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Self-Care Vs. Self-Sacrifice in Medical-Surgical Nursing Culture: A Critical Ethnography

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SELF-CARE VS. SELF-SACRIFICE IN MEDICAL-SURGICAL NURSING

CULTURE: A CRITICAL ETHNOGRAPHY

by

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ABSTRACT

The critical ethnography research examines need prioritization culture among medical-surgical nurses. Grove, Burns, and Gray (2013) define the problem statement as an explicit identification of the research need. Literature search yields scarce ethnographic research on the nursing population as a culture-sharing group, and no qualitative research exists regarding medical-surgical nurses' self-need prioritization. The purpose of this critical ethnography was to observe medical-surgical nursing culture, related to personal need prioritization, as reflected by behavior and dialogue.

Qualitative research methodology is appropriate where statistical data is not suitable. Research motivation involves seeking insight and sociocultural understanding. Critical ethnography is the chosen qualitative research methodology for this study based on research gaps. Ethnography research promotes cultural awareness and highlights change potential. Participants were full-time, day-shift medical-surgical unit nurses at a large Southeastern United States hospital. Data collection consisted of field observation, individual interviews, and surveys which occurred over a two week period. All 10 participants completed the Nurse Codependency Questionnaire (Allison, 2004) upon observation completion.

Findings provide visibility to self-sacrificial tendencies and self-care adaptations within the medical-surgical nursing culture. Multiple themes emerged, and the researcher identified complex self-care behaviors. Data lead to more questions and implicated further research. The goal of this research was to encourage cultural self-awareness and promote inward change. Cultural examination examines both positive attributes and

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limitations. Future progress, because of introspective research, may lead to a nurse

metaparadigm shift through continued scholarly reinforcement.

ACKNOWLEDGMENTS

DEDICATION

This work is dedicated to the 10 medical-surgical floor nurses who participated in this study. Their honesty was invaluable, and this work belongs to them. Additionally, the study is dedicated to medical-surgical floor nurses everywhere who seek balance as they work hard to care for so many patients, themselves, and their fellow nurses. I must also thank my husband and family for their patience and unconditional support throughout my graduate studies.

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LIST OF ABBREVIATIONS

ED	Emergency Department
IRB	Institutional Review Board
MANOVA	Multivariate Analysis of the Variance
NCQ	Nurse Codependency Questionnaire
NSI	Nursing Solutions Incorporated
PIN	Personal Identification Number
PTSD	Posttraumatic Stress Disorder
RN	Registered Nurse
SSS	Self-Sacrifice Scale

CHAPTER I - INTRODUCTION

Nurse burnout and subsequent turnover perpetuate despite efforts to remedy staffing policies and nursing practice legislation (Nursing Solutions, 2016). Written rules regulate individuals and organizations but cannot change the culture. Nursing culture supports self-neglect and self-care shaming (Hall & Wray, 1989; Pask, 2005). The existing research seeks external burnout causation while this research is introspective. Nursing research must examine nursing culture. Specifically, research is needed on self-sacrifice versus self-care and how nurses contribute to their own well-being. Cultural immersion yielded information about nursing culture and identified problem areas. This research applies to nursing burnout and overall sustainability of bedside nursing. Classical nursing theory reflects idealistic conditions while nursing practice reflects reality. Such discrepancies beg for reflection.

Different nursing specialties have various reputations. Medical-surgical nursing, also known as *floor nursing*, describes inpatient care. Patients may be hospitalized for varying degrees of illness or surgery. Floor nurses are responsible for multiple patients at once on any given shift. These patients require different levels of assistance, medications, and assessment depending on their condition. Floor nursing has a reputation as the "front line" of the nursing profession and a rite of passage to better work environments (MacKusick & Minick, 2010).

Bedside nursing often serves as a launch point towards advanced practice nursing. Relevance lies in the potential for nursing culpability and control over their own professional well-being. Critical ethnography identifies cultural trends and highlights shortcomings. Progress could revive bedside nursing as a desirable position. Lack of

existing scientific research on both medical-surgical culture boosts the relevance of potential research. Bedside nurse turnover trends illustrate the need for further inquiry.

This research examined self-need prioritization culture among medical-surgical nurses. Self-need prioritization encompasses both self-care and self-sacrifice. Research aimed to understand how working nurses rank their own needs by observing behavior, verbiage, and survey results. Field observations provided information on group behaviors while participant interviews and survey results described individual data. Combined behavioral and verbal data supported each other. Findings were examined for alignment with psychological theory introduced by Abraham Maslow (1943). New research provokes further inquiry into the status quo. Implications also pertain to well-researched areas like burnout and its impact on quality of patient care.

Background

The literature discussed in this research served as the foundation for research questions and methodologies. Research gaps steered the study. Background research also aided in disseminating upcoming research findings. The literature review extended beyond nursing. Sociological, historical, and anthropological information were also relevant to the subject of self-care and need prioritization. While related literature was abundant, the review yielded limited nurse-specific research. The lack of nurse-centric research mirrored nurses' tendencies to focus outward. Helping professions are notorious for self-neglect (Bélanger, Caouette, Sharvit, & Dugas, 2014). While occupational stereotypes may appear fictitious, widespread burnout is real. The research design was inductive in hopes that self-awareness would ignite cultural progress. The researcher brought readers into the nursing culture through immersed research. Ethnography

illustrated nurses' reality while existing literature provided reinforcement. Cultural change begins with cultural enlightenment. Identity exploration is a good starting point.

Nurse Stereotypes

Perceptions of well-being often depend on perceived expectations. Nurse stereotypes influenced the expectations of nurses throughout modern history (Fealy, 2004). Bridges (1990) discussed common nursing stereotypes. The author deduced four primary, female stereotypes as depicted in the media: the "battle-ax," the seductress, the doctor's "handmaiden," and the angel. Stereotypes represent extreme characterizations. Throughout media history, nurses have been portrayed as one or a mix of these personas.

The battle-ax nurse stereotype describes a callous nurse. Patient suffering is part of the healing process and earns little compassion from this type of nurse. The battle-ax fulfills doctor's orders abruptly and without regard for patient comfort. She objectifies the patient. The seductive nurse, often portrayed as attractive and provocative, focuses on the physician. She capitalizes on her sexuality. This nurse's workday consists of flirtation and admiration towards her male attending physician. Patient care is not her focus unless it creates an opportunity to please the physician with her obedience. Nursing skill and technical competency come secondary to submissiveness. Perhaps skill is not necessary for her to be successful. Third, the doctor's handmaiden is similar to a magician's assistant. The handmaiden nurse lacks autonomy and clinical judgment (Bridges, 1990). Finally, angelic nurse depictions are gentle and selfless. These stereotypes persist, according to a 2007 study, with the addition of the maternal nurse stereotype (Kalisch, Begeny, & Neumann, 2007). Subsequent research indicated that both registered nurses and the public perceived nursing differently based on these stereotypes. The most

common assumption is the nurse as the physician subordinate. Surveys of non-nurses affirmed the misconception that nurses are less skilled and knowledgeable than physicians (Dahl, 1991). Despite misunderstandings, nurses continue to give of themselves. For this trait, some consider nurses angels in disguise.

Nurse Martyrdom

Deification of nurses encourages self-sacrificial norms. Groesbeck (1975) discussed historical deification of professional caretakers. Healing throughout history is regarded as supernatural. This philosophy stems from superstitious beliefs that the same higher entity which allows illness also facilitates healing (Groesbeck, 1975). Biblical references mention healing miracles such as Jesus' laying of the hands (John 9:1-12, New King James Version Bible). In addition, healers often fulfill a savior-type role by rescuing someone from imminent harm. Selflessness also corresponds with savior criteria. In Greek mythology, god Chiron remained unaware of his own wounds while treating others' and later died (Graves, 1955). Such extreme selflessness crosses into martyrdom. Detrimental self-sacrifice, which takes precedence over a nurse's own well-being, breeds a nurse martyr (Hall & Wray, 1989).

Professional Gender Segregation

While nurse martyrdom is a recent concept, gender-related professional stereotypes are well documented (Gauchat et al., 2012; Lauzen et al., 2008; Yu et al., 2014). Occupational gender stereotyping occurs in both sexes. Technical professions are male-dominated while caring professions are stereotypically female. Physicians are usually portrayed by men in the media (Lauzen et al., 2008). Business executives are also usually portrayed as male. Teachers, nurses, and secretaries are typecast female (Kalisch

& Kalisch, 1982; Weaver, Salamonson, Koch, & Jackson, 2013). Female and male-dominated professions are susceptible to hyper-sexualization. An example is manual labor, like construction. Media likely portray a construction worker as a strong male type. He works hard except when he is soliciting female passers-by. The female secretary works at her desk by day in between flirtation with her boss (Lauzen et al., 2008). Female occupations are consistently depicted as less technical and less skilled. Perhaps a woman's job must only accentuate her femininity. Why are femininity and skill adversaries? Likewise, why are men questioned for pursuing female-dominated careers like nursing? Are professionals limited by these stereotypes?

Stereotypes and Professional Identity

Although nurses may outwardly reject stereotypes, professional identity manifests itself in behaviors (O'Connor, 2008). Group stereotypes impose individual expectations (Stets & Burke, 2000). For example, the nurse who questions a physician's order may appear outlandish because of subservient nurse stereotypes. Researchers proposed that identity may be inherited, not chosen. Parts of identity are teachable and vulnerable to external factors like stereotypes. Bridges (1990) expressed perpetuated nurse stereotypes despite practical evolution. A qualitative study reported that people exhibit certain professional characteristics based on qualities they would want people to associate with them, not based on qualities they naturally possess (Ibarra, 1999). Nurses have more clinical autonomy now than decades ago, yet television still portrays physicians performing nursing skills like intravenous access and Foley catheterization (McHugh, 2012). Nurses are seen coming and going from patients' hospital rooms but are rarely the

focal point of patient care coordination. Additionally, media rarely highlight nursing specialties. Much of professional identity is conveyed through language.

Verbiage

The literature review identified anthropological influence on cultural tendencies (Sökefeld, 1999). Identity is expressed by the words chosen to describe oneself. Words carry multiple definitions as seen in the term *nursing*. The word *nursing* has a dual meaning: breastfeeding and professional nursing caretaking. Ironically, both definitions of nursing involve giving of oneself to facilitate another's wellbeing and carry a feminine connotation. A 2007 qualitative analysis processed the occurrence of certain words, phrases, and images with regards to nurses using internet search engines. The study collected data for over three years. The results indicated some positive evolution in the description of nurses as intelligent, educated, and accountable while scores were low on words related to diversity. In the three-year span, some professional identity characteristics increased like "attractive," "promiscuous," "cool/with it," and "competent" while others such as "innovative," "powerful," "scientific," and "autonomous" decreased (Kalisch et al., 2007). Job titles have evolved over time such as *stewardess* to *flight attendant*, *fireman* to *firefighter*, and *waitress* to *server*. While these changes are largely geared towards gender-neutralizing, it is an illustration of professional evolution nonetheless. Other professions have interchangeable titles, such as *doctor* and *physician*. *Nurse* and *nursing* remain static.

On a larger scale, common language contributes to cultural and professional identity (Bjöernsdottir, 2001; Stets & Burke, 2000). Southern American vernacular is an example. Colloquialisms like *y'all* and *fixin' to* become a cultural trademark in the same

way "caring" and "compassion" become a part of nursing vocabulary. Nurses who do not identify with cultural norms may feel ostracized (Lee, Hsu, Li, & Sloan, 2013). Is it possible to be a good nurse without having empathy? Is scientific affinity adequate to fit into the nursing culture? Research on words and their impact on nursing could explain observed behavioral phenomena like self-sacrifice. Regardless of vernacular, nursing is established as physically and emotionally taxing (Kashani et al., 2010). Self-care behavior proves challenging in a field defined by taking care of others. Sociological and anthropological evidence is critical to accurate cultural illustration.

Compassion Fatigue

Overexertion, both physically and emotionally, contributes to compassion fatigue in multiple caretaking professions. A 2002 case study constructed a compassion fatigue model for psychotherapists (Figley, 2002). Compassion fatigue symptoms mirror the characteristics of Post-Traumatic Stress Disorder (PTSD). Both compassion fatigue and PTSD occur following exposure to emotional or physical trauma. Researchers identified PTSD in nurses (Mealer, Burnham, Goode, Rothbaum, & Moss, 2009). While most symptoms occur following first-hand exposure, some experience secondary traumatic stress. Secondary trauma occurs following the awareness or witnessing of another's trauma. While empathy is a natural and healthy response, secondary trauma causes stress internalization and causes damage. Toxic empathy can be difficult to identify since the emotion also motivates caretaking behaviors (Figley, 2002). Individuals may become desensitized to routine stressors over time although prolonged stress damages overall well-being.

Figley's (2002) research outlined the progression of caretaking to compassion fatigue. First, the empathic ability exists in a professional caretaker. Second, the caretaker expresses empathy for the patient. Following the third step, exposure to the patient, the caretaker decides on a therapeutic intervention. While some technical skills are void of emotional attachment, the caretaker experiences an overall empathic response. The first indication of compassion fatigue comes in the form of *compassion stress*. Stress may occur in response to fear or anxiety related to the patient's progress or their receptiveness to therapy. Positive patient outcomes bring the professional caretaker a sense of achievement. Intermittent positive reinforcement fosters attachment. The caretaker may attempt to detach when stress accumulates. This phase of Figley's (2002) model is called disengagement and attempts to protect the caretaker with a buffer of indifference. Caretakers repeat the cycle until negative emotional responses can be anticipated, and therefore dreaded. Finally, compassion fatigue leads to life disruption in areas not associated with the caretaking situation. Although Figley's research pertained to psychotherapists, the subject matter is ever-relevant to nurses. Nursing researchers describe the peak of compassion fatigue as burnout. Compassion fatigue is an important concept to this current research because it relates to self-sacrifice and martyrdom.

Problem Statement

This research observed behavioral demonstrations of personal need prioritization, self-sacrifice, and self-care among medical-surgical nurses. Self-care behaviors included taking allotted meal breaks, hydration, elimination, and completion of shifts on time. Self-sacrifice is detrimental over-exertion and the absence of self-care. Self-need prioritization varied with the individual although collective behavioral data implicated

cultural norms. Individual interviews noted verbal trends among participants. The researcher assessed common verbiage related to the subject matter. Emerging patterns and themes illuminated cultural trends related to need prioritization and fulfillment in the professional nursing environment.

<div align="center">Significance</div>

Turnover

Medical-surgical nurse staffing trends warrant large-scale qualitative nursing research. Salary, nurse-to-patient ratios, and legislation are external contributors to nurse retention. The nursing field lacks introspective research. Qualitative research may promote cultural self-awareness and lead to a metaparadigm shift. Bedside nurse retention trends downward with time as described in Chapter II, illustrating the urgency for nursing research from a new perspective. Seasoned nurses leave their unit seeking other opportunities. Novice nurses prematurely find themselves in a preceptor role. Trends such as this highlight the importance of nurse retention and unit diversity. Self-neglect, whether physical or emotional, feeds the burnout cycle. Individual nurse martyrdom begins early in one's career and perpetuates a culture in crisis. For example, a survey ($N = 3,266$) reported that 51% of novice nurses worked voluntary overtime in 2005, and 13% worked mandatory overtime. After one year, 37% of surveyed nurses voiced a desire for a specialty change (Kovner et al., 2007).

Stereotypes

Nursing stereotypes need careful attention. Nurses can assume the power to accept or reject these stereotypes through their actions. For example, the assumption that floor nursing is "the frontline" of nursing survives partly due to nurses perpetuating that

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stereotype. Nurse martyrdom recognized as admirable dedication is toxic to forward

progress in nursing culture. The measure of nursing goodness must rely on healthier

benchmarks. Altruistic nurse stereotypes, both unrealistic and unattainable, perpetuate

without emerging qualitative research to ask introspective questions. Ineffective nurse

stereotypes persist and manifest in individual behavior, warranting rigorous research to

promote evolution. New norms could extinguish horizontal incivility. For example,

nurses who take their entitled lunch break per regulations and hospital policy need not

feel guilty or ostracized by other nursing staff who choose to forfeit theirs. These issues

need further inquiry to bring awareness and ignite a metaparadigm shift.

Self-Sacrifice

Some degree of self-sacrifice is inevitable. For example, nurses must perform

professional duties regardless of preference. Nurses go to work despite personal stresses.

Chronic self-sacrifice stems from both the external circumstances and the individual.

Over time, individuals can become desensitized to self-neglect, rendering negative

emotional repercussions commonplace. Self-neglect leads to physical manifestations.

Health concerns like urinary tract infections and poor dietary habits have been observed

among nurses (Nahm, Warren, Zhu, An, & Brown, 2012). Some caretaking professionals

also meet codependency criteria. Depression, anxiety, and substance abuse also occur

among healthcare professionals. These problems stem from various factors but somehow

continue despite consequences. Psychological research examines possible explanations.

Research on conditioning suggested offensive stimuli to be more influential than positive

stimuli (Rescorla, 1988). Findings indicated that overall, intermittent reward is the most

powerful behavioral motivator. A nurse may skip 10 lunch breaks unrecognized, but the

one self-sacrificial gesture reciprocated with gratitude reinforces the action. In contrast, psychologists found that negative emotions such as guilt, empathy, shame, or insufficiency prompted more helpful behavior than positive reinforcement (Cialdini & Kenrick, 1976). The helper seeks to pacify these unpleasant feelings by engaging in altruism, enabling the individual to inch towards self-actualization. Thus, connections exist between prosocial behavior and Maslow's hierarchy of needs. The research identified related trends among nurses (Allison, 2004; Gillen, 2014; Hall & Wray, 1989; Pask, 2005). More nurse-centered qualitative research will better describe attributing factors. Solutions become possible with new research. Lack of existing research specific to self-care behavior among nurses is alarming compared to the plethora of literature available on burnout. Existing research describes a professional epidemic without enough research on cultural influence.

Nature of the Study

The nature of the study was embedded research and provided qualitative data through cultural immersion. Participants behaved candidly in their professional nursing environment. Interviews allowed for data elaboration. The nature of a critical ethnography, like this study, is to identify cultural shortfalls and encourage change through self-awareness.

Research Questions

The primary research question adheres to Creswell's (2014) qualitative script (pg. 141): What is the culture-sharing pattern of personal need prioritization for medical-surgical floor nurses, and how is their behavior aligned with professional verbiage trends? Sub-questions include:

a. What self-care needs are a priority in the workplace?

b. How do nurses articulate their priorities?

c. How do self-sacrifice and self-care interact in the professional nursing environment?

d. What degree of self-sacrifice do nurses demonstrate?

e. What self-care needs receive priority?

Research Objectives

Three primary objectives drove this research. First, the researcher observed medical-surgical nurses' self-care behaviors and lack thereof. Second, this study illustrated personal need prioritization culture among medical-surgical nurses. Third, the researcher interviewed and surveyed individual participants to triangulate data. These three objectives once met, resulted in rich qualitative data and fulfill the purpose of critical ethnography. Examination of cultural components opens pathways for new research to ultimately evolve the nurse metaparadigm.

Conceptual Framework

Walker and Avant (2011) illustrate conceptual development as the first step in exploring nursing practice. Research with a clear conceptual foundation allows readers to grasp the premise of the study. Conceptual frameworks reinforce the literature review in illustrating research necessity. This ethnography integrates both concepts and theories. Need prioritization was an important concept to explore as groundwork for the project.

Need Prioritization

Maslow's role in this research was to provide an analytical reference point. Readers must first understand Maslow's theory. Humans are motivated by a hierarchy of

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unconscious needs. Abraham Maslow's behavior theory proposes actions stem from a

lifelong pursuit of need fulfillment (Maslow, 1943). Although individual needs may

manifest differently, Maslow constructed a basic pyramid to illustrate his theory.

Abraham Maslow developed his theory of human motivation based on the belief that

every action is purposeful. The intention may be subconscious or conscious. Behavioral

analysis leads Maslow (1943) to develop a hierarchy of needs. Need attainment is the

endpoint while behavior is the attainment process. Maslow believed needs are innate and

fluid. Naturally, needs change with circumstances and some go perpetually unmet

Maslow's hierarchy of needs are organized in a triangular fashion and arranged from

primary to higher needs.

Primal needs provide the base of the triangle. Basic human needs are

physiological in nature and revolve around achieving homeostasis. Basic needs like

nourishment and shelter are a human priority. Next are safety and security needs. For

most American adults, physical safety is not a common concern (Maslow, 1943). Our

ancestors, however, were motivated by the need for safety in order to survive and

reproduce. Feelings of vulnerability can still occur despite physical safety. Physical and

psychological security are closely connected. For instance, disruptions in daily structure

can make a person feel anxious. Maslow theorized that environmental predictability is a

source of safety reassurance. The individual perception of safety is as important as the

reality of safety. A lack thereof could illicit defensive or protective behaviors.

The next tier of needs is love, belonging, and affection. Maslow believed this tier

is more researched than the other tiers. These needs can be stronger behavioral motivators

than physiological needs. In the fourth tier are the esteem needs which Maslow (1943)

defined as the human desire to be valued. Maslow dedicated less time discussing this tier

of needs, warranting continued related research. Adequacy and importance are regarded

as higher tiered needs although underdeveloped in terms of research.

Lastly, Maslow defined the highest tier of needs as self-actualization—living up

to one's potential. Self-actualization includes knowledge and understanding. Maslow

noted the human race's innate hunger for more knowledge, understanding, and ultimately

meaning. Perhaps self-sacrificial nurse behavior is motivated by this desire for deeper

meaning. An objective of the proposed critical ethnography is to examine how nursing

culture understands itself. Nurses perceive themselves based on cultural norms and

possibly what they have been told of themselves through verbiage and stereotypes. The

efforts towards self-actualization may be thwarted by self-perpetuated martyr behavior.

Behavior motivation theory is not isolated to psychology. One nursing theory is relevant

to Maslow's theory and the proposed research by interpreting the nursing theory in

reverse.

Self-Conservation Theory

Nurse theorist, Myra Levine (1969), researched patients' self-conservation

capabilities and how the nurse could facilitate healing. Although focused on the patient

population, self-conservation is of importance to nurses, too. Preserved well-being could

potentially relate to occupational satisfaction and retention. Levine's theory, like Maslow,

centered on behavior rationale. Behavior and body systems similarly seek homeostasis.

Environmental manipulation can either promote or discourage balance. Levine described

a unique relationship between the human being and their environment. One may examine

nurses similarly. Perhaps the environment contributes to cultural norms and ultimately

individual behaviors. In seeking homeostasis, do nurses forfeit their wellbeing? The theorist illustrated different human responses to the environment which are particularly interesting from the nursing perspective.

First, the "fight or flight" response describes the human reaction to an immediate threat. Maslow may define such threats as those to food, water, shelter, or safety. This research sought to identify such urgent self-preservation behaviors. The next reactive phase Levine discussed is inflammation. Prolonged nuisance yields irritation and may wear on the individual. Perhaps inflammation occurs culturally as a group experiences chronic irritation. How do nurses internally compensate for repeated system failures? Third, the stress response occurs when mental apprehension and fear result due to familiar, unpleasant circumstances. In what ways do nurses exhibit this stress response? Lastly, the body develops a higher awareness to detect and protect itself against predictable threats. In what ways do nurses perceive and prevent threats to their wellbeing?

Levine described holistic wellness as successful conservation of energy, structural integrity, and personal integrity. While her research focused on patient behavior, this critical ethnography examined nurse behavior. After all, nurses are just as susceptible to imbalance as the patient (Levine, 1971). Did nurses facilitate their conservation or their destruction? How many of the perceived threats to nurse wellbeing are environmental versus self-inflicted? Using Levine's theoretical foundation, this research aimed to unite the nurse with the environment. Immersion allowed for a holistic description of nursing culture and examine trends. Finally, the unedited glimpse into nursing hopefully

encouraged professional self-awareness and accountability for individual and collective well-being.

Operational Definitions

The study utilized several key terms. Operational definitions explain the meaning of frequently used words or phrases within the context of the research. While some terms are common knowledge among nurses, clarification ensures accurate interpretation by readers unaffiliated with nursing. Other terms are not exclusive to nursing but are included below to minimize any misinterpretations.

Registered Nurse

The American Nurses Association (2018) defines the registered nurse as an individual who completed nursing education at an accredited school and passed the national licensing examination. Registered nurses care for patients in several ways: assessment, education, nursing interventions, clinical decision-making, multidisciplinary care coordination, and patient advocacy.

Medical-Surgical Nursing

Medical-surgical nursing involves caring for patients admitted to a hospital who are recovering from either an illness or a surgery. The medical-surgical nursing specialty accounts for most registered nurses in the United States of America (Academy of Medical-Surgical Nurses, 2018). This study may refer to medical-surgical nurses as *med-surge nurses* or *floor nurses*.

Nursing Metaparadigm

A metaparadigm is a metaphysical foundation which envelopes smaller facets of a concept (Eckberg & Hill, 1979). Nursing metaparadigm, therefore, defines nursing practice by encompassing nursing concepts and theories.

Professional Identity

Edgar Schein (1978) defined professional identity as the way in which an individual views themselves in a professional role. Professional identity includes professional behavior perception and ethical beliefs.

Professional Expectations

For the purposes of this research, professional expectations were participant perceptions of behavior expected of them in the professional nursing setting.

Professional Nursing Behavior

This study recognized professional behavior as nursing duties such as healthcare coordination and patient care.

Quality of Care

Quality of care refers to the standard of care delivered by the nurse to the patient.

Need Prioritization

Maslow (1943) discussed his theories surrounding human need prioritization and behavior motivation. His theory established a hierarchy of personal needs in order from basic to complex. Maslow (1943) defined basic needs as requirements for survival while emotional needs were complex. Need prioritization refers to the order in which an individual or group of individuals rank their needs.

Self-Care Behavior

This research defined self-care behavior through basic needs such as nourishment, safety, rest, and elimination. Nourishment consists of eating and hydrating as permitted during observation periods. Safety refers to lack of physical harm such as verbal or physical violence. If safety is compromised, corresponding self-care behavior will consist of the nurse following designated hospital protocols to protect themselves. Rest, for participants of this study, was defined as allotted break periods as designated by hospital policy. Elimination referred to restroom visits for any reason.

Self-Sacrifice

Self-sacrifice is the absence of self-care within the context of this research proposal.

Nursing Burnout

Professional burnout is defined as the collective result of prolonged physical or emotional energy usage (Freudenberger, 1974). Symptoms include loss of interest and lax performance among others. Physiological indicators like nausea and fatigue are also documented. This research mentions nursing burnout in reference to the professional burnout experienced by nurses.

Culture-Sharing Group

Although many explanations exist in defining *culture,* shared beliefs and perceptions influenced group identity (Center for Advanced Research on Language Acquisition, 2018). A culture-sharing group is a collection of individuals who share the same culture.

Assumptions, Scope, Limitations, and Delimitations

Several assumptions existed going into the study. First, the researcher relied on authentic participant behavior. Next, the researcher assumed that the nursing sample was reflective of the culture. The scope of the research was narrow. Although research questions pertained to all nurses, the study focused on medical-surgical nurses. Field research took place during day shifts on one unit in a southeastern United States hospital. Behaviors observed were limited to self-care and self-sacrifice. Interview questions were specific to the research goal. The Nurse Codependency Questionnaire (Allison, 2004) was administered to support and reinforce field data. The sample size was determined by data saturation achievement. Intrinsic limitations included potential false feedback, researcher misinterpretation of data, and researcher bias as a nurse. Precautions were in place to combat these threats. Delimitations included bias reduction through peer auditing and a carefully chosen research location. The researcher did not function as a nurse in the field or discuss nursing with participants outside of pre-determined interview guidelines.

As with most qualitative research, non-probability sampling posed a potential weakness. Next, there was a lack of existing research validating Maslow's theory. Therefore, incorporating his theory into the research framework was risky. Third, co-variables may have impacted participant behaviors during field research. For example, personal mental health and staffing protocols may have influenced self-care behavior. The fact that the researcher was a nurse may have caused skepticism among readers despite measures taken to address bias. Artificial data due to participant awareness of observation was an ever-present threat in observational research.

This study aimed to provide a clear description of a specific nursing culture. Culture definition opens opportunities for improved self-awareness both as individual nurses and as a profession. Sociocultural themes, once realized, can then be evaluated and improved. The professional application includes acknowledgment of self-care deficits within the nursing community. Future studies may include other nursing specialties and measurement innovation. The nursing metaparadigm could begin to shift because of this and future qualitative research. Ineffective nurse stereotypes are, in part, self-perpetuated. Perceived oppression can change when the oppressed realize their strength.

Summary

This research is original in nature. The researcher gathered important qualitative data to generate both knowledge and inquiry. Critical ethnography was the appropriate research methodology to observe cultural tendencies. Nursing culture exists on a large scale made up of subcultures. The research examined one subculture of nursing that best reflects the population. Medical-surgical nursing is broad in scope and skillsets required, and many nurses have some experience in this specialty. Observed behaviors paired with interview and survey data illustrated the culture. The researcher discussed data to promote cultural self-awareness and motivate necessary changes. The next two chapters discuss existing literature and outline research methods in greater detail.

CHAPTER II – REVIEW OF THE LITERATURE

Methodology selections and research questions emerged after completing a review of the literature. Nursing research related to patient outcomes saturates research databases while nurse-focused research is less common. Scarcer is qualitative nurse-focused research. Among nurse-centric research is abundant burnout-related literature. Nurse burnout research focused on external system failures and organizational flaws. The psychological research examined personality tendencies towards behaviors which can eventually lead to burnout such as self-sacrifice and codependency. Nursing research is lacking with regards to nurse burnout self-accountability. Nursing culture and perpetuated behaviors maintain permanence in the field through sociological norms. The lack of related research directed the course of this research. Questions arose out of necessity. Nursing research that examines individual contributions to well-being, or lack thereof, not only places culpability within the nurse/nursing culture, but it also awards nurses' individual power and control over their professional satisfaction.

A preliminary research step is to conduct a literature review on the subject. The research was accomplished over the course of two years and concluded with over 60 primary sources. The review utilized Google Scholar and The University of Southern Mississippi's online library search engine, Primo. Criteria for research included classical works, reference books, and peer-reviewed studies. Ideally, research used in this chapter was published within the last decade. Google Scholar also served in this literature review to verify well-cited research. Multiple citations of research indicated a study's relevance in other scholarly work. Related concepts researched for other academic projects became part of the overall literature review. The second step was to comb the research for gaps.

Secondary information prompted further investigation into the referenced work to obtain more primary sources. Reference lists found in articles served as leads for primary sources. The researcher extracted key ideas and statements were taken from each source. Connecting information from various sources allowed for themes to emerge. Themes discussed in this research include martyrdom and nurse stereotypes among others. Research groupings were then organized by category and paraphrased.

Searches conducted utilized many keywords and word combinations. Word combinations yielded a high volume of literature prior to applying exclusion criteria: *nurse self-care* (333,000 narrowed to 5)*, nurse well-being* (75 to 0)*, nurse oppression* (99,000 to 2)*, nurse + Maslow* (20,000 to 1)*, critical ethnography + nurse* (80,000 to 6)*, ethnography + nurse* (64,000 to 2)*, medical-surgical nurse + qualitative* (231,000 to 2)*, nurse + self-compassion* (109,000 to 3)*, nursing culture* (2)*, nurse self-need prioritization* (23,000 to 0), *self-sacrifice + nurse* (24,000 to 2)*.* Initial searches results were then filtered based on nurse-focused research. Patient-focused studies were excluded. Editorial literature was omitted. Preferred literature included research conducted within the last decade. Older studies were considered but only with considerable citations visible through Google Scholar.

Critical Ethnography

Critical ethnography was the chosen qualitative methodology for the research. Prior ethnographic research helped define the necessity of this work. Also, seeing the methodology employed in various settings provided research perspective. No literature was found using critical ethnography methodologies to examine medical-surgical nurse behavior. Some critical ethnographies were found studying other nurse-centered topics

(Batch & Windsor, 2015; Mahon & McPherson, 2014; Manias & Street, 2001; Street, 1992). A 1992 ethnography examined professional identity and cultural crisis among Australian nurses (Street, 1992). The research took place in several different hospitals and included a large sample. Street's (1992) research investigated unrest within the Australian nursing population following years of unpopular nursing legislation and large-scale strikes. Immersion in the hospital setting answered research questions about power and oppression among nurses. The author later continued her research on related topics. Another ethnographer found exposed interprofessional communicative challenges.

Manias and Street (2001) examined the dynamic between nurses and physicians when giving bedside report in the critical care setting. A small project, only six participants took part. Data collection included participant journaling, field observation, and individual interviews. The study revealed communication lapses related to provider roles (Manias & Street, 2001). Researchers discussed that individual identity often reflects cultural role expectations. Another critical ethnography researched power struggles among pediatric intensive care nurses. Researchers evaluated their findings and discussed implications for bedside nurse turnover (Mahon & McPherson, 2014).

The most recent applicable critical ethnography researched temporary nurses and their impact on nurse-to-nurse communication. Contracted nurses are not permanent hospital staff, so researchers investigated full-time nursing staff adaption. The research took place on four separate hospital units by two researchers independently over two years. Researchers conducted field observations, focus groups, and interviews to boost reliability (Batch & Windsor, 2015). The results of the critical ethnography identified a

lack of cultural acceptance towards temporary nursing staff and the need for improved

clinical communication between nurses.

Native ethnography, also known as native anthropology, is a subset of traditional

ethnography in which the researcher uses their own experience as data. A 2017 study

featured native ethnography and noted several limitations (Abdulrehman, 2017). The

researcher conducted ethnographic research within her own community as she was both a

healthcare provider and researcher. Advantages of this approach relate to sampling access

and cultural literacy. Limitations included difficulty enforcing researcher boundaries.

Lack of role boundaries may surface in "off the record" dialogue related to the subject

matter based on the researcher's prior understanding of the culture. The researcher

combatted insider bias by logging her interactions through a personal diary. Self-

awareness of research limitations is called reflexivity (Madison, 2005). The native

ethnography, although similar, was not nurse research. Another noteworthy ethnographic

study was found on the night nurse subculture (Brooks & MacDonald, 2000). Although

this research examined gender stereotypes and roles in night shift nursing, the

methodology is the closest in relation to this study found in the literature review.

<div align="center">Martyrdom</div>

Martyrdom is the second topic affiliated with this research project. Abundant

research in the fields of psychology and sociology were found concerning martyr

behavior. Several studies analyzed caretaker professions and their tendency towards

detrimental self-sacrifice. Recent research defined martyr behavior as the willingness to

deny oneself for a cause (Bélanger et al., 2014). Self-sacrifice may cause harm without

enforced boundaries. Individuals who deny themselves limit their own long-term ability

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to effectively care for others. Self-sacrifice appears noble on behalf of a purpose perceived to be worth more than oneself. Researchers rejected the elusive nature of self-sacrifice and sought ways to quantify the phenomenon.

The Self-Sacrifice Scale (SSS) resulted from quantitative research consisting of over 2,900 participants (Bélanger et al., 2014). The overall research evaluated extreme martyr behavior motivated by a specific moral cause. Researchers created and evaluated the scale in eight studies. Each study examined a different facet of martyrdom. For example, one study focused on terrorism as extreme martyrdom. The literature on martyrdom extends beyond scientific inquiry into philosophy, psychology, and historical research. The literature review found no adaptation or utilization of this scale for the nursing population, leaving opportunity for future research.

The literature review yielded both quantitative and qualitative nurse research. One quantitative study outlined martyrdom behavior indicators using an existing scale (Bélanger et al., 2014). Data came from 2,900 participants and measured various martyrdom predictors—readiness to self-sacrifice, passion scale, commitment to the cause, cause valuation, depression, and suicidal ideation scale. Statistical analysis accomplished both descriptive, correlational, and predictive purposes and included factor analysis, Chi-Square, and multiple regression analysis. Data connected self-sacrificial behavior with passion and obsessive ambition. Depression and suicide showed no relation to self-sacrifice alone (Bélanger et al., 2014).

A substudy examined the makeup of martyrdom and looked at which components were more strongly correlated. Martyrdom is constructed of many similar and some opposite attributes. Most obvious, self-sacrifice constitutes martyrdom. Next, a belief in a

higher power was identified as a key component. Altruism and the belief thereof inspire martyr behavior. Someone who seeks meaning in life and believes in predestination has the seeds of martyrdom. Lastly, two opposites, optimism, and fatalism drive the momentum of perpetual self-sacrifice. Another substudy included martyrdom implications. While the research was comprehensive, researchers noted further research is needed to measure the motivation for martyr behavior.

Religions glorify martyrs, as seen in the stories of Joan of Arc and Jesus. Martyrdom insinuates physical death associated with self-sacrifice. For the purposes of this research, physical death is not a criterion for martyr behavior. Self-denial of basic needs and complacency with a stressful practice environment result in progressive physical and emotional harm. While toxic self-sacrifice constitutes martyrdom, the concept is often confused with altruism. Unlike martyrdom, altruism occurs without a motive. Altruism is benevolent and may or may not be witnessed. Martyrdom, on the other hand, is purposeful. Sometimes the message makes an impact, and the sacrifice pays off. Some martyrs leave a legacy related to their sacrifice while others go unnoticed.

<div style="text-align:center">Burnout</div>

Self-sacrifice in nurses results in a figurative death, burnout. Nurse burnout consists of several professional symptoms. Copious research exists on nurse burnout (Cimiotti, Aiken, Sloane, & Wu, 2012; Jennings, 2008; Mealer et al., 2009; Shimizutani et al, 2008). Collective nurse burnout presents a new risk that is bedside nursing extinction. Bedside nursing is any nursing practice involving direct patient care. Most nursing specialties involve bedside care, so this research on the medical-surgical inpatient environment. In the field, medical-surgical nursing is casually referred to as *floor*

nursing. Research suggests it is a dying art (Mahon & McPherson, 2014). Self-sacrifice is an unspoken standard of patient care and professional dedication (Fealy, 2004; Pask, 2005). Sacrificial behavior and over-caring can lead to burnout yet remain a recurring research problem.

Although burnout occurs throughout many occupational fields (O'Connor, 2008), the phenomenon is well documented among nurses (Jennings, 2008; Kashani, Eliasson, Chrosniak, & Vernalis, 2010; Mealer et al., 2009). Nurses often plan to advance towards specialty nursing to avoid burnout. Novice nurses often begin with floor nursing as a starting point from which to graduate to other, more desirable nursing specialties (Lee et al., 2013). Nurse turnover costs money and time according to the National Healthcare Retention and RN Staffing Report (Nursing Solutions, 2016). Turnover rates span from 8.8% to 37% in America. The review found medical-surgical units experienced high turnover at 20.7% with positions taking over two months to fill on average. What used to be the quintessential nursing job is now the least desired specialty. Newly hired nurses took an average of 68 days from being hired to function independently on the unit. Separation of employment and recruiting cost hospitals anywhere from $37,000 to $58,000 per nurse (Nursing Solutions, 2016). The burnout cycle and repercussions warrant more detailed qualitative research. Nursing professionals must consider whether the field glorifies nurse martyrs. New research will bring new insight and opportunities for cultural self-reflection. Researchers documented the same issues in the fields of medicine and psychology (Figley, 2002; Ratanawongsa, Wright, & Carrese, 2007).

Therapists and nurses share common job descriptions although the setting may differ. Caretaking exists in different forms. Compassion fatigue occurred following

chronic over-caring of patients. With negative consequences, one may wonder why detrimental self-sacrifice continues. Figley (2002) concluded further research is needed to determine motives for perpetual over-caring. This research has implications in other service professions such as education and nursing.

<center>Codependency</center>

Despite consequences, self-sacrificial behavior persists in the nursing field. Researchers drew similarities in martyr behavior and codependency (Allison, 2004; Hall & Wray, 1989). Closely related to martyrdom is codependency. A 2004 study introduced the Nurse Codependency Questionnaire (NCQ) (Allison, 2004). The researcher identified the following nurse codependency domains: (1) misplaced identity, (2) weak personal boundaries, (3) extreme self-sacrifice, and (4) approval-seeking behavior. The domains reflected the interconnectedness of self-sacrifice, martyrdom, and codependent behavior. Overall scores measured lower in more severe cases of nurse codependency (Allison, 2004).

The survey totals 24 items on a five-point Likert scale. The author included two reversed items to boost reliability. Test-retest reliability measured .90 alongside an internal consistency reliability of .80 for the instrument (Allison, 2004). A panel of field experts determined the finalized survey carried a content validity index greater than .80. Allison (2004) conducted further statistical evaluations to provide additional reliability and validity support. Factor loading illustrated reliability as 15 items loaded on factor one (.30-.58) while 9 items loaded on factor two (.30-.52). Research problems are often interwoven with other issues allowing for comparison and contrast. Binge eating is common among codependent individuals which prompted Allison (2004) to compare the

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NCQ to well-established binge eating research. The author utilized known groups validity to demonstrate the NCQ's distinctive purpose.

The instrument limitations included failure to differentiate internal versus external contributors to codependency scores. Further use of the NCQ better triangulated qualitative data found in this research. Written and verbal legends of epic self-sacrifice project a sense of heroism and honor, while other research suggests martyrdom is pathological (Allison, 2004).

The persecutor-victim-hero cycle brings intermittent positive reinforcement as a powerful psychological motivator (Schultz, 2002). Self-sacrificial behavior and passivity reflect oppressive behavior. Matheson and Bobay (2007) discussed oppressive behavior reinforcement within the nursing community. Their research incorporated classic theory from *The Pedagogy of the Oppressed* in which oppression is self-perpetuated (Freire, 1970). Codependency may arise out of external stressors but can parallel oppression in its susceptibility towards self-perpetuation.

<center>Coping with a Self-Care Deficit</center>

Researchers also worked in instrument design as a new means to evaluate aspects of professional wellbeing related to mental healthcare providers. The Professional Quality of Life Scale (Stamm, 2005) evaluated factors that make up occupational satisfaction (Sprang, Clark, & Whitt-Woosley, 2007). Researchers administered the survey to 1,121 mental health professionals. The study focused on compassion in terms of both fatigue and satisfaction. Burnout was included in the research as a severe complication of compassion fatigue. Researchers used MANOVA statistical analysis to describe trends in different populations: (1) males and females, (2) rural and city located

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providers, and (3) among different types of mental health professionals (Sprang et al., 2007). Ultimately, the research drew similarities between compassion fatigue symptoms and similar scoring in individuals with Post-Traumatic Stress Disorder (PTSD). This research helped tie compassion fatigue to long-term repercussions spanning outside of the professional realm.

Another related quantitative study researched nurse personality traits and coping strategies (Shimizutani et al., 2008). Researchers administered detailed questionnaires which contained four instruments. The first questionnaire measured personality type. The second questionnaire identified preferred coping tendencies. Next, participants used a tool to isolate work-related stressors. Lastly, participants answered questions related to burnout. Researchers analyzed data from 707 registered nurses. Data analysis included multiple regression and covariate analysis. Trends identified certain stressors and their relationship with extroversion and neuroticism traits. Research determined professional relationships influenced nurse burnout potential. Burnout occurred more because of environmental stressors that personality traits. Researchers concluded the whole nurse experience was a combination of environment and individual personality. The collection of individual nurse experiences merged to form a culture. As the authors introduced the idea of a nursing culture, they illustrated the need for ethnographic research. Ethnography is an underutilized qualitative methodology in nurse-focused research. An existing variety of qualitative research provides the groundwork for the new endeavor.

Research related to similar populations remain useful as groups often share basic characteristics. As noted earlier, helping professions often share trends. One qualitative study examined physicians in residency. Self-sacrifice, in some capacity, is commonplace

among resident physicians; how these residents coped with self-care deficits was the research focal point (Ratanawongsa et al., 2007). Researchers conducted interviews with 26 residents in various medical specialties. Residents reported coping with interrupted self-care abilities by justifying the self-sacrifice as a temporary necessity. Ratanawongsa et al. (2007) identified loss of self as a contributor to lower wellbeing. Loss of self was related to denial of personal needs such as rest, food, and free time. Nurses warrant similar research. How do nurses demonstrate self-sacrifice?

<center>Need Prioritization</center>

Qualitative nurse researchers incorporated Maslow's (1943) theories as evidenced by a 2005 study. Pask (2005) explored nurses' self-sacrifice in relation to holistic self-actualization. The author developed a philosophical justification for higher-tiered goal attainment. The study found nurses look beyond themselves for a higher cause. Personal needs took less priority when patients needed care. Nurses learned servitude and were virtue-motivated rather than ego-motivated. Dutiful morality reflects a deontological outlook on ethics. Pask's (2005) research compliments other existing research by looking at self-sacrificial motives. Another study asked nurses to elaborate on their perceived self-sacrifice. Nurses answered open-ended questions with detailed responses. Participant feedback described exhaustion and physical pain as nurses worked on their days off due to poor staffing. Existing lower back issues flared for one nurse who assisted large patients without lifting help (Huntington et al., 2011). Most nurses continued self-sacrificial behavior despite physical and emotional consequences and surrendered to unsafe working conditions.

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Summary

Research is available on a variety of subjects related to nurses and need prioritization. However, minimal data was found addressing cultural norms related to nurse martyrdom. More specifically, qualitative research is absent related to the medical-surgical nursing population. The need for research is evident in decreasing medical-surgical nurse retention. Furthermore, nurse stereotypes perpetuate martyr behavior. Ethnographic research provides an intimate glimpse into nursing culture. The critical nature of the research aims to highlight troublesome findings and elevate cultural self-awareness. Nurses can initiate paradigm shifts by redefining themselves through awareness and cultural evolution.

Nurse martyrdom is the conceptual basis for this research. Nurse martyrdom is defined by the research as personal self-sacrifice for a professional cause which inflicts harm on the nurse. This critical ethnography aimed to identify cultural and personal influences on professional identity. In addition, critical ethnography as a methodology brings awareness to problematic data trends. The literature review conducted revealed poignant indications for future research.

Literature explored multiple themes. Collective behaviors like self-sacrifice and limitless dedication to caretaking form the nurse martyrdom trend. Martyrdom is a cyclical process in which sporadic positive reinforcement perpetuates self-depreciating behaviors in pursuit of validation. Further research can help identify how self-sacrifice satisfies a human need. Abraham Maslow's work in psychology recurred in the literature although high needs are under-researched. Professional caretaking yielded burnout as a common thread influencing career satisfaction. Unspoken perceptions may influence

nursing reality on a subconscious level. Awareness allows nursing professionals to reject old ideas in both their opinions and their behavior. The overall review of literature prompted several research questions:

a. What self-care needs are a priority in the workplace?

b. How do nurses articulate their priorities?

c. How do self-sacrifice and self-care interact in the professional nursing environment?

d. What degree of self-sacrifice do nurses demonstrate?

e. What self-care needs receive priority?

These questions provided a framework for research objectives. Objectives are the actions taken to achieve the goals. Here, the goal was to answer the research questions and expose nursing culture from a unique perspective. Three primary objectives existed for this study. First, the researcher observed medical-surgical nurses' unique self-care behaviors in the field. Self-care behaviors identified following observation and documentation. Trends emerged, and the researcher utilized framework literature for interpretation. The second research objective was to identify need prioritization habits within the medical-surgical nursing culture. Interviews and field observation helped facilitate this objective. Third, the researcher investigated the implications of need fulfillment and how this translated into professional identity. Survey data supported qualitative findings.

The literature review revealed rich theory and data on widespread nursing problems. The research found investigated isolated issues like burnout or martyrdom. More difficult to find was research examining nursing culture as a medium for these

continuing problems. Ethnographies and critical ethnographies found examined nursing

culture, but not in the medical-surgical setting. Due to low medical-surgical nurse

attrition and "front line" stereotypes, this population needs to be researched. Furthermore,

research gaps concluded the need to further understand how nursing culture relates self-

sacrifice, self-care, and self-need prioritization.

CHAPTER III - METHODS

Research Design

Research design refers to the structural foundation by which the study is

conducted (Polit & Beck, 2012). Quantitative research design interprets statistical data

while qualitative research design observes phenomena in a natural setting. Within each of

these two designs are more specific research approaches. Design provides an umbrella

under which research narrows. Research design depends on the research questions.

Qualitative research focuses on the informant's experience within their natural

environment. Quantitative research investigates measurable data from subjects within a

controlled research environment. Two research avenues exist in qualitative and

quantitative studies although they both aspire towards the same research goal—to collect

and interpret data (Polit & Beck, 2012).

Qualitative Methodology

Qualitative research design is most appropriate when data is immeasurable or

when numerical data fails to address the research issue. Qualitative research design fits

this study. The research objective was to explore need-prioritization culture among

medical-surgical nurses through behavior observations and interviews.

Ethnography

Ethnographic methodology is a qualitative approach that allows for embedded

field research to more truthfully evaluate cultural components of language, non-verbal

cues, and behavioral norms. Madison (2005) summarized the history of ethnography and

its philosophical roots. Ethnography originated in anthropological research as pioneers

surveyed undocumented cultures (Boas, 1902; Frazer, 1890; Radcliffe-Brown, 1933).

Ethnography served as a vehicle for cultural understanding and preservation. Structural functionalism formed from ethnographic research of multiple tribes discovered in a cluster of islands. Descriptions included cultural norms that withstood external threats (Radcliffe-Brown, 1933). Natural disaster and colonization changed the way tribes coexisted, and subcultures unified despite geographical limitations. The anthropologist's life work illustrated how individual behavior impacts the overall cultural structure and resilience (Madison, 2005). The Chicago School of Ethnography educated more than half of the world's anthropologists in the 1930s by encouraging immersive research methodology. Following many scholarly publications, anthropology students began using ethnography to call for social reform among marginalized populations (Deegan, 2001). Experiencing culture first hand enabled researchers to contribute in post-positivism through validation of personal experience as truth (Madison, 2005).

Critical Ethnography

Ethnographic research was first described by an anthropologist who encountered a dying lineage of Native Americans (Boas, 1902). The research was immersive and sought to understand and document subjects in their natural environment. Cultural literacy and preservation are ethnographic objectives (Boas, 1902). Critical ethnography adheres to the same methodology but with different objectives. Madison (2005) discussed the evolution of ethnographic research from a descriptive methodology to an influential methodology. Critical ethnography disseminates data to promote cultural awareness and opportunities for cultural progress.

Critical ethnography was selected for this study because the design identifies cultural limitations and opportunities for growth. Ethnographers employ critical theory

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during data collection (Madison, 2005). Immersion research brings vivid awareness to cultural strengths and challenges. Research goals include cultural awareness and change promotion. Critical ethnography merges science and activism (Thomas, 1993). The author of *Doing Critical Ethnography* wrote:

> Critical ethnography is a type of reflection that examines culture, knowledge, and action. It expands our horizons for choice and widens our experiential capacity to see, hear, and feel. It deepens and sharpens ethnical commitments by forcing us to develop and act upon value commitments in the context of political agendas. Critical ethnographers describe, analyze, and open to scrutiny otherwise hidden agendas, power centers, and assumptions that inhibit, repress, and constrain. Critical scholarship requires that commonsense assumptions be questioned (Thomas, 1993, p. 2).

Quantitative research abounds disproportionate to qualitative inquiry. Among qualitative studies, no ethnographic research examining medical-surgical nursing culture was identified. Existing nurse-centered research investigates issues like burnout, professional identity, and communication. Martyr behavior research entered the nursing realm after related research in other helping professions. Self-sacrifice to the point of negative consequences constitutes martyrdom, especially when the behavior continues and is motivated by a perceived higher cause. Self-need prioritization research may unveil dysfunctions within the nursing culture warranting further evaluation. This study's design was intended to weave existing information from the literature together and examine its cultural manifestation though embedded research.

Theory is an important foundation for generating a research problem (Grove et al., 2013). Maslow's theory on human motivation serves as the theoretical framework and provided ascending need categories for observed behavior: (1) physiological, (2) safety, (3) love/belonging, (4) esteem, and (5) self-actualization (Maslow, 1943). Lack of related qualitative research and need-specific research contributes to the research problem. Maslow's hierarchy will also serve in the data analysis portion of the study by providing a theoretical rationale for behavioral and verbal data. Maslow (1943) identified need fulfillment as both an incentive and a result of behavior. The cultural phenomenon of interest is both a cause and an effect.

Social norms among nurses promote patient care at any cost. Nurses unwilling to postpone or forego personal care needs such as food and elimination experience criticism. Often, self-sacrifice becomes the perceived measure of nursing dedication. Promotion of unhealthy behaviors leads to nurse burnout. Often, the blame is cast on external factors such as legislative or organizational failure. This study sought to understand whether there was a cultural connection between nurse behavior and nurse satisfaction. Furthermore, this research explored cultural accountability and identity. Maslow's theoretical framework helped provide structure for the data. Nurse burnout repercussions impact nurses, patients, and healthcare. Professional satisfaction relates to nurse retention, quality of patient care, and burnout as evidenced by past research (Cimiotti et al., 2012; Nursing Solutions, 2016). Broad repercussions warrant an urgent and candid look at nursing culture.

Critical ethnography was the most appropriate qualitative methodology based on the research questions and the lack of existing ethnographic nurse-centered research. Creswell (2013) recommended ethnography to investigate culture because of its sociological and anthropological roots. Rather than studying an individual or an experience, ethnography captures a cohesive understanding of cultural behavior. While other qualitative methodologies may analyze data from a smaller sample size, ethnography research observes and interviews a larger number of participants.

Widespread opinions manifest in nursing practice norms. Medical-surgical nursing is internally regarded as one of the most professionally taxing nursing specialties largely due to high census combined with higher acuity patients (Weiss, Yakusheva, & Bobay, 2011). Nurse-patient ratios are often stretched throughout any given 12-hour shift. Nurse-patient ratios lack uniformity as nurse staffing legislation is not federally mandated (Cimiotti et al., 2012). Ethnographic researcher and author, D. Soyini Madison (2005), discussed the ethical and empathetic roots of most critical ethnographic studies in his book, *Critical Ethnography: Method, Ethics, and Performance*. As a nurse, the researcher's passion stems from a sense of loyalty and compassion towards nurses of all specialties.

A simple online search through various nursing forums validates many nurses regard floor nursing as the standard entry-level nursing position. Viewed as a professional stepping stone, nurses often graduate to more specialized nursing practice. New nurses often work the required year in medical-surgical nursing before moving on to their desired specialty. Nursing Solutions Incorporated (NSI) (2016) published their annual Registered Nurse (RN) retention report and cited medical-surgical nursing as the

third highest turnover rate in the profession at 20.7%. Their longitudinal data suggested, at 20.7%, medical-surgical units could experience a complete staff turnover every 3.7 to 5.3 years (Nursing Solutions, 2016). The medical-surgical nursing environment represents the utmost manifestation of nursing culture by way of diverse patient population and skill sets required for practice. For these reasons, a medical-surgical floor hosted this critical ethnography.

Ethnography emerged as the most appropriate methodology because it allows for cultural observation and interpretation through objective documentation. Other qualitative methodologies could prove useful in future research while ethnography serves a descriptive foundation. A phenomenological study may convey the personal experiences of floor nurses. Narrative research would allow nurses to tell their stories. Case studies could highlight extreme circumstances. A grounded theory study may generate explanatory ideas based on qualitative data. An ethnographic design, however, facilitates collective observation of the group and analysis of behavioral and social trends (Creswell, 2013). In addition, the researcher became culturally immersed.

The critical ethnography subset serves the nursing population by identifying self-destructive behaviors related to personal need prioritization. Once validated, data could be traced back to origin through historical research. Cultural awareness and individual self-awareness are the catalyst for cultural change and even a nursing paradigm shift. After all, critical ethnography challenges the status quo (Madison, 2005). Such momentum may solicit the need for qualitative action research. Without raw, immersion-based observation the other qualitative methodologies fall short. Ethnography is an appropriate starting point for a severely under-researched population.

Role of the Researcher

The ethnographer is embedded in the participants' culture (Creswell, 2013).
Immersion research allows for *emic*, or insider, view of the research interest (Grove et al.,
2013). Ethnography requires that the researcher connect behaviors and patterns with
cultural meaning. Underlying norms help readers understand the culture and identify
future research needs, cultural advantages, and potential shortcomings. Unlike other
methodologies, the instrument is the researcher (Polit & Beck, 2012).

In this study, the researcher was already familiar with the population. As a nurse
researcher studying medical-surgical nursing culture, some native understanding existed.
The researcher, however, had no experience in medical-surgical nursing other than
nursing school exposure through clinical coursework. Hybrid researcher roles have been
successful in ethnographic research before, like in the 2012 study where a Nigerian
researcher investigated Nigerian smoking culture (Oladele, Richter, Clark, & Laing,
2012). Bias-related concerns naturally surface in this ethnographic circumstance. Self-
auditing helps the researcher to remain objective in their observation documentation. The
self-auditing technique involves honest self-reflection in the form of journaling on
preconceived ideas, motives, and projected outcomes. Self-auditing is a practice used to
promote truthfulness in qualitative research. Third party auditing also safeguards
qualitative data purity (Creswell, 2014). Traditional ethnography maintains boundaries
between the participants and the researcher. The researcher acted as an observer and did
not participate in the culture. In this research, the nurse researcher remained in common
areas of the medical-surgical nursing floor. Common areas are defined as (1) nurses'
stations, (2) hallways, (3) cafeteria, and (4) breakrooms. The researcher did not enter

patient rooms or engage in any dialogue with the patients other than to identify herself and her purpose on the unit.

<div align="center">Research Questions and Sub-Questions</div>

The primary research question adhered to Creswell's (2014) qualitative script (pg. 141): What is the culture-sharing pattern of self-need prioritization for full-time, day shift medical-surgical floor nurses, and how is their behavior aligned with their interview-derived verbiage trends? Sub-questions included:

a. What self-care needs are a priority in the workplace?

b. How do nurses articulate their priorities?

c. How do self-sacrifice and self-care interact in the professional nursing environment?

d. What degree of self-sacrifice do nurses demonstrate?

e. What self-care needs receive priority?

The answers arose from direct observation, one-on-one interviews, and survey data. Interview questions illuminated cultural thought processes and rationales while observation documented behavioral cultural manifestation. Needs defined reflected those outlined in Abraham Maslow's *Theory of Human Motivation* (Maslow, 1943).

<div align="center">Procedures</div>

Access to participants was made available through hospital administrative approval and unit manager approval. The southeastern United States has many large, metropolitan hospitals. The researcher chose one of the hospitals based on size and accessibility. Once approved, the researcher submitted a written request for temporary access to a specific medical-surgical unit and was put in contact with the unit manager

via email. The researcher met the unit manager on the designated unit and met with present nursing staff. The researcher verbalized a brief overview of the research and answered any questions. Interested nursing staff who met inclusion criteria completed written consent forms. Signs were posted in the staff lounge and staff restroom soliciting qualified participants who may not have been present on the day of the in-person recruitment. Remaining consents were obtained upon researcher arrival for data collection prior to the start of the shift. Participants were given the opportunity to answer questions or decline participation if desired. In this case, all nurses who met the criteria volunteered to participate. Participation incentives included involvement in meaningful nursing research and a personalized badge reel of approximately $10 in value which was distributed to participants following data collection.

The researcher-participant working relationship began with a verbal study explanation and written research summary included in the consent form. A concise and non-technical research summary explained who the researcher is, research motivation, and post-data collection intentions (Madison, 2005). In addition, ethical precautions were outlined in the consent forms which were signed by both the participants and the researcher. The researcher had to establish clear role-boundaries to preserve research integrity. Participants agreed that the researcher would not assist or accompany them in any patient care despite the researchers' experience as a registered nurse. Role clarification was paramount to data integrity and established relationship expectations. A few exceptions existed. If unlawful participant behavior were directly observed, the nurse researcher upheld an ethical and legal obligation to report any such actions through the appropriate channels as per hospital policy. In case of an emergency such as fire or any

other unforeseen catastrophic event where mass evacuation was required, the researcher would act accordingly to protect herself and patients per hospital policy.

Active bias reduction was paramount to the researcher-participant relationship as the researcher had nursing experience. Reflexivity was a crucial tool as native researchers may be desensitized to certain norms (Abdulrehman, 2017). The researcher maintained a journal of the research experience to reinforce reflexivity (Madison, 2005). Observation at an unfamiliar hospital ensured reduced researcher bias because the researcher had no personal or professional connections there. In addition, the researcher had no professional experience in medical-surgical nursing which lessened pre-conceived judgments. Sociological data revealed people behave according to stereotypes they believe are assigned to them (Madison, 2005). To avoid this phenomenon, the researcher avoided expression of personal opinions about nursing. Peer debriefing aided in reliability protection and bias reduction by utilizing a third-party researcher. Debriefing involved periodic phone meetings between the researcher and the dissertation chairperson where the chair reviewed researcher practices and brought attention to any risk for bias. Both peer and self-audits promote both process and analytical integrity (Creswell, 2013). Immersed in a specific environment, the ethnographic researcher simply observes natural processes to accurately depict culture. Critical ethnographers also identify problematic trends. The researcher made handwritten notes during field observation without interrupting participants or disrupting a natural sequence of events. The ethnographic researcher avoided prompting any purposeful participant behavior. The behavior exhibited by non-participants was included in journal reflection but not in data

dissemination. Open-ended interview questions allowed for detailed expression of individual participants.

<div align="center">Ethical Considerations</div>

Creswell (2014) identified ethical considerations throughout the research process. Approval from The University of Southern Mississippi Institutional Review Board (IRB Protocol #18051701) and research site was a priority. Site selection also carried ethical weight. The observational hospital site could not be a previous employer of the researcher. With the use of peer debriefing, research integrity improved. Participant confidentiality was preserved through several precautions. Audio data was collected through a PIN-protected app on the researcher's PIN protected phone. Transcriptions were password protected in Microsoft Word and saved on the researcher's password protected computer and password protected email. Audio files were deleted following transcription. Aliases were assigned by the researcher for each participant to preserve confidentiality.

Patient privacy was an important ethical consideration during observation. Patient protective measures included avoiding patient rooms and verbal exchanges with patients unless the researcher was asked to identify herself. The researcher wore a lanyard with a student identification card consistently while on the unit to avoid role confusion. Full disclosure of the research agenda and my role established trust among both participants and bystanders. Nurse participation was voluntary, so declination came without penalty and was explained as such to each nurse (Creswell, 2014). Willing participants signed an informed consent and verbalized their willingness to participate in the interview during a recorded phone call. Participant questions and clarification took place prior to research

initiation, although participants did ask personal questions about the researcher throughout data collection. Immersive cultural research warranted transparency and personal vulnerability to establish trust between the researcher and the participants.

Ethical data analysis requires native bias avoidance. Ethical breaches occur when the researcher exploits exclusively harmful or beneficial data. Objectivity is a priority not only for ethical reasons but to meet the overall research goal for authenticity and truthfulness. Gestures of gratitude are appropriate following an ethnographic study as researchers often spend extended periods of time with participants. As mentioned, small gifts were distributed to participants who completed all components of the study following data collection. The gifts chosen were personalized badge reels which were uniform aside from the names. Each reel had a monetary worth of approximately $10. Gifts were ordered online and shipped to the dissertation chair due to geographical barriers and site location. Gifts were then given to the unit manager to disperse. Information sharing is another expression of appreciation as participants are both participants and stakeholders in the research (Creswell, 2014). Following the interview, the researcher notified each participant that the whole project will be available to them following dissertation defense via email. Additionally, the hospital was offered a white paper overviewing the study and data found. Immersion research aims to not only leave the environment unscathed but to provide participants with increased self-awareness and pride through data dissemination.

Sampling

Full-time registered nurses working 12-hour daytime shifts on a medical-surgical floor were the target population. Registered nurses qualified regardless of whether they

had a bachelor's degree, associate's degree, or diploma. Licensed practical nurses, masters prepared nurses, and advanced practice nurses were excluded. Registered nurse credentials were required to make sure all participants had equal scope of practice and workload. Ethnographic research involves a homogenous sample to identify cultural trends while encouraging individual authenticity during data collection (Creswell, 2013). A gatekeeper, in this case, the unit manager, helped the researcher access participants by allowing the researcher to make a site visit and post research flyers. The advertisement detailed inclusion criteria, dates, and time commitment required for participation. The researcher included pull-apart tabs with contact information for interested parties with questions. Participation incentives were included in the flyer.

Sampling occurred on one medical-surgical unit but could have increased to two units or additional data collection days if needed. Qualitative indicators for increased sample size or time included lack of data repetition. In qualitative research, appropriate sample size is evident when the researcher achieves data saturation—begins getting consistently similar information from participants. The researcher spoke with interested candidates during the site visit and just prior to data collection upon arrival to the unit. The researcher selected nurses who met the research criteria from those interested. Criteria assures participant uniformity while diversity helps ensure a truthful cultural illustration (Creswell, 2013). Criteria included full-time employment status on the day shift on the medical-surgical floor. As mentioned, consistent findings reflected an optimum qualitative sample size, so data saturation determined the exact sample requirements.

Data Collection

Ethnographic findings, by design, occur in the participant's natural environment. This study consisted of field observations, interviews, as well as completion of the NCQ (Allison, 2004). Field data included participant behavior and dialogue, both with each other and other staff. Field notes included gross observations of behavioral data and subtle, private verbal exchanges between nurses. Field dialogue was handwritten versus recorded to avoid any Health Insurance Portability and Accountability Act (HIPAA) breach. Dialogue exchanged organically between participants and the researcher throughout the days. Observed behaviors included self-care activities as defined by the researcher. Self-care behaviors of interest included drinking, eating, taking allotted breaks, taking medications, and using the restroom. Additional verbal data was obtained during one-on-one interviews and provided more individual insight related to field observations. The researcher began with an IRB approved interview protocol and tailored interview questions based on *in situ* observations (Creswell, 2013). Interview questions, although organic, asked different types of questions as defined using the Patton (1990) model: (1) behaviors observed, (2) personal stance and values, (3) exploration of feelings, (4) objective factors, (5) physiological response, and (6) population-based questions. Finally, completion of the NCQ connected individual perspectives to cultural patterns.

Immersion took place over the course of 5 consecutive day shifts which lasted from 7:00 a.m. to 7:00 p.m. The researcher arrived at the unit at 7:00 a.m. and stayed until 7:30 p.m. Data collection began when the researcher arrived at the nursing unit and ended when the researcher left. The researcher took restroom and meal breaks as needed while remaining on the unit at all times. Phone interviews took place apart from the

professional environment at scheduled times between the researcher and participant.

Scheduled interviews were completed the week after field observations and scheduled

based on participants' scheduled days off work. Interviews were semi-structured and

ranged from 7 to 22 minutes in length. The researcher recorded all phone interviews

using the Call Recorder application. Audio files were PIN protected within the app. Data

and notes from interviews were transcribed and analyzed with field observations.

Communication shortcuts allow for more authentic behaviors, while added steps may

deter behaviors and sway data. An established thumbs-up signal between the nurse and

the researcher was established to communicate that a participant was stepping away from

the unit. This simple hand signal allowed natural timing of events. As participants

became more comfortable with the researcher; however, participants ceased to use the

hand signal. Participants simply verbalized that they were stepping away and where they

were going. On occasion, a nurse would return from somewhere unknown in which case

the researcher asked where they went. An unanticipated return was easy to identify with

only one nurses' station and visualization of both hallways from the station. This

exchange became expected as data collection progressed, and the nurses communicated

without issue. The participants and the researcher became synchronized.

<div align="center">Data Analysis</div>

Data analysis included field observation notes, interview transcriptions, and

survey data. Ethnographic data must be delicately obtained due to the organic nature of

the methodology. Participants may withhold their true selves for various reasons, so goals

and trust must be established prior to and maintained throughout the process (Madison,

2005). If participants feel as if they are being evaluated or scrutinized, they may censor

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information to preserve their image. The researcher in this study took care to remain engaged yet neutral in response to information to better ensure authentic data (Madison, 2005).

Qualitative research yields large data, so the researcher used visual aids to compartmentalize data by participant and theme. The researcher transcribed and organized the data for analysis. Emerging behavioral and language trends were grouped and labeled. Creswell (2013) outlined a coding formula for ethnographic data. Hypotheses emerge during data analysis, unlike other methodologies. Theme classification follows coding and unites trends into overarching ideas (Creswell, 2013). Coding allows similar data to group together based on either abstract or concrete themes. Themes must be organized logically and seamlessly for readability. Lastly, the researcher will discuss themes' interconnectedness and variety (Madison, 2005). Following the researcher's independent data analysis, peer debriefing with a trusted colleague identified any questionable findings. Data representation includes tables and narratives. In addition, taxonomy and pattern identification are popular ethnographic data analysis procedures (Creswell, 2013).

Tables reflect descriptive statistics. The researcher interlaces field observations with personal nursing experience, using an impressionistic tone in narrative analysis (Creswell, 2013). Aligned with this study's critical ethnography design, Creswell (2013) identified impressionistic analysis as the most impactful. More than just information, ethnographic data analysis searches for more complex insights (Madison, 2005). Data discussion includes interpretation and change proposal in concordance with critical ethnography methodology.

Rigor

The goal of qualitative research is to tell a story pertaining to a specific informant pool. Data generalization is not the goal, but rather to reflect the consensus for others in the same positions. Transferability is the goal. Ethnographers seek authentic data although, in this qualitative realm, the scientific value cannot be quantified. Several mechanisms are available to validate qualitative research without inserting a positivist approach (Creswell, 2013). Credibility is the first vehicle for qualitative validation. Qualitative data is credible when reiterated by various participants or when observed in more than one setting. This repetition is also known as triangulation. Second, the use of multiple data collection methods establishes credibility. This study utilized field immersion, individual interviews, and a survey to corroborate data. Repetitive findings are a third credibility indicator.

Data is prone to subjectivity in qualitative research, so confirmation of data with participants defends dependability, the qualitative alternative to reliability (Creswell, 2013). Next, detailed narratives of behavior and environment provide clarity. Peer auditing can also supply external confirmation of data analysis. Audit processes facilitate tough criticism of the work prior to completion. Creswell (2013) highlighted data persuasiveness as a hallmark measure of research quality. Critical ethnography seeks to capture a culture in need of reformation. The ability of the data alone to convey this message to the reader will indicate dependability. Ethnographic research value depends on the researcher's ability to define and depict a culture-sharing group. Researcher self-reflection provides an additional emphasis for needed change in critical ethnography.

Lastly, hypotheses and themes emerge *in situ* rather than in the preliminary research phase, demonstrating the cultural value and importance of the research.

Summary

This research's methodology was a critical ethnography design based on the research questions and cultural awareness objective. The native researcher employed a few strategies to preserve data authenticity and reflexivity. Ethical considerations protect patient and participant information as observation took place in a hospital. The sample population included full-time, day shift, medical-surgical registered nurses at a large South Mississippi hospital. Data collection included observation, individual interviews, and surveys. The researcher utilized the NCQ to triangulate information with quantitative data (Allison, 2004). Ethnographic data will enlighten readers on medical-surgical culture as it relates to self-care and self-sacrifice behaviors.

CHAPTER IV – PRESENTATION AND ANALYSIS OF DATA

The Process

Data Acquisition

Data surfaced from field notes, interview transcriptions, and NCQ survey data.

Field notes were handwritten. Audio recordings of interviews were transcribed verbatim

into Microsoft Word. Participants completed surveys in person following their last shift.

Field notes accrued over the course of data collection as did the surveys. Phone

interviews occurred the following week and were stored in the PIN-protected Call

Recorder (Android) application. The researcher transcribed data the week after interviews

into password-protected Microsoft Word documents.

Data Analysis

The researcher analyzed survey data first. Participants NCQ scores were analyzed

both overall and domain-specific. Median and mean scores were tabulated for each

participant and then collectively for each item. The researcher tabulated score frequencies

and arranged participant scores from lowest to highest.

Next, the researcher processed field data. Some trends emerged during immersion

and were written in addition to observations. The researcher split the field data into

concrete and abstract groupings (Madison, 2005). Concrete groups were participant

based. Each participant was assigned a different paper color, and the researcher copied

participant-specific field notes onto strips of the colored paper. The researcher progressed

line by line and selected the appropriate color paper depending on data type. The

researcher then reviewed the field notes and separated them into different colored stacks.

The researcher kept a key to notate participant color assignments.

Interview data supported field data by providing individual insight into group behaviors. Once field observations yielded themes, the researcher analyzed interview transcriptions for corroborating information. Data selections depended on relevance to themes discussed and participant diversity. Participants unknowingly echoed each other in individual interviews. Exemplars were chosen based on which participant gave the most concise statement on a given issue. Efforts were also made to incorporate interview data from all participants throughout data analysis.

Organization

Once data was compartmentalized by the participant, it was organized into abstract groupings. Groupings varied based on themes noted during observation and evolved as data was categorized. The researcher analyzed the participant data, grouping the data by contextual similarity. Six themes emerged: (1) complaining, (2) organizational mistrust, (3) inner conflict, (4) collective caretaking, (5) humor/sarcasm, and (6) concrete self-care demonstrations. The researcher then evaluated themes within the context of established research objectives. Some arbitrary field notes remained uncategorized. Other field notes related to the environment and participants as a whole; this data contributed to narrative descriptions. Descriptive and uncategorized field notes were also color coded.

Findings

Environment

Prior to a discussion of the findings, it is important to understand the setting and participant group. The hospital, built in the 1950s, is a 512 bed, Level II Trauma center serving 19 counties in the southeastern Unites States. Research immersion took place on

one of the original hospital units. The unit was reserved for observation and telemetry patients but also took a variety of medical and surgical patients. The unit was shaped like a "T" with a nurses' station at the intersection. The left side of the "T" closed for construction a week prior to data collection. Nurses explained that a recent inspection forced the hospital to close part of the unit. Prior to the inspection, the hallway was open with caution signs displayed throughout. Nurses expressed relief surrounding the closure because the narrowed hallways and limited access created by workers presented safety hazards. Additionally, the reduction in rooms initially reduced their nurse-to-patient ratios. Staff was happy with this change. However, staffing coordinators began sending nurses home because of the room shortage, leaving remaining nurses with an increased workload.

Fluorescent lights beamed across the ceilings while natural light was barely visible in the breakroom. Evidence of old and new technology was scattered throughout the unit. Brand new computers sat next to dusty document scanners. State-of-the-art heart monitors occupied the desk next to a large, white dry-erase board. Beige tile floors paved the hallways leading to patient rooms. Staff accessed restricted areas using keypad locks. The intercom system crackled throughout the day with muffled codes and pages. Music played periodically over the speakers when a baby was born.

The nurses' station teemed with nurses, technicians, students, doctors, and ancillary staff. The nursing station was a hub of perpetual communication. Patients used call lights to reach the nurses' station. Most of the time, patients' voices were littered with static and background noise. Secretaries deciphered the requests before paging the appropriate nurse. Nurses then paged doctors. Doctors called them back. Other

departments called often with notifications or new patients. Someone always needed something. Nurses were in a constant state of seeking and being sought.

The nurses' station smelled like alcohol wipes and room deodorizer. Background noise included the rhythmic clicking of computer mice and fingers dancing across keyboards. Wheels provided a soft roar as nurses pushed their computer carts up and down the hallways. Nurses wore monochromatic pants and tops. Colorful scrub jackets hung down heavy with pens, scissors, and other gadgets. Their shoes ranged from tattered tennis shoes to shiny clogs. Nurses toted their personal stethoscopes which were customized to avoid potential heist.

Participants

The researcher was assigned to this unit because of the layout and visibility. Additionally, the unit met the medical-surgical description mentioned in previous chapters. All interested nurses who met the inclusion criteria agreed to participate in the research. Two additional nurses expressed interest but did not meet the criteria. A total of ten participants completed the study.

Table 1

Participant Demographics

Demographics	Number of Participants
Gender	
Male	0
Female	10
Age	
21-30	8
31-40	0
41-50	1
51-60	1
Years in Practice	
0-2	6
3-5	3
6-8	0
9-11	0
12-14	0
15+	1
Education	
Associate's degree	2

Table 1 (continued).

Diploma	0
Bachelor's degree	8

Jane. Jane was tall and slender with short, grey hair. She was stoic yet polite. Jane was professional and did not let much of herself infiltrate her workflow. Patient requests no matter how untimely or elaborate were responded to with a simple, "okay." She rarely sat down. Instead, she stood to chart. She did not socialize with the other nurses except to communicate about work. She was a new nurse although middle-aged. Her first career was school-teaching, but she stopped working 20 years ago to be a stay-at-home mother and homeschooler. She began a new career in nursing after her children graduated from high school. Her greying hair disguised her inexperience. If she was ever overwhelmed, she concealed it well. Her coworkers helped her without asking because she often turned down assistance with, "I'm fine." Jane skipped most meals unless one were to count the peppermints she ate throughout the day.

Vanessa. Vanessa was a young nurse with a soft demeanor. She had long, blonde hair and was naturally beautiful. Behind her delicate features was sadness. With glaring eyes, she appeared suspicious of everyone around her. She remained guarded against all staff but a select few. She rolled her eyes at most requests. A single mother, she talked about her personal life with a heavy heart. She looked at her phone often, as if awaiting news that might change her day. She seemed like she wanted to be anywhere but where she was. Vanessa hesitated to make eye contact with me at first but opened up to me after

a few hours. She was open about her professional dissatisfaction and intent to leave the unit. She prayed before every shift to be called off. She often felt conflicted about providing quality nursing care in a broken healthcare system. She became frustrated with non-compliant patients. She expected practitioners to take her patient concerns seriously. Her unmet expectations mounted throughout each day.

Minor setbacks fueled her unhappiness. By lunchtime, she was like a prisoner waiting to be liberated; she was the only nurse who left the unit for lunch. She openly discussed seeking therapy and medication for stress. Talk of her personal life caused tears to well up in her eyes. She had a sarcastic sense of humor and spoke in hyperboles. A bottle of Excedrin Migraine was hidden behind a computer. The sharpie-scribbled label read, "*Vanessa's headache medicine: DO NOT TOUCH*!"

Ali. Ali was confident and outspoken. She was petite with straight, black hair. She admitted to dyeing it bright colors on the underside. She wore a ponytail to hide her highlights. Smirking, she said unnatural hair colors were against hospital policy. She was an efficient multi-tasker. Ali strategized to make time for herself daily. She helped her coworkers but not at the risk of overcommitting herself. Ali was spunky and intelligent. She rarely censored her opinions and blurted out a witty remark for any situation. Ali used humor to boost morale. Though petite, her laugh echoed. She was instantly receptive to me and included me in every conversation.

Ali became a nurse after her father had open-heart surgery. The experience inspired her to pursue a cardiac specialty. The medical-surgical environment was her first stop on a journey to specialization. She verbalized her professional woes but carried herself as if unbothered. She, like Vanessa, discussed her anxiety related to work. She

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doubted herself professionally at times although she projected confidence. Ali paid attention to protocols, promptly finding flaws in them. Ali was special because she thought of a solution for every problem. She wanted to be heard.

Kelly. Kelly straddled the clinical and administrative staff as a charge nurse. She made nurses' assignments, facilitated patient transportation, and helped with patient care when needed. Kelly admitted patients when staff needed backup. She mediated patient complaints with her sweet, southern drawl. Kelly knew the protocols and learned the shortcuts. Occasionally, she gossiped with the secretary at the nurses' station. She was perceptive and knew each of her nurses' idiosyncrasies.

Her sweet disposition did not impair her ability to delegate. She was willing to help other nurses, but she expected them to work toward independence. She prided herself on teaching but made clear she was "not going to hold anybody's hand!" She encouraged nurses to take their breaks, repeating herself if necessary. She had no problem taking her lunch breaks and snacked whenever possible. When nurses complained, she defended unpopular administrative decisions. Privately, however, she shared their concerns.

Melanie. Melanie was another charge nurse. She was kind and graceful. She nurtured newer nurses with a maternal energy. Melanie was always one of two places— fluttering down the hallways or in a patient room helping a nurse. She floated about the unit as if on a cloud. Melanie had perfect posture and silvery, blonde hair. With decades of experience, she never appeared flustered. Melanie responded to difficult patients with her sugary, musical voice.

She smiled at everyone and encouraged each staff member. She answered call lights for nurses. Sometimes her helpfulness went unnoticed in the rush. The novice nurses relied heavily on her. She, like Kelly, defended administrative decisions and communicated in a blunt manner. She simply ignored negative commentary. She nudged nurses to eat lunch but never took a full lunch break herself. I caught her eating a plum one afternoon. When she saw me, she looked at me as if she was caught committing a crime! We both laughed. One of the most self-sacrificial nurses on the unit, she complained the least. The silver lining was her mantra.

Brittany. Brittany was soft-spoken yet confident. She was stunning with long, caramel hair which she curled. She recalled getting reprimanded for wearing her hair down but continued to do it. Brittany felt administration's concerns about her hair were misplaced priorities. Besides, her hair was fabulous. Brittany worked hard. She stayed busy all day, unphased by the chaos. She chimed in when staff conversed. She, like others, wanted a new job. Brittany rolled her eyes often but spoke sweetly. She had close friendships with some at work and took every opportunity to giggle with them.

Rachel. Rachel smiled all the time. She stood tall and thin like a ballerina. Her long hair draped over her shoulders. Rachel was conscientious and a perfectionist. Another new nurse, she was humbled by the challenges of medical-surgical nursing. She was kind to every patient, even those who were rude to her. Rachel had an endearing, nervous laugh which she interjected after every sentence.

Debbie. Debbie had kinky blonde hair and a persuasive charm. Debbie was opinionated and outspoken. She was more seasoned than the other nurses on her shift. Her career began as a licensed practical nurse but later advanced to a registered nurse.

She often contrasted work environments from past and present. Debbie celebrated being sent to other units she felt were better organized. She took pride in her nursing skills and felt strongly about patient safety. Debbie did not withhold her bold opinions. She articulated concerns followed by detailed examples and solutions. No one intimidated her. She reserved her tenderness for her patients. Her ability to balance caring and skill earned her the respect from colleagues.

Grace. Grace stood out because she had no complaints. She said very little. She worked intently from the beginning to the end of her shift. She never appeared particularly busy or hurried. Grace avoided dramatic language and did not gossip. Grace was a quiet leader, recognized by the administration on a "Thanks a Latte" recognition poster. Grace made nursing look easy. She came from a neonatal intensive care unit at another hospital and took the medical-surgical floor job out of necessity.

Amelia. Amelia was quiet and passive. She wore glasses. Her hair sat loosely in a low ponytail; several pieces fell in her face. She buried herself in her workload. She piled supplies onto her cart in the early morning and rolled up and down the hallways all day. Amelia expressed herself through facial tells. She looked terrified and on the verge of tears most times. However, she managed to curve her mouth into a coy smile when she noticed someone looking her way. She doubted her skills and sought support from other nurses. Fellow nurses volunteered to help her, especially Melanie. I wanted to rescue her on several occasions.

<center>Research Objectives</center>

Three primary objectives propelled the research. First, the researcher observed medical-surgical nurses' self-care behaviors and lack thereof. Completed over 5

consecutive 12-hour day shifts, the researcher notated participants' behaviors and verbal interactions. Second, this study illustrated the personal need prioritization culture among medical-surgical nurses. Need prioritization is evident in the frequency of primary self-care behaviors like nutrition and elimination. These represent basic human needs. Higher need prioritization data emerged during analysis. Through meeting belonging needs, nurses demonstrated a symbiotic, collective self-caring culture-sharing pattern. Individual self-care voids were minimized by group caretaking behaviors. Third, the researcher interviewed and surveyed individual participants to triangulate data. Interview data reinforced field data. Survey data enlightened qualitative data and raised new questions.

Findings reflected medical-surgical nursing culture related to self-care and self-sacrifice. The problem, as discussed in previous chapters, centered around perpetuated nurse martyr stereotypes. Martyr behavior was less common than martyr language. Participants verbalized martyrdom although most participated in some, albeit minimal, concrete self-care. Brittany reflected on nursing culture, "I think nursing in general just has that culture of sacrificing your own comfort and even safety sometimes to care for the patient." The research examined martyr tendencies as a possible cultural manifestation. Critical ethnography design allowed the researcher into the medical-surgical nursing culture to experience their workflow and interpersonal relationships. Self-care and self-sacrificial behaviors emerged consistently throughout immersion. Adaptations surfaced also, suggesting a cultural evolution in progress.

Addressing Research Questions

Themes emerged both in the field and upon data analysis. Some research questions met answers, while others sprouted new questions. The primary research

question adhered to Creswell's (2014) qualitative script (p. 141): What is the culture-sharing pattern of personal need prioritization for medical-surgical floor nurses, and how is their behavior aligned with professional verbiage trends? Sub-questions include:

a. What self-care needs are a priority in the workplace?

b. How do nurses articulate their priorities?

c. How do self-sacrifice and self-care interact in the professional nursing environment?

d. What degree of self-sacrifice do nurses demonstrate?

e. What self-care needs receive priority?

Culture Sharing Pattern.

The culture-sharing pattern found was one of collaborative caretaking as compensation for individual self-sacrifice. Need prioritization was consistently *other* before *self.* The needs of the patient and hospital came before the needs of individual nurses. Furthermore, personal needs were met to minimal standards by most participants. The frequency of self-care behaviors relative to shift length and other-care behaviors illustrated need prioritization tendencies. Perhaps a subconscious awareness of self-sacrificial habits prompted participants to take care of each other.

Nurses articulated their needs through verbalization and behavior. Nurses articulated unmet needs with humor and complaining. Self-care and self-sacrifice co-existed in the field, but interview data suggested participants regarded them as mutually exclusive. Participants ignored their individual needs while mindful of group needs. Participants discussed feeling detached from themselves at work and forgetting about physiological needs. Frequency data indicated that, while most nurses performed concrete

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self-care behaviors, these actions were abbreviated and often interrupted. Participants met self-care needs with the least possible interruption of daily tasks. Some self-care needs were more priority than others as evidenced by the frequency of the behavior. Nurses demonstrated more collective self-care than individual self-care. Unified caretaking of the *collective* self-resulted in individual need acquisition achieved by the group.

Self-sacrifice co-existed via concrete need rejection and higher need deficits. The verbiage of dissatisfaction, anxiety, mistrust, and safety concerns indicated higher need sacrifice. Self-sacrifice was evident in meal and break minimization. Participants discussed higher need self-sacrifice through internal conflict and institutional mistrust. Participants individually corroborated each other's stances. Several nurses referenced the desire for professional change and the inability to follow through. Participants used parallel verbiage to describe their post-shift feelings. Eight out of 10 participants said they felt "mentally and physically exhausted" at the end of the day. Nurses spoke alike on professional woes infiltrating their personal lives. Professional dissatisfaction persisted despite evidence of routine self-care behavior. Self-care ranged from concrete to abstract through reflection and data analysis.

Self-Care Behaviors Observed

Support Seeking. Several self-care behavior themes emerged following data analysis: support seeking, humor, expectation management, and authenticity. Delegation occurred among all participants, although in varying degrees. Some nurses delegated on behalf of their fellow nurses when they observed them struggling. More seasoned nurses checked on novice nurses throughout the day. More experienced nurses helped newer nurses despite their own workload.

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Humor. Participants used humor to make light of stressful moments. Behaviors included eye rolling, play-fighting, hyperbole, and sarcasm. Although participants maintained professionalism, all engaged in humorous comradery. Humor functioned as self-care by providing comic relief. Humor is also an outlet to cope with difficult circumstances. Laughter was an oasis amidst the call lights and mounting tasks.

Expectation Management. The third self-care behavior identified was low expectation maintenance. Readers may wonder how low expectations facilitate self-care. Expectation management acts as an insulator. Many participants mentioned stark differences between real nursing and their prior expectations. Unmet expectations can ignite feelings of professional resentment. Lowered expectations promote realism and limit disappointment. Participants described inner conflict between nursing expectations acquired in nursing school and nursing reality. Their feelings did not always align with their behavior. Some expressed performing out of obligation although they felt conflicted. For example, Vanessa discharged a patient despite her outlook on the patient's risk for non-compliance. This internal battle between trueness to oneself and system compliance weighed heavily on participants' minds. Open discussion about unmet expectations and subsequent acceptance of reality buffered further disappointment.

Authenticity. Finally, authentic self-expression was identified as self-care. Nurses spoke their minds both individually and collectively. Some participants, like Grace and Amelia, were more reserved while others readily shared their thoughts. Although the nurses performed expected nursing duties, they were uncensored and sincere regarding their personal nursing convictions. The ability to express oneself fosters individuality and provides a sense of control over one's environment. Self-expression appeared to function

as self-validation. Participants took care of themselves through authentic self-expression. Authenticity meets higher needs which may be as important as lower needs.

Non-Conforming Findings

Jane consistently did not eat lunch. Most others did although they rarely took the full 30-minute allotment. Melanie behaved differently in terms of themes observed. She participated the least in humorous conversation and group complaining. She also demonstrated the most helping behavior of all the nurses. Grace interacted minimally with me throughout data collection. Her quiet, focused disposition limited her from socializing with other nurses also.

Limitations

Census

Several limitations existed related to data collection. First, a portion of the unit was closed one week prior to data collection due to construction. Census was therefore lower. The researcher was unaware of the hall closure until data collection began. The closure resulted in a 5:1 nurse-to-patient ratio instead of 6:1. Admits, discharges, and staffing changes made for intermittently higher ratios. However, 5:1 was the standard ratio during data collection.

Staffing

The second limitation involved the duration of observation due to staffing. Some nurses were observed longer than others due to the staffing coordinator. The staffing coordinator was not involved in the research. Nurses were often floated to another unit or called off. As a result, Amelia, Vanessa, and Debbie were observed for one shift. Participants took their surveys on their last day of observation, which was different for

each participant based on scheduling changes. Therefore, each participant did not

contribute equal quantities of observational data. Despite staffing inconsistencies,

interview and survey data were equal.

Gender

The researcher sought a diverse participant pool. However, all day-shift nurses

were female. While some male nurses came on and off the unit periodically, none met

research criteria. This lack of participant diversity could influence findings.

 Experience

The hospital housed a nurse internship program. The unit assigned to the

researcher was a starting point for many novice nurses. Most nurses had less than two

years' experience which could impact findings. Of the novice nurses, several completed

training in the Spring and had practiced independently for approximately six months.

Melanie had the most tenure of all participants followed by Kelly. The experience level

of participants leaned heavily towards the novice.

Age

Eight out of 10 participants were under 30 years of age. The generational disparity

was great between those eight and the remaining two participants. The limitation exists

through varying generational differences. Younger and older individuals may express

self-care and self-sacrifice in different ways. Their philosophies on professional duty may

differ, too, which may have impacted NCQ scores (Allison, 2004).

Individuality

Self-care expression may hinder data interpretation because self-care behaviors

may manifest differently per individual. Frequency data may translate differently for each

participant. For example, a participant may feel their needs are neglected despite a lunch break while another may be satisfied with a short opportunity to eat. Individuality ties into expectations. Needs also vary with the individual. Research integrity and objectivity cannot overrule individuality. Qualitative research must own the inevitable limitation.

Time

The immersion timeframe limited observable behavior frequencies and patterns. While immersive research is typically lengthy, the culture, in this case, was familiar to the researcher. The researcher understood common terminology and role expectations of nurses from her own career. Medical-surgical nursing was, however, foreign to the researcher. Data saturation indicated adequate immersion time although one week may seem abbreviated from a purely methodological standpoint.

Visibility

The researcher recorded behaviors manually. The possibility of unwitnessed behavior exists. The researcher left the common areas for restroom breaks. Meal breaks were brief but created gaps in observation nonetheless. As participants became more comfortable with the researcher, hand signals lessened while verbal communication increased. A participant could have neglected to communicate with the researcher.

Ancillary Staff

Additionally, the arrival of student nurses lessened the workload on participants during two shifts. Students were present for a few hours, and self-care may have been subsequently more attainable. On the other hand, some participants felt hindered by the students, possibly preventing self-care.

Survey

Lastly, the survey version provided to participants did not include any reversed items. Reversed items ensure participants actively read and process each item. Reversed items are an indicator of internal reliability. Without them, the risk of participant complacency presents itself as they become used to the format of each question. The NCQ obtained for distribution omitted reversed items while the NCQ in original instrument development literature included two reversed items.

Data Interpretation

Critical ethnography was the chosen methodology focused on the nursing metaparadigm as it relates to the person. The person, in this case, was the nurse. This research focused on culture-sharing patterns through immersive interaction within the community observed. Immersive research requires transparency and trust between researcher and participant. The researcher came to meet participants prior to data collection. Additionally, casual conversation occurred naturally between the researcher and participants throughout data observation. They grew to trust the researcher. Ali said, "I'll tell you anything." Participants understood that their names would be changed for data dissemination as would location. Managers and administrators did not know which nurses had agreed to participate in the study, so participants had reduced the fear of repercussion.

Data saturation was confirmed when data duplicated from participant to participant. While all participants were individuals with different thoughts and experiences, overarching themes and patterns emerged indicating data saturation. Interview data were strikingly similar from participant to participant although interviews

were private and done individually. Survey data triangulated findings through quantitative data. Although self-care behaviors were complex, overall nurse codependency scores reinforced cultural data. The tables on the following pages describe the survey data.

Table 2

NCQ Response Frequencies

Item	1	2	3	4	5
1. I feel compelled to help my patients solve their problems.	7	1	2	0	0
2. Within the last year, a friend or family member told me that I was overly involved in my work.	4	3	0	1	2
3. At work, I often feel that my compassionate temperament is being taken advantage of.	2	3	1	1	3
4. I find it hard to take time for myself.	5	1	2	1	1
5. My self-esteem depends largely on my job performance.	1	3	3	3	0
6. If I am called into work on my "scheduled off" day, I feel guilty if I refuse.	0	2	2	4	4
7. I always go the extra mile for my coworkers because I cannot afford to make enemies.	1	2	5	0	2
8. I would rather work late on my own time than to hand off unfinished tasks or cost my employer over time.	5	3	0	0	2
9. Even if conditions are bad in your unit, I have to stay and work things out.	4	3	1	1	1
10. I have had a bladder infection from skipping bathroom breaks.	2	0	0	3	5
11. I feel compelled to offer long explanations for saying no to people with whom I work.	1	3	4	0	2
12. When I know there is work to be done, I have difficulty relaxing or having fun.	2	6	0	0	2

Table 2 (continued).

13. I find it difficult to distinguish between care that empowers and care that creates a dependency in my patients.	0	2	3	5	0
14. I have lost vacation time because I have failed to take it in time.	1	0	1	0	8
15. I find that I am often assigned the most oppositional patients because of my ability to get along with the	1	2	3	3	1
16. It is hard to view myself as an equal partner in the multidisciplinary team.	1	2	1	1	5
17. I have lost career opportunities because of failing to take action or make a decision.	0	0	1	0	9
18. Fear of retaliation or rejection has prevented me from reporting the impaired practice of a colleague.	1	0	0	1	8
19. I am reluctant to insist that co-workers assume their share of responsibilities.	1	2	2	2	3
20. Given the choice between being right and keeping the peace, I often choose to keep the peace.	2	3	1	3	1
21. I have made mistakes in my nursing career that I have never shared with anyone.	2	0	1	4	3
22. I often feel that things at work are out of control.	3	4	1	2	0
23. When asked what my vocation is, I often respond with "just a nurse."	2	1	1	4	2
24. Rarely do I find time in my nursing practice for creative self-expression.	3	3	1	3	0

Table 3

Participants' Overall Scores

Participant	Score
Ali	47
Vanessa	50
Brittany	61
Amelia	71
Jane	73
Debbie	74
Kelly	75
Melanie	86
Rachel	95
Grace	104

Lower scores indicate more codependency. Participants organized in order from most to least codependent.

Table 4

Mean and Median Responses

Item	Mean Response	Median Response
1. I feel compelled to help my patients solve their problems.	1.5	1
2. Within the last year, a friend or family member told me that I was overly involved in my work.	2.4	2

Table 4 (continued).

4. I find it hard to take time for myself.	2.2	1.5
5. My self-esteem depends largely on my job performance.	2.8	3
6. If I am called into work on my "scheduled off" day, I feel guilty if I refuse.	3.6	4
7. I always go the extra mile for my coworkers because I cannot afford to make enemies.	3	3
8. I would rather work late on my own time than to hand off unfinished tasks or cost my employer over time.	2.1	1.5
9. Even if conditions are bad on your unit, I have to stay and work things out.	2.2	2
10. I have had a bladder infection from skipping bathroom breaks.	3.9	4
11. I feel compelled to offer long explanations for saying no to people with whom I work.	2.9	3
12. When I know there is work to be done, I have difficulty relaxing or having fun.	2.4	2
13. I find it difficult to distinguish between a care that empowers and care that creates a dependency in my patients.	3.3	3.5
14. I have lost vacation time because I have failed to take it on time.	4.4	5
15. I find that I am often assigned to the most oppositional patients	3.1	3

Table 4 (continued).

because of my ability to get along with them.	3.7	4.5
16. It is hard to view myself as an equal partner in the multidisciplinary team.		
17. I have lost career opportunities because of failing to take action or make a decision.	4.8	5
18. Fear of retaliation or rejection has prevented me from reporting the impaired practice of a colleague.	4.5	5
19. I am reluctant to insist that co-workers assume their share of responsibilities.	3.4	3.5
20. Given the choice between being right and keeping the peace, I often choose to keep the peace.	2.8	3
21. I have made mistakes in my nursing career that I have never shared with anyone.	3.6	4
22. I often feel that things at work are out of control.	2.2	2
23. When asked what my vocation is, I often respond with, "just a nurse."	3.3	4
24. Rarely do I find time in my nursing practice for creative self-expression.	2.4	2

Table 5

Mean and Median Group Scores

Mean	Median
73.6	73.5

The lowest possible score is 24, and the highest is 120.

Support of Findings

Findings emerged primarily from observational and interview data with survey data to further support findings. The NCQ yielded high Cronbach's alpha scores for this research both for overall and factor-specific internal reliability. Items 1 through 15 examined the *Codependent caretaking* factor and had an alpha score of .89. Factor two illustrated *lack of voice* with an alpha score of .91. Overall, the survey yielded a .92 Cronbach's alpha score indicating satisfactory internal consistency and scale reliability. Survey results reinforced qualitative data obtained through immersion and individual interviews.

The first recurring theme noticed in field immersion was complaining. Complaining was sometimes serious and sometimes sarcastic. Complaining was usually done in groups and seemed to unite the nurses. Complaints frequently related to unpopular policies or administrative changes. Management was adamant about filling out the "something about me" portion of the dry erase board in each patient's room. Debbie said in her interview:

Um, one problem that I've had recently is that with us on our floor they have been

harping and harping and harping on, 'Fill out your whiteboards! Do bedside

report! Get discharges out in two hours!' That's not a priority to any patient.

That's not helping any patient…I feel like I can't effectively take care of my

patients some days like I'm supposed to because they're too worried about things

that don't actually matter.

Several nurses complained about administrative priorities. Vanessa said, "It seems

like administration doesn't really care about nurses as much as they care about patient

satisfaction and getting patients in and out so they can get the most profit." Debbie added,

"Doing the right thing doesn't make any money." Kelly described how hospital-

implemented flowsheets interrupt patient care, "They want us to do all of these extra, um,

paperwork sheets- they call them flowsheets…it's just a lot of extra work they're piling

on top of the nurses on top of what we already have to do." Ali speculated the reason

administrative protocols cause more stress than quality improvement, "because they're

not at the bedside." Ali said the nurses tried to contribute ideas, "but because it didn't fit

with their schedule and their agenda- they didn't feel like those solutions were worth

pursuing. So, those goals just weren't met, and it was the nursing staff to blame."

Assignment-related complaints were common. Sometimes multiple patients

would be set to discharge under the care of a nurse while the other nurses had no foreseen

discharges. "The patient assignments are not made fairly, and one nurse can get stuck

with all the discharges and admits because you gon' get an admit for every discharge,"

Debbie vented. Similarly, patients scheduled for procedures were sometimes assigned to

the same nurse. Debbie recalled a situation vividly:

Like the other day, we had three patients who were going for procedures, and they give me two of them. One of them was supposed to have a kidney biopsy, and one of them was supposed to have a heart cath- and thank the Lord that the one who was supposed to have a kidney biopsy ended up that they couldn't do it. Because if I would have gotten them- if they would have both had their procedures that day, I would have gotten them both back at the exact same time, both at risk for bleeding, and I can't be in two places at one time.

New admissions at shift change and being assigned infamously rude patients were a source of grumbling. Ali remarked, "I always get the worst ones." During observation, two nurses were "fired" by the same patient. His pain medicine would be late, or his mashed potatoes would not have any gravy, or his room would be dirty. His complaints were varied, but his treatment of each nurse was the same. Despite his condescending remarks and disruption of unit assignments, he received a new nurse at each request. He requested to speak with a patient advocate on a few occasions, but where were the nurse advocates? Several nurses mentioned during interviews that they felt a lack of support and advocacy from management. Debbie said, "we're supposed to let patients treat us like dogs." Vanessa said, "we feel like management is more concerned about budgets and meeting certain criteria than they are about… nurses."

A manager came to the unit for huddle one day. Vanessa complained about an emergency department (ED) transfer who was combative and hemodynamically unstable. She was unaware because the ED did not call report to her prior to transfer. The hospital recently decided that ED transfers did not require a telephone report because it delayed

transfer and information was visible in the electronic medical record. He replied to her concern with a simple, "no complaining." She later vented, "I feel like he doesn't care."

Some participants complained about a lack of teamwork related to inexperience. The more seasoned nurses complained about the saturation of novice nurses on the unit and felt unsafe at times leaving their patients with them for breaks. "There was a time when we were more team oriented… Now, with having new nurses, I think that teamwork isn't there and everyone's kind of on their own," Ali said. Debbie felt uncomfortable leaving her patients with an already overwhelmed newer nurse for lunch, "We've got a lot of new nurses. They don't know—their critical thinking skills aren't there to take care of your patient." Complaints were also personal. Nurses complained of a headache, hunger, back pain, and readiness for the shift to end. One remark snowballed as each nurse chimed in. Collective complaining often leads to laughter as each nurse tried to come up with a more dramatic complaint. "My heart is cold!" exclaimed Ali. Everyone laughed. Nurses vocalized to each other when they thought it was an overall bad day. Kelly predicted, "this is going to be a long day, Y'all." They shared their displeasure with work with one saying, "I hate this place."

<div align="center">Emerging Themes</div>

Mistrust

A theme emerged in data analysis reflecting a mistrust in the organization and, at times, in the healthcare system. Several nurses verbalized skepticism of administrative decisions as being primarily revenue-driven. Nurses discussed the wing of the unit that was shut down. They said it was unsafe during construction without enough room in the hallway to fit the crash cart in the event of an emergency. Some nurses notified

management of the space restrictions and safety concerns, but their response was to put up a caution sign. A recent inspection finally pushed the hospital to close the wing. Nurses believed they would have otherwise kept it open for financial reasons. "They should be worried about putting patients back there in that construction zone," warned Debbie.

Participants mentioned another organizational trust issue regarded staffing. "This is what happens when there aren't enough nurses," said Ali. Staffing coordinators would send nurses and ancillary staff home if admissions and discharges slowed down, and remaining nurses would become overwhelmed. Admits from the emergency department inevitably piled up after nurses were flexed off. "We all kind of flounder and pray," Ali said. Kelly reported in her interview that acuity has increased with patients who are more critical than they used to be in the past. "I've noticed…the more patients we are getting in, the sicker they are. They require more attention, the acuity is higher, um, so the nurses are expected to do more work with the same amount of patients," Kelly explained. Kelly also mentioned staff are sent home sometimes near shift change, which interrupted continuity of care. "They flexed a nurse home at 5:30, so they shuffle around at one time." Other times, staffing coordinators require that multiple staff members go home. Kelly recalled, "You've already sent a secretary and a tech home, so it's like you become a tech, a secretary, a nurse, and a coordinator all at once. You know you can only do so much. I am only one person."

Another unpopular administrative change was that the emergency department was no longer required to call report on transferring patients. Brittany felt powerless, "I don't like it, but what can I do?" Grace agreed, "I personally don't think it's safe."

Administrative priorities were not aligned with the nursing staff. Ali did not feel like the hospital cared about nurse retention and discussed the connection between nurse satisfaction and patient satisfaction scores. "When you have happy staff, I think you have happy patients." Mistrust leads to another common theme, inner conflict.

Inner Conflict

"Some days I go home and I'm just like *is it really worth it being a nurse?*" Kelly reflected. There was what these nurses learned in nursing school, and then there was reality. Rachel reflected, "now that I'm actually a nurse… I feel like it did change a lot from when I was in school… you don't really get the exposure you need in nursing school." She discussed how situations did not unfold like she learned in school. Rachel said, "I do still try to think of all those things I did learn in nursing school, like the nurse in the book…but it's so hard because it's not real." An overall sense of *self versus the system* existed. Nurses' expectations did not reflect reality, so often they had to act against their personal convictions. This type of inner conflict felt like the nurses had to abandon themselves in order to be loyal to their job in some circumstances. Debbie described concerning poor treatment from patients. Patients become irate about food, medicines, family matters, etc. Nurses shared stories about patients spitting on them or yelling at them.

Regarding hospital policies like the new one excusing the ED from calling report, Ali predicted it would continue until there was a bad outcome. "They'll keep doing it until somebody dies," she said after receiving a patient from the ED without report. A nurse from a different rotation echoed her thoughts, "maybe when something bad happens, they'll realize it isn't worth the money saved." Debbie admitted, "it's not about

patient safety like we learned in school." Jane described the difference between real-life

nursing and nursing school as "more tasking than nursing." Vanessa agreed, saying "at

this point, I'm on autopilot." There was a feeling of disappointment in these nurses along

with the residual desire to practice nursing as they imagined it. Amelia doubted her

abilities as a nurse saying, "I'm just thinking about this lady and how I don't know if I

can do what she wants me to do. I don't know if I can provide the care she wants."

Brittany told me in her interview that nursing does not allow for adequate time with the

patient. She explained, "I feel too overwhelmed to actually be there for my patients like I

would like to. I don't have time to sit and talk with somebody who would need it as much

as I would want to."

This inner conflict of expectations-versus-reality caused some of the nurses to

question their career choice. "Why am I even doing this?" Vanessa said nearly in tears

after being reprimanded for self-reporting a medication error. Disciplinary actions against

nurses who made mistakes had the nurses talking. "That type of reaction makes a nurse

want to cover up a mistake." Participants, each in their own way, felt betrayed by their

career choice and the general direction of healthcare. Brittany said, "I feel like everything

is on me, and that's how I go into work every day…I feel like it's me against the world."

Collective Caretaking

The next theme to emerge was collective caretaking. The nurses had a symbiotic

relationship where caretaking was circular. Ali said, "I do think as a whole our unit is

very supportive… I don't think that the *eating-your-young* culture is present. I think that

we all try to help each other." Their focus on others resulted in the indirect care of

themselves. Without collective caretaking, lower needs may have gone unmet.

Amelia admitted, "You push yourself lower on your priority list. Like, everyone

else gets a higher priority than yourself." Rachel described forgetting herself, "I don't

even really think about myself or my life or my friends or my family when I'm at work."

Jane echoed, "I just think my job is to take care of patients and not so much take care of

myself." Melanie disagreed with self-sacrificial norms in nursing. "The assumption is

that you're just supposed to do whatever needs to be done. And a good nurse doesn't

think about his or herself," she said. She combatted these ideas by encouraging self-care

among novice nurses, "I'll be like, 'have you had lunch?'". Vanessa experienced guilt in

taking allotted lunch breaks, "I feel like we have to sacrifice a lot. Not that we have to,

but that we feel like we have to."

The pressure to remain other-focused allowed nurses to sustain themselves by

caring for each other, an action which was reciprocated. Nurses checked on each other

frequently, helped each other, and reminded each other to take breaks. Ali approached

Vanessa and demanded a report on her patients so she could go eat. Kelly often became

frustrated with nurses if they had to be reminded multiple times to go to lunch. It was like

a species adapting for survival. Collective self-preservation emerged as nurses protected

each other from the temptations of self-sacrifice. Kelly and Melanie, both charge nurses,

voluntarily took patients when the ratios became overwhelming and assisted newer

nurses in skills. Melanie showed concern when her nurses were floated to other units, and

she called to check on them.

The nurses, both seasoned and novice, delegated tasks when appropriate to

prioritize their workload. They also volunteered to help each other as sometimes it

benefitted them. Vanessa explained why she looked up a report for Jane, "She is new.

She gets overwhelmed. I have a minute to do it, and it helps me learn." Ali offered to take back-to-back admits from the emergency department because "it keeps me from getting one at 6:00." The nurses demonstrated a perpetual awareness of group wellness. An imbalance was perceptible if one nurse was struggling and the others were not. The nurses were attuned to each other, and while they were not necessarily friends, they protected each other. The result was a collective self-care buffer when individual self-care fell through.

Humor

One of the most prominent themes noted in data analysis was the unanimous use of humor. Humor functioned as a sign of support for one another and a way for nurses to be candid but lighthearted. This function of individual and collective self-expression also contributed to self-care. Humor recurred in defense of emotional wellbeing. Together, the nurses enjoyed a couple of sessions telling nurse war stories. Each story triggered another, and they laughed. Grace and Ali particularly enjoyed this pastime. Sarcasm was also used to communicate truth under the guise of humor. Ali joked with Vanessa about finding the motivation for the day and gestured pulling it out of her behind. They both laughed.

One morning, the nurses were discussing their morning rituals. Each of them described how they mentally prepared themselves for the work day ahead—praying, crying, deep breathing. The girls all laughed. Debbie added that after work she prayed for forgiveness, which incited another roar of laughter. Ali stood out as quite the comedian. Before going to lunch one day she said, "If you need me, don't call me!" laughing on her way to the lunchroom. She would joke about becoming callous with a smirk on her face,

"My heart is cold." When she had a bad day, she would joke about it. "The universe is telling me *I hate you.*" They often used humor to cope with taxing patient assignments.

Rachel's patient refused to use the call light. Instead, he would yell for help. The nurses had to move him closer to the nurses' station to hear him, and other patients were complaining. Rachel could not get through a task without having to address this man's bellowing for help. As time went on, Rachel would just laugh and shrug her shoulders at him as if there was no use getting frustrated. Kelly began singing the song "Help" and laughing as she followed Rachel to the patient's room.

Sarcasm flourished both verbally and non-verbally. All of the nurses perfected eye rolling as a commonality in non-verbal responses to unpleasant situations. The nurses used humor to celebrate as well. One day, Jane went to lunch. They all cheered her when she went into the lunchroom. When she came back, they cheered again because everyone had eaten lunch before 3:00 p.m. The same thing happened on the other staff rotation with Melanie cheering, "Y'all all got lunch today!"

Concrete Self-Care

The last theme noted was concrete demonstrations of self-care. These behaviors included hydration, nutrition, and elimination. Restroom breaks were least frequent. The unit had one restroom, and another restroom was down the hall within short walking distance. Nurses scheduled restroom breaks around shift change and patient care. Amelia explained, "I know it's bad to hold it, you know? So, if I have to go to the restroom…if I know I'm going to be in a patient's room for a long time, I'll run to the bathroom first." Ali had a different strategy, "I always go to the bathroom before I clock in 'cause I think that's just the best way that you have time for yourself." Despite efforts, the most any

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participant used the restroom during a shift was twice. Melanie explained, "I get to the point where, oh my gosh! I haven't gone to the restroom all day long." While restroom breaks were personal, meal breaks were encouraged as nurses often reminded their peers throughout the shift.

Lunch breaks allotted were 30 minutes. Meal breaks were usually prompted by other nurses or the charge nurse, but occasionally self-initiated. Ali consistently initiated her own self-care behaviors. With regards to not taking breaks, "that's kind of a new nurse thing. Finally, you realize *okay, I'm more important than anything else for 30 minutes.*" She would carry a small bottle of water around in her scrub jacket. Still, her first sip of water one shift was at 4:50 p.m. Jane would keep water on her cart, occasionally sipping in between peppermints. Eight out of 10 participants took lunch breaks on every shift. The two who did not were Jane and Melanie. Although most took their breaks, they were rarely a full half hour. Several participants discussed interrupted breaks in their interviews. Nurses, charge nurses, and physicians commonly entered the lounge during someone's break to give report or tell them what their patient needed. For this reason, Vanessa always left the unit for lunch so as not to be interrupted. She explained, "I need to step off the unit for at least thirty minutes." Kelly agreed, "you need that time away." Another demonstration of self-care was social connection using cell phone which is also included in Table 6.

Table 6

Self-Care Behavior Frequencies by Day

Monday	Phone	Eat/drink	Break	Restroom	Shift End
Jane	0	5	0	1	yes
Ali	4	5	2	1	yes
Kelly	10	6	1	1	yes
Vanessa	18	5	1	1	yes

Tuesday	Phone	Eat/drink	Break	Restroom	Shift End
Jane	0	2	1	1	no
Ali	7	3	1	2	yes
Kelly	10	4	2	1	yes
Vanessa	11	4	1	2	yes

Wednesday	Phone	Eat/drink	Break	Restroom	Shift End
Melanie	0	4	1	1	no
Brittany	4	5	2	1	no
Amelia	0	1	1	0	no
Rachel	0	2	1	1	no

Thursday	Phone	Eat/drink	Break	Restroom	Shift End
Melanie	1	1	0	1	no
Brittany	4	5	1	1	no
Rachel	0	1	1	2	no
Debbie	1	2	1	1	no

Friday	Phone	Eat/drink	Break	Restroom	Shift End

Table 6 (continued).

Ali	1	1	1	1	yes
Kelly	2	2	2	0	no
Grace	3	3	1	2	no

Self-care behaviors- frequencies by day. Personal phone activity included social media, text messaging, and personal phonecall occurrences. Eating included gum and mints as well as meals. Breaks were counted when participants handed off their patients and stepped off the floor for a break. Restroom frequencies counted if participants went to the restroom for any reason. Participants who left by 7:30 pm (30 minutes after shift change) were considered "leaving on time."

An interesting perception emerged in Ali's interview that self-care took away from patient care. She discussed how self-care comes with nursing practice as nurses become "jaded" and less passionate than a novice nurse. Brittany said the purpose of going to work is to take care of patients, not herself. "If I put too much time, like, for self-care on the job, I would feel like I wasn't working my hardest for my patients," she said. So, does this statement suggest that a nurse must choose between self and patient? Can caretaking of both not coexist? Participants also mentioned their lack of self-care immediately after work and said they often go to sleep without dinner. Vanessa recalled a time when she fell asleep at the dinner table. Dreaming about work was not an uncommon topic during interviews. A handful of nurses mentioned needing time to recover from shifts and that sleep was often interrupted by worries of mistakes made or tasks missed.

Reflexivity

Throughout data collection, the researcher kept a reflective journal. Each day, the researcher wrote a few paragraphs about the research experience along with any personal thoughts. The researcher emailed the journal to the dissertation chairperson at the end of

the observation week. Unstructured phone conversations occurred between the researcher and chairperson to address issues throughout data collection. Lastly, the researcher wrote a short descriptive summary about the hospital setting and each participant to better engage the reader and illustrate each individual accurately.

Summary

In accordance with ethnographic methodology characteristics, the researcher organized the findings into themes. Emerging ideas developed during data collection and analysis in contrast to quantitative methodologies. To demonstrate data transferability, survey data provided quantitative corroboration for qualitative findings. Behavioral data provided insight into self-care behaviors and nursing culture. Additionally, field dialogue enriched behavioral data. Interview data yielded evidence of field data reliability through individual corroboration. Survey results added dimension to the data analysis findings and rigor to the overall study. Finally, the completion of data analysis allowed for scholarly interpretation of the data and exploration of possible future research.

CHAPTER V – DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Overview

Why

The purpose of this study was to bring awareness to medical-surgical nursing culture and better understand how nurses prioritize personal needs. Various nursing specialties experience high turnover. Medical-surgical nursing has a reputation for being unsustainable and a launchpad for other nursing specialties. Medical-surgical nursing, like other specialties, entails long shifts. High patient ratios also contribute to the generalized unpopularity of medical-surgical nursing.

How

Medical-surgical nursing culture examination took place through researcher immersion. The researcher observed participants in their natural environment and workflow for 5, consecutive day shift lasting from 7:00 a.m. to 7:00 p.m. Critical ethnography methodology was employed in adherence with research objectives. Critical ethnography identifies cultural trends and identifies areas for growth. Researcher immersion allows for multifaceted data and pattern identification. In addition to immersion data, the researcher conducted individual participant interviews and gathered Nurse Codependency Questionnaire survey data (Allison, 2004).

Answering Research Questions

The culture-sharing pattern of personal need prioritization observed in participants was one of minimal self-care. Self-care behaviors such as meals, breaks, and elimination were accomplished and prioritized around patient care. Often patient care or mounting tasks would overshadow personal needs. Personal needs appeared to be a low

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priority as evidenced by frequent interruptions and abbreviated self-care activities. For example, restroom breaks did not exceed two per shift, and lunch breaks were often less than half an hour.

The self-care behaviors observed were often inconspicuous. Through data saturation, the researcher noticed emerging behavior trends. These behavior patterns occurred among all the participants, and analysis suggested these behaviors addressed higher needs as well as group needs. Nutrition and elimination were obvious and primary self-care needs. Additionally, the researcher observed higher need priorities in belonging as evidenced by support-seeking behavior and group comradery. Primary and higher needs adhered to descriptions in Abraham Maslow's (1943) *Theory of Human Motivation*.

Participants were verbally expressive about their needs. While their priorities were articulated mainly through their actions, verbal communication revealed prioritization habits, too. When needs went unmet, group complaining with or without humor appeared as a coping mechanism.

Self-care and self-sacrifice coexisted in field observations although participant perceptions were that the two were mutually exclusive. Participants spoke about self-care as if it required a compromise in patient care. Nurses described job expectations which were incompatible with self-care prioritization. Professional nurses in this study lacked moderation or balance in self-care philosophy. They excelled in taking care of each other, however. In remaining other-focused, they performed indirect self-care by caring for the collective well-being of the group. The participants justified this behavior whereas individual self-care was performed hurriedly to minimal standards. Self-care interacts

with self-sacrifice like our bodies seek homeostasis. Participants collectively sought equilibrium within the group. Individuals, however, spoke differently about self-care as if inappropriate in the nursing setting. Perhaps individual self-care had a place, but realistic circumstances made it unachievable.

Nurses demonstrated a moderate degree of self-sacrifice in terms of primary needs. Basic needs were met to the minimum requirement. The sub-culture demonstrated several compensatory self-care behaviors which were accomplished as a group. Collective self-care emerged as the counterpart to individual self-sacrifice. Though individual participants sacrificed themselves, the collective self was cared for by everyone. Each nurse contributed to the well-being of the group albeit unknowingly. Overall, nurses did not demonstrate pathologic self-sacrifice in the field. Rather, their self-care was just different. Self-care priorities were more group oriented and gave attention to higher needs. Triangulation of field findings occurred in survey analysis showing that, on average, participants leaned towards non-codependent responses to survey items.

Nourishment received the highest priority out of the primary needs as evidenced by frequency data. Safety and esteem need to receive priority for higher needs. Safety and security need prioritization manifested in delegation and teamwork behavior. More experienced nurses volunteered to check on novice nurses and assist them in unfamiliar skills. Nurses verbalized several safety concerns indicative that safety needs were important. Belonging needs were met through supportive behavior amongst the group. Esteem needs like acceptance and feeling valued were sought after and sometimes met by peers. Rarely were these needs perceived to be met by the organization. This information

formulated through field and interview data. Nurses checked their personal cell phones frequently although this behavior was not originally being observed. The researcher took notice when the behavior became more frequent than other concrete demonstrations of self-care.

<div align="center">Interpretation of Findings</div>

Conclusions

The research identified patterns of self-care adaptation among medical-surgical nurses. These adaptations varied from humor to complaining, but participants were unified in demonstrating these patterns. Adaptations appeared unintentional and unrecognized as self-care. Participants verbalized self-sacrifice as a nursing culture norm. Basic needs were met by most nurses although often less than the minimum standard. Data analysis unsurfaced a pattern of collective self-care. While this behavior remains other-focused, it employs caretaking tendencies and allows them to benefit those most vulnerable to self-sacrifice. Nurses indirectly cared for themselves by participating in this type of collective self-care. Overall, the research concluded that the greatest form of self-sacrifice experienced by the nurses was succumbing to inner conflict. Participants emphasized often the difference between expectations and reality. They spoke about situations which made them question their career choices. Each day they entered their professional environment, they sacrificed a little of themselves. Reality chipped away at the image they adopted of nursing. Each day, they gave some of that expectation away and settled for what it really is: a job.

Outcomes

The outcome of this research is one of positivity and self-awareness. The research identified adaptation, a sign of thriving, among this medical-surgical group of nurses. Conventional ideas of self-care did not fit the mold. Rather than codependency and martyr behavior, resilience was found. The community was found. Nurses took care of themselves by taking care of each other. Behavior adaptations took place without deliberate effort, and awareness will only elevate future outcomes. Unmet needs may have been internally manifested to a degree although that is difficult to assess. Data showed, on the other hand, individual authenticity. Nurses spoke their minds, verbalized their expectations. Nurses bonded in their dissatisfaction which, in turn, satisfied them.

Outcomes may include improved relationships between administration and nurses. Data dissemination can open communication of important concerns to administration. Trust may be rebuilt or at least explored. Nurses reading this research may see their behaviors in a new way. Self-awareness is the goal outcome of an ethnography. Critical ethnography aims for outcomes of change. Nurses may explore their manifestation and philosophies about self-care and self-sacrifice. Nurses may ask themselves whether both can co-exist and if not- why? Nurses may examine their individual and group behaviors based on data found. Change promotion is an important part of the chosen methodology.

Changes encouraged because of this research may include more shared governance between nursing staff and administration. Perceptions about organizational goals can be discussed openly and clarified. Nurses, through increased self-examination, may choose to care for their basic needs as more of a priority. Perhaps self-care may

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become as important as patient care. New nurses may gain a more realistic understanding of medical-surgical nursing and understand the rigorous expectations. Expectation management is perhaps the most powerful action nurses can take against burnout and professional dissatisfaction.

Data Summary

 Behavioral. Behavioral data identified many patterns and self-care adaptations. Six themes developed throughout data analysis. First, nurses expressed their needs and opinions through complaining. Complaining was observed in the group setting, often bouncing thoughts off one another. Second, a disconnect between nurses and administration became clear as nurses expressed a mistrust in the system. This mistrust leads to the third theme of inner conflict. Nurses verbalized their inner struggle with their ideas about nursing versus reality. Throughout observation, nurses completed tasks and cared for patients in ways that they did not necessarily feel comfortable with. Regardless of circumstances, nurses were observed looking out for each other. Collective self-care compensated for the minimal individual self-care that took place.

 Individual self-care was observed in meals, breaks, and elimination. Nurses achieved these needs only after patient needs and team needs were met. Breaks were interrupted, and restroom breaks were infrequent. Drinking was rarely observed. The most prevalent personal behavior observed was phone activity. Social media and text messaging occurred more than hydration or nutrition.

 Interview. Similarities became apparent in interview data analysis. The first interview question surrounded their professional background. All participants except for Debbie and Grace began nursing in the medical-surgical specialty. The unit where

observation took place was the first nursing job for seven out of the 10 participants. Their unified lack of exposure to other work environments could explain why inner conflict was prevalent. Nursing school was a recent memory for most participants, and their perception of nursing may change over time.

Participants rationalized minimal self-care activity as part of their professional caretaking duty. In different terms, each participant stated that their purpose at work was not to care for themselves but to care for others. The cumulative philosophy influences cultural norms and perpetuates the assumption that self-care and patient care are mutually exclusive. Cultural beliefs may have influenced individual philosophies or vice-versa.

Responses regarding nurse burnout causation included two common answers. First, all participants mentioned unattainable productivity expectations as a major contributor to nurse burnout. Repeated mention of this problem among others formed a theme of organizational mistrust. Nurses did not feel protected or cared for by the hospital. Such trepidation could explain why nurses looked out for one another. Perhaps collective caretaking served as a protective measure against perceived threats. When asked their feelings on nurses' tendencies towards self-sacrifice or self-care, participant responses were the same. All 10 nurses admitted self-sacrifice was rampant among nurses, and self-care was not a priority.

The interviews continued by asking how nursing culture did or did not influence individual nursing behavior. The majority of participants mentioned the responsibility of nurse preceptors to instill good professional habits in novice nurses. One may interpret this to mean that preceptors are like nursing spokespeople; they steer the culture. On the other hand, such a responsibility could be too large to be controlled by one subset of

nurses. Ali stood out as the only participant who discussed nursing stereotypes in her response to this interview question. Perhaps stereotype awareness is limited in novice nurses while placing culpability on preceptors seems more tangible. Two participants said their perception of nursing culture came from nursing school. Overall, nursing culture is likely influenced by countless variables.

Finally, participants answered a question regarding how they felt after a shift. Each participant responded with the word *exhausted*. Multiple nurses recalled skipping routine activities after work in order to sleep. Jane said she no longer exercised due to her physical exhaustion. Vanessa recalled falling asleep at the dinner table. Ali stated she often went to bed without bathing after her shift. Work-related self-sacrifice may bleed into personal time based on these responses. One may argue, however, that sleep is the first self-care priority for both physical and mental restoration.

Survey. Overall, survey data yielded item scores on the lower end of neutral. Two items were answered with the highest codependency response by the majority of participants while five items were mostly answered as the lowest codependency response. Median and mean results illustrated overall neutral codependency indications. One could speculate that age and experience affected item responses. For example, the two oldest nurses' survey scores ranked the third and fourth highest out of all participants. The highest score belonged to Grace who withheld from any complaining throughout data collection. Without advanced age or experience to sway her, perhaps Grace's prior NICU job shifted her perspective and expectations. Ali, one of the most outspoken, had the lowest overall score. She was also unique as her desire to practice nursing rose from

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witnessing her father undergo major surgery. Personal attachment to nursing may contribute to increased codependency scores.

Evidence

Evidence for findings came primarily from immersion data. This data was manually recorded by the researcher throughout each shift. Patterns were identified in field notes, and supporting evidence was extracted from interview data. Interview data also provided individualized reinforcement of cultural findings. Survey data validated qualitative data. Qualitative data indicated that although nurses verbalized feelings and perceptions in alignment with martyrdom, their behavior was adaptive and compensatory. They were unknowingly finding ways to thrive through collective self-care. Survey data showed only some areas where participants scored in codependency range. Median scores reflected neutrality and, in fact, mindsets in opposition to martyrdom.

<div align="center">Theoretical Framework</div>

Hierarchy of Needs

The first concept explored in Chapter I and connected to data found is need prioritization. Human behavior is motivated by need fulfillment (Maslow, 1943). Lower needs describe primary needs like nourishment, hydration, and elimination. Higher needs include safety and security needs. The third tier is comprised of belonging and love needs. Higher still are the esteem needs and, finally, self-actualization. Maslow (1943) also discussed the persuasiveness of needs and how acquisition may not occur in ascending order. Field data supported Maslow's thoughts. Participants engaged in behaviors associated with higher needs more commonly than behaviors associated with lower needs. Needs like hunger or thirst are consciously detectable, but Maslow (1943)

suggested some needs are subconsciously motivated. Nurse participants took care of each other, but none verbalized a conscious need to feel accepted or belong. However, they verbalized how hungry they were when they took lunch breaks. Nurses spoke in their interviews about inner conflict related to being a nurse or fulfilling the expectations they held of themselves professionally. This data could be motivated by self-actualization needs. Different needs motivated behavior simultaneously and left participants no choice but to ignore some needs to meet others. Although they could not always meet their own needs independently, group need-acquisition occurred daily.

Theory of Self-Conservation

The theory of self-conservation is a patient-focused nursing theory developed by Myra Levine (1971). For the purposes of this research, however, self-conservation of the nurse is the focus. The theory can be interpreted for nurses, and self-conservation was evident in data collection. Collective self-care was a unique adaptation in self-conservation. Participants followed up with each other throughout their shifts. While this behavior relates to self-care, it also mimics the body's constant seeking of homeostasis. This parallel was something Levine also discussed. The imbalance caused a cascade of ramifications. Although data collection was five days, some of these consequences were evident in the data. No participants demonstrated the initial fight or flight response although verbiage indicated the desire to abandon their job. Field dialogue included several participants voicing their desire to apply for other positions. They often joked about being sent home or discharging all the patients.

Inflammation represents the second indicator of imbalance (Levine, 1971). Participant complaints and acute moments of distress could be interpreted as evidence of

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inflammation. These participants were individually and culturally inflamed. Nurses consistently discussed ongoing disagreement with the administration and patient care expectations. These chronic issues made them more sensitive to day-to-day stresses. To compensate, nurses developed a cohesive mistrust in anyone other than themselves.

The third stress response in the absence of self-conservation is apprehension and fear (Levine, 1971). A sense of dread was evident at certain points in the shift. Nurses expressed fear of being overloaded with newly admitted patients. The nurses had a lighthearted conversation about how they mentally prepared for work every morning. They laughed in unison about how, without their morning rituals, they were riddled with anxiety and dread about their oncoming shift. The discussion was humorous but laced with sincerity.

Finally, hypervigilance and defensiveness develop as a barrier to irritants (Levine, 1971). Participants paid attention to administrative priorities and rebutted several new protocols. The lack of trust in the healthcare system and hospital administration primed the nurses to disagree with new initiatives. Participants verbalized their predictions of what consequences would result from certain actions based on past experiences. Nurses gathered report for each other on newly admitted emergency room patients since the ER no longer had to call report. This demonstration of caretaking was protective in nature of both the individual and the collective self. Nurses advocated for each other because they felt vulnerable to organizational threats.

Implications for Change

Turnover

Nurse turnover is a national issue as discussed in previous chapters with medical-surgical nursing units having some of the highest turnover. Participant demographics indicated high turnover, also. On one rotation, all the nurses had less than one year of experience outside of the charge nurse. On the other rotation, the most experienced nurse had four years of experience. Charge nurses recalled heavy turnover with new graduates coming and going. Several nurses stated in their interviews and in the field that they intended to leave the unit as soon as possible for another job. Some participants wanted different specialties, and some wanted to pursue an advanced practice degree. Change generated by this and future research may begin to foster more desirable work environments. Positive change may be accomplished on the organizational and individual nurse level. Self-awareness and job transparency may better equip nurses to handle the immense pressures of medical-surgical nursing. Increased retention could have a positive impact on the hospital and the staff nurses. Staffing stability is also a safety measure for patients which should make it a top priority for the hospital.

Stereotypes

Data collected throughout the research process challenged old nurse stereotypes. Participants were complex and had their own individual ideas about what it means to be a nurse. Ali recalled social media posts she had seen about nurses. She ridiculed these portrayals for glorifying the exhausted, starving, disheveled nurse. Participants rejected the stereotypes examined in Chapter I. Remnants of old stereotypes were evident in the minimal participation of employee rights like breaks and lunches. Nurses neglected to

take their entitled breaks in their entirety sometimes because they knew they would be interrupted. Other participants recalled peers' injuries sustained on the job. The discussion about these situations carried an undertone of victimization and oppression. Submissive stereotyping persists in participants who feel disregarded or less important than their professional counterparts. Nurses voiced their readiness for change. A change in professional nursing identity is underway, and existing nurse stereotypes are no longer glorified.

One perpetuated stereotype, however, was the medical-surgical specialty as the brutal, front-line of nursing. Participants described it as draining to every aspect of themselves. Nurses cited endless tasks and uneasiness as a staple of each day on the unit. Medical-surgical units were regarded by most participants as stepping stones to other specialties or career paths. The workload was simply undesirable and a rite of passage. Data dissemination occurring because this research may bring awareness to the reality of medical-surgical nursing. Readers may understand some of what it is like and why the stereotype still exists. Most importantly, nursing leaders have the ability and knowledge to alter the environment in which these nurses work. Nurse leaders and hospital administrators can improve the medical-surgical nursing environment. Slowly, negative stereotypes can be replaced with productive ideas about efficient and safe patient care that does not sacrifice nurse satisfaction.

Self-Sacrifice

Nursing is caretaking. In professional caretaking, personal needs must share space with patient needs. Participants had heavy workloads of planned and acute tasks. Time management skills carried them through the day, but inevitably issues arose. Participants

shared their self-care strategies during individual interviews. Nurses planned restroom breaks around the start of shift and new admits. Amelia talked about going to the restroom purposefully before a new patient came in. Debbie discussed timing lunch breaks around medication administration and patient therapies. On the other hand, breaks were kept to a minimum. A couple of participants took lengthy breaks, but the majority were abbreviated. Some self-sacrifice went unmeasured. Knowing if participants had to go to the restroom but did not was impossible. Knowing if participants ignored aches and pains was impossible. Some self-sacrifice was notable. Self-sacrifice persisted in a deeper way and emerged in individual interviews. Nurses explained their perception of why nurses burn out on medical-surgical floors. Self-sacrifice manifested in inner conflict and feeling trapped in a healthcare environment much different than they had imagined. Field dialogue demonstrated a pattern of inner conflict as well. Nurses felt a semblance of self-sacrifice in returning to this environment day after day. The reward for this behavior was the well-being of their patients and teammates.

<div align="center">Recommendations for Action</div>

Steps

The research brought forth the potential for cultural change. Initial steps for positive change include transparency between administration and nursing staff. Nurses should identify important needs and the origin of those needs. These needs may vary from person to person as needs are prioritized individually (Maslow, 1943). Additionally, nurses should use research like this to increase self-awareness and identify areas of potential. Nurses have control over themselves and their reactions to circumstances. Nurses also have the power to change their image. Nurses can change their professional

identity through self-awareness and unity. Their teamwork highlighted their ability to band together and positively manipulate their environment. Administrators can utilize this information to provide additional support and transparency with nursing staff. Educators can better prepare nurses for the reality of nursing by focusing content on skills rather than emotional motivators.

Stakeholders

Primary stakeholders in this research are nurses. Nurses could own their career choices. Nurses could mold whichever specialty they are in through the observed self-care adaptations. Adaptations can become more deliberate and beneficial to nursing culture. Secondary stakeholders are the patients. Past research demonstrated the positive patient-care outcomes that occur because of increased nurse satisfaction. Third, hospital administration and management may benefit from this research. While hospitals employ many evidence-based, patient care initiatives, changes from nurse focused research cater to specific nursing populations. Improving unit by unit involves both administration and nurses. Cohesive and synchronized changes can help build trust between nurses and the organization. Nurse satisfaction leading to nurse retention saves money and time. Units can maintain a safe mixture of seasoned and novice nurses on staff with less turnover.

Dissemination

Dissemination of this research includes conference presentation, dissertation defense, and publications. Findings will also be shared with participants and the hospital in the form of a white paper. Embedded nurse-focused research can be duplicated in different settings to bring awareness of nursing issues. Information could also be shared and discussed on social media. Data leading to increased cultural awareness could lead to

the implementation of new support mechanisms for nurses. Forums, round-table discussions, and honest conversations among nurses can bring positive change to work environments.

<div align="center">Recommendations for Further Study</div>

Concepts

Duplicate studies would be beneficial to further confirm findings by looking at other hospitals in varying sizes and geographic locations. Ethnography is cultural research, but the broader culture related to geographical location may impact participant worldviews and tendencies. Research in other parts of the United States could introduce new data. Further research may also include more diversified experience levels and ages, bringing about new self-care concepts. Future studies may examine self-care behaviors in male versus female medical-surgical floor nurses. Generational differences may also play a role in self-care prioritization and collaborative caretaking behavior, warranting new research. Additionally, need prioritization could be unique in caretaking professions. Future nursing research could explore new theories of motivation with Maslow's (1943) work serving as the foundation. Nursing theory is patient-focused; however, progressive scientific inquiry could form nurse-focused adaptations.

Additionally, the data from this study could be re-analyzed as grounded theory research to develop new self-care theories. The concept of collective self-care warrants further exploration. Themes noted in data analysis represent opportunities for future research. For example, a future study could explore patterns of humor in the nursing profession. Finally, further cultural investigation may unearth the need for new terminology. In describing everything nurses do, perhaps the term *nurse* is outdated.

Revisiting professional titles could ignite a metaparadigm shift as the ultimate rejection of old stereotypes and toxic, self-sacrificial behavior patterns. Large-scale data would be required to support this type of initiative, and immersive data provides a complete and authentic glimpse into nursing culture.

Questions

Several questions arose throughout data analysis. If medical-surgical nursing is a subculture of nursing, what roles do nurses assume within their miniature community? What concepts taught in nursing school relate to professional expectations? What role does age play in self-care vs. self-sacrifice? What is the lived experience of a seasoned nurse in a high-turnover unit? At what point does feeling burned out translate to turnover? How is a nurses' perception of work environment different from the administration's perception of the work environment? What is *nursing*? Why are self-needs less important in caretaking professions than other fields? What would the role of a professional nurse advocate look like?

<center>Researcher Reflection</center>

Bias

The researcher carried some bias as a nurse herself. Although the researcher had no experience working in the medical-surgical environment, many of her colleagues had. These professional relationships lead to prior conversations about experiences in the medical-surgical environment. The researcher, therefore, had heard accounts of medical-surgical nursing. Biases were explored in a reflective journal throughout data collection. This journal was shared with the researcher's dissertation chairperson for reflexivity.

Influence

The researcher was purposeful in avoiding behavior prompts. If a nurse left the unit, the researcher would ask where they went upon return. Researcher follow-up may have impacted future behaviors in the nurses because they knew they would be asked where they went. Many nurses asked the researcher questions about the project. The researcher responded with a uniform answer each time and did not disclose specific research questions.

Impact

The participants in this research had a great impact on the researcher. Novice nurses in such a high-stress environment require bravery and resilience. Participants were open and candid with the researcher from the first day of data collection. They trusted the immersion process and wanted to share their experience and culture with the researcher. Participants were appreciative of nurse-focused research being conducted in their hospital and on their unit. Lastly, data analysis yielded interesting new findings. The researcher came away with future research ideas and more passion for improving the medical-surgical nursing environment. Changes in nursing culture place the control back into the nurse's hands. This power fosters hope and promise. Evidence of cultural evolution was identified in data collection, which means the work has already begun to redefine nursing. This doctoral research laid the groundwork for future studies by the researcher.

<div align="center">Concluding Statement</div>

In conclusion, this research provides a glimpse into the subculture of medical-surgical nursing. Days are filled with tasks and patient needs which receive priority over nurses' needs. Nurses have long been portrayed as weary, hungry, or variations of the

like. While this imagery is not far from the truth, evolution has begun. Nurses found a way to minimize self-sacrifice through collective self-care. In caring for each other, they cared for themselves. Although martyr behavior was uncommon, martyr portrayal was noted in field and interview data. Nurses must collectively reject verbiage that fails to empower the profession. Data creates more questions than answers. Future inquiry may help researchers understand why the martyr stereotype persists while other nurse stereotypes dissolve. Finally, the data concluded in this research provides hope in professional evolution. With continued qualitative insight into nursing culture and other nurse-focused research, problems like turnover and burnout may improve. Positive changes in nursing culture also benefit patient care. Like collective caretaking helps the nurse, cultural awareness has the ultimate capacity to improve both nurses' and patients' experiences.

Nurses have limitless potential as a critical and influential component of the medical field. Cultural self-awareness can only channel this power and propel the nurse metaparadigm to new heights. Self-care is just a starting point. New research should seek to dissect every facet of nursing culture to better navigate the future. Conceptual exploration in future research seeks to redefine what it means to be a nurse.

APPENDIX A – Interview Protocol

The following interview protocol is adapted from Creswell (2014) and follows the Patton model (1990) with probing questions derived from Polit and Beck (2012).

Date: _____

Location: Telephone interview (off-site)

Interviewer: Elise Jordan Juergens

Interviewee: _____

Demographics:

Age: ____

Education level: _____

Gender: _____

Years in practice: _____

Instructions: The following telephone interview will last approximately 30 minutes and will consist of 6 open-ended, semi-structured questions. Probing sub-questions may emerge as the interviewer deems necessary. The entire interview will be audio-recorded and safeguarded to protect confidentiality. The interview will not occur during any work shift or on hospital property. Please answer questions honestly and to the best of your ability. As a reminder, the interviewee may refuse to answer any questions that they deem inappropriate or stress-inducing although completion of the entire interview is optimal for research quality.

Interview Questions:

1. **Icebreaker***:* Can you give me a quick summary of your nursing background and how you came to work in med-surg?

2. **Behavior/Experience question:** I observed that the majority of unit nurses did not take fully allotted meal breaks or use the restroom much during shifts or did so after repeated prompting from the charge nurse. Can you describe some ways in which you independently take care of yourself at work?

   Probing questions:

   a. Could you give me an example?

   b. Go on.

3. **Opinion/Value Question:** In your opinion, why do you think nurses burn out on med/surg?

   Probing questions:

   a. Are there any other reasons?

   b. How so?

   c. Could you explain that?

4. **Feeling Question:** How do you feel about nurses' tendencies towards self-care or self-sacrifice on the floor?

   Probing questions:

   a. Why do you think that is?

5. **Knowledge Question:** How do you think nursing culture influence nurses' behavior? In other words, how do you think unspoken norms among nurses as a group influence nurses' individual behavior?

Probing questions:

a. Go on.

b. Could you explain that?

6. **Sensory Question:** How do you feel physically at the end of your shift?

Probing questions:

a. How so?

b. Is there anything else?

In conclusion: This concludes our interview. I want to thank you for participating in this meaningful, nurse-centered research. Your sincerity and truthfulness is greatly appreciated and will add immense value to the data.

████████████████

Patient Care Services—Research Committee

RESEARCH PROPOSAL LETTER OF AGREEMENT

TO: **Elise Juergens**
FROM: Research Committee
RE: Proposed project/study entitled: **"Self-care vs. Self-sacrifice in Medical Surgical Nursing Culture: A Critical Ethnography"**

On 5/8/2018 your research project/study proposal was approved by the Nurse Practice Council to be conducted within Patient Care Services at ████████████ You are free to proceed with your project/study within the following guidelines:

1. You are required to complete an online non-employee orientation that is administered though our Education Department (601-288-2677).
2. A *Non-Employee Confidentiality and Nondisclosure Agreement* must be signed during the online orientation process.
3. Any modifications to this approved study must be re-routed to the Research Committee. All activity on this project must stop until you are notified by the Research Committee Chair of Committee's decision regarding proposed changes
4. Data Collection Period: June 2018
5. Inform Research Chair when data collection is initiated and when completed (via e-mail)
6. Provide results of study to committee (may provide presentation or written documentation of findings)

Sincerely,

████████████████

I, Elise Juergens _____, have reviewed the above guidelines and agree to comply with the terms of this *Research Proposal Letter of Agreement*.
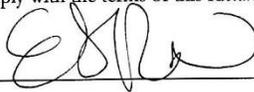
Signature:_____ Date: 5/29/18

Facility/School/Other Association: USM College of Nursing

THE UNIVERSITY OF SOUTHERN MISSISSIPPI

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.5997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 18051701
PROJECT TITLE: Self-Care VS Self-Sacrifice in Medical-Surgical Nursing Culture: A Critical Ethnography
PROJECT TYPE: Doctoral Dissertation
RESEARCHER(S): Elise Jordan Juergens
COLLEGE/DIVISION: College of Nursing
DEPARTMENT: School of Leadership and Advanced Nursing Practice
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL: 05/23/2018 to 05/22/2019
Edward L. Goshorn, Ph.D.
Institutional Review Board

3-16-18

To those responsible for granting permission for Elise Jordan to collect data necessary for her dissertation study.

Elise has my permission to use my Nurse Codependency Questionnaire, or any of its subscales, as part of her research methods.

Feel free to contact me if I need to provide further information to allow her to be able to proceed.

Sarah Allison-Kolb, RN, P/MHNP, Ph.D, author of the NCQ

512-773-4298\

Sarah.allison@gmail.com

Austin, TX

REFERENCES

Abdulrehman, M. S. (2017). Reflections on native ethnography by a nurse
   researcher. *Journal of Transcultural Nursing*, *28*(2), 152-158.

Academy of Medical-Surgical Nurses. (2018). *What is medical-surgical nursing*?
   Retrieved from https://www.amsn.org/practice-resources/what-medical-surgical-
   nursing.

Allison, S. (2004). Nurse codependency: instrument development and validation. *Journal
   of Nursing Measurement*, *12*(1), 63-75.

American Nurses Association. (2018). *What nurses do*. Retrieved from
   http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-
   Need/RNsAPNs.html

Batch, M., & Windsor, C. (2015). Nursing casualization and communication: a critical
   ethnography. *Journal of Advanced Nursing*, *71*(4), 870-880.

Bélanger, J. J., Caouette, J., Sharvit, K., & Dugas, M. (2014). The psychology of
   martyrdom: Making the ultimate sacrifice in the name of a cause. *Journal of
   Personality and Social Psychology*, *107*(3), 494.

Bjoernsdottir, K. (2001). Language, research, and nursing practice. *Journal of Advanced
   Nursing*, *33*(2), 159-166.

Boas, F. (1902). The Bureau of American Ethnology. *Science*, *16*(412), 828-831.

Bridges, J. M. (1990). Literature review on the images of the nurse and nursing in the
   media. *Journal of Advanced Nursing*, *15*(7), 850-854.

Brooks, I., & MacDonald, S. (2000). 'Doing life': gender relations in a night nursing sub-
   culture. *Gender, Work & Organization*, *7*(4), 221-229.

116

Center for Advanced Research on Language Acquisition. (2018). University of

    Minnesota. Retrieved from http://carla.umn.edu/culture/definitions.html.

Cialdini, R. B., & Kenrick, D.T. (1976.) Altruism as hedonism: A social development

    perspective on the relationship of negative mood state and helping. *Journal of*

    Personality and Social Psychology. 34(5), 907-914.

Cimiotti, J. P., Aiken, L. H., Sloane, D. M., & Wu, E. S. (2012). Nurse staffing, burnout,

    and healthcare-associated infection. *American Journal of Infection Control*, *40*(6),

    486-490.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five*

    approaches (3rd ed.) Los Angeles, CA: Sage Publications.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods*

    approach (4th ed.). Los Angeles, CA: Sage Publications.

Dahl, M. (1991). Nurses: an image change still needed. *International Nursing Review*,

    39(4), 121-3.

Deegan, M. J. (2001). The Chicago school of ethnography. *Handbook of Ethnography*,

    11-25.

Eckberg, D. L., & Hill Jr, L. (1979). The paradigm concept and sociology: A critical

    review. *American Sociological Review*, 925-937.

Fealy, G. M. (2004). 'The good nurse': visions and values in images of the nurse. *Journal*

    of Advanced Nursing, *46*(6), 649-656.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-

    care. *Journal of Clinical Psychology*, *58*(11), 1433-1441.

117

Frazer, J. G. (1890). *The golden bough*. Retrieved from https://celticearthspirit.co.uk/wp-content/uploads/2017/09/Golden-Bough.pdf.

Freire, P. (1970). *Pedagogy of the oppressed* (30th-anniversary ed.). New York, NY: Continuum.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues*, *30*(1), 159-165.

Gauchat, G., Kelly, M., & Wallace, M. (2012). Occupational gender segregation, globalization, and gender earnings inequality in US metropolitan areas. *Gender & Society*, *26*(5), 718-747.

Gillen, S. (2014). Unhealthy lifestyles adversely affect nurses' ability to deliver quality care. *Nursing Standard*, *28*(29).

Graves, R. (1955). *The Greek Myths. Vol. 1*. Baltimore, MD: Penguin.

Groesbeck, C. (1975). The archetypal image of the wounded healer. *Journal of Analytical Psychology*, *20*(2), 122-145.

Grove, S. K., Burns, N., & Gray, J. R. (2013). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (7th ed.). St. Louis, MO: Elsevier Saunders.

Hall, S. F., & Wray, L. M. (1989). Codependency: Nurses who give too much. *The American Journal of Nursing*, *89*(11), 1456-1460.

Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing*, *20*(9-10), 1413-1422.

Ibarra, H. (1999). Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly*, *44*(4), 764-791.

Jennings, B. M. (2008). Work stress and burnout among nurses: Role of the work environment and working conditions in *Patient Safety and Quality: An Evidence-based Handbook for Nurses, 2,* 137-158.

Kalisch, B. J., Begeny, S., & Neumann, S. (2007). The image of the nurse on the internet. *Nursing Outlook, 55*(4), 182-188.

Kalisch, P. A., & Kalisch, B. J. (1982). Nurses on prime-time television. *AJN The American Journal of Nursing*, *82*(2), 264-270.

Kashani, M., Eliasson, A., Chrosniak, L., & Vernalis, M. (2010). Taking aim at nurse stress: a call to action. *Military Medicine, 175,* 96-100.

Kovner, C., Brewer, C. Fairchild, S., Poornima, S., Kim, H., & Djukic, M. (2007.) Newly licensed RNs' characteristics, work attitudes, and intentions to work. *The American Journal of Nursing*, *9*(107), 58-71.

Lauzen, M. M., Dozier, D. M., & Horan, N. (2008). Constructing gender stereotypes through social roles in prime-time television. *Journal of Broadcasting & Electronic Media*, *52*(2), 200-214.

Lee, H. Y., Hsu, M. T., Li, P. L., & Sloan, R. S. (2013). 'Struggling to be an insider': a phenomenological design of new nurses' transition. *Journal of Clinical Nursing*, *22*(5-6), 789-797.

Levine, M. (1969). The pursuit of wholeness. *The American Journal of Nursing*, *69*(1), 93-98.

Levine, M. (1971). Nurses, nursing, and the changing community. In *Renewal for nursing*. Philadelphia, PA: F.A. Davis.

MacKusick, C. I., & Minick, P. (2010). Why are nurses leaving? Findings from an initial

    qualitative study on nursing attrition. *Medsurg Nursing*, *19*(6), 335.

Madison, D. S. (2005). *Critical Ethnography: Method, ethics, and performance.*

    Thousand Oaks, CA: Sage Publications.

Mahon, P., & McPherson, G. (2014). Explaining why nurses remain in or leave bedside

    nursing: a critical ethnography. *Nurse Researcher*, *22*(1), 8.

Manias, E., & Street, A. (2001). Nurse–doctor interactions during critical care ward

    rounds. *Journal of Clinical Nursing*, *10*(4), 442-450.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370.

Matheson, L. K., & Bobay, K. (2007). Validation of oppressed group behaviors in

    nursing. *Journal of Professional Nursing*, *23*(4), 226-234.

McHugh, K. (2012). Nurse Jackie and the politics of care. *Nursing Outlook*, *60*(5), S12-

    S18.

Mealer, M., Burnham, E. L., Goode, C. J., Rothbaum, B., & Moss, M. (2009). The

    prevalence and impact of post-traumatic stress disorder and burnout syndrome in

    nurses. *Depression and Anxiety*, *26*(12), 1118-1126.

Nahm, E. S., Warren, J., Zhu, S., An, M., & Brown, J. (2012). Nurses' self-care behaviors

    related to weight and stress. *Nursing Outlook*, *60*(5), e23-e31.

Nursing Solutions Inc. (2016). National healthcare and RN retention report. Retrieved

    from

    https://avanthealthcare.com/pdf/NationalHealthcareRNRetentionReport2016.pdf.

O'Connor, K. E. (2008). "You choose to care": Teachers, emotions, and professional

    identity. *Teaching and Teacher Education*, *24*(1), 117-126.

Oladele, D., Richter, S., Clark, A., & Laing, L. (2012). Critical ethnography: A useful

    methodology in conducting health research in different resource settings. *The*

    Qualitative Report, *17*(39), 1-21.

Pask, E. J. (2005). Self-sacrifice, self-transcendence and nurses' professional

    self. *Nursing Philosophy*, *6*(4), 247-254.

Patton, M. (1990). *Qualitative Evaluation and Research Methods.* Thousand Oaks, CA:

    Sage Publications.

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence*

    for nursing practice. Philadelphia, PA: Wolters Kluwer/Lippincott Williams &

    Wilkins.

Radcliffe-Brown, A. R. (1933). *The Andaman Islanders*. New York, NY: Cambridge

    University Press.

Ratanawongsa, N., Wright, S. M., & Carrese, J. A. (2007). Well-being in residency: a

    time for temporary imbalance? *Medical Education*, *41*(3), 273-280.

Rescorla, R. (1988). Pavlovian conditioning: It's not what you think it is. *American*

    Psychologist, *43*(3), 151-160.

Schein, E. H. (1978). *Career dynamics: Matching individual and organizational*

    needs (Vol. 6834). Boston, MA: Addison Wesley Publishing Company.

Schultz, W. (2002). Getting formal with dopamine and reward. *Neuron*, *36*(2), 241-263.

Shimizutani, M., Odagiri, Y., Ohya, Y., Shimomitsu, T., Kristensen, T. S., Maruta, T., &

    Iimori, M. (2008). Relationship of nurse burnout with personality characteristics

    and coping behaviors. *Industrial Health*, *46*(4), 326-335.

Sökefeld, M. (1999). Debating self, identity, and culture in anthropology. *Current Anthropology*, *40*(4), 417-448.

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, *12*(3), 259-280.

Stamm, B. H. (2005). *The professional quality of life scale: Compassion satisfaction, burnout and compassion fatigue/secondary trauma scales*. Pocatello, ID: Idaho State University.

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, *63*(3), 224-237.

Street, A. F. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Albany, NY: SUNY Press. Retrieved from https://books.google.com/books?id=cEFPp4sGgYYC&lpg=PR9&ots=bn91LCBO 4T&lr&pg=PR9#v=onepage&q&f=false.

Thomas, J. (1993). *Doing critical ethnography* (Vol. 26). Newbury Park, CA: Sage Publications.

Walker, L. O., & Avant, K. C. (2011). Concept analysis. (5th ed.) *Strategies for theory construction in nursing* (pp. 157-176). Upper Saddle River, NJ: Prentice Hall.

Weaver, R., Salamonson, Y., Koch, J., & Jackson, D. (2013). Nursing on television: student perceptions of television's role in public image, recruitment, and education. *Journal of Advanced Nursing*, *69*(12), 2635-2643.

Weiss, M. E., Yakusheva, O., & Bobay, K. L. (2011). Quality and cost analysis of nurse

    staffing, discharge preparation, and post-discharge utilization. *Health Services*

    Research, *46*(5), 1473-1494.

Yu, L., Yang, X., Lu, Z., & Yan, Z. (2014). Effects of subliminal affective priming on

    occupational gender stereotypes. *Social Behavior and Personality: an*

    International Journal, *42*(1), 145-153.