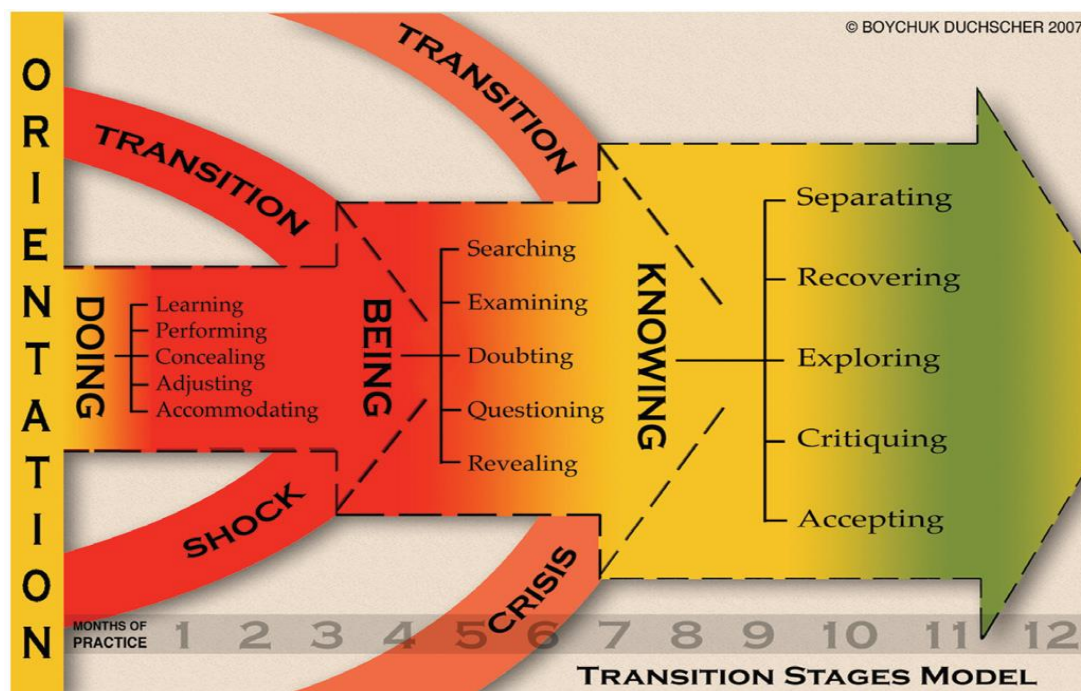Source: Duchscher (2008, p. 443). Duplicated from Chapter two.

There was a noticeable shift from the 'doing' stage to the 'being' stage as the GRNMs practice adjustment occurred. Of note was their mastering time management and nursing priorities. The timing of this adjustment was not finite, however for the majority of the GRNMs it occurred around the four month mark that aligned with Duchscher's transition timeline in her 2007 transition stages model. Although two GRNMs reported for them the timing was more towards the seventh month mark. Furthermore, the GRNMs indicated they had undertaken the elements of learning, performing, concealing, adjusting and accommodation to varying degrees during this stage; which accounted for their reveals of feeling overwhelmed, fearful, insecure, and lacking confidence in their skill levels and their ability to perform, as previously reported in Duchscher's (2008) study.

Past this four month mark, the GRNMs moved from their reactive practice behaviour and individual thoughts of needing to accomplish skills and tasks to help their allocated patients to more of a proactive team focus where they were searching and examining how they fit in to this profession as they headed into the 'being stage'. The end of this stage found to be the most challenging for the GRNMs. For some they were left doubting as to whether this was the right job for them, feeling emotionally and physically exhausted and experiencing disillusionment with their situation. Although most became at ease with their RN roles before commencing their second rotation of the GRN program around the end of the sixth month. Similar to existent literature, for the GRNMs in GRN programs, the majority felt confident towards the end of their first ward rotations (Johnstone et al., 2008). However, as the GRNMs commenced their second rotations they experienced a regression noted by their common retorts, 'seemed to be back at square one', though this was short lived. This regression has been reported previously by Johnstone and colleagues in data from a yearlong Australian study (2008) of 11 newly graduated nurses and in Duchscher's seminal work with Canadian nurse graduates. This was around the same time that the majority of the GRNMs experienced what Boychuk Duchscher (2007) Transition Stages Model highlighted as the transition crisis (Duchscher, 2008). This regression added to what the majority of the GRNMs divulged, similar to Missen, McKenna and Beauchamp's (2014) systematic review on the satisfaction of newly graduated nurses in transition-to-practice programmes, where their satisfaction waned. Missen and colleagues noted this as heightened 'reality shock'.

However, the current GRNMs revealed this was more of a transition crisis as they had experienced reality shock right from the onset of their GRN journey, all of which came to a head around the five to six months mark, thus liking this more to a crisis. This crisis grew out of uncertainty, now being in their second rotation, where they are expected to take on more responsibility that heightened their fears of making mistakes in their decision making and feeling out of their depth, which impacted on their confidence and self-image, and where job dissatisfaction crept in.

9.1.2.4 Job dissatisfaction

The GRNMs verbalised this job dissatisfaction whilst reflecting back over their initial few months into their new RN role. They concurred with existent literature where they were expected to take on RN roles and responsibilities in complex situations when they were not practice ready (Duchscher, 2009; Dyess & Sherman, 2009; Dyess & Sherman, 2010); during a period where they were developing RN skills (El Haddada, Moxham, & Broadbent, 2013); facing managerial challenges in prioritising and coordinating care (Hezaveh, Rafii, & Seyedfatemi, 2014); having adjustment difficulties (Phillips et al., 2014); and attempting to fit into the professional practice environment based on teamwork (Phillips, Esterman, & Kenny, 2015); with limited support leaving them feeling physically and mentally exhausted (Johnstone et al., 2008); and often disillusioned with their professional role transition (Duchscher & Myrick, 2008) due to the loss in their preconceived ideal of the RN role (Mooney, 2007) and the management support where they worked *(*Rajacich et al., 2013). In contrast, two of GRNMs seemed to take their job dissatisfaction in their stride and accepted it as part of the course in their transition. However, all the GRNMs did concede that their dissatisfaction and disillusionment was accentuated by the visible lack of nursing leadership.

9.1.2.4.1 Nursing leadership

Without nurse leaders support, although ad hoc at times, from experienced RNs and nurse managers providing collegial guidance within their professional practice environment, half of the GRNMs revealed that they would have left nursing. These GRNMs expressed a sense of isolation, congruent with literature (Dyess & Sherman, 2009; Hezaveh et al., 2014), that added to their frustration and their physical and

mental fatigue levels where they sought advice and debriefing to work through the issues they faced. Further, being consistent with Duchscher's (2008) findings, the GRNMs feelings of abandonment occurred "when left without experienced nurses to reach out to in unfamiliar, unexpected, or unstable situations" (p. 446). As revealed in Appendix L, it was during this crisis stage the GRNMs felt that nurse leadership support was paramount.

Collegial guidance and debriefing support GRNM found more readily in those nurses whom had recently completed their own graduate year, who on numerous occasions functioned, reported elsewhere, as "informal clinical teachers" (Johnstone et al., 2008, p. 50) The current GRNMs acknowledged that these 'informal teachers', even more so if they were male, were pivotal in assisting the GRNMs to move from the needing help from others to helping others themselves. The role model of helping, both as a professional RN and as a RNM in the delivery of nursing care proved valuable to the GRNMs as they became comfortable in their RN roles and associated responsibilities, 'the knowing stage', that occurred around the seven to eight month of their GRN journey. These experiences also aligned with Duchscher's (2012) process of 'surviving to thriving', where the GRNMs were moving towards the thriving aspect although they admitted to still being moderately stressed even with their increased RN knowledge and self-confidence, and being more able to deal with incivility and gender nuances.

9.1.2.4.2 Incivility

Caring and compassion toward patients acknowledged as the core of the nursing professional's personal satisfaction (Traynor & Buus, 2016). Although according to the current GRNMs a lot of the time this is not extended to others such as younger nurses from older nurses and between nursing peers. As with previous research (Anderson & Morgan, 2017; Boychuk Duchscher & Cowin, 2004; Johnstone et al., 2008), the GRNMs found there was also marginalisation and less than helpful attitudes from the hospital based older nurses towards GRNs both male and female. However, the current GRNMs took this in their stride as they perceived this was something that happens to new nurses although the majority of them thought this behaviour was unprofessional. Similar to previous research, the GRNMs were bewildered by the hostile treatment between females (Hodes, 2005); and further concurred with Kelly

and Ahern's (2009, p. 916) study where the graduate participants "were over-whelmed by the way some nurses spoke to each other and the overt display of a lack of unity within the profession". Further, this lack of unity within the profession and the unprofessional covert behaviour witnessed by the GRNMs included nurses berating other nurses behind their backs, back stabbing, gossiping, ignoring and refusing to helping out of favour peers and unjust workload allocations; and at other times actual 'bitchiness' with sarcasm and verbal hostility that lingered, commonly referred to as horizontal violence. These witnessed accounts shared commonality with existent literature on horizontal violence (Myers et al., 2016) and supported the long-time notion that 'nurses eat their young' (Anderson & Morgan, 2017; Kelly & Ahern, 2009; Sauer, 2012). The GRNMs clarified that 'young' in their case was referring to being new in the profession not one's age and therefore this eating their young was intergenerational (Anderson & Morgan, 2017). While the GRNMs were new to the profession, this eating their young they perceived was not targeted at them because of their gender, an element that was not found in existent literature of note. The GRNMs voiced that they tended to stay out of the firing line during incivility episodes, putting this down to the females knowing that males generally would not tolerate this type of behaviour and males being more upfront when displeased with each other. Further, they thought that the open hostility was reduced when they were present as they did not readily engage in such behaviour. This finding supported Kelly and Ahern's (2009) Australian research where their participants thought the horizontal violence tended to reduce in the presence of males. Though, perceived not to be directly implicated in this incivility, the GRNMs still found it unpleasant and believed the culture of incivility ultimately affected nursing care and patient safety, thus had them rethinking their own career pathways.

An issue that was raised by one of the GRNMs and witnessed by the majority of the GRNMs was upward incivility of disrespectful and challenging misbehaviours such as eye rolling and side glancing between some of the unregulated and lower level care workers, usually females, towards GRNs. This misbehaviour more prominent when the GRNs were delegating tasks to these workers. The antecedents to horizontal violence occurrence have been purported as imbalance or lack of power, personal oppression and a professionally uncooperative culture (Embree & White, 2010; Weaver, 2013), which maybe the case in this instance of upward incivility. With limited literature on upward incivility

from non-regulated and lower level heath workers towards RNs and the gender aspects of horizontal violence this study may add further dimensions to incivility in these instances.

9.1.2.5   Gender nuances

For the current GRNMs gender nuances prevailed with their sense of marginalisation when often being called 'the male nurse' with the majority feeling as though they were the outsider within the nursing profession, 'the visible minority'. These findings, consistent with literature, where men in nursing do not see themselves as 'the male nurse' noted that they are nurses (LaRocco, 2007; Muldoon & Reilly, 2003); and often mistaken for medical students and even doctors (Meadus & Twomey, 2011; Rajacich et al., 2013). As reported in an early publication from this study (Appendix I), the current GRNMs did not want to 'the visible minority' nor singled out as a nurses who is nurse, they wanted to have the professional identity of a RN in their own right with no gender attached and certainly not the outsider within.

9.1.2.5.1   Outsider within

In common with the Hodes Study (2005) of 498 men in nursing who completed an online survey, some of the GRNMs when sharing their lived experiences repeatedly mentioned themselves as the 'outsider within'. As reported in an earlier publication Appendix I, these GRNMs used the term the 'outsider within' to highlight their feelings of marginalisation, singled out as a minority within nursing, and being called 'the male nurse'. Furthermore, added that the feeling like an outsider who does not belong was consuming in the first half of the graduate year although lessened as they neared completion of the year. Herakova (2012) put men's minority in nursing through the perspective of co-cultural experiences and used the term a sense of otherness; this 'otherness' in turn contributed to negative feelings about the quality of work-life for the eight NMs participants in her study. Likewise the current GRNMs expressed concerns about their quality of work-life as 'the outsider within' but reiterated that until more men enter nursing and nursing is seen as a gender-neutral profession they will always be the outsiders within; so it is something that they felt they needed to adjust too if they wanted to continue with nursing as a career.

What the current findings add to existent literature was that marginalisation still continues today and that nothing has changed over time in regards to promoting

nursing as gender-neutral profession. The consensus of the current GRNMs being that in a gender-neutral profession they could still maintain their masculinity as well as be an RN and so to for the registered NFs they could still maintain their femineity as well as be an RN. An Irish quantitative study (Loughrey, 2008) of 250 RNMs revealed that men who are nurses actually do identify with stereotypical male and masculine values, which gave credence to the GRNMs consensus.

9.1.2.5.2   Masculinity and care provision

For some of the GRNMs, their masculinity being questioned was an issue as covert evident emerged throughout their interviews and consistent with literature, with them not acknowledging that they were nurses outside the professional practice environment (Moore & Dienemann, 2014) or using every opportunity to mention his girlfriend or wife, being engaged or getting married or speaking in a macho way (Fisher, 2009). They did concede that the public perception was that most NMs are effeminate (Harding, 2007; Stanley, 2012).

Literature purported that NMs maintain their masculine role by distancing themselves from traditional bedside care by going into low touch specialties (Black, 2014) and mental health nursing due to it been seen as more masculine (Simpson, 2005). Although the GRNMs disagreed with the idea of moving into low touch specialities as avoidance strategies to reduce intimate care involvement. For them it was more about the type of nursing that suited their skills that they brought into nursing and where they felt they could be of best value to all. Their skills of technical and logistical acumen and excelling in high pressure areas thought best suited to areas such as operating theatre, intensive care and emergency. However, they all admitted to being cautious care givers (Evans, 2002) but thought all nurses, male and female, should be cautious about the care they provided due the diversity of patients that now frequent the health services, believing that cultural sensitive care was paramount.

There was an abundance of literature on NMs experiencing vulnerability and being cautious while touching patients during nursing care provision (Evans, 2002; Fisher, 2009; MacWilliams et al., 2013); with this being problematic for men in nursing (Harding et al., 2008; O'Lynn & Krautscheid, 2014). This was true for the current

GRNMs who have an awareness of their care provision vulnerability. Further, the GRNMs reiterated that they fully explain any care they are about to provide and they are careful to seek permission before providing any touch type nursing care such as physical assessments, performing procedures and assisting with personal hygiene. As in the literature, the GRNMs maintained that overall patients were non-discriminatory towards the gender of the nurse providing their care (Cudé & Winfrey, 2007). Although a recent Australian study (Stanley et al., 2016) explored the perception of men in nursing from the perspective of NMs and NFs, revealed that over a third of the participating nurses believe that some female patients are still reluctant to be cared for by males.

In addition, Stanley et al. (2016) study discovered that over half the participants suggested that men in nursing were often used as 'muscle' by female colleagues. However, only one current GRNM supported this suggestion whereas the other GRNMs revealed more of a reciprocal culture in existence. This culture of reciprocity has been reported previously (Hodes, 2005; Rajacich et al., 2013) where male colleagues were called upon to assist with physically demanding tasks such as dealing with heavy or aggressive patients, in turn female colleagues assisted them with female patients who were uncomfortable with males providing nursing care. The GRMs in this study also revealed that they were often called upon by female colleagues to assist with male patients who were uncomfortable with females providing the care, believing that collegiality being an essential part of nursing.

9.1.2.5.3 Communication

The current GRNMs advocated that effective communication was the core to this collegiality and to providing optimal patient care. Although they concurred with others that communication was problematic in nursing generally and more so from both a GRN and a male in a predominant female profession (Herakova, 2012; MacWilliams et al., 2013).

From a GRN perspective, consistent with literature (Anderson & Morgan, 2017; Dyess & Sherman, 2009), the majority of the GRNMs felt that initially as new nurses they were often dismissed, not listened to and their contributions not acknowledged by colleagues and doctors; even though they were tasked with the full responsibility

for their patients. They also concurred with others (Fenwick & Nerland, 2014; Newton, Henderson, Jolly, & Greaves, 2015) such exclusions perpetuated feelings of 'being an outsider' that inhibited their opportunity for professional learning. Further, the majority of the GRNMs, as previously mentioned, found difficulty in their delegation to unlicensed assistive staff and sighted incidents where these staff did not respond to the GRNMs requests. While they found the need to adjust their communication style to respond to patients and families effectively, for them it was about being more assertive as patients' advocates with their colleagues, those they delegate to and doctors alike. Although the majority of the GRNMs did admit, like those in Raines (2010) study, that previous life experience had a strong influence on their communication and conflict resolution skills. They further revealed a 'been there and done that before attitude' so the adjustment for them was mainly their recognition of the communication culture within their professional practice environment and adjusting accordingly.

This adjustment from the RNM aspect, comparable with Fisher's (2009) Australian study of 21 RNMs, where right from the start of their GRN journey the GRNMs knew the importance of building trust between them and their patients. This trust building occurred by providing clear explanations in a culturally sensitive manner and by obtaining informed permission prior to their delivery of nursing care to ensure the patients' needs were met, and that their demeanour was appropriate. Appropriate demeanour was important for the GRNMs so that they were not misunderstood or their actions misinterpreted by either the patients or their female colleagues.

9.1.2.5.3.1 Co-cultural communication

When working with female colleagues, the key issue for the GRNMs was in trying to understand staff expectations of them and in learning how to behave in a way was 'acceptable' whilst searching for a sense of belonging and their professional identity as a RN. The GRNMs in this study, similar to the study findings by Nilsson and colleagues (2005), reported that female colleagues used a non-direct or 'round-about' style of communication and were more relationship orientated; whereas GRNMs themselves had a more direct matter of fact communication style that has technical 'practical' and more detached orientation. Further, females seemed conditioned both as nurses and as women to take passive roles (Roberts et al., 2009) and in relation to

communication enhanced that stance whereby registered NFs tend to use in-direct and emotional based communication techniques. Thus, the GRNMs identified more with what Pullen and Simpson (2009) in their descriptions of how they care, in this case in RNM demeanour within the professional practice environment, as direct and matter of fact and seemingly having a 'cool headed detachment'. Although the GRNMs added that at times these distinct styles were not conducive to a harmonious professional practice environment.

Despite the abundance of literature on communication between nurses and other health disciplines such as doctors, non-regulated health workers, and patient and families, there was a dearth of literature on communication between male and female gendered nurses. Although, Orbe's co-cultural theory does provide some understanding to the communication disparities between the NMs and those who are female. According to Lapinski and Orbe (2007, pp. 138-139), the co-cultural theory provided "the process by which individual co-cultural group members negotiate their 'cultural differentness' with others (both with others like, and unlike, themselves)". Furthermore, their summary of the theory was comparative to the GRNMs experiences:

> Situated within a particular field of experience that governs their perceptions of the costs and rewards associated with, as well as their capability to engage in, various communicative practices, co-cultural group members will adopt certain communication orientations, based on their preferred outcomes and communication approaches, to fit the circumstances of a specific situation. (Lapinski & Orbe, 2007, p. 139)
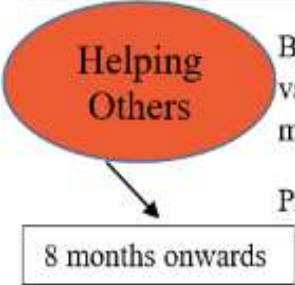
The GRNMs referred to "having to watch their 'Ps' and 'Qs'", in other words be mindful of both their manners and language, so as not to offend especially when using humour as a form of communication. They emphasised that their use of humour was used for reducing stressful situations with both patients and colleagues, and in general conversation depending on the situation at the time. According to Williams (2009) humour was an important communication tool for men. Whilst, NFs in Haydon, van der Reit and Browne's (2015) narrative inquiry gave credence to humour as a male trait, they added that humour can change and be a derogative at times, even sleazy. Here in lies the dilemma for the GRNMs, especially when using humour to communicate with female colleagues to ensure that their humour was not misunderstood. Deborah Tannen (1991) in her book, '*You just don't understand:*

women and men in conversation' revealed that men and women have equally valid styles of communication although different; moreover, they communicate in the ways of speaking as men and women that seek very different things which can lead to frustration. Thus, as the current GRNMs suggested the different communication styles was at times not conductive to themselves nor for helping others.

9.2   Helping others

The question was explored as to how GRNMs perceive their professional practice experiences within their first twelve months employed as a GRN, and were their expectations met? This was investigated from the time the GRNMs commenced their RN graduate year into the mid stage of their second half of the year for the majority of the GRNMs. Although two GRNMs required the full twelve months to reach their interpretations of their lived experiences where they were helping others. The overall finding of their professional practice experiences, although challenging and overwhelming initially, provided the platform for their growth in their ability to help others. Their ability to help others, the GRNMs felt developed from gaining experience through their exposure to the skills of other helpers. Further, the skills of leadership in the art of helping evolved from exposure to significant others, mainly nurse leaders when visible although limited at times as previously discussed earlier in this chapter. Table 8 was extracted from Table 6 to outline the key themes and areas for the helping others discussion.

Table 8   Helping others discussion

Essence of Helping	Superordinate	Subordinate	Areas for discussion
Helping Others → 8 months onwards	Becoming a valued team member	Socialisation RN role consolidation	Outsider within Team work Helper skills
	Professional self	RN mastery	Competent RN Workplace culture

The GRNMs, congruent with existent literature, showed that leader role modelling was paramount for positive socialisation and enhancement of others to synthesis

theory into practice especially "the ability to manage crisis while guided by a set of moral principles" (Anonson et al., 2014, p. 127). Further, the role modelling the art of helping of 'being around, being there, being wise' (Smith & Smith, 2008) and recognition of the value in men's, thus these GRNMs, ability to help others during difficult times (Rajacich et al., 2013), was the essence of helping that drew these GRNMs into nursing in the first place. Of note that emerged from this current study, and reported elsewhere recently (Zahourek, 2016), was the GRNMs discovery that they needed to focus on their own self-care needs in order to holistically care for others. Due to the GRNMs synthesising this information on helping others and reflection on their own self-care needs, they felt there was augmentation of their own helper skills that enabled them to help others and develop in their own self-leadership persona; all of which, ultimately lead to their perceptions of becoming a valued nursing team member.

9.2.1 Becoming a valued team member

The 'becoming a valued team member' was regarded by the GRNMs as their turning point in their professional RN progression. The majority of the GRNMs indicated that this point was around the eight month mark, whilst for two of them it was more towards the end of the graduate year closer to the twelve month mark. Yet again this timing demonstrated their GRN journey alignment with the Stages of Transition Theory (Duchscher, 2008), where on this continuum they had transitioned through 'the doing' and 'the being' stages and were now positioned in 'the knowing' stage. The GRNMs were now in this knowing stage affiliated with the Transition Stages Model (Duchscher, 2007) where they utilised the ordered processes of separating, recovering, exploring, critiquing and accepting to complete the overall becoming stages of a GRN in their full socialisation as a professional RN.

9.2.1.1 Registered nurse socialisation

The GRNMs in this study found that bridging the gap between theory and practice was accepted as they entered the professional practice environment but also found the adjustment to the environment unnerving and difficult at times. However they were unable to decipher if this was their status as a GRN or as a GRNM. The full extent of the socialisation process, moving from their novice state of needing help

from others to an autonomous RN that provided help to others was challenging for the GRNMs, something that they had not expected as their entered their GRN journey. Similar to Moore's (2006) reveal on the experience as a student transitioning to a RN role although be it that this role was a qualified Royal Air Force staff nurse, the GRNMs had mixed feelings in regards to level of responsibility and accountability they took on in their RN roles; and although very stressful at times, acknowledged this anxiety did provide them with the opportunity to become autonomous in their practice.

For the current GRNMs, they saw the procurement of full RN socialisation in their becoming a valued team member; as in the same way as Andersson and colleagues (2010) Swedish study portrayed leaving the 'rookie stage' as the sign of maturity in their role, was their ability to time manage allocated workloads. In completed their allocated workloads, the GRNMs had additional time to be with their patients; and ultimately for the GRNMs freed up value time to be able to assist their colleagues. Although in contrast to Andersson et al.'s finding, the GRNMs revealed that being a valid member of the team was part of being a valued team member and as such in their thinking was not part of being a novice 'rookie'. The reasoning for this was that the GRNMs felt like 'the outsider within' so they never really felt like a valid nor valued team member until they could show their worth. This sense of worth for the GRNMs was when they were recognised and accepted as a valued nursing team member giving them a sense of belonging that enhanced their professional identity.

9.2.1.1.1 Professional identity

As they journeyed into the last third of their graduate year, the GRNMs focused more on defining their professional identity and pursuing the meaning of being a RN. Although for most of them this took the full twelve months and longer to reach this stage. Finding their professional identity proved to be challenging for the GRNMs due to the minority of men in nursing whom they sought out as role models as the GRNMs acknowledged that men and women approach the delivery of nursing care differently. What was disconcerting was the suggestion that graduate nurses were not being properly socialised until completion of their graduate year thus affecting their professional identity augmentation. Professional identity was found necessary for nurses to function at an appropriate level with the prerequisite being a sense of

belonging and acceptance to the profession (Zarshenas et al., 2014). In contrast, it has been reported that the "sense of belonging does not occur until post graduate year once graduates feel they belong to a specific setting" (McKenna & Newton, 2008, p. 12), which maybe the case for the current GRNMs in this current study.

Furthermore, the majority of the GRNMs concurred with the graduates in McKenna and Newton's (2008, p. 14) Australian study where they "did not see themselves as fully fledged registered nurses during the graduate program, rather they were 'graduates' somewhere between student and registered nurse". What was evident from the GRNMs responses, although they regard nursing a gender-neutral profession, they purported that positive RNM role models were important in their progression towards establishment of their professional identity and their ability to be an effective team member.

9.2.1.1.2   Team member

Being an effective member within a team transpired for the current GRNMs when they perceived that they had mastered their prioritisation skills of both self and the team they lead. For the majority of them this occurred post the eighth month mark of their GRN journey with two GRNMs still not at that stage as they finished their first graduate year. It was in this 'knowing stage' (Duchscher, 2008) where the majority of the GRNMs conceded that they felt synthesis of their experiences and their learning of what their RN role was within the professional practice environment, that provided a greater awareness of their fit within the nursing profession. . The current GRNMs had become more comfortable and confident with, what Wangensteen, Johansson, and Nordström's (2008) nurse informants reported as, "having an overview, knowing the patients, knowing the co-workers and most of all being able to delegate seemed to be the key to managing the leadership role as a nurse" (p. 1881).

Although all the GRNMs acknowledged that delegation was difficult initially, even those who have previous management roles, as they sighted the lack of respect for their RN position was an issue. However as the majority of the GRNMs progressed through their graduate year and faced the delegation challenges head on, they perceived that they demonstrated their worth and ability to manage situations before

them. Thus confidence within the team grew that gave the GRNMs a sense that they were valued and now trusted. All the while being careful with their communication for reasons as previously discussed, noting that co-cultural communication was an added factor that influenced their delegation and leadership acceptance.

9.2.2　　　Professional self

The current GRNMs felt that both the ability to delegate and their leadership acumen defined their professional self. Moreover, they impressed the importance of self-awareness in obtaining their professional self. Moreover, they GRNMs concurred with other studies (Dyess & Sherman, 2011; Ekström & Idvall, 2015) that this self-awareness focused on their recognition and management of emotional states and limitations. This then further focused on their taking responsibility for their own professional development in the essential areas of the RN role. They perceived these essential areas to be clinical and professional leadership and the delegation and delivery of safe nursing care. The GRNMs, similar to Kelly and Courts (2007) findings, revealed that the more confident they got the more they identified with their colleagues, which gave them a greater sense of control and enhancement of their professional self that contributed to their sense of RN mastery.

9.2.2.1　　　Registered nurse mastery

Two areas identified by the GRNMs in this study that influenced their RN mastery was workplace culture and attainment of their competent RN status. As previously mentioned the majority of the current GRNMs perceived that they reached this mastery midway through the 'knowing stage' post the eighth month mark; although two of the GRMs felt that they had not reached RN mastery at the end of their graduate year. However, these two GRNMs were confident that they would reach this mastery within the following six months post their graduate year, revealing that they just needed more RN experience to fully feel competent and gain their sense of belonging. This being in line with previous studies (Dyess & Sherman, 2009; McKenna & Newton, 2008) where it has been revealed that it can take up to twelve months or more to reach this stage of belonging. The consensus from the GRNMs was that it depended on the professional practice environment and the workplace culture embedded in that environment as to when RN mastery was attained.

9.2.2.1.1 Workplace culture

The findings of this study supported other studies that have examined the GRN experience in the acknowledgment of workplace culture influence on the socialisation and transition of new GRNs (Duchscher, 2008; Walker et al., 2013). The majority of the current GRNMs gave credence to the Duchscher and Myrick (2008) remit of '*the prevailing winds of oppression*' with factors, such as understaffed and overworked seasoned nurses, role ambiguity, increased patient acuity, low morale and exhaustion in senior staff; all whilst the new GRNs attempted to adjust to unrealistic and unachievable work expectations with their lack of confidence and uncertainty in their practice; further added to the dissatisfaction, disillusionment and distress in the transitioning new GRNs.

Only two of the current GRNMs revealed experiencing a supportive and inclusive collegial workplace culture during their initial transition into their clinical practice. They felt this type of workplace culture was empowering and provided them with the foundations of their RN mastery much earlier than their GRN colleagues who were experiencing unsupportive workplace cultures, as was the case for the other GRNMs in this study. These two GRNMs, similar to Wangensteen, Johansson, and Nordström, (2008) study nurse informants, although admitted at times it was tough going they actually never felt a sense of despair putting this down to their exposure to an inclusive and welcoming workplace culture with supportive co-workers who provided consistent constructive feedback. Further, they added that the visible nurse leadership within this environment paved the way for their competent RN self.

9.2.2.1.2 Competent registered nurse

In line with Phillips and colleagues (2014) secondary data analysis in relation to GNs' transition needs, the current GRNMs revealed that respect from senior staff and being recognised repeatedly as doing the RN role well was the indicator that they had succeeded in their transition to competent RNs. Further, receiving feedback on their performance was described by the GRNMs and others (Phillips et al., 2014; Wangensteen et al., 2008) as a pivotal process for attainment of RN experience that enabled the successful transition to their competency level. The current GRNMs performance feedback they obtained mainly focused on CT and their clinical judgements.

The GRNMs, similarly to Duchscher's (2003) study new GRNs, revealed that initially they relied heavily on their academic nursing theory and practice principles, as they 'put theory into practice'. The GRNMs added that it was not until they were familiar with the ward procedures and routines that they had any time to critically think and reflect on clinical judgments made. They further concurred with Tanner (2006) that they only really gained RN experience when they began to understand clinical situations and interpret the patients' needs then having to make the decision on the urgency of these needs based on the situation at the time.

The consensus from the majority of the GRNMs that critical thinking evolved towards the third month with clinical judgements more towards the sixth month of their graduate year, was consistent with Duchscher's (2003) study. Although "there is no universally accepted conceptual framework for describing and evaluating critical thinking in nursing" (Zuriguel-Pérez et al., 2015, p. 827). Some of the current GRNMs went into deep discussion on critical thinking and clinical judgment, saying that what they experienced in professional practice was more complex than critical thinking or clinical judgement but they were unable to provide a word for such.

They believed that critical thinking and clinical judgment focused purely on the patient and that they practiced from a holistic approach that was more encompassing. From their narratives, situational even clinical reasoning seemed a reasonable description of what they were trying to get across. Benner (2015) posited the following:

> From a focus on critical thinking alone, to emphasizing multiple ways of thinking particularly in nursing to an emphasis on clinical reasoning across time about particular changes in the patient and/ or the clinician's understanding of the patient. . . .This situated-thinking allows the student to develop a sense of salience about what the most and least important is in a particular clinical situation (p. 2). . . . Thinking-in-action meant the nurses' engagement in actively discerning and problem solving the patient's and their family's immediate needs (p.4).

The majority of the current GRNMs had sporadic exposure to empowering and engaging clinical nurse leaders, formal and informal and both male and female, whom they admired and respected. The GRNMs felt that these leaders enhanced

their critical thinking and informed their clinical judgments that added to their clinical reasoning. These visible clinical leaders had traits that the current GRNMs wanted to emulate in their own practice. These traits perceived by the GRNMs, similar to those reported by Cook and Leathard (2004), were that these clinical nurse leaders focused on quality patient care and critiqued practice to enhance improvements, had enquiring minds that influenced others to think outside the box that was done with respect, and they provided support when needed. Moreover, these leaders ensured that the GRNMs were exposed to opportunistic learning where most the RN competencies evolved. In considering the aforementioned traits there was evidence to suggest the type of leadership the current GRNMs were exposed to, although infrequently, and influenced by was that of the authentic leader (Wong & Laschinger, 2013).

9.2.2.1.2.1 *Authentic leader*

The current GRNMs, as was the case with the participants in Laschinger and colleagues (2015) study, revealed congruency with authentic leadership, although sporadically, where they were provided with a supportive engagement with a manageable workload, and encouraged ask for help when making clinical decisions. This type of leader reinforced their confidence in their own capabilities and thus added in their RN growth. Further, the GRNMs as followers concurred with existent literature that the authentic leader's role modelling of moral and ethical values, this leader's self-awareness and information sharing, being realistic, trustworthy and inclusive provided the credibility that augmented the followers' sense of self-efficiency (Gardner, Cogliser, Davis, & Dickens, 2011; Wang, Sui, Luthans, Wang, & Wu, 2014). Moreover, the GRNMs valued the engagement, respectful, empathy and listening attributes of the authentic leaders in their interactions with them and voiced this as skills of a true professional helper in which they wanted to emulate in their own practice.

9.3 Professional helper

The current GRNMs had a preference for helper rather than carer in relation to the title 'professional helper' as it was their strong desire to help that drew them into nursing in the first place. They aligned with Davis (2007) in that the GRNMs

believed as Davis stated "inherent human qualities of the helper were crucial. . .
Helper qualities included respect 'believing people can change', genuineness,
empathy and humility" (p. 13).

The majority of the current GRNMs felt that they were now beginner professional
helpers as they supported new nurses, health students and other health professionals
in their socialisation into the professional practice environment. The GRNMs,
similar to Madsen's (2014) article on collaborative helping, revealed that helping
was not a simple single process it was more complex pulling on all their knowledge
(theoretical and experimental) and skills gained to ensure that their helping was
effective to the person(s) who sought their help. Moreover, their narratives
concurred with Davis (2007, p. 13) where he described helping as an activity, a series
of complex and different tasks, and that "it was not just about 'fixing it' but about
being with people in a way that enables them to feel better about themselves". In
addition, Hilton gave reference to the helping process with, " it is the nursing process
in some sense" included relationship building, exploration, understanding, goal
setting, strategy planning, implementation, review and ending" (p.13).

The GRNMs had become 'the go to person', who were able to answer questions,
mentor and assist others in their professional development. More importantly they
felt that they were making a difference to those in need whether this be patients and
patient families, other health staff or the community in general. They were
comfortable with making clinical and sometimes difficult decisions for the benefit of
those who sought help. For the majority of the GRNMs they had completed
Duchscher's (2008) 'becoming' process. Figure 14 presented in Chapter 8 and
duplicated here provided the detail as to who was the external helper at what time
along their journey in relation to the development of their professional helper skills.

Figure 14   Professional helper. Duplicated from Chapter eight.

From the professional helper aspect of *the helper within* on entry to nursing, the GRNMs had a strong altruistic to help others. The exposure to significant others and nurses in action who displayed the essence of helping draw these men into nursing.

During their initial journey as a GRNM in the first three to four months ('the doing' stage), they were putting their nursing theory into practice and consolidating their RN role. Then up to the eight month mark, 'the being' stage, they were becoming more aware of their RN role and its complexity. During these two stages of the Transition Stages Model (Boychuk Duchscher, 2007), the presence of nursing leaders; informal such as nursing colleagues in particular the recent former GRNs and formal in their senior nursing staff in particular the nurse managers and clinical nurses; and their visibility and role modelling of helping enabled the GRNMs development of the helping skills required of a professional helper.

Around eight months and onwards consolidation of their art of helping and their growth as a self-leader evolved in the presence of authentic leadership. If this authentic leadership was absent then their art of helping consolidation and self-leadership can be stunted. As the GRNMs engaged in their professional helper role embedded in their RN status they progressed through 'the knowing' stage of Boychuk Duchscher's (2007) Transition Stage Model processes of separating,

recovering, exploring, critiquing and accepting in order to find their better RN fit. Table 9 was extracted from Table 6 to outline the key themes and areas for the professional helper areas for discussion inclusive of 'better RN fit'.

Table 9   Professional helper discussion

Essence of Helping	Superordinate	Subordinate	Areas for discussion
8 months onwards	Professional Helper	Better RN fit	Self-leadership Job satisfaction

9.3.1.1   Better registered nurse fit

The GRNMs posited that trying to enact authentic leadership can be exhausting especially in the emotionally and physically demanding job of nursing. They found this enactment took effort when a novice in this leadership area due to the amount of self-reflection and feedback sought, and time restraints within the professional practice environment. Further, they came to realise that the sporadic leadership engagement they experienced may be due more to the professional practice environment being fully overstretched and lacking in the relevant human resources, such as experienced RNs. However, as time went on and with the GRNMs mantra of being an authentic leader, for those GRNMs who had reach the stage of critiquing and accepting formed their own self-leadership style reflective of the moment, ensuring that they retained the transparency, trust, integrity, and ethical and moral standards characteristics of the authentic leader.

9.3.1.1.1   Self-leadership

As a consequence, the current GRNMs believed that and in line with Gardner and colleagues (2005, p. 345) "an authentic leader must achieve authenticity, through self-awareness, self-acceptance, and authentic actions and relationships". Further, before this was achieved, both the exposure to authentic leader role models and professional development was required to fully establish self-leadership from the followers' self-awareness and self-regulation to that of the authentic leaders' self-

awareness and self-regulation. The majority of the GRNMs found accessing professional development was problematic due to staff storages and not being able to be released to attend. Therefore, they relied heavily on the experienced staff that they deemed authentic leaders to observe and learn from.

The GRNMs purported and concurred with Jooste and Cairns (2014) study participants on the importance of their RN professional identification before they could establish accountability for their own action to enact self-leadership. This obtained through being RN role self-aware, self-motivated and self-regulated. The GRNMs felt that until they could 'self-lead' they could not lead others. Moreover, this required them to take on responsibility and control over their own personal actions. The achievement of self-leadership was when the GRNMs demonstrated their ability to take ownership of their daily RN responsibilities and problem solving the associated pressures and stress often when leading allocated teams and delegating in their current RN role. They were mindful that this required their enactment of self-leadership and effective communication skills, although these GRNMs are fully aware of co-cultural communication behavioural styles needed and the inherent scrutiny of being a minority within the female dominant profession of nursing,

The GRNMs purported, comparative with existent literature, that being self-motivated in nursing meant having the courage to be a patient and staff advocate (Johansson et al., 2010) through the use their professional helper skills needed to enact the doing, that resulted in display of their self-confidence and positive attitudes in action (Ross, 2014). This self-confidence and positive attitudes in action was part of becoming a self-leader, who demonstrated nursing role self-awareness and self-regulation (Jooste & Cairns, 2014). According to the current GRNMs all of which was influenced by their job satisfaction.

9.3.1.1.2   Job satisfaction

At the conclusion of their graduate year, the majority of the GRNMs were satisfied with what they had achieved, although admitted that there had been some really challenging times along the way and acknowledged that "there will be more to come". None of the current GRNMs were disappointed nor regretted their decision to enter nursing, including the two GRNMs who had not reached what they felt as

their full RN competency. All the GRNMs revealed that what they had imaged nursing to be and what they actually experienced in their RN journey was not congruent.

The GRNMs were seeking job satisfaction. Similar to D'Intino and colleagues (2007), they sought personal work-life harmony and enjoyment from their new RN career to gain the fulfilment of meaningful work. Although the majority of the current GRNMs, alike with Skinner, Madison and Humphries (2012) Australian study, experienced moderate amounts of work-related stress, these GRNMs were still satisfied with their work. Moreover, the majority of the GRNMs felt more suited to the current area they were in and expressed interests in staying in these areas. When exploring the work-related stress further, the GRNMs found that as they gained their professional RN identity and competency and had more autonomy in their self-leadership, they were better able to cope with the stress. They had accepted that stress was part of the course in health due to the combination of patient care complexity and inadequate nursing mix ever increasing. Although managing ambiguous or problematic work situations with certainty still remained a challenge, the GRNMs believed that as they gain more experience these types of challenges they will be more manageable and less stressful. This was certainly the case in Lavery and Patrick's (2007) Australian study that revealed the more experienced nurses demonstrated lower burnout and suggested that GRNs do not have the necessary skills to adequately deal with every problematic situation in the workplace, this only comes with experience.

The GRNMs maintained that burn out to them was associated with extreme physical and mental exhaustion due to workload stress, compassion fatigue and job dissatisfaction, all of which they had experienced at some point in their journey. Hence, they were seeking job flexibility as a strategy for burnout reduction. This was consistent with Lavery and Patrick (2007) where those who worked reduced hours were likely to have more work-life balance than those who worked full-time. In contrast, some of the current GRNMs thought it was not the full-time status that was the issue that it was more the intensity of the work environment. One GRNM revealed that he now worked in the acute hospital setting three days a week and then takes on more hours in a subacute nursing area that was not so demanding to take his

working hours to full-time status. This combination of work environments proved to be both mentally and physically less stressful for him.

As the GRNMs were completing their graduate year, there was the potential for most of them to negotiate both job flexibility and part-time work, although for most of them this would be on fixed term contracts as was the current workforce climate while they sought permanency. Some of the current GRNMs were remaining in the mental health setting or applying for jobs this area, even though mental health nursing initially was not their choice. These GRNMs have found that the mental health setting was more conducive to NMs and they felt that they fitted in better in this environment. They revealed during their graduate year working in mental health had exposed them to comradeship that they felt was lacking in the general nursing environment and that they were less vulnerable in regards to their communication style and masculinity. Other GRNMs, were seeking or had gained jobs in the higher acuity, more challenging and technical areas of nursing. Similar to (Penprase et al., 2015) findings, these areas were believed by the GRNMs to be more suited to their male aptitudes. Contrary to repeated reports elsewhere, the GRNMs expressed the desire for the aforementioned areas was not due the issue of imitate touch care delivery. Of the two GRNMs who were still to find their niche, one GRNM has been accepted into a second year graduate program in remote and rural nursing, and the other has now expressed a keen interest in neonatal intensive care due to his personal experience as a parent in this area recently.

Would they recommend nursing to other interested males? Yes they would but they were cautious in recommending nursing to males who were leaving school. As mentioned previously, the majority of the GRNMs felt being that little bit older and having work-life experiences equipped them better to the challenges they faced as a male in a female-dominant nursing profession.

9.4   Summation

In bringing it all together this gave me an opportunity to reflect on both mine and the participants' journey as a whole. I remain committed to my realisation that GRNMs, in fact men in nursing generally, more often than not genuinely face continual challenges in the female dominant profession of nursing. I strongly maintain that

this study has provided an insight into some of the issues that men in nursing encountered on a regular basis. I remained surprised at how sensitive these GRNMs were in relation to how they delivered nursing care and the importance of recognition sought by them for their helping that reinforced the meaningfulness of the work they do.

From my perspective the conceptual framework I followed has given a structure to both the workability and readability of this thesis, and provided a foundation of enquiry that informed the discussion that followed. Duchscher's seminal work in regards to graduate nurses' stages of transition proved important and reflected the journey that the GRNMs undertook through the stages of the doing, the being and the knowing time line. With slight variations depending on their professional practice environment experience in relation to their socialisation. They all indicated varying degrees of transition shock with the majority reaching transition crisis just before or around the midway mark. The two that did not appear to reach transition crisis point were the two that were fortunate enough to enter positive and supportive workplace cultures for both of their graduate program rotations. Thus giving credence that nursing professional practice environments still have a long way to go in providing a safe workplace environment that is inclusive of a supportive workplace culture.

I applied Duchscher's stages of transition model as one of the concepts in the conceptual framework for this study more as a guideline pertaining to the appropriate times to conduct the participant face-to-face interviews and have them undertake reflective diaries. However, I came to realise that this model provided more than just a guideline, it proved to be informative and reflective of GRNs experiences that also is inclusive of GRNMs, was the case for the participants in this study, therefore gender-neutral in the model's approach. I purposefully did not read Judy Duchscher's (2012) book 'from surviving to thriving: navigating the first year of professional nursing practice' early in this project. The reason for this being I wanted to stay true the IPA process and needed to resist the temptation of using directional questions at the individual face to face interviews and influencing my reflexivity. Hence the reading of Judy's book was done after I have completed the data collection, transcriptions and undertaken my reflexivity on each longitudinal phase of this study. This ensured I captured the GRNMs meanings behind their

narratives not what I thought they meant from the insight gained had I undertaken in-depth literature searches as part of the initial literature review. This in-depth literature search and the reading 'from surviving to thriving: navigating the first year of professional nursing practice' book only occurred during the analysis and writing up stages in the IPA process.

Orbe's co-cultural communication theory proved insightful and provided explanations regarding why men in nursing communicate the way they do. Having worked with RNMs early in my career and then managed RNMs later on, I now have a new appreciation of their style and communication behaviours. Often when I perceived that these men were aloof and not interested, even uncaring, with issues brought up at mixed gender meetings, now on reflection this may have not been the case. Occasionally after such meetings when the opportunity arose they would individually further engage with me on such issue from their view point but when challenged why their input was not brought up at the meeting I would receive non-descript replies, sometimes with humour such as a laughter when they added 'they [the registered NFs] might think I'm too big for my boots', 'I've got to work with this lot everyday', 'I value my life too much', etc.

For Holland's typology of personal traits in my initial belief of their alignment with classification of SAI, I found they stayed true to their strong desire to help others and their personal sense of altruism. They also remained sensitive and supportive of equality for all; with the extreme of one GRNM wanting to leave his area of interest when he found that particular environment he was in proved to be unsafe for patients and unsupportive of staff. The majority of the GRNMs indicated their further interests in seeking nursing positions that required technical and high levels of problem solving and analytical skills.

Incivility within nursing and limited nursing leadership were two of main areas that influenced their job dissatisfaction. Their reaction to witnessing nurse-to-nurse hostility and the insidious nature of inter- nurse conflict proved to be distressing for the GRNMs in this study; which on the surface I would not have thought this would be the case as men in nursing appear to remove themselves from such situations and do not express their feeling of such readily. Their new interest in seeking out more gender equal areas such as mental health and high technical areas where there was

more of a one to one patient and better NF to NM ratio I now felt was more to do with their desire to further remove themselves from the aforementioned incivility; their seeking a more comradeship supportive environments; and had nothing to do with imitate touch nursing care issues reported elsewhere.

I mulled over how best to describe what brought these men into nursing; the essence behind their decision; the reasons behind what they were seeking; and how to best to outline the phases needed for them to reach the point of obtaining meaningful work which was the focus for the majority of these men in this study. After many attempts to do so I kept coming back to the ultimate goal being the professional helper and how they got to that stage. For affirmation that I may have captured such, at the same time concluding this project with touching base with the participants four months after the completion of their graduate year, I emailed all the participants. In the email I attached the published articles from this study, and a final draft of Chapter eight the essence of the journey and Chapter nine bringing it all together, both that included the professional helper stance. Feedback and final member checks, were affirmative with no alterations suggested. Exemplars of emails:

> Hi Di, I loved reading it back. It feels so long ago that we had those interviews and it's helped me feel reignited for nursing. I'm still in ED. Have started a social group with each of the new grad starters and have a social helping between us all. I'm now in Lead roles where I'm responsible for small sections of ED. Looking at doing post-grad in ED next year. The paper itself looks great, thoroughly enjoyed reading it. I think you captured each of our voices well. I also like how you gave us each "roles/characteristics" and think I very much am the logistics guy. (Connor email communication, 12th October, 2017)

> Hey Di, it's really quite interesting from all sides of the fence. It's that long ago (but not that long ago) I'd really forgot what I'd said! But yes, its fine - a fine depiction. What a great contribution you're making with this PhD, it's good to see what the other guys think and what they're up to. Particularly RE: mental health I really echo some of those sentiments. I'll be giving it a try at some point - if nothing else but to tick off the box to say that I know something about Medical, Surgical, Emergency and MH Nursing. But gotta be honest, as I get older the political correctness of the general field, 'to get with the feminine' so to speak, it wears on me. Despite all the general skills I've learnt (which I'm glad to have done so, and are invaluable in their own right) the cultural shift in work place may be the overarching factor that could finally give me the sense of 'contentment and belonging' that makes all the difference. (Dean email communication, 15th October, 2017)

Chapter 10. Implications and Recommendations

"To do what nobody else will do, in a way that nobody else can, in spite of all we go through; is to be a nurse"

Rawsi Williams

The study provided awareness into the lived experiences of the GRNMs who participated in this study. The study findings may inform human resource managers, nursing academia and senior nursing professionals around recruitment and retention and the socialisation requirements of this minority group within the female dominant nursing profession.

The recommendations from this study focused on recruitment and retention of men in nursing, and their socialisation into the nursing profession. These three areas require consideration and discussion by all within the nursing profession and especially the influential decision makers, in light of the looming nurse shortages that will impact on the nursing workforce.
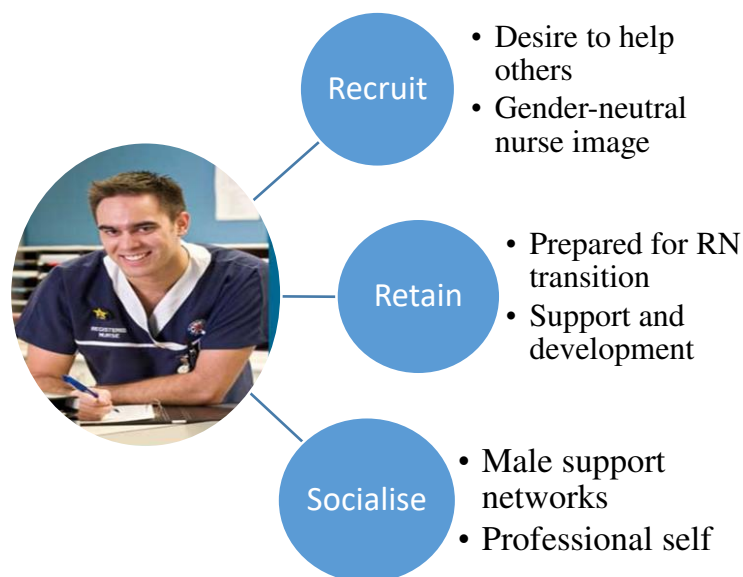

Figure 19   Recommendations from the study findings of the lived experience of a Western Australian GRNM

10.1 Implications

This study's findings contributed to existent literature of the long held impression that males are attracted to nursing for the same reason females are, the desire to help others. What this study brought to existing literature was that the promoting of nursing as a caring profession did not ignite interest for the majority of them as caring can be seen as effeminate. As such the GRNMs explicitly focused more on the helping aspect of nursing instead. These GRNMs believed that the desire to help is fundamental in nursing and in becoming a RN, especially as a professional helper.

The findings added to the existent body of literature in pertaining to the challenges men in nursing face and further provided an insight into the implications for professional practice and the engagement of second career men, although the findings cannot be widely generalised due to the methodological approach used in the study. The focus of the second career men who participated, in this case being the majority of the GRNMs, decision to enter nursing was that they were not fulfilled in their previous occupations; thus, they sought out nursing to pursue a meaningful and fulfilling career. The skills that they brought into nursing should not be downplayed in the usefulness that such skills can contribute in their workplace resilience, care provision, and work-related systems and decision-making processes.

The perception of the nurse as female impacts on the nuances that men in nursing constantly face and this cannot be underestimated. In fact, as the GRNMs in this study referred back to the nurse image throughout their interviews in multifaceted categories. These categories included regarding nurses as females, altering their male communication styles, and being constantly mindful of not being misunderstood by the manner in which they present to both female staff and patients alike. Hence there is a need to diversify the image of a nurse to a gender-neutral stance.

Amongst the highest proportions of nurses leaving the profession are those in their early career with males in this cohort twice more likely than the females to leave. It was apparent that orientation and induction into the professional practice environments for the majority of the GRNM participants' in this study was mainly ad hoc and inadequate as they were still left feeling overwhelmed and disillusioned

earlier in their GRN journey. Hence, it is imperative that new GRNs are equipped with the skillset that the health industry requires when they graduate to augment their transition into the health workforce.

Study findings further revealed that GRNMs participants, like those GNs before them, perceived that there was a requirement for them to 'hit the ground running' as fully functional RNs and that they were allocated complex patients requiring nursing care beyond their skill levels at the time. Thus indicated that the perceptions of unrealistic expectations of the GNs, regardless of gender, continues within the professional practice environment. With the nursing shortage looming it is in the best interest of those who influence the nursing workforce to consider how to engage the health industry in regards to having graduate nurse positions more readily available with the human resources needed to support these novices in practice.

The findings from this study gave credence to Duchscher's (2007) Transition Stages Model of doing, knowing and being in the process of becoming a RN. In this study first year post graduation experiences being gender-neutral was articulated through the words of the GRNM study participants. The findings further supported Duchscher's (2008) suggestion of the need to appropriately support the GRN during each of the three transition stages that relates to each stage unique requirements and challenges that the GRN faces. The GRNMs participants reported feeling unprepared for the responsibility and accountability of their new RN role and frustrated with the feeling of abandonment they initially had. Their depiction of the professional practice environments did not appear conductive to the support needs, both formal and informal, of these GRNM participants alongside a lack of recognition that these needs change as they transition during their first year.

Socialisation of men into nursing is complex and more attention to accommodate this cohort in nursing is warranted, especially in the area of communication. Orbe's co-cultural communication theory aligned with study findings with the GRNM participant's experiencing their need, as the minority group, to adjust their communication styles to reduce the disparities between the NMs and those who are female. The GRNMs felt that more could be done within the nursing profession to alleviate the misunderstanding of gender communication demeanours and to foster

better communication for the benefit of cohesive nursing teams to deliver more effective patient care.

10.2   Recommendations

This study has contributed to advancing the knowledge related to what motivates men to enter nursing and their lived experience as NMs through to the end of their first GRN year. The following section makes recommendations for recruitment, retention and socialisation of men as RNs. These recommendations apply to education providers, industry and further research.

10.2.1   Recruitment

The study highlighted the importance of the essence of helping, demonstrated by significant others such as family members and those close to men, particularly females; also nurses in action within the professional practice environment, in this case especially NMs, that drew these participating men into nursing. Moreover, participants highlighted that the professional behaviour of health professionals, particularly nurses, whether as significant others or nurses in practice are scrutinised by those around them. Participants behaviour, attributes and opinions appeared to influence those who come into contact with them and when viewed in a positive light has the potential to encourage others to take up nursing as a career.

Recruitment focuses on what draws men into nursing and what can be done to increase nursing as a career option for men. Therefore areas for consideration included; the essence of helping in relation to the professional helper as the mantra of a nurse, a gender-neutral nurse image, and second career men as potential nurses.

10.2.1.1   Recommendation: The promotion of the nurse's role as the professional helper

The promotion of the nurse's role in their demonstration of helping others to highlight their meaningful work in their everyday complex patient care environments is recommended. This is threefold:

- Promoting nursing as a helping career, especially when targeting men, is important as men observing nurses in action and knowing women who are nurses has identified that it is the 'helping factor' that draw men into nursing.

Moreover, when their observation was accompanied by the technical and complex decision making during patient care delivery, interest in a nursing career was further enhanced.

- Impress on practising nurses their advocacy role to promote nursing by portraying the helping profession element through their nursing actions as a positive, unique and highly skilled professional.

- The use of Holland's (1997) typology of personality theory for consideration when interviewing potential men for nursing careers as a selection strategy. This theory surfaced from the GRNM's narratives that indicated they were attracted to nursing because of their high empathetic traits and their altruism, along with a 'desire to help'. In addition, their sensitivity and support for equality, and their preferences toward technical specialties pinpointed the SAI classification for them that assimilated with personality traits of nurses.

10.2.1.2   Recommendation: The promotion of a gender-neutral nurse image

Promotion of nursing as a gender-neutral career was purported in order to accommodate gender diversity within the nursing workforce to meet the demands of diverse patient populations; in particular in regards to patient preferred gender sensitive care delivery. Approximately one in ten nurses are male therefore strategies to increase the visibility of men in nursing requires attention, this visibility has the potential to normalise the image of nursing as gender-neutral and thus to attract more men into nursing.

10.2.1.3   Recommendation: Review of nursing titles within the profession

The dislike for the term used 'male nurse' by the GRNM participants became evident with their preference to be called 'nurse' noted. They believe nursing should be a gender-neutral profession as both female and males who are nurses provide the same nursing care, undertake the same training, do the tasks with the same ultimate goal of delivering high quality nursing care that is culturally sensitive, and holistic with respect of the patient's preference. Hence, it was agreed that more attention was needed as to how men in nursing are addressed in the professional practice environment and the wider nursing profession.

10.2.1.4   Recommendation: Target second career men as potential nurses

The majority of men entering nursing currently are those from other careers. Although there is a push to target school aged males as potential nurses, the participants in this study felt this area requires further investigation. They believe it may not be in male school leavers' best interest until nursing becomes more gender equal due to the challenges men currently face in nursing. Hence, it is recommended that:

- It would be more appropriate to focus on second career males as the better option as a recruitment target.
- Universities are encouraged to find a greater gender balance within their teaching faculty.

10.2.2   Retention

The focus on the retention of GRNMs highlighted the importance of investigating how they transition into practice, in particular, what supports are needed to support them in the workplace. The GRNMs in this study emphasised issues around not being prepared for the professional practice environment, the importance of male role models and the need for a gender-neutral title. The study also emphasised the issue of co-cultural communication for men in nursing.

10.2.2.1   Recommendation: Realistic anticipatory expectation of transition into the professional practice environment

It became evident in this study that anticipatory expectations and actual socialisation of the GRNMs were not congruent and as such undergraduate nursing students (both male and female) need to be exposed to the realities of their transition into the professional practice environment. Duchscher's seminal work goes a long way in identifying the stages of transition and the unique challenges the new GRN will encounter and as such maybe beneficial in scenario based learning. Hence, it is suggested that academics, clinical supervisors and nurse leaders within industry consider:

- Commence discussions with undergraduate students in the academic setting and when on clinical practicum on the role and responsibility of a RN early in the undergraduate nurse program.

- Focus on professional transition in the third year of undergraduate nursing studies that outlines the reality of transition and the challenges within each of the transition stages they will face as new RNs. The use of scenario based learning promotes discussions on strategies to meet these challenges such as working within a team, leadership, and the art of delegation, and decision making in a collaborative inter-professional framework as a RN.
- Collaboration between academia and the health industry to review nurse orientation and induction programs. Investigate the possibility of reducing the gap between theory and practice as a RN, with shared information of what is needed in industry that can be provided or commenced by academia prior to the new GRNs entry into the professional practice environment.
- Education for nursing staff within the health industry of what skills and knowledge novice registered nurses bring into the professional practice environment and the support these nurses require to reach their full potential.

10.2.2.2   Recommendation: Co-cultural communication inclusion

Co-cultural communication issues for men in nursing was a recurrent theme for the participants of this study throughout their journey within the nursing profession. Alongside the cultural sensitivity and awareness programs that are wide spread within health, it is recommended that co-cultural communication be included.

- Review of local and health department policies on cultural competent communication and equal opportunity and diversity in regards to consideration of co-cultural communication inclusion within their descriptors.
- Education and awareness sessions on working within a diverse workforce to include co-cultural communication styles and behaviours of the minority group(s) within the dominant workforce gender.

10.2.3   Socialisation of men as registered nurses

In regards to the socialisation of men as RNs, the study findings revealed the value of male role models for men in nursing and both formal and informal support networks, and the co-communication issues they faced. In relation to professional self the GRNMs participants identified the qualities and skills of the authentic leader as those that they will incorporate into their leadership style as a RN.

10.2.3.1   Recommendation: Male role model and male support networks

The influence of male faculty on the development of the NMs in the way they provide nursing care, their professional behaviour, and their RNM identity was demonstrated. This focused on the importance of male role models for NMs and was deemed by the GRNM participants to be essential in professional practice settings. They further emphasised the need for the establishment of male networks within nursing, both formal and informal, in academia and within the professional practice environment, as a resource and support for men in nursing to reduce the isolation and marginalisation that they felt at times.

10.2.3.2   Recommendation: Leadership education

The study findings supported the importance of authentic leaders within the nursing workforce. Authentic leadership skills can be inherent in those who have a desire to help, however the skills can also be learnt. Hence this learning would be beneficial in the undergraduate curriculum in preparation for the GRN socialisation into the professional practice environment, as an element in graduate nurse programs and in continual professional development of nurses.

10.2.3.3   Recommendation: Further research

It is recommended that further research be undertaken in regards to the socialisation of men in nursing. In doing so the unique challenges that men face when considering and entering the nursing profession can be investigated further to ensure this valuable human resource as a potential nursing workforce is not overlooked.

10.3   Conclusion

New GRNMs face unique challenges when transitioning to the workforce in addition to those challenges that all new GRNs' face. These challenges occur long before men enter the profession. These include the typical image of nurse as female, the titles RNMs are given such as male nurse, men are seen as less caring and the gender stereotyping associated with men in nursing. All of which has the potential to inhibit men with the personal traits of the nurse from contemplating entering the profession.

When their strong desire to help others is ignited by the support of significant others, such as family members or from observing nurses in action, then these challenges come to the forefront. Their socialisation as they enter are influenced by the support afforded them and workplace cultures that they are exposed to. The importance of male role models both within academia and in the clinical setting cannot be underestimated. It is through these gender contacts that they learn how to deliver nursing care from a male's perspective, how to side step unprofessional behaviour and develop their co-cultural communication styles that are conductive to a collegial work environment.

Men as they continue their journey seek recognition of their worth as a registered nurse in their professional helper role and for their male aptitudes that enhance nursing as a cohesive gender-neutral highly skilled and unique profession. Their inclusion as part of a diverse nursing workforce that will meet the needs of a diverse population in an ever challenging complex health environment cannot be underestimated with the imminent nursing workforce sustainability issues looming.

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Appendix A   Information sheet

The lived experience of the WA male graduate registered nurse

Information sheet

My name is Dianne Juliff. I am a PhD student and the nurse researcher in a study that is investigating the lived experience of the WA male graduate registered nurse. The study is being conducted within the metropolitan health area in Western Australia with nurses who are male and who are about to commence their first year as a graduate nurse in 2015.

Nature and Purpose of the study

You are invited to participate in this study, the purpose of which is to document your lived experience as a male registered nurse in your first year in the nursing workforce. It is acknowledged that the low recruitment rate of males into nursing coupled with the difficulties in retaining graduate nurses, and the impacts of the ageing Australian nursing workforce is particularly challenging for a sustainable nursing workforce in the future.

The study is seeking to describe what interested you in entering the nursing profession and to gain an understanding of your experiences in relation to your values and beliefs of your new role and responsibilities. Furthermore, the intention is to explore your fit as a graduate nurse within the workplace as you transition into the workforce.

Voluntary Participation, Study Process and Withdrawal from the study

If you consent to take part, you will be asked to participate in face to face interviews at the commencement of your graduate year, at the six month period of your employment and again at the completion of your first year. You will be asked to write a reflective diary over five consecutive days at six weeks and thirty-six weeks stage of your graduate year. Your participation in this study is entirely voluntary. If for any reason you wish to withdraw from the study at any time during the study you may do so without it affecting your employment and professional status. In such cases, the record of your participation and the information that you have provided will be destroyed, unless otherwise agreed.

The researcher will de-identify study information; all data will be treated with confidentiality with data being coded in a manner that the data will not be identifiable. Member checking where you are invited to review, clarify and authenticate information you provide will occur throughout the research process.

All hard copy study information such as demographic data and analysis information will be secured in the School of Nursing and Midwifery at the University of Notre Dame Australia (UNDA), Fremantle campus and in accordance the university's policy on the Code of Conduct for Research. The data will be transcribed from audio-recorded interviews and will be stored electronically, and password-protected on a designated computer hard drive. Once the recorded data are transcribed, the data will be destroyed. The electronic data will also be stored in a password-protected digital file maintained in a secure location. Five years after the conclusion of the study all data files are to be destroyed.

Significance of the study

Understanding how you see your world through your experiences as you enter your nursing career can assist workforce decision makers look at ways to support new male graduate nurses in the workplace and how to retain them in the workforce. Moreover, by investigating why males become nurses and how male graduate nurses view their transition into the workplace may enable both the health service managers and the university faculties to modify their curriculums to support and encourage more males into the nursing profession.

If you have any questions, please contact me on my mobile on 0419956222. In addition, if you have any complaints or concerns about the conduct of this research you may contact my supervisor Doctor Kylie Russell, Postgraduate Coordinator School of Nursing and Midwifery, the University of Notre Dame Australia, Fremantle via phone: +61 8 9433 0563 or by email: kylie.russell@nd.edu.au

Thank you for taking the time to read the information sheet.

Mrs Dianne Juliff RN RM BSc(Nsg) MSc(Nsg)

Researcher and PhD Candidate

Appendix B   Contact schedule and interview guiding questions

Recruitment	Stage 6 undergraduate male nurses will be invited to participant in the study. Information on the study and consent forms will be available at this time. Interested male nurses contact details will be taken, and a time, venue and date of next contact will be arranged.
Phase One *Commencement* *GRN year*	The participant will be welcomed to the study and any further information required will be provided. Ice breaker used. Verbal/written consent will be obtained prior to commencement. Demographic information will be sought: <u>Questions</u> "What brought you into nursing in the first place?" "How has the journey as a male nurse been so far?" *Probing questions will be utilised to clarify items of interest related to the phenomenon under investigation*
Participant Diary 4 months	Participants to diarise over five consecutive days - thoughts on experiences during this time with preference to daily entries.
Phase Two *Midway, at the* *6th month* *interval of GRN* *year*	Ask participant if he is happy to continue in this study. Verbal/written consent will be obtained prior to commencement. <u>Questions</u> "What have you experienced as a new graduate" Plus new questions generated from Phase two *Further questions will be formulated based on data analysis from the phase two contact.*
Participant Diary 8 months	Participants to diarise over five consecutive days - thoughts on experiences during this time with preference to daily entries.
Phase Three *GRN year* *completion*	Ask participant if he is happy to complete this last interview for this study. Again verbal/written consent will be obtained. <u>Questions</u> "What has been your experience overall as a male graduate registered nurse?" "Where do you see your future?" Plus any new questions generated from phase three contact will be asked
Three to four month post *GRN* completion	Follow-up with the individual participants to review their current employment status and their preferred career pathway

Appendix C   Electronic reflective diary instructions

THE UNIVERSITY OF NOTRE DAME
AUSTRALIA

> The lived experience of the WA male graduate registered nurse

Electronic Reflective Diary Instructions

Dear Participant,

Part of this research project is your involvement in completing a five (5) day consecutive reflective diary at your four (4) month and your eight (8) month stage of your graduate nurse year.

You will be contacted by email as a reminder of and to confirm your participation in the five (5) day consecutive reflective diary one week prior to your four (4) month and your eight (8) month stage by me (Di Juliff), the researcher and PhD student. You may either do a daily email to me for the five consecutive days or you may like to diarise in a word document and at the end of the five days email your document to me.

The following points are a guide for you to follow when compiling your reflective diary:

- Write a narrative of your interactions with health professionals, patients, family members or others whom you may have come into contact with during your shift. This may be a summary of the shift or a particular instance of an individual interaction that has left an impression (negative or positive) with you.

- You may wish to relate these experiences on how you perceive that they might impact on your personal growth and development as a graduate nurse or as a male nurse.

- The more detail of the event/experience provided will assist the researcher to understand the moment/event.

- Please use full sentences and minimise abbreviations to assist the researcher to understand your intent.

- Do not include names in your diary.

- Reflections can only be received by email.

Thank you for participation in this electronic reflective process and for sharing your lived experiences as you undertake the journey through your graduate nurse year.

Dianne Juliff
Researcher and PhD Candidate
School of Nursing and Midwifery
The University of Notre Dame, Fremantle Campus

Appendix D   Trustworthiness criteria linkage to examples of the techniques used

TRUSTWORTHINESS CRITERIA with explanation	TECHNIQUES to promote rigour used in this study (Techniques are relevant across most of the criteria hence this table is inclusive of but exclusive to noted techniques)
CREDIBILITY Findings make sense	*Internal member checking* by participants after phase 1, 2 and 3 for accuracy of data and to validate interpretations. *Prolonged engagement* through conducting a longitudinal study with 3 interviews, 2 diary entries and a follow-up contact with each participant in order to build trust and rapport, and gain better understanding of the phenomena *Triangulation* by collecting data via face-to-face interviews and participants' diaries to enhance credibility. *Peer review, external member checking*, by supervisors enabled scrutiny of the research process and validation of the emergent themes. *Negative and exceptional views* amongst the participants reviewed, revisited and noted in the study.
DEPENDABILITY Conducted in a dependable way that can be audited	*Audit trail* of decision making throughout the research process. Availability of interview and diary transcripts, summaries of findings provided to participants after each phase with feedback noted, in-depth data analysis and process explanation, and final document (thesis). *Reflexivity* through participants' interviews and their diaries reflecting the consistency of the data in defining the features of the participants' experience of the phenomena under investigation through self-reflection
TRANSFERABILITY Potential for findings to be transferred to another setting	*Thick description* of the setting and participants to enable conceptualization and decisions about the proximal similarity of study contexts and the phenomena.
CONFIRMABILITY Confirmation of the researcher's position and influence	*Rich participant quotes* personalises their lived experiences. *Reflexivity* through reflective commentary in the researcher's reflective journal providing evidence of continuous self-reflection of actions, feelings and perceptions to increase awareness of biases and assumptions; and to also increase confidence and congruency of findings.

Source from: Baille, 2015; Enosh & Ben-Ari, 2015; Houghton et al., 2013

Appendix E   Ethics approval

THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

21 October 2014

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Fremantle, Western Australia 6959
Telephone: +61 8 9433 0555
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Dr Kylie Russell & Mrs Diane Juliff
School of Nursing & Midwifery
The University of Notre Dame Australia
Fremantle Campus

ABN: 69 330 643 210
CRICOS PROVIDER CODE: 01032F

Dear Kylie and Diane,

Reference Number: 014158F

Project Title: "The lived experience of the West Australian male graduate registered nurse."

Your response to the conditions imposed by a sub-committee of the university's Human Research Ethics Committee, has been reviewed and based on the information provided has been assessed as meeting all the requirements as mentioned in *National Statement on Ethical Conduct in Human Research* (2007). Therefore, I am pleased to advise that ethical clearance has been granted for this proposed study.

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Dr Natalie Giles
Research Ethics Officer
Research Office

cc: Dr Karen Clark-Burg, Acting Dean, School of Nursing & Midwifery;
       Dr Caroline Bulsara, SRC Chair, School of Nursing & Midwifery.

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Appendix F   Informed consent

The lived experience of the WA male graduate registered nurse

Informed Consent Form

I, *(participant's name)* _____hereby agree to being a participant in the above research project.

- I have read and understood the Information Sheet about this project and any questions have been answered to my satisfaction.

- I understand that I may withdraw from participating in the project at any time without prejudice.

- I understand that all information gathered by the researcher will be treated as strictly confidential, except in instances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.

- Whilst the research involves small sample sizes I understand that a code will be ascribed to all participants to ensure that the risk of identification is minimised.

- I understand that my employer would not receive any information regarding my perceptions of my transition into the workplace that could comprise me.

- I understand that the protocol adopted by the University Of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the *Privacy Act* are available at http://www.nhmrc.gov.au/

- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

- I understand that I will be digital audio-recorded.

PARTICIPANT'S SIGNATURE:		DATE:	
RESEARCHER'S FULL NAME:			
RESEARCHER'S SIGNATURE:		DATE:	

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, email research@nd.edu.au

Appendix G   Graduate nurses face frustration in gaining registered nurse experience

There are challenging times ahead for the nursing workforce due to the increasing global nursing shortage and the continued marked attrition rate of newly graduated registered nurses.

A recent study on the lived experience of nine male West Australian GRNs in their first year has revealed that two of them, James and Oliver (not their real names), had trouble securing GRN positions post-graduation.

Their experiences concur with the findings of a 2014 graduate nurse and midwife questionnaire. Respondents who were unable to obtain employment, even after applying for multiple positions, cited issues such as lack of nursing experience, lack of nursing positions for new graduates, and lack of jobs without the completion of a nursing graduate program.

It had been over six months since James had completed his undergraduate nursing degree before he started in the mid-year GRN program, although he would have preferred to start straight after his registered nurse (RN) registration.

James continued to work in patient care assistance while waiting for his program, as he knew many other new GRNs who had been unsuccessful in obtaining nursing positions despite copious applications to various health services. The reasons for this, according to James, included their lack of RN experience and novice status.

He also revealed that as the months went on after graduating, he became more nervous about commencing as a new GRN and was not sure how it would go for him. He further recapped on his lack of confidence: "The responsibility of having a patient load on my own was definitely a big factor, coupled with the medications – ensuring not to make an error, etc."

This lack of confidence intensified as he neared his entry into the graduate program. He doubted his ability to perform as an RN and meet the team's expectations of him in his new role, stating: "I fear not holding up my end when it comes to being in a team environment."

Although his previous career was in a team environment – his background in the army and the associate life experiences he saw as a big advantage – James still felt he required a transition platform such as the GRN program due to the nuances of the nursing profession and the socialisation required when entering a dynamic and ever-changing health environment.

For Oliver, he did not apply for a GRN program as he could not find one that was specific to aged care, the area he believed was his best fit. The months after his graduation proved very challenging as he received rejection after rejection on his nursing job applications.

His frustration is illustrated in one of his responses: "They keep saying I need more experience – this coming from both the acute and aged care jobs I applied for – but how can I get the experience if I can't get jobs in the first place?"

Finally, four months post RN registration, Oliver started working in a small private aged care facility as the casual RN. On the first day, he felt overwhelmed and overloaded with his duties. As the shift progressed, he found himself getting faster and becoming more confident: "I just needed to find my way around the ward and get my head around what I was expected to do. It was because of my limited experience but mainly due to the lack of support – no one there to ask how things worked, etc. It was really hard when I was the only RN on duty."

The next shifts, which were a few days apart, proved to be no better. Two residents needed hospitalisation and took up a substantial amount of his time, resulting in some uncompleted duties being handed over to the following shifts.

As a result of the uncompleted work, and with no consideration for Oliver's overall workload and his novice status, he was not given any further shifts. He said: "I was not alone in this situation, as other graduates had faced the same fate."

He went on to comment: "I felt really let down and really disappointed, and felt very disillusioned. I am rethinking my career and if I should look for something else."

Oliver said finding a nursing position, as a new GRN, was very difficult. "Employers seem to seek out more-experienced nurses for permanent roles and use the inexperienced nurses as casual relief as a last resort.

"I personally feel that in order to support myself and a family in the future, if this is the problem you face when entering the field of nursing, then it is quite discouraging. It has made me feel that nursing isn't a stable career option and that I may need to consider other opportunities."

At the six-month post-RN-registration contact, Oliver acknowledged that he had persevered in his quest to gain a GRN program, remarking: "I felt that after my aged care RN experience, the only way I would find the support needed to transition into a competent RN, and then be able to obtain a permanent position within nursing, was through doing a GRN program."

On his first attempt, he was given an interview but was not successful, due to very limited graduate positions, but he was offered a place on his second attempt.

Oliver said: "I am excited and happy about this opportunity but a bit disappointed it will be nearly a full year before I gain entry into a GRN program."

He discussed his experience and voiced his disappointment at the lack of opportunities for new graduates who are unable to obtain entry into GRN programs in order to find a job for which they have been trained. He further reiterated that there is a very unrealistic view of what new GRNs should be able to do as they enter their new career environment.

The challenging situation faced by Oliver and James in finding employment due to their novice RN status and lack of clinical nursing experience is a phenomenon common across the Australian nursing workforce.

The concerns about decreased employment opportunities for Australian graduate nurses and health employers' tendency to employ 457 visa RNs are outlined in the March 2016 Senate report, A National Disgrace: The Exploitation of Temporary Work Visa Holders. The report highlights the lack of transition support as a major issue, which is consistent with the experiences of James and Oliver.

New GRNs require access to the professional practice environment to gain RN experience with given time to synthesise their nursing theory to practice. Therefore, the challenge to reduce graduate nurses' frustration in gaining registered nurse experience requires health industry financial investment for GRN professional support and the opportunity for successful transition into the professional-practice environment with gainful nursing employment are paramount.

Moreover, it can be argued that there is a need to establish quarantined graduate registered nurse positions within the health environment and to invest in nurse leadership in the form of mentor support and role modelling supportive transition for novice nurses in professional practice.

Appendix H   The essence of helping: significant others and nurses in action draw men into nursing

The essence of helping: significant others and nurses in action draw men into nursing

Dianne Juliff[*], Kylie Russell and Caroline Bulsara

School of Nursing and Midwifery, The University of Notre Dame, 19 Mouat St (PO Box 1225), Fremantle 6959, Western Australia, Australia

Background: Nurses are ageing placing nursing workforce sustainability under threat. An untapped potential resource of men in nursing exists within Australia. *Objective*: The aim of the first phase of this longitudinal study was to investigate why men choose nursing. *Design*: Qualitative methodological approach used interpretative phenomenological analysis (IPA). *Research question*: "What are the experiences of male graduate nurses regarding their career choice?" *Method*: The IPA method focused on personal subjective experience where the participants' own sense-making is important. Discussions were audio-recorded, transcribed verbatim and analysed using a format relevant to IPA. *Participants*: Purposeful snowball sampling recruited nine nurses. *Findings*: The "essence of helping" permeated the key theme through significant others and career choice triggers impacting on their decision to enter nursing. *Conclusion*: Exposure to nurses in action is purported to enhance the awareness of nursing as a career option for men that may contribute to increased recruitment of men into nursing.

Keywords: motivators; helping; significant others; career choice triggers; men in nursing

Introduction

Men remain a minority in nursing. According to an Australian Nursing and Midwifery Workforce report 2011, "the proportion of registered nurses who were men increased slightly between 2007 and 2011 (10.2% in 2011, up from 9.6% in 2007)" (Australian Institute of Health and Welfare [AIHW], 2012, p. 13). The phenomenon of fewer men than women choosing a nursing career is not an issue specific to the Australian nursing workforce. Nursing workforces in the European countries such as Norway along with the United States and Canada also remain female-dominated, with male registered nurse rates under 10% (Rajacich, Kane, Williston, & Cameron, 2013; Solbraekke, Solvoll, & Heggen, 2013; United States Census Bureau, 2013).

A nursing workforce challenge facing Australia is the predicted shortage of 109,490 nurses by 2025 (Health Workforce Australia (HWA), 2012). The emphasis is currently being placed on the retention of newly graduated registered nurses and the recruitment of males; ultimately to generate a sustainable nursing workforce to replace those retiring and leaving the nursing profession (AIHW, 2012; HWA, 2013).

Various studies have explored the reasons why men choose nursing, suggesting men approach a career in nursing in order to seek greater job satisfaction (Harding, 2009), and income security (Meadus & Twomey, 2007; Zamanzadeh et al., 2013). Other related reasons such as stable

employment and advancement opportunities have all been reported (Ierardi, Fitzgerald, & Holland, 2010; MacWilliams, Schmidt, & Bleich, 2013). Moreover, the literature revealed that the gendered division of labour within the nursing profession still exists with men more prominent in certain areas such as mental health and specialties that highlighted the technical, and intensive nursing assessment and treatment areas such as critical care and emergency (Stott, 2007). Furthermore, technology-rich areas have been found to be an ideal career motivator for men (Rambur, Palumbo, McIntosh, Cohen, & Naud, 2011).

However, it is also postulated that there are issues around intimate touch nursing care along with the desire to avoid the more "female focused" perceived nursing areas (Stott, 2007). Therefore, it is not surprising to find that one-third of the male workforce is focused in the perceived low-touch less intimate nursing care areas of mental health followed by critical care and emergency units (AIHW, 2012). The higher percentage of Australian nurses who are male in these settings "may be perceived that these settings as more acceptable or masculine" (HWA, 2013, p. 15).

Rationale for this component of the study's first phase was to investigate the factors that influenced first year registered nurses who are male to choose nursing as a career. Thus opening the discussion on schemes that may expose males to the idea of nursing as a career in order to increase the future recruitment of men into nursing.

Method

A qualitative methodological approach using interpretative phenomenological analysis (IPA) was employed to investigate the reasons and the impetus for men who decide to undertake nursing. Moreover, IPA enhanced "the making sense" of how the individual perceive their experience by providing detailed interpretation of the understandings (Smith, Larkin, & Flowers, 2009).

Participants

Purposeful sampling used a snowballing technique where four participants obtained from the initial study information contact enabled the recruitment of a further five participants amongst their peers. These nine participants fitted the study's inclusion criteria of being male and newly graduated registered nurses about to commence their employment in various health settings in the metropolitan region of Western Australia. The health settings included mental health, emergency department, operating theatre, general medical and orthopaedic wards, and aged care. The participants' ages ranged from 20 to 32 years, with the mean age of 26 years. One participant had entered nursing straight from secondary school and two participants from health worker positions, with the others having varied working backgrounds such as the defence force, electronic sales and computer marketing, and hospitality. Some participants had degrees outside the health sector that included environmental science, international relations and politics, and agriculture. Furthermore, the majority of the participants had entered nursing as their second career.

Research question

The research question that guided this enquiry was posited to participants as what are the experiences of male graduate nurses who have chosen nursing as a career? Probing questions were then utilised to clarify areas of interest related to their lived experiences.

Procedure

The University of Notre Dame, Human Research Ethics Committee approval (041158F) was obtained prior to the commencement of the first interview. The study information sheet and

consent form that outlined the voluntary withdrawal and confidentially processes was provided to participants. To protect the participants' anonymity, they were informed that de-identified data would be used in the reporting of the findings. The data collection trajectory approach was decided upon by mutual agreement. It occurred at a venue of comfort and convenience to the individual participant to enable enhanced engagement and establishment of the researcher (first author) participant relationship. Each individual semi-structured in-depth interview using flexible and non-directional open-ended guiding questions enabled the participant to explore his personal perspective for his decision to enter the nursing profession. The first author transcribed the audio-recorded interviews verbatim.

The data analysis was concurrent with data collection. Although there is no finite process for conducting the data analysis for IPA, the present study followed the several steps outlined by Smith et al. (2009, pp. 82–104). Commencing with the first interview, the first author re-read the transcript multiple times and referred back to the field notes and research journal to gain a sense of the meaning behind the participant's responses. The second step was the initial noting with exploratory comments before developing the emergent themes. Step three focused on searching for and capturing the emergent themes from the participant's own words and the author's interpretation. Consensus from the co-authors on the categories and the themes reached by the first author was provided after their reading of the transcripts and discussions on the themes. Further searching in step four resulted in the clustering and integrating of similar emergent themes into a master list, with inclusion of relevant superordinate themes. Repeating the aforementioned steps with the next interview transcript occurred in step five, which was then repeated for all the participants' transcripts. Step 6 was the cross-transcript comparison of the master lists, inclusive of the in-depth interpretations and idiographic focus for each transcript. The final analysis produced the main theme of "motivators for entering nursing" with the essence of helping resonating throughout the subordinate themes.

Trustworthiness

Strategies employed to enhance trustworthiness were inclusive of credibility, dependability, confirmability (Lincoln & Guba, 1985) and authenticity (Denzin & Lincoln, 2005). Validated interpretations to obtain credibility and confirmability occurred through internal member checks. Each participant was provided with a summary of their interview transcript for agreement that it accurately reflected the dialogue between the researcher and himself (Creswell, 2013). Each transcription was read numerous times and reviewed by the co-authors to ensure dependability and the consistency of the data (Polit & Beck, 2008). Authenticity was achieved by the study's descriptive manner through the use of the participants' quotes (Cope, 2014).

Findings

The findings provided a rich account of each participant's experiences through the use of individual narratives when considering the key and subordinate themes. As previously noted the majority of the participants had entered nursing as their second career. A common thread amongst these participants, as expressed by one of them, was " ... *sort of bounced between different jobs ... customer service jobs and sales ... and just was not satisfied with what I was doing*" (P4).

Motivators for entering nursing

The key theme, "motivators for entering nursing", was the outcome of the iterative stages in the analysis process. The subordinate themes that informed the key theme were "significant others' influence and support", and "career choice triggers".

Significant others' influence and support

For the participants in this study, the positive influence to enter nursing came from significant others such as family and friends. Family members were the main influence possibly due the presence of nurses in their families, and related health fields such as medicine and allied health. Several of these men were personally associated with female nurses either as friends, partners or family members before they became nurses. One participant revealed "*on mum's side they are all nurses and doctors so it seemed the way to go for me as well*" (P1).

The support to become nurses mainly came from family members. Affirmations from these family members included "*you will be a great nurse*" (P9) and "*always thought you would go into a caring role*" (P4). Two nominated their mothers as their main supporters. One revealed that his mother, although now a doctor had previously been a registered nurse, was very supportive both in his decision to enter nursing and throughout his studies. He commented, "*she was a great help as she understood what nursing was all about*" (P3). The other stated, "*I found it quite hard going, she* [mother] *was a big motivator saying 'you can do it' and she would help me financially as well, she was very encouraging*" (P1).

The importance of positive support received during the journey to registration was reiterated numerous times by the participants. The majority of the men verbalised the importance of having other men to relate to during their undergraduate years. Reference to other men included both the nurse educators, other nursing students and clinical colleagues. Comments included

> "*I don't know if I would have got through my degree if I didn't have the other guys, we had informal study groups*" (P7), "*we would study together even if we weren't in our allocated study groups and stuff, we still studied together and helped each other out*" (P9), "*just to catch up and have chats with the boys and discuss things that are happening in prac*" (P5), "*great to have like-minded fellows to discuss and share things with*" (P3), and "*it's the same on the ward there's two guys my age I just naturally move towards them ... good to have them to bounce things off*" (P7).

Two of the participants spoke of "continual support" from their partners who were also undertaking the nursing degree or already working in the nursing profession. This support was present in having someone to debrief with who understood the issues and challenges nurses faced as they enter the profession. Other participants found that work colleagues, family and friends provided encouragement and support. One of the participants was even provided financial support for the first year of his nursing degree from a Director of Aged Care whom he worked for. Another received encouragement from a community support friend to take up a community support worker role that re-ignited the participant's desire to do nursing.

Of note, one revealed that when he was deciding on what future career pathway to take, it was his school counsellor who initiated the thought of nursing as a career. Furthermore he expressed, as did other participants, the value of school counsellors' influence on career choices, and felt that more school and career counsellors could be promoting nursing to males as a career choice.

Career choice triggers

Career choice triggers identified by participants were previous employment, nurses in the working environment and in particular the specific encounters with registered nurses who were male, in conjunction with impressionable/critical events. Although, one participant had taken the opportunity during his last two years of school to undertake vocational education training as an enrolled nurse as he did not have the tertiary level requirement needed to go straight into registered nursing. However, he did have a "fleeting moment" where he had considered an electrical

trade in his father's field but, on reflection he acknowledged that this trade was not for him and declared, "*My heart wasn't in it … I've had it in the back of my mind that I've always wanted to do nursing*" (P1).

Previous employment exposure by those participants engaged as health workers believed that nursing was a natural progression and a natural fit for them after assisting and observing nurses in action. Moreover nurses in action, specifically the encounter with registered nurses in their professional-practice environments, were a major trigger that ignited the majority of the participants' desire to undertake nursing. Some of these encounters transpired whilst these men worked in other health worker roles such as patient care assistant, first aider, orderly, carer and enrolled nurse. For example, as one participant revealed

> *I saw nurses and what they did … remember one patient taking him to theatre I was the orderly, he wasn't old about 16 or 17, I was about the same age … he was freaking out and as an orderly I couldn't do much, the nurses ensured he was ok. I thought I'd be good at talking to and caring for people, I have a scientific mind I like being precise I think it's just my calling, that's how I discovered it … nursing that is.* (P6)

In the instance of the participant who had previously been an infantry rifleman, nurses in action were poignant in his desire to enter nursing. Whilst on deployment in the Middle East he observed nurses on active duty in combat. He explained

> *I was in the army and we did some medical training, and I ended up enjoying the medical training and looking after casualties more than I did my actual job at the time … the American nurses in the coalition's war hospital were really good. They were working hand in hand with the doctors and making a lot of decisions, and I realised just how much responsibility they had, and I thought that nursing was probably for me.* (P8)

The exposure to neighbours during childhood, one who was a male Royal Flying Doctor Service flight nurse and his wife, a community health nurse, ignited one of the participant's interest in nursing as a career. For another being an actual emergency department patient himself with a hand injury revealed that it was his observation of, and talking to, his attending nurse who was male that initiated his thoughts of becoming a registered nurse. Although, one participant shared a negative experience from a male registered nurse colleague who tried to discourage nursing as a profession, which left him "*feeling disheartened*" (P2); however, he quickly added "*this feeling was short lived*". This was not the case for the others who reported that having other male colleagues when they were on their clinical placements supported the consolidation of their identity as a nurse who is male.

Other participants had observed men in nursing whilst visiting family members in hospitals. Their responses are reflected in the following comment from one of the participant's

> *One of the reasons I thought about nursing is because I've been in hospital and many people I know have been in hospital, and it something that takes you out of your comfort zone, but the people who made it better were the people who were around you … nurses are an essential part to that.* (P4)

Working with disadvantaged youth led another participant to nursing although he had initially thought of being a teacher. He remarked,

> *I was leaning towards primary school teaching … decided before I committed to it I had better get some time actually spent with children … I was involved in camps mainly for school kids but also did it for DCP (Department of Child Protection) kids … I did that for a year before I decided I wanted to do nursing.* (P5)

On further probing, he explained that he felt nursing would enhance his ability to provide holistic care to vulnerable groups and afford him more time and learnt skills to engage with the individuals within these groups. He concluded that he wanted to fulfil his need for job satisfaction.

Impressionable events triggered the idea of becoming a nurse for two participants. One had come across a road accident whilst out running. Although he had first aid skills he felt that he could have done more, he explained

> ... not really knowing what to do that sort of got me interested in maybe ambulance work and from there I began searching that, and when nursing came into my researching it seemed more of a natural fit for me. (P7)

The other participant had a background in international relations and agriculture and had travelled overseas. His exposure to the impact of sustainability, particularly on "*how certain communities care for each other and make that the prime focus*" (P3), acknowledged this experience had generated his thoughts of nursing as a career.

Essence of helping

To ascertain the meaning, moreover the essence, of the newly graduated participants lived experience required frequent referrals back to the field notes reflecting on the verbal and non-verbal participants' responses and the review of the researcher's journal by the first author. "Helping" evolved as the essence throughout the transcripts. The probing question of "what is it about nursing that actually drew you to nursing?" revealed two aspects of helping, the external influences on and the altruism within the participants. Visual representation is provided in Figure 1.

The external influences were the exposure to significant others who were in helping roles such a nursing, medicine and other health/social support professions. Additional exemplars' included

> "*I have watched my parents all my life, mum and dad are doctors but mum was a nurse before that, helping people ... I'm not interested in medicine but I really admire what they do and I wanted to do something like that ... so I thought nursing was a better fit for me*" (P9), "*as a patient you spent more time with nurses than you did with anybody else so I felt like they* [nurses] *had the most potential for being a people focused helping profession that it* [nursing] *allows you to help people out when they are probably as far out of their comfort zone as they will find themselves*" (P3).

Hence the exposure to their significant others, their parents and other family members and work colleagues, in their roles of helping, assisted with the formation of the participants' intention to enter nursing. These roles included health professions of medicine, allied health and nursing.

Altruism was evident in participant comments along with the associated enthusiastic gestures such as change in tone and volume of voice and facial expressions. Two participants articulated the concept of altruism as follows

> "*I've always wanted to and I guess excited more now about just being able to help people ... as an army reservist I wanted to help to protect my country ... but now I find myself wanting to help the people of my country in a different way, help them improve their lives*" (P7), and "*helping people in terms of just living their everyday lives, help them along the way, different people at different stages in their lives need that too*" (P4).

Further probing on what nursing meant to them caring was mentioned. On clarifying caring the participants' responses included
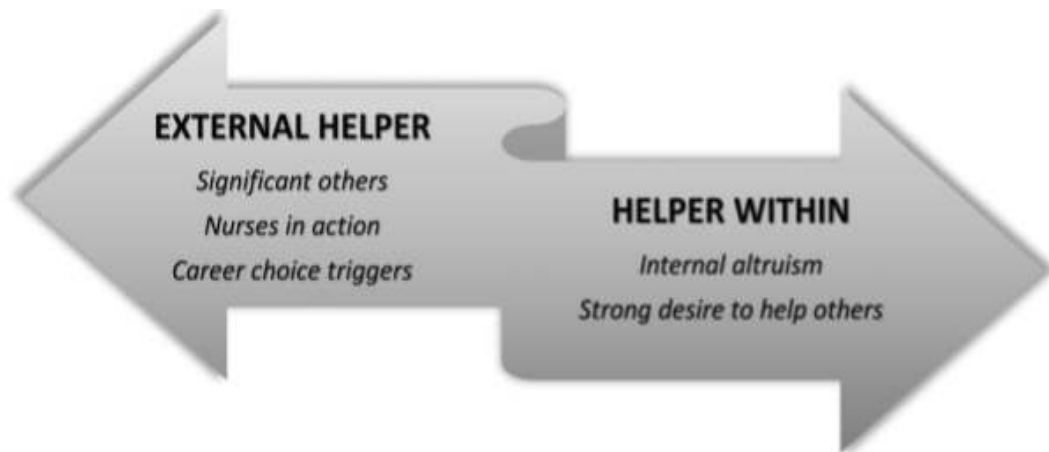
Figure 1. Essence of helping.

> "Caring is helping the patient focus on their immediate and future health" (P2), "caring to me is a nursing word we nurses use when we really mean helping as nursing is a caring profession through helping" (P1), "caring is the help in terms of people's health and just everyday life and provide support when it's needed" (P4), and "just can't be a good caring person in a hospital you actually need have skills that help them in what they are there to get fixed" (P3).

When asked what they can bring to nursing, altruism resurfaced from the participants' comments such as

> "With the computer skills I have and with wanting to help others I feel that I have the ability to assist people when they require technological assistance to get better" (P4), "my problem solving abilities and science research focus using medical technology I see this is where I can help with best care" (P7), and "just love being with the patients and playing with all the machinery, helping them get better and helping them understand the workings on the monitors and mechanical devices they are on" (P2).

Adding to a diverse nursing workforce from the helping stance, most participants felt that more patients these days want a say in the gender of their caregiver. Comments included

> "I feel really good and valued when female colleagues come up and ask me to do a shower or a procedure for their male patient who prefers a male nurse to do the care" (P1), "sometimes young male patients and even the older Indigenous men get embarrassed with females attending to them so this where I can help" (P7), and "being male and having been in the defence force the older blokes, especially those who have served, often seek my help for care they need" (P8).

In the instance of the altruism within, it was the urge to help through seeking out a career that provided the participants with fulfilment and meaning in what they do. This fulfilment was very apparent as the driving force behind the second career participants who chose to enter nursing.

Discussion

The findings of this study were in accordance with earlier studies in relation to similar areas of importance for entering nursing being revealed. For some of the younger participants, job security was a factor in choosing nursing (Rambur et al., 2011). However, for the participants with health

worker jobs, they sought out bedside nursing technical expertise and decision-making, along with career advancement that their previous health worker roles did not provide (Ierardi et al., 2010; Snyder, 2011). The second career participants noted that they were more interested in fulfilment of greater job satisfaction (Harding, 2009; Zamanzadeh et al., 2013), and seeking meaningful work (Moore & Dienemann, 2014; Rajacich et al., 2013). Moreover, all the participants had thought extensively about nursing as a career as they were all aware of the implications of entering this female-dominant profession (Simpson, 2011).

The findings supported an earlier study (Stott, 2007) whereby most of the support for the graduate nurse who is male comes from females who are close to men considering nursing. Participants' in this current study reported that their parents, in particular their mothers, played a major part in influencing their decision to enter a helping profession such as nursing. They also concurred with previous findings on peer support from significant others including other men in nursing were important during their nurse educational phase (O'Lynn, 2004). This study's participants, in accordance with earlier studies (O'Lynn & Tranbarger, 2007; Wilson, 2005), revealed that the encounter with registered nurses and particularly those nurses who were male was a major trigger for igniting their aspirations to undertake nursing as a career. Furthermore, they reinforced a recent finding by Christensen and Knight (2014, p. 101) of registered male colleagues as role models "who bring a sense of maleness to the role". For the participants, the consolidation of their identity as a nurse who is male occurred through exposure to male nurses in action within the workplace. The majority of the study's participants naturally gravitated towards the other males of similar age and backgrounds, and established their own informal support and study networks. However, these participants did voice the value of having a more formal group with access to nurse educators who are male to assist with their assimilation into this female-dominant profession. Access to male nurse educators was valued despite the fact that they all proclaimed that they saw nursing as gender-neutral helping profession.

Increasing the profile of and exposure to nurses who are male should not be underestimated as a robust recruitment strategy to influence other young men to view nursing as a first career choice and older males who maybe rethinking their careers, and produce more positive attitudes and a gender-neutral stereotype for nurses. The participants felt that it is the observation or the experience of receiving nursing care in the professional-practice environment that provides the opportunity for nurses to showcase the diversity and complexity that enhances the exclusivity of their role. Conversely, rejecting the stance of the nurse being the one "behind the scenes", "the handmaiden" and of "just a nurse" mentality.

Furthermore, as previously highlighted (Moore & Dienemann, 2014) and reiterated by the participants in this study, more could be done to encourage additional second career men to undertake nursing; and to facilitate male health workers to move across into the nursing profession. Ultimately to aid in providing a diverse workforce to meet the growing needs of the changing patient profile and patient expectation to have a say in their care, in particular who provides this care.

Adding to existing qualitative literature on men in nursing, the study's participants' acumen towards technology provided valuable insight into the significance of promoting the bedside technology involved in nursing care delivery of today. The participants concur with others that technology is becoming more prominent in bedside nursing practice (Elgin & Bergero, 2015) and a desired work element for men (Rambur et al., 2011). The increasing dependence on technological devices as the complexity of nursing care increases and advancement in health management evolves, puts men who have a tendency towards technology and the desire for helping others well placed for recruitment as a potential nursing workforce. These potential nurses who are male may also complement diversity within the nursing profession to meet the multiplicity of the health consumer beliefs and requirements. It was with the information provided by the

study participants and their consensus that showcasing the registered nurse as a helper is crucial to encourage more men into nursing. Moreover, for this helping to focus on being a highly skilled nurse with bedside technology acumen as a competent decision-maker that enables optimal health outcomes for the patient.

Limitations

Limitations pertained to those related to the qualitative nature of this study. These limitations included a sampling technique wherein a snowballing technique was used. This was due to the fact that the participants were voluntary and were purposefully selected as they were deemed "experts" in terms of their experiences as graduate nurses who are male. Given the qualitative approach, this sampling technique does not meet the underlying principle of replication nor generalisability due to the small sample size of participants. However, this small sample size is supported in IPA due to the idiographic stance of exploring in-depth understandings of the individual participant's lived experiences (Smith et al., 2009). Furthermore, it does provide an insight into the dialogue between the first author and the study participants of what motivated them to choose nursing as a career.

Implications for nursing

The implications from this study pertain mainly to the nursing workforce. They may inform or evoke discussions on effective ways to increase the recruitment of more people, especially the minority groups such as men, into nursing.

Firstly, registered nurses themselves need to be aware that they play an important role in portraying nursing as a career of choice whether this is from the nurses as family members, partners, and others such as neighbours and community members. Likewise, nurses who work with health workers and those persons, in particular youth and those considering their career direction, and along with others that show an interest in nursing, who are treated by nurses should be seen as potential nursing recruits.

Secondly, the image of nurses who are male undertaking diverse nursing roles has been previously suggested (Rambur et al., 2011) and is supported by the participants in this study as a strategy that would entice more men into nursing. This study is supportive of nursing recruitment personnel enhancing the importance of role diversity promotion to enable informed nursing options for young men in their informative years of career selection and those men exploring second career options. This depiction of nursing as a diverse career accommodating multitudes of functionalities and bedside technology in nursing practice is endorsed if increasing the percentages of men entering nursing is desired for the future. Therefore, it would be advantageous to market this aspect in the wide range of current nurse positions and nursing settings.

Another area for consideration is career counsellors' promotion of nursing as a gender-neutral career to accommodate both males and females is recommended. Nursing faculty collaboration with career guidance counsellors in promoting accurate information on gender-neutral nursing to interested youth and parents of school-aged children is supported by this study and others (Meadus & Twomey, 2011). Sponsoring male faculty nursing staff to visit education institutions and participate in career exhibitions may well shift attitudes towards nursing being considered as an appropriate profession for both genders (Mohamed & Mohamed, 2015).

Finally, more formalised male network groups within the health degree sectors of university settings are supported to assist those men who are seeking support and direction in developing their professional identity and meeting the challenges as a nurse who is male. The

opportunity to share their experience and their unique challenges is thought to be beneficial (Stott, 2007).

Conclusion

Overall, it is the influence and the support of significant others, in particular family members, alongside career choice triggers that were the motivators for the participants in this study to enter nursing. However, it was the essence of the helper, both from the exposure to helpers or the experience of being helpers' linkage with their own intrinsic need to help that drew them into nursing as a career. The continuation of support, especially from both formal and informal male peer groups, was also sought as they undertook their journey to qualify as registered nurses.

Further research is recommended on whether the idea of nursing as a career may be formed well before males actually decide to enter the profession. Furthermore, due the qualitative nature of and the small participant number in this study, quantitative research for generalisiblity on whether highlighting the technical and varied aspects of nursing practice does ultimately increase the rate of men becoming registered nurses may be beneficial to inform nursing workforce recruitment strategies.

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Appendix I   The value of male faculty from the perspective of newly graduated male registered nurses

The value of male faculty from the perspective of newly graduated male registered nurses

Dianne Juliff, Kyle Russell, Caroline Bulsara

As part of a study that explored the lived experience of newly graduated male nurses one recurrent theme has became evident - the value of male nursing faculty.

The study questioned nine male participants on how their journey to qualification had been so far. What became evident was the value and impact of male faculty on male nurses' retention in their student phase.

The men interviewed provided comments such as:

"If I am in any doubt of why I'm doing nursing just being in the class with a male nurse lecturer all the doubt disappears."

"Find the male lecturers very positive and their portrayal of nursing really great, enlightens me."

"Good to hear nursing care stuff from a male."

These findings indicated that male faculty was clearly welcomed. What impressed the participants was the presence and the professionalism of the male faculty members, which included their enthusiasm and positive attitudes towards nursing practice.

These findings have been supported by another recent study whereby both enthusiasm and positive attitudes is shown to impact greatly on students' understanding of professional behaviour (Baldwin et al. 2014). Moreover, providing a safe environment devoid of embarrassment, enhances the exchange of differing values respectfully (Morrissette & Doty-Sweetnam, 2010).

Participants also commented on their ability to learn and to inquire when appropriate when there was male faculty: "I don't get embarrassed about things I ask as much", "I tend to ask more questions", and "it's good to hear how they see things as opposed to the female lecturers".

These comments sit well within Watson's (1996) theory of transpersonal caring (Wade & Kasper, 2006). From the nursing education aspect, transpersonal caring occurs between the faculty and students (Bevis & Watson, 1989), and replicates the professional-client relationship (Watson, 1988). Furthermore, similar to other studies, the participants' perceptions of their male faculty role modeling of caring for men may assist with how they learn to care (Grady et al. 2008) and establish the attitudes and behaviours they will utilise in the clinical setting (Horsfall et al. 2012).

Due to the presence of male faculty role models, the participants reiterated no issues of uncertainty or isolation during their attainment of registration, as was once previously reported when there was a lack of role models (O'Lynn, 2004) .

Similarly to a previous study (Etheridge, 2007), the participants reported they had most interaction with faculty members during their undergraduate years and saw them as role models.

What these finding add is the importance of the early stage of male faculty role modeling.

The recommendations from this study focused on the retention of male nursing students within the nursing profession to assist in alleviating the forecasted nursing shortages. Therefore, educational institutions should consider their gender mix within their academic nursing staff, as the presence of male faculty goes a long way in enhancing the stance of a genderless/gender-neutral nursing profession, and with the promotion of nursing to men. The learning to care via role models is well documented in the clinical practice setting, however, in nursing education literature it is limited (Baldwin et al. 2014). Thus this study supports Baldwin's et al. (2014) recommendations, which is the significance of male faculty members as nurse role models requires further investigation.

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Appendix J   Male or nurse what comes first? Challenges men face on their journey to nurse registration

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ABSTRACT

Objective –
This paper aims to provide an account of the first phase of a qualitative longitudinal study that explored the initial challenges men in nursing face to become registered. What is known is that men, a minority group within nursing, face the usual challenges of all new nurses in their quest to register as nurses. In addition, they have added pressures that hinder their quest due to being male.

Primary Argument
An Australian nursing shortage is looming due to nurses retiring from this female-dominate profession. Hence, the retention of men in nursing is an area requiring attention in order to support a sustainable workforce.

Subjects and Setting
Nine newly graduated male registered nurses participated. These nurses had recently commenced employment in the Western Australian metropolitan health region.

Findings
Individual face-to-face interviews produced the theme of role misconception with a major focus on male or nurse what comes first. This theme was derived from the categories of gender stereotyping and marginalisation.

Conclusion
This study suggests the need for a gender-neutral image when promoting nursing within and outside the professional environment. Furthermore, consideration for a professional title mutually accepted by both women and men in nursing, with the gender-neutral 'nurse' title preferred by the men in this study. Moreover to acknowledge that men in nursing will augment a technical savvy workforce that will complement emergent complex nursing practices, and enhance a more comprehensive Australian nursing workforce that will assist with meeting the health care needs of a diverse population.

INTRODUCTION

Within Australian health workforce management, an emphasis is placed on the retention of newly graduated registered nurses and the recruitment of males to generate a sustainable nursing workforce to replace those retiring and leaving the nursing profession (HWA 2013; AIHW 2012). However, there remains a consistent and a slow increase in men entering nursing due to nursing still being regarded as a female-predominant profession (Moore and Dienemann 2014). Of concern is that men employed in female-dominated workplaces leave at a greater rate than women (Bygren 2010). Furthermore, some areas are still resistant, from both staff and patients, to men in nursing where high intimate nursing care is required, (Inoue et al 2006). Gender-based role strain and issues around intimate touch nursing care have been suggested as a reason why men in nursing migrate more towards the technical, rapid assessment areas of emergency and intensive care (MacWilliams et al 2013; Harding et al 2008). Although, the reasons for the higher percentage of nurses who are male in these areas are not really known, "these areas may be perceived as more acceptable or masculine" and have "a preference for male employee in these areas" (HWA 2013, p15). Men who enter nursing have usually 'thought long and hard' about their decision to undertake this career path and are aware of the nuances such as the female image and stereotyping in nursing (Moore and Dienemann 2014).

METHOD

The aim of this component of a qualitative longitudinal study was to explore initial challenges men in nursing face in the attainment of their registered nurse qualification. The study utilised a phenomenological approach in order to explore the lived experiences of the men. Personal perspectives on their journey, via each participant's own words, was gained through the use of face-to-face in-depth semi-structured interviews with open-ended questions. This interviewing style was employed to "facilitate rapport and empathy, and permit great flexibility...to produce rich and interesting data" (Smith et al 2009, p66).

Research question and sample

The research question that informed this first phase was "how has your journey as a male nurse been so far?" Nine newly qualified registered nurses who were male were recruited via purposeful sampling using snowballing technique.

Ethics

This study was conducted in accordance with the National Health and Medical Research Council's (2007) Australian code for the responsible conduct of research. Prior to commencement of the study, ethical approval was gained from the University of Notre Dame Australia, Human Research Ethics Committee.

Procedure

Once recruited, participants were invited to select a location for their interview to take place, along with the nominated time and day that suited individual participants. To protect the confidentially of those recruited they were referred to as participants or men in this study, and their data was de-identified. Verbal consent was gained prior to the commencement of each audio-recorded interview to confirm the prior written consent. The research question was asked to elicit their experience in a non-threatening manner. Probing questions were then used to explore more in-depth experiences they volunteered. The participants' responses were audio-recorded by the first author. The interviews varied in length, lasting for approximately 45 minutes. After each interview, the first author transcribed verbatim the participants' responses. The data analysis was concurrent with data collection and involved the coding of the transcripts through the comparison between codes and categories to produce the theme. The analysis process via the iterative stages fashioned the categories that revealed the theme of role misconception as a major challenge they faced.

Trustworthiness

Trustworthiness was derived from Lincoln and Guba's (1985) credibility, dependability, confirmability and transferability criteria. This was met by the use of member checks for accuracy of transcription; peer assessments of interview transcripts, data process and analysis; direct participant quotes to support findings; and an audit trail evidence of the analytic decisions through the use of the researcher's diary (Houghton et al 2013).

FINDINGS

When the men in this study were asked, "how has your journey as a male nurse been so far?" the majority of them responded by indicating that they had enjoyed the study and learning aspect of their journey. Comments included "*loved the whole experience of nursing so far*", "*loved the study and clinical practice*" and "*the whole identity of being a nurse*". Although two felt their nursing education was female orientated, and at times this gender orientation was off putting, thereby leading to the identification of a key theme of role misconception.

Role misconception was extracted from the issues of gender stereotyping and marginalisation that the participants experienced on their journey to registration. Gender stereotyping within the health setting for most of the men in this study was being mistaken for a medical student and even a doctor. Furthermore, some of them verbalised that often patients were surprised that they were doing nursing, comments included "*what's a guy doing nursing*", "*didn't you want to be a doctor?*" Another participant stated, "*I think society has a skewed view of what nurses do and how males fit into the nurse role*".

A common theme emerged that participants did not want to be seen as unique or different. All the participants respected and supported the title of nurse. Of note, they felt that the image of nurses was female fixated, with two of them vocalising their disdain for the title of 'sister'. One of the men narrated "*I wasn't expecting to be so identifiable as a male nurse*". The major issue for most of the men was centred more on being called a male nurse. Three of the men revealed that on occasions they have stated, "*I am not a male nurse, I am a nurse*", finding the male and female differential "*distasteful and unnecessary*". One declared he does not like the reference to 'how good it is seeing more males in nursing' and verbalised "*I am just a nurse*". Another retorted with "*being a nurse as opposed to being a male nurse at the end of the day we're all nurses and we all have to do the same job*". Other exemplars included a nursing academic referred to "*having a boy look*" when a student could not find a reference he needed; another with "*academics alluding to males not being able to express themselves when reflecting on how they feel with their experiences isn't right*".

A consequence of the stereotyping impact for some of the men in this study meant that when going out socially and asked what they do, many would give responses such as "*I work in health*", "*I'm a public servant*", leaving the enquirer to interpret what they actually do. Reason for their avoidance in providing their actual job title was due to previously experiencing the looks of surprise or being teased about their career choice or being asked about their sexual orientation. Similar comments like "*my friends outside nursing joked and teased me about nursing and that I might turn gay*" were also reported.

Marginalisation consisted of two main areas, the feeling of being the outsider within and when providing nursing care. The provision of nursing care covered both issues of intimate touch and patient allocation. The majority of the men in this study initially feel overwhelmed with feelings of being the 'outsider within'. Comments included "*initially coming into the large student group was daunting*", "*sometimes you feel a bit on the periphery*". Hence there was a gravitation towards self-formed male groups in an attempt to nullify the outsider within feeling. One of the men commented "*the boys tended to hang out a bit...I think because most were mature age... you just tend to relate a bit better and I guess it's the male thing also*". Another with "*it was the same in the practice environment where I would engage more easily with the males working on the ward who were of similar age and background*". However, two participants revealed that although of

the same gender they had nothing really in common with the male groups and aligned more with those who had previously worked in the health field as they had.

The 'outsider within' from a practice environmental aspect was an expression some participants mentioned to highlight the feeling of being isolated, and a minority within nursing, with comments from female colleagues such as *"it's good you're standing up and being different from the norm"*. One participant expanded this with *"through my pracs (clinical placements) I felt like an outsider most of the time"*. Another participant shared an instance in a mother and baby unit where both the mothers and the female nursing staff questioned his presence. He stated *"felt a kind of hostility towards me for being a guy; this was actually hanging over me while I was there"*.

Providing nursing care marginalisation related to intimate touch in varying degrees for the men in this study, with most of them just taking it as a given barrier in the career they had chosen. Most stated that as student nurses they were always supervised when performing intimate touch nursing care. So they felt it was not a real issue for them as yet. It was seen as more of an issue for the nurses who allocated patient loads with participant comments of *"coordinator will avoid assigning a guy to a specific patient"*. However, they were aware of the potential for accusations of inappropriate behaviour and innuendoes of sexual deviance or homosexuality. Furthermore, acknowledged that intimate care by a nurse who is male can be an issue generally in instances when the patient is female, due to cultural beliefs and in gender sensitive ages such as the adolescent patient. Similar comments of *"she allowed me to do obs and medications but she didn't want me to doing the catheters and toileting and the more intimate stuff... I can see where she was coming from"* were elicited during the interviews. Two of the men stated that on occasions it happened in the reverse where a patient has a preference for a nurse who is male. One commented,

> *"when faced with age and gender issues I give the patient a choice. I don't get upset nor discouraged*
> *when the patient prefers care from a nurse who is female as at times the reverse has occurred*
> *where a patient has had the preference for a nurse who is male"*.

This is not to say that male patient intimate touch was not as an issue for them, with some of men in this study concerned not to been seen as 'gay'. One of the men stated *"there's a little bit of stereotype, every now and then, a comment or someone asked me if I was gay...I think my wife would be disappointed with this suggestion"*.

Intimate touch issues did not seem to be what enticed the men in this study to a more low touch technical area of nursing. They provided comments of,

> *"the intimate stuff is not an issue for wanting to go to emergency"*, *"just love the excitement and*
> *the never knowing what is coming through the ED door"*, *I loved my mental health prac...I really*
> *did think that's what scored it for me"*.

Most of men in this study, as they entered the practice environment, gave their preferences toward mental health and the technical specialty areas such as critical care, operating theatres and emergency departments with comments such as *I'm always interested in the technical elements of nursing, the drips, all that stuff"*, *"get to use my critical thinking in a pressured environment"*. They believed these environments would constantly change and would challenge them, and resonated with *"can't wait to be challenged"*, *"it's great having that theory and actually seeing it in practice"*, *"in emergency it's triaging, critical thinking skills and prioritising... at the forefront...making a difference"*.

Patient allocation marginalisation occurred when the participants were predominantly allocated male patients instead of female patients. Thus excluding them from gaining experience in nursing duties relevant

to their learning needs at the time. One reported, "I kept being allocated menial tasks in a female ward", and felt the opportunity for learning was not provided nor encouraged by a clinical nurse. He felt he was treated differently because he was a male student nurse. Another added that being both older and a male "have different expectation of you...you are the exact same level as fellow nursing students (they) assume you bring something different to the table that's not necessarily the case".

DISCUSSIONS

The gender orientation findings of this study add support to previous research where the male nurse's role in care provision is often negated due to gender bias (Ierardi et al 2010; Duffin 2006), and the feminised nursing curriculum (Christensen and Knight 2014). The men in this study, similar to a recent study (Koch et al 2014), felt men in nursing were more acceptable these days. Although, they also agreed with others that barriers still exist (Stott 2007; O'Lynn 2004). These men lend weight to previous findings that gender discrimination and gender stereotypes still occurs within the nursing profession (Kouta and Kaite 2011). Most of them articulated with other studies in that nursing is still seen as a 'woman's job' (Snyder 2011; Wingfield 2009). They also supported the notion that to improve society's acceptance of men in nursing required the nursing profession to de-feminise by enhancement of the image of nurses who are male through portraying them in their caring roles (Colby 2012).

This study reinforced previous research where there was expressed surprise that men were doing nursing (Wingfield 2009). Furthermore it concurred with other studies that gender stereotypes are constructed by society and influenced by the media (Weaver et al. 2014; O'Brien et al 2008). Reported elsewhere (Rajacich et al 2013; Herakova 2012) and claimed by the men in this study, the male nurse title reinforced their minority status and add to the gender-bias and stereotyping, both within and outside nursing. Moreover, they reiterated the need for a gender-neutral title for men in nursing and concurred with previous studies that recommended 'nurse' as opposed to 'male nurse' be used (Rajacich et al 2013; LaRocco 2007).

Being teased about their career choice or being asked 'if they are gay' resonated with this stereotype as a unique conflict for men in nursing previously reported (Stott 2007). Furthermore, reluctance at revealing they were nurses when asked about what they do to avoid being viewed as feminine has been reported recently (Zamanzadeh et al 2013).

The finding related to feeling overwhelmed initially and of being the outsider within on entry into the female-dominant nursing profession has been reported elsewhere (Christensen and Knight 2014). The reported marginalisation of the outsider within and gravitation towards male groups due to being in a female-dominated profession is consistent with other studies (Christensen and Knight 2014, Stott 2007). Most of the men in this study supported strategies that promoted networking with other men in nursing (Moore and Dienemann 2014) and the presence of male role models in nursing education (Stott 2007).

They all agreed with previous studies that female intimate care provision nursing can lead to them being uncomfortable about fulfilling role obligations (MacWilliams et al 2013) and feeling vulnerable (Harding et al 2008). However, it was not seen as a major issue for them. Similar to a finding by Harding et al (2008) the men in this study respected the fact that patients have rights and were not perturbed when they were met with refusal of their care from patients. The 'not too been seen as gay' theme was congruent with a previous study that revealed intimate touch in clinical practice in relation to both male and female patients is a concern for men in nursing (Harding et al 2008).

Although initially interested in the clinical setting, men often find themselves being drawn to more low-touch technical specialty areas (MacWilliams et al 2013). This was the case for the majority of men in this study

as they entered the practice environment insomuch as their desire for technical specialty areas. Their desire to work in the emergency department was predominantly due to an inter-professional team environment this area provided. Moreover, they dispelled the assumption that intimate touch was also a reason for their decisions of careers in mental health or the more technical areas.

Patient allocation marginalisation by being treated differently during clinical placement has been reported previously (Wingfield 2009; Keogh and O'Lynn 2007). Some of the participants supported previous research in relation to the limiting of their full participation in some nursing specialty areas (Evans 2004), and of feeling isolated in clinical practice at times in the female-dominant workplace (Wilson 2005). Another participant added that being both older and a male he was given more responsibility and inclusiveness in complex care than others on clinical practice at the same student level. This finding concurs with a recent study (Koch et al 2014) where staff delegated more responsibility to older students and treated them as qualified nurses.

LIMITATIONS

Inherent limitations were the qualitative nature of this study. It does not meet the underlying principle of replication nor generalisability due to the small sample size of the voluntary participants. However, it does provide an insight into the dialogue between the first author and the study participants in relation to their lived experience in their journey to qualification as registered nurses.

CONCLUSION

What this study adds reinforces the concerns of men entering the nursing profession. As they journey towards nurse registration, concerns are commonplace in relation to their professional identity, gender stereotyping and marginalisation that has been reported over the last two decades and still remains today. The men in this study emphasised that the image of a nurse, from within and outside the nursing profession, requires attention to enhance a more cultural and societal normalisation of nursing as a gender-neutral profession. Moreover, supporting the belief that a gender-neutral nurse image will encourage more men into nursing.

RECOMMENDATONS

Retention of men in nursing will assist in meeting the increasing health service demands as the population ages. The study's findings may foster discussions on ways to improve their journey in the quest to obtain registered nurse qualification. Improvement recommendations include:

- Nurse educators and nursing curriculum developers' enhancement and promotion of a gender-neutral stance in nursing practice that reduces men in nursing being seen as unique.

- Nursing curriculum to include effectively protective strategies for nurse-patient relationships in relation to touch. Furthermore to include this education for both male and female nursing students due to increased population diversity requiring patient centered cultural sensitive nursing care provisions.

- Consideration for a professional title that is mutually accepted by both women and men in nursing that may lead to reducing men as a gender minority.

- A model of inclusivity with the establishment of male support groups to aid in a more seamless transition of men into the nursing profession.

- Consideration in the nursing faculty gender mix to expose both male and female nursing students to male faculty members, supporting the "importance of regular male role model contact" (Stott 2007, p330). Thus to demonstrate how men apply their nursing knowledge and skills to the art of nursing especially in complementing the complex technical nursing practices that are emergent.

All of the above is recommended, ultimately to increase the recruitment and retention rates of men in nursing. Thus to enhance a gender neutral Australian nursing workforce that will assist with meeting the health care needs of the rapidly growing diverse population.

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Appendix K   GRNM email and response

Mon 06/10/2015 8:42 AM

To: Dianne Juliff (juliff_di@███████████

Hi Di,

Thanks for sending that through, I like it. It is an accurate representation of what I experienced and what some of my mates experienced too. I think it will be a valuable research piece. I am looking forward to reading the finished paper.

Regards ████████

From: juliff_di@███████████
To: ██████████████████
Subject: Summary of first interviews: Confidential
Date: Wed, 23 Sep 2015 11:55:22 +0800

Dear ██████████

Hope this email finds you well. Please find attached the overall summary of the first interview done as you commenced RN employment. The information in the summary will be what I will use mostly for the articles that I am drafting at the moment and will be the basis of the findings chapter in the thesis being: Draft articles attached are

- Motivators for men to enter nursing: first phase of a qualitative longitudinal study

- Male or Nurse what comes first, the challenges men in nursing face on their journey to registration: a qualitative study

- The value of male faculty from the perspective of newly graduated registered nurses who are male

Need to keep the attachments confidential please as it is unpublished material and hasn't been verified by you that you are fine with this information that will be published. In the decision sections you can see why I chosen certain quotes and what direction I am writing from.

Please review when you have time and let me know what you think of it so far by either replying to this email before we meet or we can have the discussion at our scheduled meeting in two weeks.

Regards

Di

Mob: ██████████████

Appendix L   Dublin nursing leadership presentation

Nursing Leadership Influence on Male Graduate Nurses Retention Experiences Explored in the Professional Practice Environment

Dianne T. Juliff, MSc(Nsg), PhD candidate

School of Nursing & Midwifery, University of Notre Dame Australia, Fremantle

What is known

Nursing leadership influences nurse retention[1]. Lack of leadership increases stress within the professional practice environment (PPE) that erodes workforce stability, and adds to the continued attrition rates of graduate nurses, thus having a considerable cost impact to both the health budgets and patient outcomes[2]. This PPE stress is dealt with in various ways by the diverse workforce such as men in nursing who are underrepresented; therefore the attraction and retention of men is imperative to support a sustainable workforce[3]. Professional socialisation of new graduate nurses major barrier is marginalisation[4], with nurses who are male often treated differently[5]. For graduate registered nurses who are male (GRNM) the ability to change their communication styles to enhance assimilation into a female-dominant workplace aids in reducing this PPE stress and increases their retention.

THE STUDY

Purpose:

To investigate the lived experience of GRNMs with view of understanding how these nurses transition into the PPE and ultimately the nursing profession in the second phase of this longitudinal study. Thus opening the discussion on schemes that may assist with future recruitment and sustainability of males entering the nursing workforce.

Design & Methodology

INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA)

Interpretative: double hermeneutics *"Researcher is making sense of the participant, who is making sense of x"* (Smith, Larkin & Flowers, 2009, p. 35)[6]

Phenomenological: insider viewpoint of the GRNM lived experience

Idiographic as IPA focuses on the particular, *the individual's lived experience*

Figure 1: Analysis process
p = GRNM participant

Purposeful sampling: Snowball technique ensured expertise was obtained through the voiced experiences of 9 GRNMs about to commence the first year in their PPE.

Findings & Discussion

Second phase findings supports Duchscher's 2007 Transition Stages Model (Figure 2) in exposing the likelihood of crisis around the 4 to 6 month stage of newly graduated nurses commencement in their new profession[7]. Leadership and collegial support, moreover the lack of, seeded doubts on whether nursing was right career for the GRNMs. Unprofessional nurse to nurse communication and workplace marginalisation of GRNM adding to their doubts. For the newly GRNM the added issue focused on the co-cultural aspect of working in a female-dominant profession; with their need to fit in, to be part of the team; thus is consistent with Orbe's (1998)[8] co-cultural communication model's 'outsider within perspective' in relation to their professional socialisation.
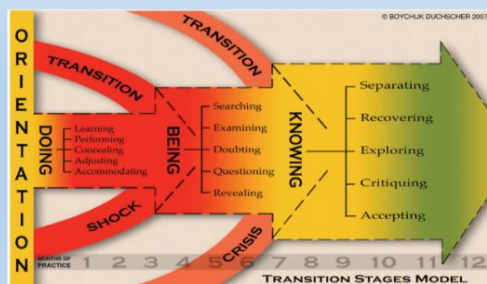

Figure 2: Boychuk Duchscher's 2007 Transition Stages Model Source: Duchscher (2008)

"Often worked in shell shock mode especially when the realisation hits home that you are no longer a student and you are in the lead role... frustrated from the lack mentors or support staff...definitely being thrown into the deep end" (Connor)

"If you are ever confused of why somebody goes something you can just ask someone without being treated like you a stupid, the staff really look after you...this kept me going in those turbulent times" (Ben)

"The staff had really a huge impact on how, in terms of support and friendliness, really made it for me...they made an effort to be welcome me" (Wade)

"Transition from student to grad is pretty full on, it's massive, just so different...self-doubt was more focused on performance rather than my nursing skills...without the support of the staff I wouldn't have made it" (Ryan)

Figure 3: Transition shock
Source Duchscher (2007)

Pseudonyms are used to protect the identity of the GRNM participants

Consistent with previous literature:

- Constant pressure, both from within and from others to 'hit the ground running'[9] leading to repeated expression of being overwhelmed and being afraid of their actions more so than lack of actions.
- Fear of making a mistake and feeling unsafe relates to 'Transition Shock'[7] (Figure 3) impacting on the GRNMs' confidence and self-image that heightened around the 4 to 6 month stage, 'Transition Crisis'[7].

It was during this crisis stage the GRNMs felt that nursing leadership is paramount. Without explicit nursing leadership in the form of collegial support and caring behaviour within their PPE, the majority of the GRNMs revealed that they would have left the nursing.

Overall, the GRNMs reinforced that a viable work environment is embedded in role modeling the nursing leadership characteristics of a welcoming, supportive and inclusive culture. This modeling starts with the welcoming of newcomers (including student nurses and graduates) into the workplace, through constructive support in their learning and assimilation into a no blame gender-neutral culture. Moreover, the acknowledgment of the newcomers' status and the willingness to support them in their transition into the PPE is important in the retention of a sustainable nursing workforce.

Conclusion

Nursing leadership at all levels is at the forefront of recruitment and retention of nurses. Support for newly graduated nurses in promotion of a proactive and engaging nursing profession and investment in leadership programs, especially of the minority groups such as men, cannot be underestimated.

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